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# Implying implausibility and undermining versus accepting peoples' experiences of suicidal ideation and self-harm in Emergency Department psychosocial assessments

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## Conflict of interest statement

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest

## Author contribution statement

RM and CB led on conception of the study, with input from all authors. Data were collected by RM. Data analysis was led by CB and all authors participated in data analysis. CB wrote the first draft of the manuscript with sections written by LB and RM. RM and CB led on manuscript revision with all authors contributing to manuscript revision.

## Keywords

Suicide, Clinical communication, Risk Assessment, Mental Health, Crisis care, Emergency Department (ED), Conversation analysis (CA)

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## Abstract

Word count: 350

Background
Patients seeking emergency care for self-harm and suicidality often report they are not believed or taken seriously and there is increasing interest in the concept of epistemic injustice in mental health contexts. Communication practices implying implausibility in a person's story or undermining their experience have been identified outside healthcare settings e.g., courtrooms where they are used to contest and recharacterize a person's experience.

Aims
To investigate communication practices in Emergency Department (ED) psychosocial assessments that may (1) undermine, imply implausibility and recharacterize or (2) accept peoples' experiences of suicidal ideation and self-harm.

Method
We micro-analysed practitioner-patient communication in 5 video-recorded psychosocial assessments with people presenting to the ED with self-harm or suicidal ideation, and conducted supplementary analysis of participants' medical records and post-visit interviews. We describe 3 negative cases where accounts were not accepted and undermined/recharacterized and 2 positive cases where accounts were accepted.

Results
In the negative cases, practitioners undermined peoples' experiences of suicidality/self-harm by: not acknowledging or accepting the person's account; asking questions that implied inconsistency or implausibility; juxtaposing contrasting information to undermine the account; asking questions that asserted a different characterization; and resisting or questioning the person's account. Multiple practices across the assessment built on each other to assert that the person was not suicidal, did not look or act like they were suicidal; that the person's decision to attend the ED was not justified; and that self-harming behaviours were not that serious and should be in the person's control. These alternative characterizations were used to justify decisions not to provide further support or referrals to specialist services. In other cases, communication practices were used to acknowledge, accept and validate suicidality/self-harm and introduce a shared understanding of experiences that patients found helpful.

Conclusions
These findings advance our understanding of how peoples' experiences are undermined, a phenomenon which has been reported by patients, leads to further deterioration in their mental health and can discourage future help-seeking even when very unwell. Conversely, acknowledging, accepting and validating suicidality/self-harm and introducing a new way of understanding peoples' experiences generates shared understanding and may reduce epistemic injustice in mental healthcare interactions.

## Contribution to the field

In the UK, patients seeking emergency care for self-harm and suicidality often report that they are not believed or taken seriously. However, very little is known about what happens on the ground in these encounters. Drawing on a collection of video-recorded Emergency Department (ED) psychosocial assessments, we identify specific communication practices that may work to undermine and recharacterize patient's suicidal crises as 'less risky'. Through this analysis, we explore the connections between the Philosophical concept of Epistemic Injustice and the Socio-Linguistic concepts of Epistemic Status and Epistemic Stance.

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## Ethics statements

### Studies involving animal subjects

Generated Statement: No animal studies are presented in this manuscript.

### Studies involving human subjects

Generated Statement: The studies involving human participants were reviewed and approved by London Central Research Ethics Committee (17/LO/1234). The patients/participants provided their written informed consent to participate in this study.

### Inclusion of identifiable human data

Generated Statement: No potentially identifiable human images or data is presented in this study.

## Data availability statement

Generated Statement: The datasets presented in this article are not readily available because Patient privacy restrictions. Requests to access the datasets should be directed to Not Applicable.

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**Implying implausibility and undermining versus accepting peoples' experiences of suicidal ideation and self-harm in Emergency Department psychosocial assessments**


## Structured Abstract

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In review

These findings advance our understanding of *how* peoples' experiences are undermined, a phenomenon which has been reported by patients, leads to further deterioration in their mental health and can discourage future help-seeking even when very unwell. Conversely, acknowledging, accepting and validating suicidality/self-harm and introducing a new way of understanding peoples' experiences generates shared understanding and may reduce epistemic injustice in mental healthcare interactions.

## Introduction

Self-harm and suicide are public health priorities worldwide (WHO 2021; NHS 2019). In the UK, one in five adults has experienced suicidal thoughts (McManus et al 2014) and one in sixteen has self-harmed (McManus et al 2019). Yet some people seeking mental health treatment report they are not believed, and experiences (e.g., of suicidality) are not taken seriously by healthcare practitioners (Clarke et al 2007; Buston 2002; Cereal et al 2006; Wadman et al 2018). Disclosures of suicidality and self-harm may also be taken less seriously for certain groups of people, such as women and older adults nearing the end of life (Kjølseth & Ekberg 2012; Lindgren et al 2004). Interactions with healthcare practitioners can shape peoples' perceptions of whether they need and deserve medical attention (Liberati et al 2022). People describe a fear of being seen as 'faking' or 'just wanting attention' as a major barrier to seeking mental health care (Dixon-Ward & Chan 2022).

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The fields of Philosophy and Sociology have theoretical and empirical tools for unpacking how peoples' experiences are downplayed, dismissed, and disbelieved. In the field of Philosophy, there has been increasing interest in the notion of *epistemic injustice,* which includes testimonial and hermeneutical injustice (Fricker 2007). According to the notion of *testimonial* injustice, a person's reports are dismissed or challenged because a feature of the person's identity triggers a negative stereotype, which leads to denying credibility and authority to that person as a knower. In other words, the person is thought to be unreliable in producing or sharing knowledge and thus the person's reports are overlooked, even when these are reports of the person's own experience. Examples would be discounting a woman's suggestions on how to conduct an experiment in a lab due to the stereotype that women are not good at science; or discounting a teenage patient's report that they feel suicidal due to the stereotype that teenagers are overly dramatic.

Another aspect of epistemic injustice is hermeneutical injustice. This is where a person is denied the conceptual resources to understand their own experience (see Lee et al 2018). An example would be how women who live in a misogynistic society in which the concepts of sexual harassment or domestic abuse are not available, lack the opportunity to understand their own adverse experiences as experiences of harassment and abuse.

Although the original notion of epistemic injustice has been developed to explain power asymmetries in social interactions due primarily to sexism and racism, the phenomena described have been recently applied to the mental health context, where negative stereotypes can be associated with people seeking mental health treatment or with those diagnosed with mental illness (Scrutton 2017). For instance, when reporting their own experiences, people may not be taken seriously due to having a history of psychotic symptoms (Houlders et al 2021). In this case, they are not credited with the capacity to understand and share their experiences.

Epistemic injustice provides a conceptual framework to explore how peoples' experiences of self-harm and suicidality are discussed in mental healthcare settings. This framework can be paired with empirical tools drawn from the field of Sociology and the study of *epistemics* in interaction, i.e., the study of how

knowledge is claimed, contested and negotiated in interpersonal communication (Heritage 2012a; 2012b). One area of sociological research, Conversation Analysis, has used microanalysis of naturally occurring video-recorded social interactions to study this topic in depth (Heritage 2011, 2012a, 2012b; Heritage & Raymond 2005; Stivers, Mondada, & Steensig 2011; Mondada 2013; Lindström & Weatherall 2015).

In interpersonal communication, speakers continually mark levels of knowledge about a topic relative to one another (Heritage 2012). For example, asking a question ("How are you feeling?") can mark a lower level of knowledge on the topic (how they feel), relative to the person being asked. Similarly, asserting information ("I've been feeling really down.") can mark greater knowledge relative to the person being spoken to. Relative knowledge shifts constantly in interaction depending on the topic being discussed (Heritage 2012; Heritage 2012). For example, a healthcare practitioner might indicate they have more knowledge relative to the patient about what medication is appropriate to prescribe.

Sociologists distinguish between epistemic *status* and epistemic *stance* (Heritage 2012). Epistemic status involves *expectations* of knowledge, based on roles, e.g., doctor/patient, teacher/student, and experiences such as having studied a topic or having witnessed an event (Fig 1). For example, a teacher would typically be expected to know more about the topic of a lesson relative to a student. Similarly, a doctor would be expected to know more about diagnosis than a patient. This would mean that the teacher/doctor had a higher *epistemic status* than the student/patient on that topic. While a doctor would have higher epistemic status than a patient with respect to diagnosis, a patient would have higher epistemic status than a doctor on their experiences and emotions.

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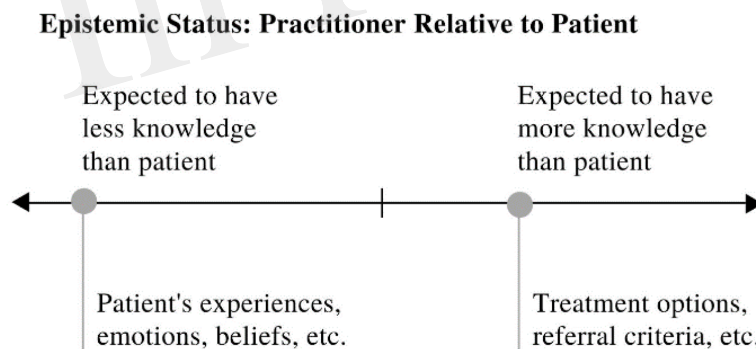


Fig. 1: Linear representation of epistemic status with illustrative examples

In contrast, epistemic stance involves *communication* of knowledge (Fig 2). For example, when a teacher corrects a student, they take a higher epistemic stance, or implicitly communicate that they know more about that topic relative to the student. Similarly, when a doctor *informs* a patient of their diagnosis, they take a higher epistemic *stance* on the topic of that diagnosis.

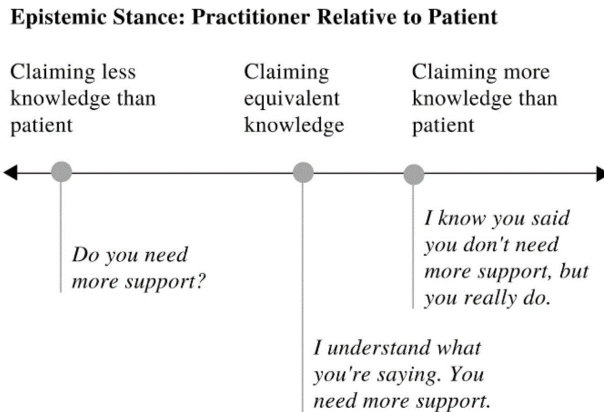


Fig. 2: Linear representation of epistemic stance with illustrative examples

In social interaction outside of institutional contexts, people have primary rights to know and report on their subjective experiences (Heritage 2011). In healthcare interactions, patients typically have primary epistemic rights to know and report on their experience of symptoms while healthcare practitioners hold primary epistemic rights over diagnosis and treatment options (Heritage & Robinson 2006, Peräkylä 1998, 2002). Communication practices can be used to undermine peoples' accounts of their experience. For example, there is a large body of literature examining communication practices in courtroom and police settings that seek and use evidence to undermine peoples' accounts (see Drew 1992; Antaki 2013; Stokoe et al 2020; Jol & van der Houwen 2014). For example, police questions may subtly imply inconsistency or implausibility e.g., "Didn't you just say that you were at home that evening?" (Stokoe et al 2020; Drew 1992) or indicate objection or disagreement e.g., "But how could you have known that?" (Jol & van der Houwen 2014). In political discourse and mass media, communication practices are used that contribute to a subtle erasure and rewriting of a person's experience (see Heritage 2010; Clayman 2002; Waring 2005). For example, politicians may repeatedly assert unsubstantiated information about other people (Heritage 2010), or newscasters may assume or presuppose a different characterization of events in interviews (Heritage 2010, Clayman 2002).

There is little research on epistemic communication practices in a mental health context where subjective experiences are the basis of psychiatric diagnosis. As there are typically no physical tests or investigations involved, mental health practitioners ask patients about their mood, thoughts, feelings, behaviours and physical symptoms. Suicidal ideation involves thoughts and feelings of not wanting to live. Meanwhile, self-harm refers to intentional self-poisoning or injury, irrespective of the apparent purpose (NICE 2022). Self-harm can take many forms, including cutting, overdoses, burning and hitting oneself. When patients present with suicidal ideation or self-harm, practitioners explore their feelings, thoughts, behaviours and intent if they have harmed themselves. There is no objective measure of suicidal ideation or intent underlying self-harm. This is explored and negotiated by practitioners and patients in interaction.

When presenting to the Emergency Department with suicidal ideation and self-harm, people report that they are not believed or their experiences are not taken seriously (Clarke et al 2007; Buston 2002). Hence, the aim of this study was to micro-analyse communication about suicidal ideation and self-harm in video-recorded psychosocial assessments in the Emergency Department to investigate communication practices in Emergency Department mental health encounters used to (1) accept peoples' experiences of suicidal ideation and self-harm or (2) undermine, imply implausibility and recharacterize these experiences.

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## Methods

The study involved detailed analysis of six video-recorded Emergency Department (ED) psychosocial assessments for self-harm and suicidal ideation, participating patients' medical records, and post-visit patient interviews. Self-harm was defined as intentional self-poisoning or injury, irrespective of the apparent purpose (NICE 2022).

Ethics: The study was developed in collaboration with a lived experience group and obtained ethical approval from London Central Research Ethics Committee (17/LO/1234).

### *Video Data and Participants*

After presenting to the ED, participants were assessed by medical staff in the ED and had their medical needs addressed before being referred for a psychosocial assessment with the ED Liaison Psychiatry team (NCCMH 2004). The psychosocial assessment involved an assessment of needs and risks, including the risk of harm to self and determined whether the person will be admitted or discharged along with support required from other community based services.

Consent: Before the psychosocial assessment, patients were approached by a liaison psychiatry practitioner who assessed capacity to give informed consent and asked if the person would be willing to speak to a researcher. There was a multi-step consent procedure due to people presenting in a mental health crisis. If patients agreed to be approached, a researcher explained the study and obtained written informed consent before the psychosocial assessment. The practitioner re-affirmed consent during the assessment, and the researcher obtained re-affirmation of consent 1-2 weeks after the assessment.

Data: Data were from three sources (1) a corpus of 46 video-recorded Liaison Psychiatry psychosocial assessments collected between September 2018 and April 2019 in an ED in England (see Xanthopoulou et al., 2021; Bergen & McCabe, 2021). Two GoPro cameras were placed in the assessment room and the assessment was recorded with no researcher present. (2) Each patient's ED medical records including the written risk assessment and patient care notes were obtained after the assessment. (3) Patient participants were interviewed two weeks and three months after the assessment. A semi-structured interview explored patients' thoughts about the assessment and their health and treatment after the assessment.

Detailed notes were taken summarising the content of all video-recorded assessments. These notes were reviewed to identify assessments in which the practitioner did not accept the patient's description of their experience (e.g., of suicidal thoughts) and introduced an alternative characterization. Three assessments were selected as having particularly clear and recurring examples of this phenomena. Two comparison cases were then selected to show how practitioners accepted peoples' experiences. Ultimately, this paper focuses on 5 assessments: 3 assessments in which the patient's experiences were recharacterized by the practitioner and 2 assessments in which the patient's experiences were accepted by the practitioner.

Patients presented with suicidal ideation (N=3) or after a suicide attempt (N=2). Patients identified as white British (N=4) and Indian (N=1), male (N=2) and female (N=3), and were aged between 18-55. Five Psychiatric Liaison Practitioners (PLPs) participated: 2 were mental health nurses, 2 were occupational therapists, and one was a social worker. PLPs identified as white British (N=4) and African (N=1), male (N=2) and female (N=3), and were aged between 40-60.

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***Data Analysis***

Video recordings: Conversation Analysis (Sidnell and Stivers, 2013) was used to analyse verbal and nonverbal communication. We sought to identify when a person's experiences are not acknowledged or accepted and the specific communication practices that are then used to subtly recharacterize a person's description of their experience. We analysed communication practices over the course of an assessment as individual practices may not immediately be seen as recharacterizing the person's experiences but multiple practices over the course of an assessment could be hearable as seeking and using evidence to discredit a person's characterization of their experience and introduce an alternative characterization.

We draw on conversation analytic findings from police, courtroom, and political settings to identify these practices. Data were also presented and discussed in data sessions to (1) a diverse group of five people with experience of receiving professional support for mental health and suicidal thoughts, and (2) a multidisciplinary group of six professionals from psychiatry, psychology, and philosophy.

We analysed practitioner-patient talk about suicidal ideation and self-harm. We focused in particular on patient responses indicating lack of agreement with the practitioner's questions including: explicit disagreement; correcting the practitioners' talk and more subtle signs of patient disengagement including silence, minimal responses, quiet or flat voice quality, reduced eye contact, and not contributing to the forward progression of the assessment, i.e., not answering questions or sharing information to facilitate the practitioner conducting the assessment (see Peräkylä et al 2021).

A range of communication practices were identified in this data. The main practices are listed in Table 1 and discussed in detail using data extracts below.

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| **Communication Practice** | **Studies in Other Settings** | **Examples (Hypothetical, Simplified)** |
|---|---|---|
| **Not accepting or acknowledging** a person's characterization of events | Marquez-Reiter et al 2018 | Pat: I'm feeling suicidal.<br>Pra: **[writing notes, no response]** |
| Question **implies inconsistency or implausibility** | Stokoe et al 2020 | Pat: I'm feeling suicidal.<br>Pra: **Didn't you tell your General Practitioner** you were coping okay? |
| Question **embodies a compromising respons**e that could be used against the person's characterization | Drew 1992 | Pat: I'm feeling suicidal.<br>Pra: But you've felt like this before and **you got through it, right?** |
| Statement **juxtaposes information** that may undermine characterization or strengthen argument for alternative characterization | Drew 1992 | Pat: I'm feeling suicidal.<br>Pra: **You said** you were coping okay before, and **now you're saying** you feel suicidal. |
| **Asserting an alternative** characterization (sometimes repeatedly) | Heritage 2010<br>Clayman 2002 | Pat: I'm feeling suicidal.<br>Pra: But overall **you've been coping okay**. |

| **Questioning or resisting** a person's characterization of events | Waring 2005 | Pat: I'm feeling suicidal.<br>Pra: **Really?** |
|---|---|---|

Table 1. Communication practices used to recharacterize patients' experiences

Medical records: Risk assessments and notes entered after the assessment in the medical records were reviewed to identify how practitioners described the patient's account of their suicidal thoughts/feelings and self-harm.

Patient Interviews: Two week and three month post-visit patient interviews were reviewed for patients' perspectives on the assessment and interaction with the practitioner. Patient quotes are provided.

## Findings

### *NEGATIVE CASES*

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We present 5 cases in-depth: 3 negative and 2 positive cases. Practitioners used specific communication practices to recharacterize and downplay patients' descriptions of their experiences. In each case, multiple communication practices built on one another to support an alternative characterization. In this section, we explore how this evidence is built across each psychosocial assessment and where the patient's primary epistemic rights to know and describe their subjective experience is undermined across 3 cases.

### *Case 1 Patrick: Recharacterizing the patient's experiences of misery, feeling suicidal and undermining a decision to seek help in the ED*

Patrick was brought to the Emergency Department by his university counselling service after he disclosed thoughts of suicide. Here, we examine brief extracts from Patrick's video-recorded psychosocial assessment and three-month post-visit interview. At the start of the assessment, Patrick confirmed that he was "feeling suicidal" (transcript not shown) and described feeling fearful that he would end his life if he left his flat (see Extract 1).

**Extract 1**

1 PR: What would have happened if you had gone for a walk.
2 PT: I don't kno:w.=I think, (2.0) I hadn't thought that far ahead,
3 PR: Mm.=
4 PT: =but li:ke (2.0) I was just- I figured, **if I leave here it's**
5 **the e:nd. I'm gonna kill myself.** So.

Later, after Patrick describes his experience, the practitioner asks what happened when the university counselling service got involved (transcript not shown). Patrick's answer is shown in Extract 2 (lines 51-3).

**Extract 2**

51 PT: We had a conversation: and then (.) >they spoke about the<
52 possibility of going to hospital,=and I tho:ught, prob'ly a

53      good idea.
        ...
61 PR: So they spoke about that possibil- What (.) From your point-
62      What made them think that um
63      (1.0)
64 PR: 'Cause they're- they see you because of mental health
65      reaso:ns, (.) and **what made them think that their i:nput**
66      **wouldn't be he:lpful for you.**
67      (0.5)
68 PR: **an:d that it would be helpful for >you to come to hospital.<**
69      from your point of [view.
70 PT:                    [They're not- They're not- I dunno. They're
71      not trained in any of this kind of stuff. They're kind of .hh
72      the go: between. Between (.) different places. And they
73      thought. (.) They'd be- I think- I think- >I mean I don't
74      know< for certain because I didn't ask them.
75 PR: Mm.
76 PT: But I think they tho:ught that (.) it would be good for me to
77      speak to someone (.) who knew what they were on about.
78 PR: .hh I see. **So they felt that they didn't have the- enough**
79      **trai:ning [to- to to talk to you and reassure you.**
80 PT:            [Yeah.
81 PT: Mhm.

Patrick initially characterises his decision to attend the Emergency Department as a "good idea" prompted by a recommendation from a university counsellor (lines 51-53). The practitioner does not agree and instead asks a follow-up question (lines 61-69) indicating that it is not clear why it would be helpful for Patrick to come to hospital, and why his problems could not be addressed by the university counselling service. This introduces a potential alternative characterization, that attending the Emergency Department was not a good idea.

Patrick shows difficulty responding; after multiple restarts and expressions of uncertainty (lines 70-74, 76-66), he provides justification for the counsellor's recommendation. The practitioner summarises the university counsellor didn't feel they had the training to "talk to you and reassure you" (lines 78-79). This implies that talking and reassurance should be enough to address Patrick's concerns, thereby positioning Patrick's concerns as not warranting further intervention.

When discussing the reasons underlying his suicidal thoughts, Patrick describes feeling miserable. In Extract 3 below, a second practitioner asserts that he is either not miserable at times or able to give the impression that he is enjoying things (lines 4-6) then implies that Patrick's facial expressions provide evidence for this alternative interpretation (line 8) (Antaki 2015) of Patrick's feelings.

**Extract 3**

1   PT: So I (.) feel like miserable kind of (.) sums it up,
2   PR: **And yet in your fa:ce, you [know=**
3   PT:                              [Yeah,
4   PR: **=when you're speaking. You've- You've got a variation. haven't**
5        **you. of- of your expressio:n,=and you know you smi:le and**
6        **things like that.**
7   PT: >Yeah,< ((no nonverbal response))
8   PR: **>So you have times< when you clea:rly (0.3) aren't miserable,**

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9          you're sort of enjoying things, or you're able to [give the
10 PT:                                                        [Mhm,
11 PR: impression [that you are enjoying thi:ngs,
12 PT:            [Yeah, ((small nod))
```

The practitioner does not accept Patrick's description of his emotions (feeling "miserable") at line 2. Instead, she cites his facial expressions ("you smile" lines 4-6) as evidence of an alternative interpretation; he has "times when" he isn't miserable (line 8) and is "enjoying things" (line 9). Presenting her observation of his demeanour (lines 4-6) as evidence that he is not always miserable, this challenges the patient's description of his emotional state (see Drew et al 2016; Stokoe et al 2020; Joel 2020).

The contrastive formulation (line 2) and assertion of the alternative interpretation that he is "enjoying things or able to give the impression that you are enjoying things" (lines 8-9), paired with a lack of acceptance at line 2 (e.g., *okay*), discount Patrick's characterization. Patrick responds minimally (lines 3, 7, 10), showing signs of disengagement (Peräkylä et al 2021) and passive participation, withdrawing from the conversation and not agreeing with the practitioner's interpretation "when you clearly aren't miserable, you're sort of enjoying things" in line 10 (Goodwin 1986) until after the practitioner self-corrects (lines 11-12).

In Extract 4, later in the same assessment, a different practitioner asks what plan Patrick would have had if he were not brought to the Emergency Department.

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**Extract 4**

```
47  PR: What- What plan would you have [had if you-
48  PT:                                 [I just- Well I've got a
49      few events on. 'Cause I'm part of rugby skiing and tennis.
50      And they were all putting events on tonight I couldn't go
51      to.
52  PR: I see. So could we safely say, you know. you wouldn't end
53      your life?
54      (1.0)
55  PR: Or something that would have=
56  PT: =What tonight?
57  PR: Yeah. [Y-
58  PT:       [I wouldn't have ended it toni:ght. ((shakes head))
59  PR: ((nods)) You wouldn't have. Okay. So maybe there was a bit
60       of miscommunication because they- they brought you he:re
61       because they were saying you were suicida:l, and=
62  PT: =No I ((nod)) am.=But [I-
63  PR:                       [You a:re.
64  PT: But I've- I feel I can (3.0) I mean I haven't done it yet,
65  PR: Mm. ((nods))
```

Patrick indicates he would have attended a sporting event, and the practitioner makes an inferential connection "So could we safely say…you wouldn't end your life" (Bolden 2007) implying that his answer provides evidence that he wouldn't end his life (lines 52-53) (see Antaki 2013). Patrick pushes back against the question by requesting clarification (line 56), giving a repetitional answer ("I wouldn't have") (Stivers & Hayashi 2010; Heritage & Raymond 2012), and qualifying that he wouldn't have ended it *that night*.

The practitioner repeats Patrick's statement without the qualification - sequentially deleting - "toni:ght" ("You wouldn't have") and makes another inferential connection ("So maybe…") (Bolden

2007). He asserts that it may have been a miscommunication when the university counselling center said Patrick was suicidal. Patrick immediately pushes back, asserting "I am", stating that he has not "done it yet" (lines 62, 64).

Across the course of the assessment, the two practitioners undermine the legitimacy of Patrick's decision to seek help (Extract 2) and recharacterize Patrick as 'not always miserable' (Extract 3) and 'not suicidal' (Extract 4). Ultimately, Patrick was advised to visit a self-help website and continue to access university counselling. Over the next three months, Patrick returned to the Emergency Department twice; once for suicidal ideation and once for a pharmaceutical overdose with suicidal intent. In his three-month post-visit interview, Patrick reported that he would not have gone to the Emergency Department again, but was brought back by university counselling services.

***Case 2 Laura: Recharacterizing the patient's experience of suicidal intent to justify no referral***

In Case 2, a practitioner rescharacterizes Laura's experience of suicidal ideation as brief and her act as impulsive. This is then used to justify a decision not to refer the patient to mental health services (anonymized). In contrast to impulsive acts of self-harm, practitioners treated premeditated suicide attempts as relatively more serious.

Laura was brought to the Emergency Department by ambulance after a pharmaceutical overdose. Earlier in the assessment, Laura said she visited her General Practitioner earlier in the day seeking mental health support but "they didn't help me" (transcript not shown). She reported that she later took a pharmaceutical overdose because she felt "very suicidal". She does not indicate that she took the overdose impulsively. In this section, we examine brief extracts from Laura's video-recorded psychosocial assessment and documents in her medical file, including a summary letter written for Laura's General Practitioner by the Liaison Psychiatrist.

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**Extract 6**

1 PR: And then >what was the< intention when you took the overdose.
2 What was=
3 PT: =To kill myse:lf,
4 PR: **To kill yourself. And then I hear that you called the**
5 **ambulance straight away? Or: 111,**
6 PT: N::o, I got- I got on the phone with 111 and then they got an
7 ambulance.
8 PR: For you.
9 PT: For- For- Yeah.
10 PR: **So when you called 111 what were you expecting them to do:.**
11 PT: All I expect- All I expected them to get an ambulance out to
12 me to be honest? That's [(the way it works,)
13 PR: **[A::h. So would you say you took the**
14 **tablets, at the spur of the moment,**
15 PT: Well I [took the tablets and then later
16 PR: **[Thinking I wanna end my li:fe,**
17 PT: on, I told [them how many tablets I had,
18 PR: **[And then-**
19 PR: **And then you got worried that you wanted to die, and then you**
20 **called them.=**
21 PT: =Yeah.

```
22 PR: So they would get you the [help. Is that
23 PT:                            [Yeah.
24 PR: how, [Is that how it worked,
25 PT:      [Sort of, yeah.
26 PR: Yeah okay.
27 PT: I sort of wanted to di:e,
28 PR: Yeah. ((nod))
29 PT: Sort of didn’t. Because I have the two kids to live fo:r,
       ... ((discuss family relationships))
51 PR: So it was a more of an impulsive thing, at the time,
52 PT: It was just I- I’d had enough. Of people like Kate picking
53     on me.
```

In response to the practitioner’s question at lines 1-2, Laura states her intention was “to kill my:self” (line 3). The practitioner does not accept Laura’s answer (line 4) and asks her to confirm that she called for an ambulance “straight away”. The question grammatically anticipates a compromising response (Drew 2016), i.e. a response that would indicate she quickly sought life-saving support. When Laura doesn’t immediately confirm (lines 6-7), the practitioner pursues, asking a question (“what were you expecting them to do:.” line 10) that directly implies inconsistency between ‘wanting to end your life’ and ‘calling 111’ for help (Stokoe 2020, Jol 2020).

The practitioner makes an inferential connection (“So would you say”, line 13) (Bolden 2007) between Laura’s answer and the characterization that she took the tablets “spur of the moment” (line 14). The practitioner does not invite Laura to describe her thought process. He instead invites Laura to confirm a characterization that would be considered lower risk (relative to a ‘premeditated attempt’). Laura does not agree (lines 15/17, see Schegloff & Lerner 2009) and asserts she disclosed the overdose “later on”. The practitioner speaks over Laura in overlap (lines 13, 14, 16, 18) as he continues to describe his characterization of events (“and then you got worried…”) and does not acknowledge Laura’s talk (lines 16, 18-20, 22) (see Jefferson 1972, p. 319).

Laura agrees with aspects of the practitioner’s description (“you called them.=So they would get you the help” lines 21, 23), but when the practitioner asks her to confirm the overall characterization (including taking the tablets “spur of the moment”), she indicates it is not completely accurate (“Sort of,” line 25). She again attempts to describe her experience with conflicting feelings of suicidality and emphasizes the factors contributing to her decision to ultimately call for an ambulance (line 29). The recharacterizations offered by the practitioner (that Laura wanted to die momentarily, then changed her mind and contacted an ambulance) does not leave space for the possibility that Laura may have experienced conflicting thoughts of suicide, both wanting to die and not wanting to die simultaneously.

Laura never agrees with the characterization ‘spur of the moment’. The practitioner later asks Laura to confirm that the overdose was “an impulsive thing” (line 51). Laura again does not accept this characterization and describes reaching a point where she’d “had enough” (line 53).

In the discharge letter to Laura’s General Practitioner, the Liaison Psychiatry Practitioner writes: *[Laura] told us that [she] took the overdose impulsively because [she was] “Fed up with people picking on [her], especially [Kate].”*

In review

| Practitioner's characterization of suicidal act: "an impulsive thing" | |
|---|---|
| **Practitioner Communication Practice** | **Examples from Extract 5** |
| Asking questions that anticipate a compromising response (Drew 1992) | "And then I hear that you called the ambulance straight away?" |
| Asking questions that imply inconsistency or implausibility (Stokoe et al 2020) | "So when you called 111 what were you expecting them to do:." |
| Juxtaposition of contrasting information (Drew 1992) | "Thinking I wanna end my li:fe, ... and then you called them. So they would get you the [help." |
| Implying information provides evidence of an alternative characterization (Antaki 2013) | "A::h. So would you say you took the tablets, at the spur of the moment," ... "So it was a more of an impulsive thing, at the time," |

Table 3. Communication practices recharacterizing Laura's experience in Extract 6.

In review

Extract 7 occurs a little later in the same psychosocial assessment. The practitioner is asking a series of questions assessing to what extent the overdose was pre-planned (see lines 1-2).

**Extract 7**

```
1  PR: And the co-codamol. Was- Was it there for your pa:in,
2      or wh- why: was it in your house.
3  PT: Uh well I originally had it for pain relief.=
4  PR: =A[h.
5  PT:   [But then I (.) took a ((inaudible)) of i:t, and I took an
6      overdose.
7  PR: ((nod)) I see. Why didn't you take your overdose on your:
8      Depakote [and- and other: (.) medications,
9  PT:          [((shakes head))
10 PT: Because I didn't think it will: have effect.
```

Laura explains that she purchased the co-codamol for pain relief, not providing clear evidence that she planned the overdose in advance (line 3). The practitioner then asks Laura to justify why she didn't overdose on her prescribed medications, naming one particularly harmful medication (lines 7-8). The question implies implausibility that it was really Laura's intention to end her life (Stokoe et al 2020).

Extract 8 occurs later in the same psychosocial assessment. In Extract 7, the practitioner characterizes Laura's suicide attempt as "impulsive" as he resists her suggestion of accessing a rapid response team if in crisis.

**Extract 8**

```
8  PR: And would you ask for help if
9      those thoughts came back and,
10 PT: I might ring the response team in.
```

11      To make sure I'm not taking
12      overdoses [and-
13 PR:             [I- ((nods))
14 PT: to make sure ((inaudible)) it's
15      alright. [Yeah-
16 PR:            **[You want the rapid**
17      **response team.**
18 PT: Yeah. If there- If there is any,
19      [I don't- I don't know.
20 PR: **[Well we'll talk about that but-**
21 PT: There was one where I used to live,
22      [A rapid response team,
23 PR: [Yeah. **I can appreciate that you**
24      **feel this but until Kate upset you,**
25      **you've been coping generally okay,**
26 PT: Yeah.
27 PR: **And then this happened and then**
28      **caused this impulsive um behavior.**
29      To kind of uh-
30 PT: Yeah.
31 PR: You took the overdose. So at this
32      point in time you say you don't have
33      any plans to do anything to cause you
34      harm.
35 PT: No.
36 PR: ((transitions back to standard risk
37      assessment questions))

In review

The practitioner asks whether Laura would ask for help if she had suicidal thoughts (lines 8-9). Laura responds that she might ring the rapid response team (lines 10-15). The practitioner asks Laura to confirm (lines 16-17), indicating this is problematic (see Benjamin & Mazeland 2013) and not indicating he plans to facilitate the referral.

The practitioner acknowledges she wants this support (lines 23-24 re lines 16-17) and frames what comes next as countering Laura's stated interest ("but" line 24). In this case, the practitioner also speaks over the patient in interjacent overlap (lines 20, 34). He asserts that until the triggering event Laura was "coping generally okay" (lines 24-25). He frames her overdose as "impulsive… behavior" that was "caused" by Kate (lines 27-29). Laura minimally agrees (lines 26, 30) and the practitioner requests re-confirmation that she has no plans to harm herself (lines 31-34), a leading question that anticipates Laura will confirm she does not have plans to harm herself (McCabe et al 2017; Ford et al 2021). This all works to build a case that the Rapid Response Team is not needed (see Anonymized, in press).

After Laura states that she has no plans to harm herself in response to the leading question, the practitioner transitions back to suicide risk assessment. Later, the practitioner recommends speaking to a friend or calling a charity helpline if she finds herself in a similar situation. In the risk assessment document, the practitioner writes: "*We have… encouraged you that if you are feeling low or have a fall out with someone you care about to try to talk to someone who will be kind, such as your landlord, or ring Samaritans. If you feel suicidal and this isn't enough we have advised you to ring 111."* There is no reference to the rapid response team. There was no patient interview, which we have found is often the case when a person has had a negative experience in treatment.

### *Case 3 Sasha: Recharacterizing the patient's experience of food restriction shifts the burden of care*

As shown in the extracts above, recharacterizations can be built up across an assessment and can be cited to justify decisions not to provide specialist care. In the next extracts, we demonstrate how these recharacterizations can be used to shift the burden of care off of the healthcare system and back onto the patient (Bergen & McCabe SSM).

Sasha attended the ED seeking help for worsening symptoms of obsessive compulsive disorder (OCD) restricting her food intake, including feeling unable to control her intrusive thoughts of suicide and the need to do things in blocks of eight. This included dietary restriction to 800 calories per day, which had resulted in the rapid loss of about 22 pounds and a Body Mass Index bordering underweight. Eating disorder behaviours are viewed by some as an extreme form of self-harm. In the ED psychosocial assessment, Sasha asked about specialist support for eating disorders multiple times. In this section of the paper, we share brief extracts from Sasha's video-recorded psychosocial assessment and her three-month post-visit interview. In Extract 9, Sasha describes her experience of food restriction.

Extract 9
1 PT: Because: **my obsessive behaviors have been getting worse and**
2 **worse as well.=They've now kind of spread into: (1.0) um (.)**
3 **areas of my life like eating:,**
4 PR: Mm. ((nod))
5 PT: Um (.) yeah Steve said that he was really concerned, (.) about
6 (.) the weight that I've lost so |rapidly: and I
7 PR: |Mm. ((nod))
8 PT: can feel my heart slowing do:wn:, and **I can feel the physical**
9 **symptoms from it.**
10 PR: Mm:.

Sasha describes her food restriction as an obsessive behavior stemming from her diagnosed OCD (lines 1-3), thereby framing the behavior as a symptom outside her control. She emphasizes the speed of her weight loss, others' concern, and the physical impact on her body (lines 5-6, 8-9). She positions the food restriction as a concerning symptom for which she is seeking help. She describes her experience of food restriction again in Extract 10A

Extract 10A
1 PR: And and in terms of you:r understanding. What's your diagnosis
2 Sasha,
3 PT: Um: OCD, and (.) anxiety, I think, ((shakes head))
4 PR: Okay. ((nods))
5 PT: ((nods))
6 PR: And you- That- For you: that makes sense does it. ((nod))
7 PT: Yes. ((nod)) **The only thing that doesn't make sense is why:(.)**
8 **I'm feeling unable to eat:. |And restricting what I'm eating.**
9 PR: |Mm::. ((nod))
10 PR: Okay.
11 PT: And having (.) um (.) ((voice breaks)) kind of unpleasant
12 thoughts about my body shape? |and,
13 PR: |Mm:. ((nod)) Okay.

In review

14 PT: that.

Sasha describes feeling "unable" to eat and that it "doesn't make sense" why she is experiencing these thoughts and behaviors. Sasha frames her food restriction as a serious problem, something she cannot control and needs help to address. In Extracts 10B and 10C, the practitioner indicates that the food restriction is not yet serious, something she may be able to control, and something she already has the resources to address. Extract 9B occurs immediately after 10A.

Extract 10B
15 PR: Alright, Okay, **And I assume that you're rea:lly (.) try:ing?**
16 eating, ((nod)) as in you're (.) you know trying to give
17 yourself permission (.) to (.) you know, enjoy food. Whatever.
18 (.) 'Cause I guess if you're quite slim and you're worried
19 about losing more weight. **Now's not ((shakes head)) the time to**
20 start thinking Well I shouldn't have any custard ((smiles)) or
21 I |shouldn't have any- So you're trying t- **Are you trying to**
22 PT: |((looking down, nods)) °Mm.°
23 PR: **just have what you fa- fancy when you- when you could (.) eat**
24 **it.**
25 PT: I- ((shakes head))
26 PR: Again it's e:asier said than |done but,
27 PT: |Whatever it is it's not letting
28 me.
29 PR: **It's not what, |Sorry.**
30 PT: |It's not letting me.
31 PR: **Right.**
32 **(2.0)**
33 PR: Okay.
34 PT: Like I- (1.0) haven't eaten anything today,
35 PR: Mm.
36 PT: And I've barely eaten anything since Monday, |Just-
37 PR: |Okay.
38 PT: Yeah. It's got out- out of control.
39 PR: **Mm::. Okay, ((nods, looks away))**
40 **(1.0)**

In review

The practitioner immediately asks Sasha to confirm she is "try:ing" to eat and to give herself permission to "enjoy food" (lines 15-17). The question communicates an assumption that Sasha has the choice to try to enjoy food. This does not align with Sasha's previous descriptions that she is unable to eat (Extracts 9, 10A). The practitioner then tells Sasha that "now's not the time" to think that she should restrict her food (lines 18-21).

Sasha pushes back on the presupposition that she has the choice to 'try' to eat (lines 27-28). She frames the problem as a force outside of herself "Whatever it is….it's not letting me". The practitioner does not show agreement or affiliation and responds with minimal acknowledgement ("Right.") and silence (lines 31-32). Sasha expands on her answer, providing an illustration (lines 34, 36). She summarizes that her eating has gotten "out of control". The practitioner minimally accepts (line 39) but does not agree with or validate her experience. The practitioner looks away and there is a long silence.

In Extracts 10B, the practitioner subtly communicates a stance that Sasha's food restriction is not yet serious and is something she may be able to control. Extract 10C occurs immediately after 10B.

Extract 10C

41 PT: But I feel like no one's gonna take me seriously until I'm
42 underweight. Which- (1.0) I don't know. I've=
43 PR: =**So you're gonna make yourself underweight, So people take you**
44 **seriously, Is that' what you're=**
45 PT: =I don't want that to happen. ((shakes head))
46 PR: No. |We wouldn't either.
47 PT: |I don't want that to be the deciding factor in whether I
48 get help for it or not.
49 PR: Mm:. ((nod))
50 PT: But I know it's tricky 'cause there's so many people °needing
51 help.°
52 PR: I was gonna say ((nod)) if you think there's a wait for
53 anxiety.
54 PT: Exactly.=
55 PR: =and mood problems, it- you know- eh for- **for the earlier**
56 **stages of catching and diagnosing eating disorder it's- it's**
57 **wo:rse and longer than that. So have you got anybody**
58 **supporting you: about eating. Anyone prompting: you: or**
59 **willing to sit with you:,**

In review

After the practitioner's minimal response (Extract 9B, lines 39-40) Sasha says she feels she won't be taken seriously until she is underweight (Extract 9C, lines 40-41). This also implies that the current practitioner is not taking her problem seriously. The practitioner resists this with an accusation, asking Sasha to confirm that she plans to "make" herself underweight so people will take her seriously (lines 43-44). This again recharacterizes Sasha's food restriction as within her control and implies that she may try to exploit this intentionally. Sasha again pushes back, stating that she does not want her weight to be the deciding factor in whether she receives care (lines 47-48).

Sasha acknowledges the burden on eating disorder services (lines 50-51) and the practitioner emphasizes the length of the waiting list for eating disorder services (lines 52-53, 55-57). She describes the wait as "wo:rse and longer" than anxiety disorder services if a person is in "the earlier stages" of an eating disorder. Sasha has not described her eating problems as "earlier stages", so this further works to minimize and recharacterize her concerns in a way that discourages her from seeking help from specialist services. The practitioner then transitions to ask about friends and family supporting her at mealtimes (lines 57-59). Throughout the rest of the assessment, the practitioner repeatedly encourages Sasha to seek out social support (e.g., "it would be really good to collaborate with somebody in a bit of a buddy way").

Sasha did not receive a referral for specialist eating disorder services. After attending the ED, Sasha was encouraged by her parents to continue to seek specialist support and began treatment with an eating disorders specialist three months later. By then, she had lost a substantial amount of weight. In a three-month post-visit interview, Sasha reported: "I did get the impression that some people weren't taking me seriously because I still looked vaguely normal… I've lost even more weight since then so kind of firmly within the anorexic range. So I think if- I don't know- Maybe if I'd been able to access the help sooner then it wouldn't have got to that stage."

***POSITIVE CASES***

Below, we present two positive cases where patients' experiences were acknowledged, accepted (rather than contested or recharacterized), validated and practitioners worked to develop a shared understanding with the patient about their experiences.

***Case 4 Emily: Accepting and validating the patient's thoughts of suicide***

Emily presented to the Emergency Department with suicidal thoughts. In extract 5, she describes feeling "I might be better off dea:d" but is seeking help because "I don't want to hurt anyone:". In this section, we present brief extracts from Emily's video-recorded psychosocial assessment and her one-week post-visit interview.

```
Extract 5
1   PT: I just always think 'A:ctually I'll go jump in front of the
2       tra:in.' [or whatever I'm doing.
3   PR:          [Mhm. ((nods, eye contact))
4   PR: ((continues nodding)) (0.5)
5   PT: Yea:h. ((wipes face))
6   PR: ((continues nodding)) (1.0)
7   PT: Yeah that's- that's the kind of thought I have.
8   PR: Mhm. It's a sca:ry thought.
9   PT: I kno:w. [It's ho:rrible.
10  PR:          [((nods))
11  PT: Or I'll be like, my anxiety will be ba:d. So (.) even when I'm
12      like (.) around the ho:use, [and I pick up a knife, [I'm like
13  PR:                             [((nods))               [((nods))
14  PT: >Okay I can just do this< now, [Or like (.) I can just hang
15  PR:                                [((nods))
16  PT: myself now, [I just- It's just like always going on in…
17  PR:             [((nods))
```

Emily describes her suicidal thoughts in lines 1-2. The practitioner immediately accepts her description (line 3) and continues to nod as she gives Emily space to continue (lines 4, 6). Nodding conveys affiliation, i.e., understanding and support of the person's perspective (Stivers 2008). The practitioner then validates her perspective by acknowledging these thoughts are "sca:ry" (line 8).

Emily does not show signs of disengagement (as in Extract 3) (Peräkylä et al 2021) or push back against the practitioner's response (as in Extract 4). She indicates this is a shared understanding of her experience ("I kno:w") and aligns with the practitioner's description ("sca:ry") by offering a similar upgraded description ("ho:rrible") (Pomerantz 1984).

Emily did not describe her suicidal thoughts further when given the opportunity at lines 4/6. However, immediately after the practitioner acknowledges her thoughts as scary, Emily shows a willingness to disclose more sensitive information, describing similar thoughts about ending her life in other ways (lines 11-12, 14, 16).

In a post-visit interview, Emily described the assessment itself as "really really useful", particularly "getting off my chest how I was feeling". Emily reported she "felt quite safe when I went home" because of the conversations she had with this practitioner.

***Case 5 Sam: Building on the patient's characterization of his experience leading up to suicide attempt***

It is common in mental healthcare encounters to negotiate about the meaning of and recharacterize a person's experiences in a more positive way. For example, practitioners can work to reframe patients' negative thoughts about themselves to facilitate a different understanding (Cohen et al 2002). Cognitive reframing is a therapeutic tool commonly used to manage negative assumptions and automatic thoughts (Robson et al 2014), wherein the practitioner challenges the thought process and introduces alternatives. For example, a practitioner might challenge a patient's assumption that nothing will help them. This does not involve denying the person's emotions (e.g., hopeless) or experiences (e.g., of treatment-resistant depression).

In Extract 11, the practitioner introduces a new way of understanding the thoughts Sam experienced before attempting suicide. Sam was brought to the Emergency Department after an overdose with suicidal intent. He recently left the army and moved back to his mother's home. We present brief extracts from Sam's video-recorded psychosocial assessment and his one-week post-visit interview.

In review

**Extract 11**

```
1   PR: I think, from what you've said, that you've been struck by
2       a NAT.
3   PT: What's a NAT.
4   PR: A NAT is a Negative Automatic Thought.
5   PT: Mhm,
6   PR: And what's happened, is since you've left the army
        ... ((practitioner lists challenges patient is facing))
18  PR: Yeah? It's hard for you to get a job,
19  PT: ((nods))
20  PR: You struggle with your mom, 'cause your mom doesn't understand
21      the situation,
22  PT: Yeah.
23  PR: Yeah?
24  PT: Mhm.
25  PR: So what happens is you get this build-up of negative thoughts
26      in your mind.
27  PT: Mhm?
28  PR: Negative th[oughts. Negative thoughts.
29  PT:            [Yeah.
30  PR: What happens with the build up of the negative thoughts?
31  PT: Yeah.
32  PR: Yeah? All of a sudden,
33  PT: Yeah. Yeah.
34  PR: what will happen is, "What the heck. I'm opening up the ah-"
35  PT: Paracetamol.
36  PR: "medicine cabinet and I'm gonna take all the pills."
37  PT: Yeah.
38  PR: Those negative thoughts become the norm then don't they. It's
39      hard to get out of that sort of mindset.
40  PT: Yeah I guess.
41  PR: Yeah. What do you think of that?
42  PT: You're right. One hundred percent you're right.
```

The practitioner proposes that Sam experienced a negative automatic thought (lines 1-2, 3). He lists challenges Sam described earlier in the visit (e.g., unemployment, relationship with mother) (lines 6, 18, 20-21) and gives Sam opportunities to confirm that the practitioner understood him correctly (lines 19, 22, 24). He describes a build-up of negative thoughts (lines 25-26, 28) and frames the pharmaceutical overdose as an understandable outcome (lines 32, 34, 36). Sam responds with agreement and shared understanding (lines 29, 31, 33, 35).

The practitioner does not recharacterize, contest or undermine Sam's experiences. Instead, he gives these experiences a name and introduces a new way of understanding them. He validates how difficult it can be to stop these thoughts (lines 38-39) and asks what Sam thinks of this understanding (line 41). Sam agrees fully, asserting "One hundred percent you're right".

In the post-visit interview, Sam described how he felt after the overdose; "I had no one to talk to, I had nothing to do… and then I spoke to him and the team [liaison psychiatry] and they understood… That's never happened before in my life. No one has actually understood me." Sam repeatedly emphasized how important this mutual understanding was and described it as the "most helpful" outcome of the meeting. When asked what he would do if he experienced another suicidal crisis, Sam responded; "Talk to someone first. I wouldn't do it. I'd talk to someone first."

In review

**Discussion**

We identified communication practices used to undermine, imply or assert alternative characterizations of peoples' accounts of self-harm and suicidality. These practices were not acknowledging or accepting the person's account; asking questions that implied inconsistency or implausibility ("Didn't you tell your GP that you were coping okay?"); juxtaposing contrasting information to undermine the account ("You said you were coping okay before, and now you're saying you feel suicidal."); asking questions that asserted a different characterization ("So when you called 111 what were you expecting them to do" "So would you say you took the tablets, at the spur of the moment," "So it was a more of an impulsive thing, at the time?"); and resisting or directly questioning the person's account ("Really?").

Multiple practices were used across the assessment that built on each other to imply or assert that: the person was not really suicidal as they did not look or act like they were suicidal; the person's decision to attend the ED was not justified; that an overdose was impulsive and the person didn't really intend to end their life; that self-harming behavior (restricting eating) was not that serious and should be in the person's control. Together, they were used to evidence inconsistency or implausibility in patients' descriptions of their experiences. Importantly, we also identified communication practices that were used to acknowledge, accept and validate suicidality/self-harm and introduce a new way of understanding suicidal thoughts and a suicide attempt that patients found helpful as reported in post-visit interviews with patients.

The current findings contribute to an understanding of how peoples' accounts of self-harm and suicidality are undermined, a phenomenon which has been reported by patients and leads to negative consequences for them (Clarke et al 2007; Buston 2002). They also contribute to an understanding of the communication practices used when this does *not* happen, i.e., acknowledgment, acceptance, validation and creating meaning and new understandings. Patients report that feeling listened to and understood is vital for effective relationships with health care practitioners (Gaillard et al. 2009). However, many patients feel that they are not understood and feel judged for seeking help (O'Keeffe et al. 2021). The current findings

In review

show that acknowledging, accepting and validating peoples' experiences and developing a shared understanding with the person are critical but often overlooked in mental health assessments.

Previous conversation analytic studies of epistemic injustice in mental health have been conducted in social work and substance use settings. Similar to our findings, Lee et al. (2019) found two contrasting patterns (i) the worker aligns with the client, actively listening and working to demonstrate understanding and communicating this understanding back to the client, eliciting a deeper client account (ii) the worker assumes a stance of expert and refutes the client's account of her experience, ending with the client agreeing with the worker's version. In the current data, practitioners also worked to get patients to align with their alternative characterization. In a substance abuse setting, Auvien et al. (2021) analysed a group discussion between two rehabilitation clients, a peer support worker and a social adviser. The discussion was based on a motivational interviewing approach which emphasises the person's perspective and motivation to change. The authors focused on how sharing experiential knowledge, elaborating on personal experiences and developing intersubjective understanding can provide the conceptual resources for people to understand and describe their experience.

The practices we focused on were identified across police, courtroom, and political settings (Stokoe et al 2020; Drew 1992; Clayman & Heritage 2002; Antaki 2013; Jol & van der Houwen 2014). While in police or courtrooms, they are used to assess innocence or guilt, ED practitioners appear to use these practices to generate alternative characterizations of peoples' experiences to justify decisions not to refer to specific mental health services. Practitioners are under pressure not to refer patients to overburdened mental health services (Fisher 2022) and need to justify denying care in an under-resourced mental healthcare system (see Beale 2021). Practitioners describe feeling powerless to help patients navigate exclusionary referral criteria (e.g. not meeting threshold with respect to symptom severity for specialist mental health services, and simultaneously too risky for entry level primary care based services) and long waiting lists (O'Keeffe et al 2021). At the same time, they are held liable for discharging people that are assessed as high risk of self-harm who subsequently die by suicide. Hence, they are under pressure not to report their clinical assessment of need and risk of harm when treatment is not available. As such, undermining and recharacterizing peoples' experiences may be unconsciously used to justify no further care where services are unavailable or inaccessible, reflecting a wider context of practitioners as gatekeepers, forced to ration mental health services in the UK National Health Service (Anonymized, in press).

Candidacy for mental health services

Research has shown that interactions with healthcare practitioners have a substantial impact on peoples' understanding of their own candidacy for mental health services, i.e. their perceptions of whether they have a problem that needs or deserves professional support, and are entitled to seek care (Liberati et al 2022). By recharacterizing a person's negative experiences (e.g., recharacterizing a suicide attempt as 'impulsive', a person's food restriction as within their control), through their epistemic status and epistemic stance, a practitioner defines the person's experience in a specific way e.g., as 'impulsive', 'not really suicidal', 'not serious enough to be in the ED' or 'in their control'. The subsequent decision not to provide further support/refer on to other services communicates that the person does not need further professional support.

Poor communication can leave patients questioning whether adverse mental health experiences were "all in your head" or "not true" (anonymized 2022), as these recharacterizing communication practices can be subtle and difficult for patients to recognize and contest. Hence, the impact on the person may go

beyond claiming that the person does not need further professional support; it conveys that the person has a misplaced understanding of their own adverse experiences as 'worse than they really are.' There is an inherent power imbalance and the potential for patients to accept practitioners' claims at face value. This has a knock-on effect on subsequent help-seeking with patients reporting that when they don't feel their experiences were validated or they feel negatively judged for seeking help, they are less likely to seek help in the future even if their mental health has deteriorated further (see Anonymized, in press). On a population level, this undermines efforts to promote early intervention and improve long-term mental health outcomes.

*Hermeneutical Injustice*

Patients attempted to report how they were feeling using concepts such as feeling miserable or being suicidal. Sometimes, the response was to undermine the appropriateness of those concepts, challenging their use with alleged counterevidence, e.g., when the practitioner implied that the patient could not have felt suicidal when he said he had plans for the evening or that he was able to given the impression he was enjoying things. Similar to Lee et al. (2019), at other times, the response was to offer alternative expressions to describe the person's experiences, expressions that the practitioner found more appropriate, e.g. recharacterizing a suicide attempt as impulsive (because the person called an ambulance after an overdose) when the person had not described it in those terms and to persist with the alternative characterization despite the patient's resistance. This does not reflect a more nuanced understanding of suicidality that can include complex and conflicting thoughts, i.e., wanting to die coexisting with a fear of death. As a result of these challenges and recharacterizations, patients' feelings and thoughts as they experience them are minimised in further discussion and decision making. In some cases, the person may defer to the practitioner as the expert and stop using the contested concepts, for example stop using the term 'suicidal'. In this way, patients may be subject to hermeneutical injustice as the practitioner does not accept the person's descriptions or does not negotiate with the person to develop a shared understanding of their experiences.

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*Testimonial Injustice, Medical Records and Barriers to Future Access to Care*

Carel and Kidd (2014) argue that people with mental and physical illness are more vulnerable to testimonial injustice because they may be considered "cognitively unreliable, emotionally compromised, or existentially unstable in ways that render their testimonies and interpretations suspect." For example, when a person reports feeling suicidal, their reports can be questioned and challenged more easily if the person has a known mental health issue. While the practitioner-patient interaction is critical in whether people are treated as credible knowers, what is entered in the person's medical record is also important. For example, one patient's suicide attempt was recharacterized as "impulsive" although she did not agree with this. While mental health is by its nature negotiated between patients and practitioners, recharacterizations in medical files are likely to go uncontested and potentially shape other healthcare practitioners' understandings of the patient. Where recharacterized and downplayed versions of patients' experiences are recorded, other practitioners may not recognize the patient's risks or may not consider the need for further support. For example, a practitioner might be less likely to consider providing a referral to eating disorder services if previous practitioners did not record the full extent of food restriction in the medical file.

***Strengths and Limitations***

This is the first study we are aware of to subject the concept of epistemic injustice to empirical analysis using conversation analysis in mental health assessments for people presenting with self-harm and suicidality. However, we only analysed five cases as this was an in depth analysis and assessments lasted up to 90 minutes. The data were collected in one service and hence may not be representative of other services. It was a challenge to comprehensively analyse practices across a full assessment. Longitudinal conversation analysis is a rapidly developing field and is highly relevant to analysing epistemic injustice as multiple communication practices build on each other over the course of an assessment and in mental health interactions over time. Triangulating interactional analysis with interviews was informative in highlighting how each assessment was experienced by the specific patient. The longitudinal perspective also shed light on the downstream consequences for patients and carers of having their experiences undermined.

### *Future Research*

Future research should explore to what extent recharacterization could be minimized through further communication training or unconscious bias training, and to what extent a long-term solution may lie in increasing accessibility of mental health services for people that self-harm and experience suicidal ideation. Future research could triangulate multiple data sources, i.e., observation of interactions along with video-stimulated comments and interviews with patients and practitioners to investigate epistemic injustice more closely and the impacts on patients over time. Analysing interactions using conversation analysis may also shed light on empirical approaches to the study of epistemic injustice in other fields such as philosophy.

### *Conclusion*

Multiple communication practices were used to evidence inconsistency or implausibility in patients' descriptions of their experiences across the assessment. These practices built on each other to imply or assert that: the person was not really suicidal as they did not look or act like they were suicidal; the person's decision to attend the ED was not justified; that an overdose was impulsive and the person didn't really intend to end their life; that restricting eating (in the context of an eating disorder) was not that serious and should be in the person's control. These findings contribute to an understanding of *how* peoples' accounts of self-harm and suicidality are undermined, a phenomenon which has been reported by patients, leads to further deterioration in their mental health and can discourage future help-seeking even when people are very unwell. These findings advance our understanding of *how* peoples' experiences are undermined, a phenomenon which has been reported by patients, leads to further deterioration in their mental health and can discourage future help-seeking even when people are very unwell. Conversely, acknowledging, accepting and validating suicidality/self-harm and introducing a new way of understanding peoples' experiences generates shared understanding and may reduce epistemic injustice in mental healthcare interactions.

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**References**

Antaki, C., Biazzi, M., Nissen, A., & Wagner, J. (2008). Accounting for moral judgments in academic talk: The case of a conversation analysis data session. *Text & Talk*, *28*(1), 1–30.

Antaki, C., Richardson, E., Stokoe, E., & Willott, S. (2015). Can People With Intellectual Disability Resist Implications of Fault When Police Question Their Allegations of Sexual Assault and Rape? *Intellectual and Developmental Disabilities*, *53*(5), 346–357.

Benjamin, T., & Mazeland, H. (2012). Conversation Analysis and Other-Initiated Repair. In *The Encyclopedia of Applied Linguistics*. John Wiley & Sons, Inc.

Bergen, C., & McCabe, R. (2021). Negative stance towards treatment in psychosocial assessments: The role of personalised recommendations in promoting acceptance. *Social Science & Medicine*, *290*, 114082. https://doi.org/10.1016/j.socscimed.2021.114082

Bolden, G. B. (2006). Little Words That Matter: Discourse Markers “So” and “Oh” and the Doing of Other-Attentiveness in Social Interaction. *Journal of Communication*, *56*(4), 661–688.

Buston, K. (2002). Adolescents with mental health problems: what do they say about health services? *Journal of Adolescence*, *25*(2), 231–242.

Clarke, D. E., Dusome, D., & Hughes, L. (2007). Emergency department from the mental health client’s perspective. *International Journal of Mental Health Nursing*, *16*(2), 126–131.

Clayman, S., & Heritage, J. (2002). *The News Interview: Journalists and Public Figures on the Air*. Cambridge University Press.

Drew, P. (1992). Contested evidence in courtroom cross-examination: The case of a trial for rape. In P. Drew & J. Heritage (Eds.), *Talk at work: Interaction in institutional settings* (pp. 470–520). Cambridge University Press.

Ford, J., Thomas, F., Byng, R., & McCabe, R. (2021). Asking about self-harm and suicide in primary care: Moral and practical dimensions. *Patient Education and Counseling*, *104*(4), 826–835.

Fricker, M. (2007). *Epistemic injustice: Power and the ethics of knowing*. Oxford University Press.

Heritage, J. (2012a). Epistemics in Action: Action Formation and Territories of Knowledge. *Research on Language & Social Interaction*, *45*(1), 1–29.

Heritage, J. (2012b). The Epistemic Engine: Sequence Organization and Territories of Knowledge. *Research on Language & Social Interaction*, *45*(1), 30–52.

Heritage, J., & Clayman, S. (2010). *Talk in Action: Interactions, Identities, and Institutions*. Wiley-Blackwell.

Heritage J. Territories of knowledge, territories of experience: Empathic moments in interaction. The morality of knowledge in conversation. 2011 Jun 2;29:159-83.

In review

Jefferson, G. (1972). Side Sequences. In D. Sudnow (Ed.), *Studies in Social Interaction* (pp. 294–338). The Free Press.

Jol, J. A. H. (2020). *Police interviews with child witnesses: a conversation analysis*. Doctoral Thesis: Radboud Universiteit Nijmegen.

Jol, G. A. H., & van der Houwen, F. (2014). Police interviews with child witnesses: pursuing a response with maar (= Dutch but )- prefaced questions. *International Journal of Speech Language and the Law*, *21*(1).

Loeb, L., & Clayman, S. E. (2017). Conversation Analysis and News Interviews. In *Oxford Research Encyclopedia of Communication*. Oxford University Press.

McCabe, R., Sterno, I., Priebe, S., Barnes, R., & Byng, R. (2017). How do healthcare professionals interview patients to assess suicide risk? *BMC Psychiatry 17:1*, *17*(1), 1–10.

Sidnell, J., & Stivers, T. (Eds.). (2013). *The Handbook of Conversation Analysis*. John Wiley & Sons.

Schegloff, E. A., & Lerner, G. H. (2009). Beginning to Respond: Well-Prefaced Responses to Wh-Questions. *Research on Language & Social Interaction*, *42*(2), 91–115.

Stokoe, E., Antaki, C., Richardson, E., & Willcott, S. (2020). When police interview victims of sexual assault: Comparing written guidance to interactional practice . In *The discourse of police interviews*. Univeristy of Chicago Press.

Xanthopoulou, P., Ryan, M., Lomas, M., & McCabe, R. (2021). Psychosocial Assessment in the Emergency Department. *Crisis*, 0227-5910/a000786.

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