Challenges in Advising People with Severe Mental Illness to Quit Smoking: A Conversation Analysis of Patient Resistance

Abstract

Objectives:

People experiencing severe mental illness (SMI) smoke at rates 2.5 times higher than the general population and have a reduced lifespan by 15-20 years, causing substantial health inequalities. This study examined how people with SMI resisted smoking cessation advice, delivered by primary care clinicians (general practitioners and nurses) during routine annual health reviews.

Methods:

Using conversation analysis (CA), we analysed 56 audio-recorded consultations from a randomised controlled trial of annual health reviews in which smoking cessation advice was discussed. We identified a core collection of 21 instances of patient resistance and conducted detailed sequential analysis to examine how resistance to smoking cessation advice was expressed, and how clinicians responded.

Results:

Analysis revealed two distinct patterns of resistance to smoking cessation advice: implicit rejection and explicit rejection. In implicit rejection sequences, patients foreground mental health concerns, thereby indicating that quitting cannot be acted upon at the moment. In explicit rejection sequences, patients rejected the advice with an explicit 'no' and expressed indifference to the health risks of smoking, presenting smoking as non-negotiable and making further discussion redundant. In both scenarios, clinicians responded with acknowledgements (e.g. "mm", "yeah", or "okay" indicating receipt and alignment), neither explicitly agreeing with the patient nor pushing back on their resistance.

Conclusions:

Addressing smoking-related health inequalities among people with SMI is challenging because quitting is often deprioritised in the context of competing mental health and social concerns. These difficulties are compounded by clinicians' challenges in raising and sustaining smoking cessation discussions. Recognising how resistance to quitting advice is interactionally produced can support more flexible and tailored cessation approaches that better align with patients' priorities.

Practice implications:

This study highlights the unique resistance sequence presented in consultations advising people with SMI to quit smoking. It provides implications for clinical professionals to adopt more responsive and tailored responses to the resistance.

Keywords: severe mental illness, reduce smoking, quit smoking, resistance, conversation analysis

1. Introduction

People living with severe mental illness (SMI), such as schizophrenia or bipolar disorder, experience significant functional impairment and have a shortened lifespan of 15-20 years compared to people without SMI, with smoking the leading cause of this health inequality [1-4]. National guidelines recommend tailored smoking cessation support for people with SMI [5]. In primary care, clinical guidelines describe standard care for smoking cessation as an offer of brief advice to quit smoking alongside support to quit. However, whilst smoking cessation can improve both physical and mental health outcomes [6], providing cessation advice to people with SMI is challenging because some patients view smoking as integral to coping with their condition, routines, identity, and/or lifestyle [7]. As a result, people with SMI may resist cessation advice [8]. Resistance refers to an interactional phenomenon that impedes, or outrightly suspends the progression of a course of action [9]. Understanding how resistance is enacted is crucial for improving engagement with smoking management and supporting guideline implementation.

Addressing smoking-related health inequalities among people with SMI is particularly challenging because quitting may be perceived as less attractive in the context of competing priorities such as poverty, poor housing, unemployment, and complex co-morbidities [10]. These challenges are further compounded by professionals' reluctance to raise smoking or offer cessation support, given the perceived difficulty of such conversations [11-12]. Many clinicians hesitate to raise the topic because they anticipate negative reactions from patients and worry that doing so might damage the therapeutic relationship [12]. Studies that have explored smoking consultations within the general population [11-13] have focused largely on how to initiate the topic in ways that minimize resistance, rather than on the interactional patterns of resistance and how post-resistance management is formulated. Conversation analysis (CA) is regularly used in applied health communication research, focusing on the relationship between conversational patterns and specific outcomes [14]. This approach enables the identification of ways to optimise health communication, such as strategies for clinicians to tailor their responses to promote uptake of advice about health behaviours and avoid unnecessarily lengthy negotiations [15]. Previous CA research has examined how patients resist lifestyle advice, but these studies have primarily focused on weight management or referrals [16-18]. Findings show that patient resistance to weight-loss advice is common yet subtle, with few instances of explicit resistance (i.e., an explicit 'no' to an offer [17]). When explicit resistance occurs, it typically draws on patients' personal experiences, making the advice seem irrelevant. Clinicians usually accept this and rarely pursue further weight-loss advice beyond offering future support [18]. Research also suggests **that general practitioners (GPs)** can pre-empt resistance [17], and that accepting refusals may foster more constructive conversations [18].

Although resistance has been examined in other health behaviour talks, there remains limited understanding of how resistance unfolds in smoking cessation interactions, particularly in consultations involving people with SMI. In these contexts, patients face particular challenges in quitting, as they prioritise immediate mental health concerns over the long-term health and financial benefits of cessation [19]. In this study, CA was used to examine the interactional practices through which patients resist cessation advice and the strategies clinicians use in

response. By identifying these patterns, this study aims to understand the ways that people with SMI resist cessation advice, with a view to informing more responsive, tailored approaches to smoking management in primary care.

2. Method

2.1 Context

The data for this study were collected as part of the Management of Smoking in Primary Care (MaSC) trial [20], a two-arm randomised controlled trial which took place in primary care general practices in England, UK. Patients who were current smokers with a smoking-related chronic condition or SMI were identified through participating practices via searches of GP electronic medical records. Between March 2018 and April 2019, patients were invited to attend a baseline assessment conducted by the study team, during which eligibility was confirmed (i.e., current smokers with no intention of stopping smoking) and informed consent to participate was obtained. Participants were informed in the participant information sheet that the study examined how GPs and nurses discussed smoking during routine consultations, including analysis of smoking-related interactions within recorded consultations. Eligible participants subsequently attended a routine annual health review with a healthcare professional (HCP) and were randomised to either a control group, who received no further support beyond standard care advice on stopping smoking, or an intervention group, who were offered brief advice and a free electronic cigarette starter pack (otherwise known as an e-cigarette or nicotine vape) to support smoking reduction. A total of 326 participants were enrolled across the intervention and control arms.

Participants indicated whether they consented to the audio-recording of their annual review consultation by selecting an optional checkbox on consent forms. Consultations were recorded by HCPs using a digital audio-recorder, after reconfirming participants' consent immediately prior to recording. Consultations were intended to be recorded in full to minimise disruption to the natural flow of the consultation and to capture discussions about smoking as they arose naturally within the appointment. The study team collected audio recorders at the end of each day of annual review consultations. Audio files were then encrypted, uploaded to a secure restricted-access University of Oxford server, and deleted from the recording device. Approved transcribers operating under confidentiality agreements subsequently transcribed and pseudonymised the recordings. All data were stored securely on the restricted-access University server in accordance with the study protocol [20] and relevant regulations.

Of the 326 consultations, 164 were audio-recorded, the remaining 162 were unavailable due to non-consent or technical failure. From the 164 available recordings, 56 had a documented diagnosis of SMI (participants were identified from GP electronic records using specific diagnostic codes for schizophrenia, bipolar disorder or other psychoses.). For the present study, we extracted these cases from the trial database. This subsample was selected to examine how patients with SMI responded to cessation advice in routine consultations. Ethical approval was received from the National Research Ethics Committee Wales REC 4 (REC reference: 17/WA/0352) and the Health Research Authority (HRA).

2.2 Data

The dataset consists of audio-recorded consultations between clinicians and patients collected during patients' annual health reviews. Across both control and intervention groups, some recordings captured the entire consultation, while others contain only the brief smoking advice and e-cigarette offer. The average length of recording was 13.06 minutes. Resistance was identified within these sequences and was not influenced by variation in recording length. As noted previously, participants had already provided written informed consent for their consultations to be recorded and analysed; however, at the beginning of each recording, clinicians also obtained verbal consent.

2.3 Data Analysis

Table 1. Overview of patient resistance to quitting advice

Participants	Account in resisting quitting advice	Account sub-type	Account type	Outcome
204153 (Extract 1)	"I know I do put it off, and I know I am blaming it, but I suffer from depression."			
201011	"It calms me down …when I came out, I went depressed, so it was like, the cigarette was my bit of sanity, if you know what I mean."			
203079	"And then paranoia started drilling in, which might be one of these underlying problems that I suffer with. I think they mature over years and I got illusions, hallucinations that then once I stopped smoking, toxins were going to start growing."			
205186	"But, it's quite a bit stressful at the moment."	Smoking as a coping mechanism		
203112	"I have a stressful life with my kids."			
203106	"I'm getting a bit stressed at the minute, so."			
205188	"The anti-smoking products are a nuisance. I don't think the willpower's working. I've got too much stress from work."			
203107	"At the end of the day, it's the same and it holds me down, so I know it's a poor excuse. life is stressful at the moment"			

118309	"I know, I get relief when I have smoke."		Mental health as a here-and-now concern	Implicit rejection
205197 (Extract 2)	"I would, but not at the moment because I've got too much going on. I'm on anti-depressant tablets and all that. A few things are going on in my life, so I'm just getting them sorted. I'm not drinking at the moment."	Mental health medications as competing activities		
202060	"I've just got that many things though, like take tablet for this and take a tablet for that. And now they're trying to put me on the tablet for my bladder retention and depression. It's a nightmare. My life is a total..."			
121405 (Extract 3)	"No. I don't think I'll ever be interested I've had a heart attack…"			
203076	"No. I *[inaudible]* anything. One of my few sins left, they haven't got any drink. There's no sex. So yeah, it's all..."			
107111	"No I know it would be a good idea to but um, I don't feel that it's affecting me that badly."	Minimizing health consequences of smoking		
201003	"No not at all I am ok with it, I don't think smoking has any bearing on it and if it has it's very small."			
203069	"No, never, that doesn't bother me."		Accepting health consequences of smoking	Explicit rejection
213292 (Extract 4)	"Not really to be honest I'd quite like to get cancer."			
118313	"I'm not that bothered. I enjoy a cigarette. And it's one of them a few things I have left to enjoy at my time alive."			
208385	"No, I am not really worried about the health side, never."	Showing indifference to health consequences of smoking		
204146	"No. As I say, I've done it, not just once but several times. You'd think I'd know better because I watched			

	my mum dying of lung cancer painfully."	
207213	"Listen, young lady, can I tell you something. So, I'm 76 years old. I no longer have sex, the only thing I've got, which I enjoy is a cigarette…no, I don't think, I don't think, it's to do with that at all, right?	

(Note: Table 1 provides an overview of the resistance patterns identified in the dataset.).

Table 2. Participant demographics (N=21)

Participant demographics	**N (%)**
Age	**Mean, standard deviation (range)**
	47 ± 14 (23–71)
Sex	
Female	10 (48)
Male	11 (52)
Ethnicity	
White British	20 (95)
Other white background	1 (5)
IMD quintiles	
1-2 (most deprived)	9 (43)
3-4	1 (5)
5-6	3 (14)
7-8	1 (5)
9-10 (least deprived)	4 (19)
Not known	3 (14)

IMD: Index of Multiple Deprivation. scores ranging from most deprived (deciles 1-2) to least deprived (deciles 9-10).

(Note: Table 2 summarises participant characteristics for the 21 cases included in the analysis.)

Recordings were Jeffersonian-transcribed to capture features such as timing, intonation, silence, emphasis, and other vocal details relevant to interactional meaning [21]. Transcription (see transcription conventions in the Appendix) was initially conducted by a university-approved transcription service. In the transcripts, 'CLN' denotes the clinician and 'PAT' denotes the patient. Lines that were analysed are highlighted in bold. ELAN 7.0 was used to support transcription and data analysis.

The data were analysed using CA, which examines how participants produce and respond to talk turn by turn [14]. The collection was analysed by identifying recurrent practices in resisting smoking cessation support and their sequential consequences (e.g. how clinicians responded and managed resistance), iteratively comparing across cases [22]. Analysis was checked in discussions with other conversation analysts in data sessions [23]. Based on inspection of how participants designed their turns in response to advice, an initial distinction was made between responses involving minimal refusals and those incorporating accounts. Three patterns of

resistance were identified: 17 cases involving direct refusals without accounts (e.g., "no", "not really"); 18 cases involving willpower/effort accounts (e.g., "I am not interested, unless there is a magic wand that doesn't require any effort"), consistent with patterns reported in prior literature [11-13]; and 21 cases involving accounts explicitly or implicitly linked to mental health concerns (see Table 1). The present study focuses on these 21 cases (see Table 2 for participant characteristics) with the aim of understanding how these interactional practices are accomplished in clinical consultations and informing more responsive, tailored approaches to smoking management in primary care. Within these 21 cases, two further patterns were identified: 11 cases of implicit rejection, where participants did not explicitly refuse but instead invoked mental health concerns as here-and-now concerns that foreclose further advice-giving; and 10 cases of explicit rejection, where participants combined a direct refusal with a mental health-related account that rendered future cessation advice redundant.

3. Results

Analysis revealed that patients resisted the quitting advice through implicit or explicit rejection. Implicit rejection typically occurred when patients introduced 'here-and-now' mental health concerns that indicated the advice could not be implemented at that present time (Extracts 1 & 2). In doing so, they rejected the advice without explicitly saying 'no'. Clinicians often accommodated the resistance by acknowledging the account. Explicit rejection typically involved patients clearly rejecting the quitting advice with 'no', rejecting the advice outright, and providing an account that presented smoking as non-negotiable, making the advice redundant. This made pursuit of cessation advice less relevant (Extracts 3 & 4). In these cases, clinicians shifted to advising smoking reduction or to addressing patients' feelings. These patterns should not be understood as rigidly discrete categories, but as analytically distinguishable tendencies that may overlap across cases [24].

The 4 extracts presented below were selected to illustrate the range and nuance within these patterns of implicit and explicit rejection.

3.1 Implicit rejection: Mental health as a here-and-now concern

As noted above, patients may resist the clinician's quitting advice by foregrounding here-and-now mental health concerns. In Extract 1 the concern raised is depression and in Extract 2, anti-depressant medication. Across both extracts, resistance is achieved over a series of turns rather than delivered as a refusal in a single turn. In both cases, quitting is presented as currently unmanageable because of mental health circumstances. These practices situate non-uptake as contextually warranted within patients' ongoing mental health trajectories, rather than as a direct rejection of cessation advice per se. More detail on the context of these extracts is given below.

Extract 1 '204153'

```
001   CLN:    but (.) .h you know there's- >there isn't any time like the
002           present<. =Is ther[e. (I think) it's the:re but-
003   PAT:                     [I know (.)  I-  I do: put it off, and I
004           know I'm blaming it but I do suffer from depression
005           (.)
006   CLN:    yes:= yea:h.
007   PAT:    And I do feel like if I- (0.3) I know it's an excuse  but if
008           I     do qui:t, [(0.4) it's=
009   CLN:                    [An- an- y-
010   PAT:    =going to make [me feel wo:rse.
011   CLN:                   [And  y-   w-   what you would doing with
012           this >you wouldn't be sorta-<  we're not asking you to <stop
013           sm[o:king>
014   PAT:    Yea:h
015   CLN:    Uh let me- this is sort of like you can smoke ,and use this.
016           to see to t- >>t-t-t<< try it > and see how you [go? <can't
017           you,=and use it it [t-
```

Extract 1 illustrates a mitigated form of resistance in which a patient aligns with the relevance of cessation while treating quitting as potentially detrimental to their mental health, thereby warranting non-uptake and shifting the activity from health promotion to risk management.

Prior to the beginning of the extract, the clinician is advising the patient to stop smoking, and the patient resists by saying "now is not a good time". Line 1 begins with the clinician pushing back by emphasising the urgency of following the cessation advice.

At the possible turn completion position (the tag question "is there" (line 002)), the patient comes in with a claim of knowledge ("I know") and continues their turn in overlap with the clinician's turn which projects continuation ("it's there but…"). However, this is overridden as the patient builds on their turn by disclosing their depression (line 004) [25] and using it as an account for not stopping now.

Rather than simply stating "I suffer from depression", the patient legitimates the account with prefaces: "I know I do put it off, I know I'm blaming it" (line 004). This is followed by a moment of interactional suspension (line 005), where neither the clinician nor the patient takes the turn. In CA, micro-pauses can signal interactional trouble [10]. The clinician subsequently produces minimal acknowledgement tokens ("Yes:, Yeah", line 006), which neither pursues the advice nor explicitly validates the patient's account. The patient then incrementally extends the account ("and", line 007). Before stating that quitting would worsen their mental health (line 010), they delay delivery by suspending mid-turn and inserting a pre-emptive remark: "I know it's an excuse". In doing so, patients provide accounts for resistance and manage its moral accountability by pre-emptively orienting to its potential status as an excuse. The delivery is further delayed with a conditional clause "if I do quit" and pause before the ***then*** *component* (i.e., the consequences of quitting) [26]. The clinician in line 009 intercepts with the attempt to resume the advice trajectory, as further shown in line 011 [26]. However, this interception is stopped by the patient's completion of the *then component* "it's going to make me feel worse"

(lines 009-010). By invoking mental health concerns, the patient treats immediate cessation as interactionally difficult to pursue.

Before the patient completes the then component ("make me feel worse"), the clinician intercepts with an and-prefaced turn [26, 27]. In doing so, the clinician contests the assumption inherent in the patient's prior "we are not asking to stop smoking". This is followed by the clinician shifting to the randomisation activity (i.e., advising smoking reduction, lines 015-017).

Similar to Extract 1, Extract 2 illustrates how patients may resist cessation advice by foregrounding current mental health concerns. In this extract, mental health is invoked through reference to ongoing treatment ("I am on anti-depressant tablets"). The patient deploys pre-emptive accounts that manage the moral accountability of their resistance (e.g., "I would but…", references to "too much going on", and ongoing treatment). The quitting advice is phrased away and ultimately rejected, and the clinician shifts the topic to weight management (line 29).

Extract 2 '205197'

001	CLN:	so wh↑at ab↑out your smo:king?
002	PAT:	still the sa:me
003	CLN:	is it? how much d'you smo:↑ke?
004	PAT:	(2.5) about 50 grams every two weeks(hh°)
005	CLN:	oka:y so about 25 grams a week
006	PAT:	yeah
007	CLN:	so what's that about 20 - °10 cigarettes° a day
008	PAT:	around about that, yea:h
009	CLN:	do you filter it
010	PAT:	yeah
011	CLN:	°oka:y° would you li↑ke to stop smo↓king
012		**(2.0)**
013	**PAT:**	**I would but not at the moment because I've got too**
014		**much going on so=**
015	CLN:	=>have you<
016		**(1.0)**
017	**PAT:**	**I'm on anti-depressant tablets and all that so: (.)**
018	CLN:	(°h)oka:y
019	**PAT:**	**a few things are going on in my life so I'm just getting**
020		**them sorted I'm not drinking at the moment so:**
021	CLN:	°o::k°a↑y
022	PAT:	but I haven't drunk for (2.0) it's been over 12 months way
023		over
024	CLN:	°o::k°a↑y o::h
025		(16.5)
026	**PAT:**	**I used be seven days a week drinker at one time**
027	CLN:	di↑d'you? you've done rea:lly well then you've got the
028		motivation to do that [well
029	**PAT:**	**[I haven't even missed it to be honest**
030	CLN:	it just shows you, doesn't it yeah how brilliant is that -
031		have you lost weight since you stopped drinking?

The quitting advice in Extract 2 is initiated in line 011 through a question. The patient's response has three key features: (a) it is delayed (2.0 seconds), (b) it is non-straightforward ("I

would but…"), and (c) it is followed by an account ("have got too much going on", lines 012–013). Together, these features form the basis of the patient's resistance to the quitting advice.

In response to the patient's resistance, the clinician produces a confirmation-seeking question ("have you", line 014). Following a delay (line 015), the patient continues their prior turn with more information: they are on antidepressant tablets (line 015). Notably, the turn ends with a turn-final "so", which invites the clinician to draw a conclusion [28]. The clinician's minimal response, "okay" (line 016), offers little validation and functions primarily as a receipt. In response, the patient extends their talk, recycling earlier content that they are sorting out other things in life, and volunteering one candidate 'good' behaviour: not drinking. This turn in line 018 ends with another turn-final "so", inviting the clinician once again to draw a conclusion.

In line 020, the patient continues by specifying the length of their abstinence from alcohol, a behaviour that makes a positive assessment relevant [29]. Rather than celebrating the patient's achievement, the clinician responds with a prolonged change-of-state token "o::h", treating the information as new knowledge [30]. After a brief suspension in the conversation (line 023), the patient re-engages, this time emphasising how frequently they used to drink (line 024). This escalation finally prompts the clinician to respond with a positive assessment (lines 025–026).

Through these accounts, cessation advice is treated as less actionable within the current mental health circumstances of the patient. In doing so, they reject the advice without explicitly saying 'no'.

The above extracts illustrate a recurrent resistance pattern whereby patients mobilise mental health-related accounts to reject quitting advice. Rather than producing outright refusals, patients accomplish resistance through accounts that present quitting as potentially incompatible with their mental health priorities. This practice allows resistance to be managed in an interactionally accountable manner that clinicians may find it difficult to directly challenge.

3.2 Explicit rejection: accepting smoking consequences

Apart from the implicit rejection illustrated in the previous extracts, patients may also reject quitting through explicit disagreement with advice. Compared with the mitigated practices described in the prior section, these extracts involve explicit rejections to disalign with the cessation advice, invoking serious smoking-related conditions, such as heart attack or cancer, which are mentioned without displays of worry or orientation to risk. These responses differ from implicit rejection in that they do not justify non-uptake. Instead, resistance is accomplished through explicit rejection alongside a stance that normalises the relevance of negative health consequences. Examples of this pattern can be seen in Extracts 3 and 4 below.

Extract 3 ‘121405’

```
001   CLN:    the last question I need to ask you then xxx is about your
002           smoking status are you smoking at the moment?
003   PAT:    yeah
004   CLN:    you are  ok. and is it roll ups or cigarettes?
005   PAT:    roll ups
006   CLN:    roll ups. and how many grams of tobacco (0.6) a week would
007           you be having >[do you think?<
008   PAT:                  [normally 200 grams - but I think (1.0) since
009           I split up with my girlfriend two weeks ago it's been about
010           5 so it's been about 250 a week
011   CLN:    about 250, ok then .hhh so: (.) like when we have this -you
012           know befo:re we've - we've explained about the smoking
013           cessation advi↑ce u:mm  how do you feel about smoking y-you
014           [know - where're things about]
015   PAT:    [I feel     (  )             ]
016   CLN:    you a:re                     [not thinking about quitting?
017   PAT:                                 [alcohol doesn't bother me
018   CLN:    no you know that if you did   you can get a stop
019           smoking programme here like we've discussed before you know
020           the 12-week programme? u:mm where you can come for the
021           support and the advice [and the replacement projects
022   PAT:                         [I don't think it will do anything
023   CLN:    no  not interested in stopping at the moment?
024   PAT:    no. I don't think I'll ever be interested [I've had a heart
025   CLN:                                              [okay
026   PAT:    attack  I've had cancer  so I'm not really worried.
027   CLN:    okay [just-
028   PAT:         [I can leave alcohol alone  that doesn't bother me
029   CLN:    no okie
030   PAT:    but my fags I do like
031   CLN:    ok let me just click onto this that would give you the thing
```

The clinician’s quitting advice is first introduced in line 012 and subsequently reformulated as a negatively valanced question “you’re not thinking of quitting?”, which is designed to favour a dispreferred “no” response. The clinician then continues the advice trajectory through an “if–then” formulation (lines 018–019), invoking the stop smoking programme [31]. However, the patient interjects mid-turn with a negative assessment of the cessation programme’s efficacy (line 022), thereby displaying resistance to the projected uptake of the quitting advice. Here, the clinician treats the patient’s stance as temporary, framing it as a lack of interest ‘at the moment’ (line 023). This framing allows the clinician to keep the advice trajectory open for future discussion. In response, the patient escalates the resistance by producing an explicit rejection (“I’ll never be interested”, line 024), combined with an account referencing prior experience of smoking-related health consequences (lines 024–026), which together reduces the interactional relevance of continued pursuit of cessation advice. The clinician acknowledges this with “okay”, but just as they begin to speak again (“just” in line 027), the patient intercepts with further account (line 028, line 030), limiting opportunities for advice continuation. The clinician’s subsequent shift to the procedural activity of randomisation (“let me just click onto this”, line 031) indicates a reorientation of the interaction away from cessation advice.

Like the previous extract, resistance is accomplished through an explicit rejection of cessation advice in conjunction with a stance toward smoking-related consequences. However, rather

than merely neutralising the relevance of such consequences, this case shows an escalation through the use of an extreme formulation.

Extract 4 '213292'

```
001   CLN:    and smoking, you're still smoking though, yeah?
002   PAT:    I do smoke, yeah.
003   CLN:    and how many roughly are you smoking a day?
004   PAT:    between 15 and 20 a day.
005   CLN:    and do you want any help to stop with that?
006   PAT:    not rea:lly↑ to be honest I'd quite like to get can↑ cer
007   CLN:    °don't sa↑y tha::t°
008   PAT:    I've had enough of this life=
009   CLN:    =oh don't sa↑y tha::t [don't sa↑y tha::t
010   PAT:                          [why do you think I've been smoking
011   CLN:    don't say that
012   PAT:    if I - I tell you if I found out I had cancer tomorrow I'm
013           not having treatment
014   CLN:    oh don't say that ((patient name))
015   PAT:    I'm not what am I missing
016   CLN:    oh don't sa:[y that though
017   PAT:                [someone that lives just [on ( )
018   CLN:                                         [you've got a partner,
019           you've got people who love you haven't you it's not just all
020           abo↑::[ut
```

Here, the patient explicitly rejects the clinician's cessation advice (line 005) with "not really" (line 006), and within the same turn, expand further in the turn completion position: "to be honest, I'd quite like to get cancer". This turn expansion invokes a non-normative, extreme stance toward smoking-related consequences. The non-normative nature of the answer is indexed by the patient's reflexive framing "to be honest" [32]. By displaying an orientation in which adverse health outcomes are not treated as undesirable, the patient undermines a key resource for advice-giving based on health risk. The turn can therefore be seen as doing more than rejecting the immediate advice, it also addresses a broader trajectory in which health consequences might otherwise be mobilised.

The sequential consequences of this can be observed in the clinician's subsequent turns. Rather than pursuing cessation advice, the clinician produces corrective responses ("don't say that", lines 007, 009, 014), which do not reintroduce the prior advising trajectory. Across these turns, the relevance of quitting advice is not re-established. This shift suggests that extreme formulations of this kind can redirect the interactional agenda, constraining the relevance of further health-based advice in the immediate sequence.

Extracts 3 and 4 illustrate a recurrent practice in which explicit rejection is coupled with health consequences account that reduces the relevance of further advice. Such cases show how resistance may operate not only at the level of rejecting a proposal, but also by undermining the premises on which subsequent advice would typically be built. Across both, resistance is not merely a refusal but is sequentially accomplished through turn designs that limit the relevance of health-based resistance management. This is evidenced by the absence of uptake of the advice trajectory, the patient's continued turn expansion, and the clinician's eventual

reorientation to alternative activities (e.g., patient's stance, randomisation procedures), rather than further pursuit of quitting. These extracts therefore show a more explicit form of resistance compared to earlier cases, where patients used mental health accounts to account for non-uptake. Together, they demonstrate how resistance can take different forms, ranging from account-based explanations to explicit rejection, depending on how patients orient to the consequences of smoking.

4. Discussion and conclusion

4.1 Discussion

In this conversation analytic study of 21 smoking-related discussions within a randomised controlled trial, 1 we examined how advice to quit smoking is resisted. Two interactional patterns of resistance were identified: implicit rejection and explicit rejection. Implicit rejection was observed where patients produced accounts grounded in 'here-and-now' mental health concerns, which oriented to a conflict between cessation advice and ongoing mental health management. These responses did not take the form of overt refusals; instead, patients often displayed alignment with the advice (e.g. "I would, but…"; "I know it's an excuse, but…") while accounting for their inability to act on it. Sequentially, these turns treated the advice as not to be pursued at that moment. In such cases, clinicians typically acknowledged or aligned with the patient's account. Explicit rejection involved clear refusals (e.g. "no"), often accompanied by accounts that presented smoking as non-negotiable. In these sequences, patients also present a stance in which health consequences are not oriented to as a reason for stopping. Following this, the trajectory of cessation advice is not continued in the subsequent talk, as clinicians move away from pursuing quitting and instead shift to other courses of action, such as smoking reduction or responding to the patient's stance.

Patient resistance is common in consultations between clinicians and people who smoke experiencing SMI. Pilnick and Coleman found that introducing smoking advice by linking it directly to negative health consequences often leads to resistance [11, 12]. One explanation is that patients and clinicians have not yet established a shared presumption that smoking is a problem. To manage this, clinicians frequently use interactional pre-sequences (e.g., "Well what about the fags" or "Are you smoking?") to elicit information before pursuing the main activity of discussing smoking. These sequences help prepare the ground for advice and are sensitive to the need to achieve that shared understanding before suggesting cessation. The current study extends Pilnick and Coleman's analysis by showing that resistance can be accomplished not only in response to health-linked quitting advice, but also through the pre-emptive removal of health consequences as a relevant basis for future advice. In doing so, patients orient to the sequential organisation of the interaction in ways that constrain the pursuit of a quitting trajectory within the unfolding sequence. Another CA study examined how clinicians ask, advise, and act on smoking when giving very brief advice [13]. Treating smoking as a delicate issue, clinicians often linked smoking topics to their assessment of the patient's presenting concern or embedded it within routine checks (e.g., blood pressure). Clinicians also offered cessation support with low agency (e.g., using conditional clause) to manage anticipated or actual difficulties in giving advice [33], a pattern also found in other lifestyle

discussions [15-18, 31]. Previous work on patient resistance to smoking has also used coding-based approaches to identify resistance behaviours and their associated patient attitudes [34, 35]. The present study complements this work by showing how patterns of patient resistance to quitting advice are interactionally accomplished in real time within the context of SMI. In responding to clinicians' smoking management advice, we found people with SMI resist quitting advice through rejection. They do so by drawing on two key resources: here-and-now mental health concerns and expressions of indifference toward the health consequences of smoking. Common resistance responses from patients in other health behaviour literature include claiming prior action had been taken to address smoking or invoking social scenarios to justify smoking [17]. In our data, one form of resistance is accomplished through accounts in which patients display alignment with the relevance of smoking as a topic but sequentially shift away from cessation advice by orienting to the management of mental health concerns as a more immediate priority. In doing so, quitting is not explicitly rejected, but is rendered not currently actionable, and the pursuit of a cessation trajectory is not sustained in subsequent talk. A second form involves explicit rejection, where patients directly refuse cessation advice (e.g. "no"), often followed by accounts positioning smoking as non-negotiable. In these sequences, clinicians shift the advice trajectory, from cessation to smoking reduction.

Studies on smoking cessation in general populations have shown that patient resistance can be mitigated by carefully managing how the topic is introduced. For example, avoiding direct questions about why patients should stop smoking and steering away from linking cessation advice to health risks has been found to reduce resistance [11-13]. However, what appears distinctive in this trial context of smoking cessation advice for people with SMI is the complexity of, and priorities reflected in, participants' accounts for resistance**.** Cessation advice may inadvertently prompt people with SMI to articulate distressing thoughts or reinforce smoking as a coping mechanism, complicating the interaction and potentially leading clinicians to abandon the advice trajectory. People with SMI use accounts that explicitly accept, minimise, or even express indifference toward the health consequences of smoking (e.g., referencing cancer or death without concern). These accounts leave little room for the clinician to pursue the topic further. In some cases, people with SMI also escalate their responses by introducing distressing thoughts, which may not have surfaced had the topic of smoking not been raised. These accounts further reinforce the resistance and contribute to the early closure of the cessation discussion.

Clinicians' responses to these forms of resistance varied considerably. Some bypassed the patient's account by shifting the topic (e.g., to weight management), others pivoted to a harm reduction approach, and some attempted to manage extreme formulations produced by patients. In all cases, however, clinicians did not directly challenge patients' resistance. This pattern may point to a broader difficulty of managing resistance to quitting advice when it is grounded in mental health concerns. Previous studies on managing resistance in the vaccination of children show that if rejections were pursued by clinicians, around half of parents who initially resisted would agree [36]. In weight-loss consultations, it is found that interactional trouble was less pronounced when clinicians accepted refusals rather than seeking to overturn them [15-16]. Similarly, in smoking consultations, there were few instances of clinicians pursuing a response

to an offer of cessation support [11]. This stands in marked contrast to how health professionals normally pursue responses to treatment recommendations [37-38]. Our data show that clinicians usually acquiesce the patients' resistance. One noticeable exception was their seamless transition from cessation to reduction.

4.2 Conclusion

Addressing smoking-related health inequalities among people with SMI is challenging because quitting is often deprioritised in the context of competing mental health and social concerns. These difficulties are compounded by clinicians' challenges in raising and sustaining smoking cessation discussions. Recognising how resistance to quitting advice is interactionally produced can support more flexible and tailored cessation approaches that better align with patients' priorities.

4.3 Practice Implications

Analysing authentic interactions provides practical strategies (e.g., acknowledgement, topic-shifting, and harm-reduction framing) for validating mental health concerns while managing smoking. Understanding patient resistance and equipping clinicians with tailored responses is essential for managing resistance effectively and reducing smoking-related health inequalities among people with SMI. Our findings underscore the need for tailored communication strategies when addressing smoking in the context of SMI. It is important to note that our findings do not suggest that patients with SMI are categorically more resistant than others. Rather, within this trial context, participants were randomised on the basis that they had explicitly reported no intention to quit smoking, which is likely to have shaped their orientation to subsequent cessation advice. While this may partly account for resistance as a recurrent interactional outcome, the resistance they occasion, may also be shaped by different mental health concerns and are accomplished through a range of interactional strategies. When patients foreground mental health concerns to implicitly reject cessation advice, clinicians' acknowledgements can function as validation of those concerns, helping to preserve the therapeutic relationship while keeping smoking on the agenda. In such cases, clinicians may productively shift from cessation to harm-reduction approaches. In cases of explicit rejection, where patients present smoking as non-negotiable and downplay health risks, clinicians' use of acknowledgements without further pursuit may reflect a strategic decision to avoid escalating resistance. Recognising when continued advice is interactionally treated as redundant may help clinicians judge when to pause, defer, or reframe smoking discussions, rather than repeatedly reintroducing cessation advice that patients have clearly rejected.

Making these strategies visible through training and guidance may support clinicians in responding flexibly to resistance, while reducing frustration and contributing to more equitable smoking-related care for people with SMI.

One limitation of this study is that the dataset does not capture instances in which clinicians actively pursue or act upon patients' resistance to quitting advice. As a result, the analysis cannot specify the full range of strategies clinicians may use to manage resistance in smoking-

related discussions. Future research could examine the specific strategies clinicians employ to manage resistance in discussing smoking with people with SMI.

A further limitation of this study is that the sequential organisation of the trial may have shaped clinicians' responses (e.g., acknowledgements such as 'mm') to patients' resistance to quitting advice, in that within this trial design the management of resistance could be followed by progression to randomisation and discussion of alternative interventions (e.g., e-cigarettes).

Although audio-recording may introduce some degree of reactivity in principle, previous research suggests that its impact on consultation behaviour in clinical contexts is minimal once interactions are underway [39–41]. In this study, smoking-related talk occurred within routine annual review consultations for chronic conditions rather than being the sole focus of the encounter, which further limits the likelihood of any meaningful recording effects.

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