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Communication Study

Are there interactional reasons why doctors may find it hard to tell patients that their physical symptoms may have emotional causes? A conversation analytic study in neurology outpatients

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ABSTRACT

Objective: This qualitative study analyses patients' conversational behaviours to explore whether there are interactional factors that could explain why doctors find clinical encounters in which the diagnosis of functional symptoms (physical symptoms with presumed emotional causes) is explained and psychological treatment offered particularly challenging.
Methods: Twenty out-patient consultations between neurologists and patients with functional symptoms were recorded and analysed using Conversation Analysis. Patients' communication behaviour was characterised by pervasive interactional resistance. Instances of resistance were identified and counted.
Results: Interactional resistance was especially evident when the aetiology of symptoms and treatment recommendations were discussed. Resistance was expressed overtly (through disagreements, challenges, rejections) or more passively (through moves such as lack of engagement with the interaction, silences or the use of minimal responses).
Conclusion: This study provides objective evidence that doctors face interactional challenges when they try to explain that symptoms are medically unexplained and suggest psychological treatment.
Practice implications: Doctors may try to avoid provoking patients' overt resistance because they perceive it as unpleasant. However, the display of overt resistance enables them to deal explicitly with the grounds on which patients reject their explanations and recommendations, and to address patients' particular concerns.

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1. Introduction

Functional physical symptoms are medically unexplained and thought to have emotional causes. Functional symptoms constitute 10–20% of cases in primary care [1,2] and 16% of unselected outpatient encounters in neurology [3]. Despite the absence of organic abnormalities, these patients undergo diagnostic tests, receive inappropriate medical treatments (including surgery) and consume substantial healthcare resources [4–6]. They are as disabled as those with neurologically explained disorders, but more likely to be depressed and suicidal [7]. Non-epileptic seizures (NES) are the commonest functional symptom in neurology [3], accounting for 12–18% of new contacts in seizure clinics [8,9].

Previous research focusing on consultations with patients with functional symptoms in primary and secondary care settings has highlighted the fact that doctors find these encounters particularly difficult. For instance, consultations about functional symptoms are described as "contests" in which doctors' and patients' agendas collide [10]. Whereas patients seek legitimacy for their apparently physical complaints, doctors often try to reassure with "normal" test results but often without any further explanation [11–13]. Patients may feel challenged by the doctors' reassurance and conclude that doctors' do not believe their symptoms are real [14]. The doctors' attempt to normalise their experience may encourage patients to elaborate their symptoms and underscore the legitimacy of their complaints, feeding a vicious (collaborative) cycle of somatisation [12,15].

Doctors report that consultations in which they deliver the diagnosis of functional symptoms and recommend psychological treatment are particularly challenging [16]. Conversations with patients with NES, for instance, have been described as 'walking through a minefield' or as 'extremely difficult to manage' [17]. A

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study investigating how doctors talk to patients with conversion disorder has highlighted how they perceive the need to adapt what they say to the patients' receptiveness. Doctors tend to avoid discussing the psychological nature of the symptoms or psychotherapeutic treatment if they face resistance because they do not want to jeopardise their relationship with the patient [18,19].

The encounter in which neurologists explain their diagnosis of functional symptoms is clinically of great importance, because these symptoms can stop in a substantial number of cases after an explanation has been provided [20]. Furthermore, the successful psychosocial attribution of the symptoms is likely to be a key component of engagement in psychological treatment [21], which has been shown to be effective for a large proportion of patients [22].

Most previous investigations of consultations with patients with MUS have used post hoc interviews [16] or methods based on the coding and counting of segments of content [23–25] or communication function (such as 'elaboration of psychosocial disclosure' or 'catastrophisation') [13,15,25,26]. Even though content coding methodologies have provided helpful insights into medical consultations, they are associated with some short-comings. The Roter Interaction Analysis System (RIAS) [27], for instance, which has been most influential in this area, has been criticised because some important categories of communication content are ambiguous. It may, for example, be difficult to distinguish reliably between talk about socio-emotional or medical matters in this patient group [28,29]. Most importantly, coded events tend to be analysed out of the micro-interactional context in which they occurred, thus failing to account for the interactional dynamics constituting the very basis for understanding their actual meaning [30–33]: the meaning of each utterance and the social activity it conveys is shaped by the utterance it responds to [34,35].

These shortcomings can be overcome by using Conversation Analysis (CA), which accounts for the turn-by-turn unfolding of talk and focuses on the meaning of utterances, as they are interpreted by the participants in the evolving interaction and in relation to the sequential context in which they occur: each utterance is influenced and shaped by the talk of the previous speaker [34,35]. CA is a "bottom-up" approach and not based on pre-constituted categories of content or interactional events [31,34,35]. All CA observations are derived directly from close study of 'data'—audio- or video-recordings of interactions which are transcribed in their most minute details [30,34,35]. The use of CA does not preclude 'coding and counting', but CA codes interactional observations rather than content [31]. Coding at this level of abstraction can be combined with quantitative methodologies to answer practical questions, such as whether a diagnosis of epilepsy or nonepileptic seizures is more likely [36,37]. In view of its particular focus, CA seemed the ideal method to explore whether there are interactional reasons why doctors may experience encounters in which they explain the diagnosis of functional symptoms and recommend psychological treatment as such a challenge.

2. Methodology

2.1. Sample

Between February and May 2009, three doctors in two clinical neuroscience centres (Sheffield Teaching Hospitals NHS Foundation Trust and Southern General Hospital, NHS Greater Glasgow & Clyde) recorded a total of twenty conversations in which they anticipated having to explain a diagnosis of MUS and recommending psychological treatment. Three encounters were video-recorded, 17 patients only consented to audio-recordings. Patients' median age was 38.5 (range 20–75), 60% were female. Sixteen encounters occurred in outpatients, four in an inpatient setting. Seventeen of the patients had NES, three other neurologically unexplained symptoms (weakness, paralysis, pins and needles, e.g. "functional sensory symptoms"). Some patients had more than one symptom (see Table 1 for clinical and demographic details).

Seizures ('non-epileptic attacks' or 'non-epileptic seizures') were the commonest functional symptom (17/20 cases). The

Table 1
Clinical and demographic details.

Patient	Age	Diagnosis in consultation	Certainty of diagnosis from the consultation	Treatment discussed/offered during the consultation
Kelsey	40	NES	Yes	Psychotherapy
Michelle	38	NES or epilepsy	Yes	Psychotherapy
Andy	61	NES (+subjective memory problems)	No	Psychotherapy
Jude	48	Functional disorder (weakness, pain, fatigue)	No (clear) diagnosis (i.e. no clear label)	Admission to specialised centre
Chris	36	NES	Yes	Psychotherapy
Rose	50	NES	No	Psychotherapy, further tests
Kevin	34	NES	Yes	Psychotherapy
Joyce	55	NES and epilepsy	No	Psychotherapy, admission to specialised centre, further tests
Sharon	33	NES	Yes	Psychotherapy
Claudia	36	NES	Yes	Psychotherapy
Edith	34	NES	NES certain, possibly single epileptic seizure in past	Psychotherapy, stopping anti-epileptic drugs (AEDs)
Christian	34	NES	Yes	Psychotherapy
Jenny	29	NES	Yes	Psychotherapy
Cath	20	NES	Yes	Psychotherapy
Julie	75	NES	Yes	Psychotherapy
Chloe	46	NES+suspect that she suffered from epilepsy in the past	NES certain	Psychotherapy, admission to specialised centre to be taken off AEDs
Mark	51	NES	Yes	Psychotherapy
Fred	30	Functional disorder (paralysis)	Yes	Psychotherapy
Simon	41	NES	Yes	Psychotherapy
Steph	39	Functional disorder (paralysis, pins and needles, etc.)	Yes	Psychotherapy+physiotherapy

Extract 1. Passive Resistance (Kevin 393–416)

The doctor tries to identify psycho-social problems which could have made an aetiological contribution to Non-Epileptic Seizures (NES) and may motivate the patient to accept a recommendation for psychological treatment:

```
1   D:  I don't know what other problems you've discovered. d' you,d'

2       you go out the same as you did be[fore?

3   K:                                    [no.

4       (.7)

5   D:  d' you have friends the same as you did before ( )?

6       (.9)

7   K:  no.

8   ?:  .hhhh

9   D:  see, you know, there are consequen[ces. and often then

10  K:                                    [yeah

11  D:  people think that they're they're weird, they become isolated,

12      they, they worry about approaching people, they become

13      dependent more on others, they, the

14  K:  m[m.

15  D:   [are much lesser than an (.4) an independent [person.

16  W:                                               [mm.

17      (4.5)

18  D:  and and um and and that can undermine them further.

19  W?:   ((clears throat - 2 beats lasting 1.2 secs))

20      (2.3)

21  D:  so sometimes it seems to come out of the blue and then e

22      HHHHH. just
```

(D: doctor, K: Kevin, the patient, W: wife).
Even though Kevin collaborates with the interactional project of the doctor, his responses to the doctor's questions display passive resistance. First, by limiting his reply to the first question to a polarity marker (l. 1–2; l. 3, ''no''), the patient responds in a minimal way, with no elaboration. The answer to the second question (l. 5) is preceded by a delay of almost 1 s, indicating interactional trouble (l. 6) [50]. The acknowledgement token (''yeah'', l. 10) offered in response to the upshot of the questions posed by the doctor (''there are consequences'', l. 9) is characterized by a flat intonation: whilst this indicates a receipt of the information given by the doctor, it displays only formal but not substantial alignment. The long silences which follow the doctors' talk indicate major interactional trouble [50]. Having only offered weak alignment with the doctor's interactional project, the patient drops out of the interaction at this point by remaining silent, thus displaying passive resistance to the main points made by the doctor. The patient's silence makes it more difficult for the doctor to continue (as evidenced by the formulation effort seen in the doctor's talk after 4.5 s. silence in line 17).

diagnosis of non-epileptic attacks remained unproven at the time of the recorded encounter in three cases, in all other cases typical attacks (not associated with ictal epileptic discharges) had been recorded by video-EEG.

2.2. Method of analysis

We used CA to examine the recorded data. By focusing on the actual interactional and linguistic resources speakers use in conversation, CA investigates the methods they employ to achieve social activities as they unfold step-by-step in interaction. CA has previously been used to examine the interactional underpinnings of many different social actions in medical settings including the communication of diagnoses [38,39], provision of advice [40], negotiation of treatment decisions [41], and the communication of bad news [42,43]. Of particular relevance to this study are descriptions of how doctors achieve psychosocial attributions when talking to patients with medically unexplained symptoms (MUS) in primary care settings [18,19], and of the resources doctors employ when they anticipate patients' resistance [44], or when patients resist advice and treatment recommendations [45–48]. Importantly, CA studies have yielded insights with immediate significance for optimal clinical communication practice: For instance, one study showed that the use of "is there something else you want to address in the visit today?" as opposed to "is there anything else you want to address in the visit today?" as a closing question dramatically increases the coverage of topics patients would present to doctors [49].

In this study we initially produced verbatim transcripts of all consultations. In the first step of our analysis of the data we focussed on the activity phases (like history-taking; discussing the diagnosis) and isolated those of particular interest: the presentation of the results of the tests, delivery and explanation of the diagnosis, presentation of the aetiology of symptoms and treatment recommendations. These sequences were transcribed in greater detail to capture the more fine-grained aspects of talk using the method elaborated by G. Jefferson (such as silences, overlapping talk and in-breaths; see Table 2) [50]. To enhance the readability of quotes, we have simplified the transcripts used in this paper: we have retained only those features of talk relevant for the point made in the analysis. All names have been pseudanonymised.

In line with CA methodology, we did not approach the data with any preconceived ideas about the likely findings or about interactional observations suitable for coding. However, in the second analytic step, we identified patients' resistance to the doctors' interactional objectives as the outstanding feature of these encounters. In keeping with previous CA studies of interactional resistance, we distinguished between two main categories: passive and overt ('active') resistance [40,45–48]. Passive resistance comprised actions like remaining silent (extract 1, line 17; extract 3, line 8) providing only minimal responses and/or acknowledgements (extract 1, lines 3 and 7); or withholding affiliative moves (such as confirmations, collaborative completions/elaborations, reformulations, volunteering of new information, questions, positive assessments, agreement

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Extract 2. Passive Resistance (Fred 487–96)

After the doctor has explained the aetiology of the symptoms he explicitly invites the patient's opinion:

```
1   D: Does that sound um plausible to you, do you think that that's

2      reasonable [or does that sound very unlikely?

3   F:            [.HHHHHH

4   F: It sounds reasonable but I can't (2.4) apply it to me.

5   D: You can't apply it to you, yeah.

6   F: It's, there is nothing.

7      (2.5)

8   F: I can't think of any bad things that

9   D: Yes, (    ) and [so.

10  F:                 [I'm trying to (   ) huh huh huh
```

(D: doctor, F: Fred).

By inviting the patient's opinion, the doctor is anticipating resistance to his explanation [42,43]. At first, the patient gives a positive assessment of the doctor's explanation (that traumatic experiences can cause physical symptoms) but then denies that this possible link can be used to explain his symptoms (line 4). This is followed by quite a general account. The structurally positive assessment is given through a format which displays mis-alignment with the doctor (by repeating some of words the doctors used in the question: "reasonable") [51]. Moreover, note the stress on "can't" and the extreme case formulation used in the first part of his account ("there's nothing"; [52]), which make it difficult for the doctor to challenge the patient's statement.

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with the doctor and overt acceptance of treatment recommendations). Overt resistance comprised moves like disagreements, rejections (extract 3, lines 10–21), denials (extract 4, lines 8–9), disaffiliative moves or challenges (for instance, Chris intervened in the doctor's explanation with "well how?" as the doctor is telling him how all possible physical causes of his problem have been ruled out).

In a third analytic step, we got a first impression of the distribution of resistance in the different action-sequences of the encounters. In view of the close links between overt and passive resistance [40,47], we focussed on tokens of overt resistance because these could be identified more easily. Each turn indicating overt resistance as described above was counted as one token.

2.3. Statutory approvals

This study was conducted with the approval of the Sheffield Ethics Review Committee and the Research Departments at the Sheffield Teaching Hospitals NHS Trust and NHS Greater Glasgow & Clyde Health Board.

Table 2
Legend transcription conventions.

Transcript details	Explanation
(.5), (1.2)	Numbers in brackets indicate silences measured in tenth of a second.
A: [so B: [I'm	Square brackets indicate simultaneous, overlapping talk
()	Empty brackets indicate stretches of talk which could not be transcribed
I can't	Underlined words or syllables indicate stress
BUT	Capital letters indicate louder voice
.Hhhhh	Indicates inbreaths
Huh	Indicates laughter
£it's just where it is£	The pound symbol – '£' – indicates 'smiley voice": i.e. that part of the utterance is produced in a way which may anticipate laughter
Nods	Non-verbal communication is indicated in italics

Extract 3. from Passive to Overt Resistance (Steph 365–84)

The doctor is explaining the psychosocial aetiology of symptoms after having provided his diagnosis.

```
1  D: and often there are other stresses that have=have

2     triggered them (.) comin'=on in later life. Um: even

3     though the o-=origins of it may go back, way back to

4     childhood;=it's something (.6) quite (.4) a bit closer to

5     home that's causing the immediate problems.

6     (.6)

7  D: .hhh but not unfortunately very easy to treat.

8     (4.2)

9  D: Does that sound a plau:sible explanation for you=to you?=

10 S: =To=to be honest I- I don't believe in things like that.

11    (.6)

12 S: I'm a::=I'm a counsellor, I'm well edu[cated and (1.0)

13 D:                                       [°mm.°
```

```
14 S: I=I understand that some people may hang=on to:: to

15    baggage and traumas a::nd (.5) but it's (.) it's not how

16    I live my life. I don't (.6) don't believe in: in the

17    pas'.

18    (.8)

19 S: So:: (.4) >it's very difficult for me because if the only

20    way of treating this is by going back to the past,< (1.2)

21    it's something that (.4) that I=I don't believe in.

22    (.)

23 D: >Mm.<
```

(D: Doctor; S: Steph)

Here the doctor is explaining the psycho-social aetiology of symptoms after having presented his diagnosis of functional disorder. At first the patient passively resists the doctor's explanation by remaining silent: i.e. she withholds active participation (see l. 6, 0.6 s. gap; line 8, 4.2 s. gap) [40,47]. When the doctor asks for her evaluation of his explanation (l. 9, ''Does that sound a plau:sible explanation for you = to you?'') [43], she immediately responds with an outright rejection (l. 10, ''=To=to be honest I- I don't believe in things like that.''). She continues with an extensive account which undermines the basis of the doctors' explanation (lines 12–21).

3. Results

3.1. Structure of the consultations

The structure of these consultations differs slightly from the typical structure of other medical encounters [30], as these are not first appointments: the patient had already seen the same doctor, or other doctors from the same medical team, for the current complaint. The primary aim of these consultations was to present the diagnosis and discuss treatment recommendations. The specific nature of the encounters is reflected in the five phases in which most encounters (16/20) could be subdivided: history-taking, presentation of test results (or, in one case, the overt assessment of physical examination), presentation of the diagnostic conclusion, explanation of the aetiology of symptoms and treatment recommendations. Whilst this structure was readily apparent in twelve consultations, the doctor switched backwards and forwards among interactional phases in the other encounters (i.e. some issues were discussed recurrently).

3.2. Overt versus passive interactional resistance

The most evident interactional challenge faced by doctors in the examined encounters was patients' resistance: Some degree of resistance was evident in all interviews examined here (20/20, 100%). Overt resistance occurred in 15/20 interviews (75%), passive forms in 18/20 interviews (90%). Whilst resistance was pervasive in some interviews, it was more sporadic in others. For instance, the most adversarial consultation of the entire corpus was characterized by eleven occurrences of overt resistance, whereas there was only one occurrence in four cases and none in five.

Extracts 1 and 2 show evidence of resistance in a passive format. In extract 1, the patient's passive resistance makes it more difficult for the doctor to construct a link between his psychosocial problems and his symptoms. In extract 2, the patient expresses passive resistance first by minimally aligning with the doctor's general explanation (line 4) but then denying that it can be applied to his specific case (lines 4, 6, 8).

Extract 3 is similar to (2), in so far as here as well the patient accepts that functional symptoms could be caused by trauma from the past but then rejects this explanation for herself.

In extract 4, resistance is even more overt: the patient immediately rejects the doctor's explanation through an outright denial.

Patients may also resist in overt but slightly less confrontational ways. In extract 5, for instance, Jude undermines the previous diagnosis of the doctor and rejects his treatment recommendations by asking for more tests.

Extract 4. Overt Resistance (Chris 1074–80)

Here the doctor makes general attributions which implicitly categorise the patient as a person with NES and a person who is likely to have experienced traumas in his life.

```
1   D:     we often see that nine out of ten people (.5)


2                                   _____


3                                      C. nods


4      with non epileptic seizures (.2) have a traumatic event or


5      _____/


6        C nods


7        something that is [really exceptional


8   C:                    [BUT I HAVEN'T (.25) Y'KNOW WHAT I MEAN


9   C:   I KNOW I HAVEN'T


10       _____/


11       C shakes head
```

(D: Doctor; C: Chris)

The implicit attribution that the patient has NES is not rejected (the patient nods during this part of the doctor's explanation), displaying alignment to this point. By contrast, the attribution that the patient may have had traumatic experiences in the past is immediately rejected in an outright and unmitigated fashion (lines 8–9). Firstly, the patient interjects the doctor's utterance at a point at which the doctor clearly has not finished his utterance [53]. Secondly, the patient starts with a contrastive token (''but'') and he carries on with a negative formulation through which he rejects the statement being made by the doctor. His utterance is composed exclusively of denials, i.e. he does not give an explanation and/or account for his statement. His rejection is also characterized by louder voice (indicated by capitals) and stress on ''I know'' (indicated by the underlining). The force of the rejection suggests that the patient resists the diagnosis of NES, despite previously showing a degree of alignment. By denying the psychosocial causes usually associated with NES, he implicitly rejects this possible diagnosis.

3.3. Distribution of interactional resistance

In total we identified 57 occurrences ('tokens') of overt resistance in the 20 encounters. Resistance tokens were not distributed evenly throughout the encounters. These occurrences were much less frequent in those phases in which doctors presented test results or discussed their diagnostic conclusions: we identified between 0 and 2 tokens per encounter in these phases. By contrast, overt resistance was more frequent in the phases in which doctors explained the diagnosis or recommended psychological treatment: 0–9 tokens per encounter were identified. 'Passive' resistance is more difficult to quantify but appeared to have a similar distribution.

Whilst the discussion of test results and diagnosis is solely in the epistemic domain of the doctors, psychosocial attributions are mainly in the patients' epistemic domain. As a consequence, patients are better able to challenge the doctor at these points. Patients could respond to psychosocial attributions of their symptoms with outright rejections or disagreements (5/20 patients, 10 instances). They might deny the presence of trauma in their lives (extract 3, "but I haven't (.25) you know what I mean I know I haven't", lines 8 and 9); or reject a link between adverse experiences in their lives and emotional consequences, even when doctors based these links on information previously given by patients themselves. For instance, Chris talked about his depression associated with suicidal thoughts. When the doctor reintro-

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Extract 5. Overt Resistance (Jude 1286–95)

The patient here rejects the proposals about treatment previously proposed by the doctor:

```
1  J:     But if you have the tests and it and it and it out: and

2         it (.4) over rules something out rules something then:

3         (.) that's fine innit

4         (.4)

5  J:     (          ) wouldn't it with [(          )]

6  D:                              [See I mean I::]

7         I think- I have no more tests to offer. You know

8         I think you've you've you've you've had them.
```

After having passively resisted the doctor's (non-)diagnosis and his treatment recommendations of seeing a physiotherapist and a psychotherapist (data not shown), the patient overtly suggests to have further tests to rule out any other potential physical causes of his symptoms (lines 1–3, 5) [47]. After his rejection of this proposal, the doctor's turn is characterized by formulation effort (''I think you've you've you've you've had them.'', line 8) indicating an orientation by the doctor to this activity as problematic [54–57].

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duced this issue and related it to the fact that he had not been able to work, the patient forcefully rejected the doctor's suggestion by providing an account demonstrating that the link is not correct (''no I'm ALways busy''). Three patients (Jude, Chris, Steph) implicitly resisted the psychosocial attribution of their symptoms by stating explicitly that they were looking for or would prefer a physical explanation for their symptoms.

The link between patients' resistance and doctors' attempts to link the symptoms to psychosocial causes was highlighted especially by two consultations (Steph and Chris) in which psychosocial problems were explicitly sought by doctors *before* delivering the diagnosis. Once the possible link had been explicitly discussed, overt resistance remained evident throughout the rest of the encounters. Similarly, overt resistance was more frequent in those consultations in which the doctor interactionally involved the patient in a psychosocial explanation of the symptoms (extract 1) or explicitly invited the patient's opinion about the diagnosis (extracts 2 and 3) [58].

Treatment recommendations were also resisted, albeit on different grounds: Jude and his wife had been resisting the proposed (psychological) treatment quite strongly at various stages of the interaction: they had asked for more tests to explain Jude's symptoms, and to lead to more appropriate medical treatment (this was a recurrent theme in patients showing resistance). When Jude finally seemed to have accepted the recommended treatment and the doctor re-offered it, he explicitly rejected the doctors' suggestion with an account which did not take issue directly with the nature of the treatment but with the location of the hospital where the treatment was offered (''£it's just where it is £ huh huh .hhh (.7) it's a nightmare in London''; the pound symbol—'£' – indicates ''smiley voice'': i.e. that part of the utterance is produced in a way which may anticipate laughter). This negative assessment of the location implicitly rejects the offer of treatment. Patients could also take issue with the nature of psychological treatment and discuss their opinion on its likely ineffectiveness. Claudia, for instance, explicitly stated her intention to accept the treatment at first (extract 6). However, she then went on to express her doubt whether psychotherapy could actually work.

There was evidence that patients' resistance could affect the course of the interaction. In a number of instances, doctors discussed potential psychosocial problems recurrently because their initial attempts to establish links between symptoms and psychosocial causes had failed. In the most dramatic sequences examined in this study, the neurologist actually stepped back from making a treatment recommendation because his attempts to link the patient's symptoms to psychosocial causes were so strongly resisted, that there was no basis for a recommendation of psychological treatment.

4. Discussion and conclusion

4.1. Discussion

The phenomena demonstrate that there are interactional difficulties in consultations in which neurologists communicate the diagnosis of functional symptoms and recommend psychological treatment. Resistance from patients is the main feature characterising these interactions. In many of the encounters, patients' resistance is pervasive. It is strongest in those sequences in which doctors address the aetiology of symptoms and try to make psychosocial attributions. This particular focus of resistance is not surprising: patients are not in a position directly to challenge test results, the diagnosis itself or treatment recommendations (which fall within the doctor's area of expertise). Patients' resistance is maximal when topics are within their own epistemic remit. Focussing their resistance on psychosocial attributions allows patients to resist the diagnosis and recommendation of psychological treatment indirectly whilst staying within their own area of expertise (their subjective experience). By rejecting or not fully aligning with the doctors' psychosocial explanations, patients invalidate the diagnosis and rationale for psychological treatment. If the causes of the diagnosed condition do not apply to them, the diagnosis cannot apply regardless of any objective test results. Patients' failure to accept psychosocial attributions makes it very difficult for doctors to offer psychotherapy as the way forward.

Our data do not suggest that patients show interactional resistance because the doctor is giving them a 'non-diagnosis'. Doctors expressed their certainty about test results and the diagnosis, acknowledged the disabling nature of the patients' condition, discussed the nature and causes of the problems and offered treatment for them. In other words, they formally treated their conclusion that the symptoms are medically unexplained and likely to have a psychosocial or emotional basis very much as an ordinary medical diagnosis [54,58].

Patients' resistance seems also to have interactional consequences. There seems to be a co-occurence between patients' resistance and formulation effort (hesitations, self-corrections, reformulations) in doctors' utterances, indicating doctors' difficulties with the discussion of the psychosocial aetiology of symptoms and treatment recommendations (i.e. formulation effort is particularly evident in those sequences marked by particularly high level of patients' resistance; see extract 5) [54,55]. Doctors might also be 'forced' to discuss topics recurrently or abandon the idea of making a treatment recommendation altogether.

However, doctors' formulation effort was not always provoked by resistance. It was sometimes in evidence at the beginning of the encounters before patients had shown any resistance or in consultations in which patients were fully aligned with the doctor. These observations suggest that doctors were approaching these consultations with particular delicacy. This impression was also supported by their complex approach to the labelling of the diagnosis [58] and the use of indirect linguistic constructions like litotes, a rhetorical form employed indirectly to indicate a referent through negations (i.e. "this is not epilepsy") and through which doctors provide nonspecific explanations where more specific ones are due [59]. This raises the possibility that some of the resistance described above is generated or enhanced interactively by doctors' conversational moves, which may alert patients to points they may want to or are able to take issue with.

Extract 6. Conditional acceptance (Claudia 521–552)

Here the doctor has been proposing psychological treatment and the patient produces a conditional acceptance:

```
1   D: .hhhh And psychologist can't of course (.) beam things into your

2      head any more than I can so, you know, it is a two-way thing

3      that you have to kind of participate [in.

4   C:                                      [OK,

5      so far as I want to do this cos I'm, I'm, I would be quite

6      happy to do [that um (.4) if I was willing to do this

7   D:             [(    )

8   C: and I worked really hard, (.) this is this is my concern.

9   D: mm mm.

10  C: right I work really, really hard

11  D: ye[ah

12  C:   [I'm really up for it.

13  D: yeah.

14  C: I'm very open about it.

15  D: yeah.

16  C: I don't feel judged,[that I don't feel it's negative, I feel

17  D:                     [yeah.

18  C: it's positive.

19  D: yeah.

20  (.4)

21  C: and it still doesn't work.
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22  D: yeah.

23  (.4)

24  C: I mean my fear is,

25  D: =yeah.

26  (.)

27  C: and I'll be tryin' to be honest; (.5) I didn't try they'll

28     think I didn't try hard enough.

29  D: e[r.

30  C:  [or they'll think this or they'll think that or

31  D: e [e

32  C:   [THERE IS a definite anxiety to hear about that.
```

At first glance one might think that Claudia is accepting the treatment offer. However, her acceptance is not only conditional with regard to the actual effectiveness of treatment: this sequence is also characterised by linguistic features displaying resistance. For instance, when she explicitly states her willingness to accept treatment, the start of the second part of her utterance features a self-repair (''I'm I'm I would be quite happy to do that'', l. 5–6), through which she switches from the present tense (''I'm I'm'') to the conditional (''I would be''). Moreover, she makes quite explicit claims which might seem quite redundant. In lines 12 and 14 she overtly accepts the offer through two upgraded formulations (''I'm really up for it'', ''I'm very open about it''). In line 16, she uses a litotes, a rhetorical device through which a referent is indirectly indicated through its negation (''(I don't feel) it's negative'') [59]. Through the litotes she makes an implicit positive appraisal which is subsequently made explicit (''I feel it's positive'', line 18). Through all these apparently redundant features, she is underscoring the truthfulness of her statement and her commitment to it, which is, however, later contrasted with the subsequent turns in which she expresses her reservations about the treatment [39]. It seems that this resistance was anticipated by the doctor, when he presents psychotherapy in a rather qualified way, highlighting the need for engagement from the patient to assure success (l. 2–3, ''so you know it is a two way thing that you have to kind of participate in'').

Our findings of the co-occurence of resistance and formulation effort, as well as extended spates of conflictual talk arising from overt resistance, offer interactional reasons why consultations with patients with functional symptoms or MUS may be difficult for doctors and how they may be experienced as 'contests'. Our findings offer complementary insights to those of studies using other methodologies, which have shown that doctors' and patients' agendas may clash in such encounters [10,12,13,16,23].

However, there are also important differences between our findings and those of previous studies analysing encounters with patients with MUS. Several such studies in primary care settings demonstrated that patients actually wanted to discuss psychosocial problems and volunteered stressful or difficult events whilst doctors avoided discussing psychosocial problems and treating them as possible causes of the symptoms [15,18,23]. In our data, patients rarely volunteered psychosocial problems. If they did, they were usually trying to stress that their current symptoms could not possibly be related to psychosocial issues because they had not had any symptoms when they were facing much more significant emotional problems in the past. In other words, they use these reports to reject doctors' current aetiological model. We suspect that these differences are explained by the fact that patients involved in our study had much more chronic and disabling functional symptoms than patients described in the primary care studies. In fact the resistance seen in our patients may be the result of cycles of collaborative somatisation resulting from previous healthcare contacts with the same problem [12,15].

4.2. Study limitations

This study has a number of limitations. The relatively small number of cases allowed us to focus on conversational details but means that the findings cannot necessarily be generalised to different settings, especially outside a secondary care environment. The majority of our patients had NES. Although our findings are in line with reports using other methodologies, like post hoc interviews [16] or methods based on the coding of content [15,23–25], interactions with patients with other functional symptoms or MUS could be different. Our study also only describes the communication behaviour of three different doctors. It is possible that some aspects of the patients' interactional activities could be related to the idiosyncratic styles of these doctors. However, overt or passive resistance was found in encounters with all doctors to a greater or lesser extent, although they deployed rather different conversational strategies. The change in the number of resistance tokens reported in Section 3.3 should be interpreted with caution as a rough and tentative indicator of the prevalence of the described phenomenon because resistance tokens were coded by a single analyst without reference to a coding manual. Due to limitations of space the authors had to focus on patients' interactional activities. The limitations of space mean that doctors' possible interactional contribution to patients' resistance (as discussed in Section 4.4) will need to be explored more fully elsewhere [54,58].

4.3. Conclusion

Our study reveals that there are interactional reasons why neurologists may find encounters in which they discuss their conclusion that symptoms are functional in nature and recommend psychological treatment as challenging. These encounters are characterised by patient resistance. Passive resistance was evident in most interactions studied, overt resistance or clear disagreements between patient and doctor were present in three quarters of all consultations. Doctors may experience this degree of resistance as challenging and as a threat to their medical authority. Given that conflict or overt disagreement is very unusual in the doctor-patient setting and may well be experienced as unpleasant, doctors may make attempts to avoid it—for instance by not making psychosocial attributions or by not recommending psychological treatment [16].

4.4. Practice implications

Patients' resistance is pervasive in these interactions, justifying the descriptions offered of these consultations in previous studies as particularly challenging. Most of the resistance is related to the doctors' psychosocial attribution of the patients' physical symptoms. However, some resistance may be related to doctors' use of interactional resources anticipating possible problems and orienting to these interactions as potentially problematic. Resistance is not necessarily a bad thing: Even though overt resistance can be experienced by doctors as challenging, it also provides them with an opportunity to drive forward their interactional aims. When patients strongly oppose doctors' explanations by making the grounds of their rejection explicit, doctors can address the patients concerns or look for other ways which may allow patients to engage with psychological treatment. In contrast, more passive resistance, marked by a failure to engage with the doctor's explanation, makes it much harder for doctors to convince patients of their own point of view. Whilst an outpatient clinic encounter with a silent patient may be easier to tolerate than one with a patient who openly rejects a psychosocial explanation to their symptoms or a treatment proposal, it may actually be of strategic interest for the doctor to bring the patient's objections out into the open. This could be achieved quite inoffensively by saying "I notice that you were very quiet when I explained what may have caused your symptoms".

We confirm all patient/personal identifiers have been removed or disguised so the patient/person(s) are not identifiable and cannot be identified through the details of the story.

References

[1] Peveler R, Kilkenny L, Kinmonth AL. Medically unexplained physical symptoms in primary care; a comparison of self-report screening questionnaires and clinical opinion. J Psychosom Res 1997;42:245–52.

[2] Weijden T, van der Velsen M, van Dinant GJ, Hasselt CM, van Grol R. Unexplained complaints in general practice: prevalence, patients' expectations, and professionals' test-ordering behaviour. Med Decis Making 2003;23:226–31.

[3] Stone J, Carson A, Duncan R, Roberts R, Warlow C, Hibberd C, et al. Who is referred to neurology clinics?—the diagnoses made in 3781 new patients. Clin Neurol Neurosurg 2010;112:747–51.

[4] Barsky AJ, Orav EJ, Bates DW. Somatization increases medical utilization and costs independent of psychiatric and medical comorbidity. Arch Gen Psychiatry 2005;62:903–10.

[5] Barsky AJ, Borus JF. Functional somatic syndromes. Ann Intern Med 1999;130:910–21.

[6] Fink P. Surgery and medical treatment in persistent somatising patients. J Psychosom Res 1992;36:439–47.

[7] Carson AJ, Ringbauer B, Stone J, McKenzie L, Warlow C, Sharpe M. Do medically unexplained symptoms matter? A prospective cohort study of 300 new referrals to neurology outpatients. J Neurol Neurosurg Psychiatry 2000;68:207–10.

[8] Angus-Leppan H. Diagnosing epilepsy in neurology clinics: a prospective study. Seizure 2008;17:431–6.

[9] Kotsopoulos IA, de Krom MC, Kessels FG, Lodder J, Troost J, Twellaar M, et al. The diagnosis of epileptic and non-epileptic seizures. Epilepsy Res 2003;57:59–67.

[10] Salmon P. Conflict, collusion or collaboration in consultations about medically unexplained symptoms: the need for a curriculum of medical explanation. Patient Educ Couns 2007;67:246–54.

[11] Coia P, Morley S. Medical reassurance and patients' responses. J Psychosom Res 1998;45:377–86.

[12] Fitzpatrick R. Telling patients there is nothing wrong. Brit Med J 1996;313:311–2.

[13] Marchant-Haycox S, Salmon P. Patients' and doctors strategies in consultations with unexplained symptoms. Interactions of gynaecologists with women presenting menstrual problems. Psychosomatics 1997;38:440–50.

[14] Werner A, Malterud K. It is hard work behaving as a credible patient: encounters between women with chronic pain and their doctors. Soc Sci Med 2003;57:1409–19.

[15] Ring A, Dowrick CF, Humphris GM, Davies J, Salmon P. The somatising effect of clinical consultations: what patients and doctors say and do not say when patients present medically unexplained physical symptoms. Soc Sci Med 2005;61:1505–15.

[16] Kanaan R, Armstrong D, Wessely S. Limits to truth-telling: neurologists' communication in conversion disorder. Patient Educ Couns 2009;77:296–301.

[17] Thompson R. What is it like to receive a diagnosis of non-epileptic seizures. Unpublished D.Phil dissertation. University of Sheffield, Sheffield, UK; 2007.

[18] Joosten A, Mazeland H, Meyboom-de Jong B. Psychosocial explanations of complaints in Dutch general practice. Fam Pract 1999;16:245–9.

[19] Burbaum C, Stresing AM, Fritzsche K, Auer O, Wirsching M, Lucius-Hoene G. Medically unexplained symptoms as a threat to patients' identity? A conversation analysis of patients' reactions to psychosomatic attributions. Patient Educ Couns 2010;79:207–17.

[20] Hall-Patch L, Brown R, House A, Howlett S, Kemp S, Lawton G, et al. Acceptability and effectiveness of a strategy for the communication of the diagnosis of psychogenic nonepileptic seizures. Epilepsia 2010;51:70–8.

[21] Howlett S, Grünewald RA, Khan A, Reuber M. Engagement in psychological treatment for functional neurological symptoms—barriers and solutions. Psychother Theor Res Pract Train 2007;44:354–60.

[22] Reuber M, Mitchell AJ, Howlett SJ, Crimlisk HL, Grünewald RA. Functional symptoms in neurology: questions and answers. J Neurol Neurosurg Psychiatry 2005;76:307–14.

[23] Salmon P, Dowrick CF, Ring A, Humphris GM. Voiced but unheard agendas: qualitative analysis of the psychosocial cues that patients with unexplained symptoms present to general practitioners. Br J Gen Pract 2004;54:171–6.

[24] Salmon P, Humphris GM, Ring A, Davies JC, Dowrick CF. Why do primary care physicians propose medical care to patients with medically unexplained symptoms? A new method of sequence analysis to test theories of patient pressure. Psychosom Med 2006;68:570–7.

[25] Ring A, Dowrick CF, Humphris GM, Salmon P. Do patients with unexplained physical symptoms pressurize general practitioners for somatic treatment? A qualitative study. Brit Med J 2004;328:1057–60.

[26] Peters S, Stanley I, Rose M, Salmon P. Patients with medically unexplained symptoms: sources of patients' authority and implications for demands on medical care. Soc Sci Med 1998;46:559–65.

[27] Roter DL. Patient participation in the patient-provider interaction: the effects of patient question asking on the quality of interaction, satisfaction and compliance. Health Educ Monogr 1977;5:281–315.

[28] Salmon P, May C. Patients' influence on doctors' behaviour: a case study of patient strategies in somatisation. Int J Psychiatric Med 1995;25:319–29.

[29] Salmon P, Ring A, Dowrick C, Humphris G. What do general practice patients want when they present medically unexplained symptoms, and why do their doctors feel pressurized? J Psychosom Res 2005;59:255–60.

[30] Heritage J, Maynard DW, editors. Communication in medical care: interaction between primary care physicians and patients. Cambridge: CUP; 2006.

[31] Heritage J, Maynard DW. Problems and prospects in the study of physician-patient interaction: 30 years of research. Annu Rev Sociol 2006;32:351–74.

[32] Charon R, Greene MJ, Adelamn RD. Multi-dimensional interaction analysis: a collaborative approach to the study of medical discourse. Soc Sci Med 1994;39:955–65.

[33] Stiles WB. Evaluating medical interview process components: null correlations with outcomes may be misleading. Med Care 1989;27:212–20.

[34] Sacks H. Notes on methodology. In: Atkinson JM, Heritage J, editors. Structures of social action: studies in conversation analysis. Cambridge: CUP; 1984 p. 21–7.

[35] Sacks H. In: Jefferson G, editor. Lectures on Conversation. Oxford: Basil Blackwell; 1992.

[36] Plug L, Sharrack B, Reuber M, Seizure. Seizure, fit or attack? The use of diagnostic labels by patients with epileptic or non-epileptic seizures. Appl Linguist 2010;31:94–114.

[37] Reuber M, Monzoni C, Sharrack B, Plug L. Using interactional and linguistic analysis to distinguish between epileptic and psychogenic nonepileptic seizures: a prospective blinded multirater study. Epilepsy Behav 2009;16:139–44.

[38] Heath C. The delivery and reception of diagnosis in the general-practice consultation. In: Drew P, Heritage J, editors. Talk at work: interaction in institutional settings. Cambridge: CUP; 1992. p. 235–67.

[39] Peräkylä A. Communicating and responding to diagnosis. In: Heritage J, Maynard DW, editors. Communication in medical care: interaction between primary care physicians and patients. Cambridge: CUP; 2006. p. 214–47.

[40] Heritage J, Sefi S. Dilemmas of advice: aspects of the delivery and reception of advice in interactions between health visitors and first time mothers. In: Drew P, Heritage J, editors. Talk at work: interaction in institutional settings. Cambridge: CUP; 1992. p. 359–419.

[41] Collins S, Drew P, Watt I, Entwistle V. 'Unilateral' and 'bilateral' approaches in decision-making about treatment. Soc Sci Med 2005;61:2611–27.

[42] Maynard DW. On clinicians co-implicating recipients' perspective in the delivery of diagnostic news. In: Drew P, Heritage J, editors. Talk at work: interaction in institutional settings. Cambridge: CUP; 1992. p. 331–58.

[43] Teas-Gill V, Maynard DW. On 'labelling' in actual interaction: delivering and receiving diagnoses of developmental disabilities. Soc Probl 1995;42:11–37.

[44] Mangione-Smith R, Stivers T, Elliott M, McDonald L, Heritage J. Online commentary on physical exam findings: a communication tool for avoiding inappropriate antibiotic prescribing? Soc Sci Med 2003;56:313–20.

[45] Stivers T. Participating in decisions about treatment: overt parent pressure for antibiotic medication in pediatric encounters. Soc Sci Med 2002;54: 1111–30.

[46] Stivers T. 'Symptoms only' and 'candidate diagnoses': presenting the problem in pediatric encounters. Health Commun 2002;18:41–74.

[47] Stivers T. Non-antibiotic treatment recommendations: delivery formats and implications for parent resistance. Soc Sci Med 2005;60:949–64.

[48] Stivers T. Treatment decisions: negotiations between doctors and patients in acute care encounters. In: Heritage J, Maynard DW, editors. Communication in medical care: interaction between primary care physicians and patients. Cambridge: CUP; 2006. p. 279–312.

[49] Heritage J, Robinson J, Elliott M, Beckett M, Wilkes M. Reducing patients' unmet concerns in primary care: the difference one word can make. J Gen Intern Med 2007;22:1429–33.

[50] Jefferson G. Notes on a possible metric which provides for a "standard maximum silence" of one second in conversation. In: Roger D, Bull P, editors. Conversation. Clevendon: Multilingual Matters; 1989. p. 166–96.

[51] Raymond G. Grammar and social organization: yes/no interrogatives and the structure of responding. Am Sociol Rev 2003;68:939–67.

[52] Pomerantz A. Extreme case formulations: a way of legitimizing claims. Hum Stud 1986;9:219–29.

[53] Schegloff EA. Overlapping talk and the organisation for turn-taking in conversation. Lang Soc 2000;29:1–63.

[54] Monzoni CM, Duncan R, Grünewald R, Reuber M. How do neurologists talk about medically unexplained symptoms: a conversation analytic study. J Psychosom Res; forthcoming.

[55] Houtkoop H, Mullen P. Talking delicacy: speaking about sexuality during gynaecological consultations. Sociol Health Illn 1993;15:295–314.

[56] Silverman D, Peräkylä A. AIDS counselling: the interactional organisation of talk about 'delicate' issues. Sociol Health Illn 1990;3:293–318.

[57] Silverman D. Describing sexual activities in HIV counselling: the cooperative management of delicacy. Text 1994;14:427–53.

[58] Monzoni CM, Reuber M. Linguistic and interactional restrictions in an outpatient clinic: the challenge of delivering the diagnosis and explaining the aetiology of functional neurological problems. In: Chevalier F, Moore J, editors. Constraints and interactional restrictions in institutional talk: studies in conversation analysis. Amsterdam: Benjamin; forthcoming.

[59] Bergmann JR. Veiled morality: notes on discretion in psychiatry. In: Drew P, Heritage J, editors. Talk at work: interaction in institutional settings. Cambridge: CUP; 1992. p. 137–62.