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How General Practitioners Raise Psychosocial Concerns as a Potential Cause of Medically Unexplained Symptoms: A Conversation Analysis

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ABSTRACT
A common explanation for medically unexplained symptoms (MUS) relates patients’ psychosocial concerns to their physical ailments. The present study used conversation analysis to examine how general practitioners (GPs) ascribe psychosocial causes to patients’ unexplained symptoms during medical consultations. Our data consisted of 36 recorded consultations from Dutch general practice. We found that GPs raise psychosocial concerns as a potential cause of MUS in 14 consultations, either captured in 1) history-taking questions, or 2) diagnostic explanations. Whereas questions invited patient ideas, explanations did not make relevant patient responses in adjacent turns and subordinated patients’ knowledge in symptom experiences to the GP’s medical expertise. By questioning patients whether their symptoms may have psychosocial causes GPs enabled symptom explanations to be constructed collaboratively. Furthermore, additional data exploration showed that GPs lay ground for psychosocial ascriptions by first introducing psychosocial concerns as a consequence rather than a cause of complaints. Such preliminary activities allowed GPs to initiate rather delicate psychosocial ascriptions later in the consultation.

Introduction
Medically unexplained symptoms (MUS) – also labeled persistent somatic symptoms or functional symptoms – are physical symptoms that cannot directly be attributed to detectable underlying diseases or an organic pathology. Treatment options are limited, which makes the general practice consultation itself the central place for management of MUS. Effective symptom explanations are crucial in MUS consultations, since they prevent unnecessary and potentially harmful diagnostic testing (Ring et al., 2005).

A common explanation for MUS links the experience of complaints to patients’ psychosocial concerns such as tensions, worries, or other (psychosocial) issues (Gask et al., 2011). Yet, patients often reject this ascribed link between symptoms and psychosocial concerns (Burbaum et al., 2010; Monzoni et al., 2011; Peters et al., 2009), which we refer to as “psychosocial ascriptions.” They sometimes hold different beliefs about the causes of complaints (Johansen & Risor, 2017) and the lack of a somatic explanation could undermine the legitimacy of their illness (Mik-Meyer & Obling, 2012). Patients may worry about being labeled as malingerers (Burbaum et al., 2010), or that symptom experiences are imagined or “all in the head” (Ding & Kanaan, 2016; De Rudder & Craig, 2016). The challenge for doctors, then, is how to communicate with patients who are potentially resistant and may hold conflicting ideas about causes and treatment of their physical, burdensome symptoms.

Fine-grained analyses of medical consultations show that doctors orient to the potential threat to the legitimacy of a patient’s illness by displaying delicacy of their (psychosocial) explanations. With delicate, we refer to the anticipation of a potentially unfavorable response (Burdett et al., 2019). During MUS explanations, GPs use delicacy markers such as implicit words (e.g., “tensions” rather than “mental”), and vague references (e.g., “you feel about this thing”) to talk about complaints and possible causes (Aiarzaguena et al., 2013; Burbaum et al., 2010). Explanations are designed with epistemic downgrades, presented as potential rather than actual as they co-occur with hesitations, and refer to what other patients may experience (Aiarzaguena et al., 2013; Monzoni & Reuber, 2015). Furthermore, while affirmatives prevail when discussing somatic causes, Joosten et al. (1999) observed that potential causes tend to be raised in interrogative form.

By treating symptom explanations as delicate, doctors orient to the different epistemic domains of their medical profession and patient experiences (cf. Heritage, 2012b). As Heritage (2012a) shows, doctors and patients have unequal epistemic access to diagnostic information, i.e. there is an information imbalance. Doctors are generally more knowledgeable (K+) in diagnostic testing and treatment decisions than patients. Both orient to this interactional asymmetry that entitle (Drew, 1991) doctors to have authority in biomedical reasoning, e.g., patients obliquely present candidate explanations (Gill & Maynard, 2006), and doctors merely assert diagnoses adjacent to physical examinations (Peräkylä, 1998). However, when symptom explanations relate to patients’ psychosocial environment, doctors are less knowledgeable (K-). Patients know their own psychosocial concerns and symptom experiences, i.e. these are in the patient’s “empirical realm” (Gill, 1998). Relatedly, doctors do not claim unconditional authority in diagnosing psychosocial complaints (Peräkylä, 1998). They rather ratify patients’ knowledge by cautiously ascribing
symptoms to psychosocial causes, and patients have resources to challenge the doctor at this point of the consultation (Monzoni et al., 2011).

Whereas previous research described various explanatory models for GPs (e.g., involuntary physiological processes or patients’ influence on symptoms) (Morton et al., 2017), this article aims to further refine our understanding of the social actions (e.g., asking or asserting) underlying GPs’ psychosocial ascriptions, and how they make relevant patient responses. This is especially relevant for MUS consultations because, although some patients initiate the relationship between emotions and symptoms (Bekhuis et al., 2020), GPs often find it hard to further explore patients’ emotions (Houwen et al., 2019), or to reach agreement on this relation (Banks & Prior, 2001; May et al., 2004). The primary aim of this paper is to examine how different forms of psychosocial ascriptions affect relevancy of patient responses in a selection of Dutch GP consultations about MUS. As a secondary aim, we explore how GPs lay grounds for ascribing psychosocial causes to symptoms earlier in the consultation.

Data and method

Participants and setting

The data for this study were drawn from a corpus of 390 videorecorded consultations of 20 GPs (see Houwen et al., 2017). After each consultation, GPs defined whether they thought patients had MUS, indefinite MUS, or medically explained symptoms; following previous research about MUS consultations (Ring et al., 2005). This resulted in a final sample of 43 patients with MUS. We analyzed 36 videos of 16 GPs in total (2 recordings had technical problems and 5 could not be viewed due to consent restrictions). Ten of the patients were male and 26 female, and of the GPs eight were male and eight females.

Analytic procedure

We used conversation analysis (CA) to analyze how GPs discuss the role of psychosocial concerns in patient experiences of complaints. CA is a data-driven, qualitative research method for the analysis of naturally occurring spoken interaction, aimed at uncovering interactional patterns that structure social action (Sidnell & Stivers, 2012). The data were transcribed verbatim. Names were replaced by pseudonyms and other personal information was deleted from the transcripts. Our analysis started with explorative analysis and data sessions of the MUS videos. Data sessions serve to generate observations, arrive at, or verify analyses. This led to the identification of the phenomenon that the discussion of potential psychosocial causes seems not to be “just” done by physicians, but that it involves a trajectory throughout the consultation; GPs seem to make small steps in the direction of psychosocial causes before they actually launch these. Next, one researcher (IS) identified all instances of psychosocial ascriptions, done either by GP or patient, in the data and transcribed these fragments according to CA-conventions (Jefferson, 2004).

We found that patients and GPs ascribed psychosocial causes to symptoms in 29 out of the 36 consultations of our dataset. This was not discussed in the remaining seven consultations. Patients initiated a psychosocial link to their symptoms in 15 of these consultations after GPs’ open-ended cause-seeking questions (Joosten et al., 1999) or by self-initiation – either as a potential suggestion or a rejection of the possibility. GPs initiated talk about psychosocial concerns in 14 of the consultations. Since our aim was to analyze GP-initiated psychosocial ascriptions, our analysis was restricted to this limited set of consultations. Our collection included 23 instances of GP-initiated psychosocial ascriptions. Ten GPs (4 female, 6 male) raised psychosocial ascriptions in consultations with nine female and five male patients. GP age varied between 37 and 69 years (M = 48.9, SD = 10.5) and patients were between 19 and 73 years of age (M = 53.2, SD = 16.2). The consultations ranged in length from 8:35 to 35:02 minutes with a mean duration of 20:17 minutes. In most of the consultations (11), patients made a return visit, with various reasons for the visit; e.g., headache, nausea, chest pain, blood pressure, and stomach pains.

Results

We identified two distinct ways in which GPs suggest the relevance of psychosocial concerns as explanatory for the patients’ complaints. As we will show, GPs ask patients whether they believe that their complaints relate to psychosocial circumstances, and/or they explain this psychosocial link to them. These differing actions to ascribe psychosocial causes to symptoms expect different responses in adjacent turns. Questions expect an answer in the next turn, whereas explanations do not make relevant a full response (patients withhold responses or provide minimal acknowledgment, and GPs interrupt elaborate responses). Furthermore, additional exploratory analyses suggest that psychosocial ascriptions – either as questions or explanations – are preceded by preliminary activities that create a context of talk about psychosocial concerns. Saliently, in this preliminary work psychosocial concerns are proffered as a consequence of complaints. The suggestion that symptoms lead to concerns tends to be unproblematically confirmed by patients. These initial observations suggest that preliminary activities could open up talk about potentially delicate psychosocial issues.

We first present the two different approaches of GPs in raising potential psychosocial concerns for the presented physical complaints. Next, we demonstrate an initial analysis of preliminary activities preceding these psychosocial ascriptions. Finally, we show an example representing the building blocks of psychosocial ascriptions, i.e. establishing concerns as a consequence of complaints prior to raising it as a potential cause.

Raising potential psychosocial causes of physical complaints

GPs initiate a discussion of potential psychosocial causes with 1) a history-taking question, or 2) a diagnostic explanation. See some examples of these two formats in various consultations in Table 1. The initiation of psychosocial ascriptions was less frequent with history-taking questions (4 out of 14 consultations) compared to diagnostic explanations (10 out of 14 consultations). History-taking questions were followed by diagnostic explanations later in the consultation, and GPs switched from explanations to questions in only two
Table 1. Psychosocial ascriptions as questions and explanations.

<table>
<thead>
<tr>
<th>History-taking question</th>
<th>Diagnostic explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP 5: But could it BE that-that when you hear something like that that it also has an effect on your body or not?</td>
<td>GP 4: Because you (.) you: (.) are WORried; because it really bothers you; -hhhh e::h w-w-w- (.) that only reinforce reinforces these kinds of complaints &quot;more&quot;.</td>
</tr>
<tr>
<td>GP 6: COULD IT ALSO be a-a e:h &lt; a reaction&gt; to e:h (0.5) e:h how you’re feeling &lt;mentally&gt;?</td>
<td>GP 5: E::hm &lt; do know&gt; that e:h physical complaints (.) &lt;become WAY worse&gt; when you are fretting about them all the time.</td>
</tr>
<tr>
<td>GP 7: Could there be something else that (.) e:h has an effect on these complaints (0.4) are there tensions: stress?:</td>
<td>GP 8: So that your &lt;BOdy is apparently reacting&gt; to all sorts of (0.4) well (.) in you- sometimes (.) -hh tensions, sometimes physical efforts.</td>
</tr>
</tbody>
</table>

Consultations. In the next section, we demonstrate that the design of psychosocial ascriptions affects patient responses in the next turn.

**History-taking question**

Extract 1 shows how history-taking questions about psychosocial causes elicit a patient response in the next turn. The consultation starts with a lengthy sequence about the patient’s son’s health condition and the complex relationship between the patient and son. Then, the patient presents the current complaints: irritable bowels. This patient has been suffering from these complaints for a long time. Despite a new treatment and a change of diet (line 1), she still experiences the complaints. The patient proffers a lay theory of these somatic aspects that are stressed in line 1 (“do you notice something there”) but only implicitly without a direct reference to the symptoms (“do something”) (Bergmann, 1992). The third question (line 4) aligns with the patient’s previous attempts to control or understand the occurrence of symptoms as stressed in line 1 (“do you notice something there”) (Silverman & Peräkylä, 1990). These implicit formulations (back-references, deictic expressions, mirroring patient’s words) indicate that the GP carefully introduces psychosocial concerns as a potential cause of complaints, thereby anticipating potential resistance. Psychosocial causes of complaints are thus carefully introduced with a history-taking question that acknowledges the patient as relatively knowing.

Though the GP carefully attempts to introduce the psychosocial ascription, there is disalignment between GP and patient.

Extract 1: History-taking question, rejected by patient (GP 1)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PT: &quot;ik krijg diarree van suiker (.). &quot;gebruik ik niet meer&quot;, sugar gives me diarrhea (.). &quot;don’t use it anymore&quot;,</td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>GP: [EN en en et dit] soort spanningen met Matthias?= [AND and it ] this kind of tensions with Matthias?=</td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>→-doen die daar nog wat in? merk je daar wat op? do they do something there? do you notice something there?</td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>GP: helemaal niet. (0.5) not at all. (0.5)</td>
</tr>
</tbody>
</table>
| 10 | PT: nee et is Z:O <onvoorspelbaar>; no it is s:o <unpredictable>;
First, she introduces the ascription without producing any uptake or confirmation of the patient’s lay theory about potential (somatic) causes (Gill & Maynard, 2006). Second, the patient responds with a straightforward “no” to the psychosocial ascription in line 5, despite the question’s positive polarity, i.e. expecting a positive answer (Boyd & Heritage, 2006). The GP then incrementally shifts to a relatively more “knowing” position on the epistemic gradient, pursuing a reconfirmation of the patient’s position with a reversed polarity repetitive question (“not affected by it?” line 6) (Koshik, 2002). By repeating the link, the GP indexes the patient’s answer as relevant for establishing a diagnostic hypothesis (Park, 2011), while, more importantly, not accepting her rejection of the suggestion. The GP increasingly strengthens her role as a medical authority as she persists to establish a potential link between concerns and symptoms. This culminates in an extreme case formulation as a candidate response (“not at all”) in line 9 (Schegloff, 2007) after the patient shakes her head in line 7, redoing her denial. Finally, the patient expands her rejection by referring to the unpredictable nature of complaints as a reason for denying the link (line 10).

The psychosocial ascription in this example is thus embedded as a history-taking question. The GP raises a potential psychosocial concern that may cause or exacerbate the complaints, but it is left to the patient to respond to. The interrogative syntax positions the patient as relatively knowing (K+) about the link between her psychosocial concern and the experience of complaints. Such response-eliciting actions differ substantially from an alternative practice for ascribing psychosocial causes to patients’ symptoms: diagnostic explanations.

**Diagnostic explanation**

In contrast to history-taking questions, patient responses only play a minor role when GPs raise potential psychosocial ascriptions as diagnostic explanations. Explanations usually occur during the diagnostic phase of the consultation when the GP evaluates the patient’s condition (Heritage & Maynard, 2006). Suggestions in this format have a declarative syntax and they inform rather than inquire about the potential link between psychosocial circumstances and physical ailments. We will show that patient involvement is now limited, which is typical for the diagnostic phase of the consultation (Heath, 1992). In other words, GPs and patients orient to the norm that GPs have medical authority in establishing a diagnosis when they use the explanation format.

Extract 2, which is the continuation of the interaction presented in extract 1,

**Extract 2: Diagnostic explanation format (GP 1, continued)**

<table>
<thead>
<tr>
<th>Line</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>“m hm.” *pt *hh ja dat is natuurlijk waker hè,=</td>
</tr>
<tr>
<td>12</td>
<td>“m hm.” *pt *hh yeah that happens more often right,=</td>
</tr>
<tr>
<td>13</td>
<td>-bij: e::[h &lt;SPASTI]SCHE DARMEN&gt;,=</td>
</tr>
<tr>
<td>14</td>
<td>=dat het zo onsp- onvoorspw- [&gt;SPELBAAR] is&lt;,</td>
</tr>
<tr>
<td>15</td>
<td>=that it is so unpr- unpredictw- [&gt;DICTABLE]&lt;,</td>
</tr>
<tr>
<td>16</td>
<td>PT: [en ALS IK]</td>
</tr>
<tr>
<td>17</td>
<td>[and IF I ]</td>
</tr>
<tr>
<td>18</td>
<td>GP: =dat het zo onsp- onvoorspw- [&gt;SPELBAAR] is&lt;,</td>
</tr>
<tr>
<td>19</td>
<td>=that it is so unpr- unpredictw- [&gt;DICTABLE]&lt;,</td>
</tr>
<tr>
<td>20</td>
<td>PF: [ja maa- ]</td>
</tr>
<tr>
<td>21</td>
<td>[yes bu- ]</td>
</tr>
<tr>
<td>22</td>
<td>GP: maar dat is E:igenlijk,</td>
</tr>
<tr>
<td>23</td>
<td>but that is in fact,</td>
</tr>
<tr>
<td>24</td>
<td>→ (ja) uit onderzoeken &lt;lijkt&gt; *hh dat inderdaad alle:n</td>
</tr>
<tr>
<td>25</td>
<td>(yeah) it seems from research *hh that indeed only</td>
</tr>
<tr>
<td>26</td>
<td>de &lt;emotionele:le problematiek&gt; echt een duidelijke invloed heeft,=</td>
</tr>
<tr>
<td>27</td>
<td>&lt;emotional matters&gt; really have a clear Influence,=</td>
</tr>
<tr>
<td>28</td>
<td>=en dat de rest v(h)aak hee:i l e:h eh onvoorspelbaar &quot;is&quot;.</td>
</tr>
<tr>
<td>29</td>
<td>=and the rest often is very e:h eh unpredictable.</td>
</tr>
<tr>
<td>30</td>
<td>“a- e:::h normaal gesproken”;</td>
</tr>
<tr>
<td>31</td>
<td>“a- e:::h generally speaking”;</td>
</tr>
<tr>
<td>32</td>
<td>*hhhh ik DENK dat e:::h[m:]</td>
</tr>
<tr>
<td>33</td>
<td>*hhhh I THINK that e:::h[m:]</td>
</tr>
<tr>
<td>34</td>
<td>PT: [maa]::r als ik nou to[ch (?) ]</td>
</tr>
<tr>
<td>35</td>
<td>[but]::t if I st[i]ll (?) ]</td>
</tr>
<tr>
<td>36</td>
<td>GP: [maar JE] HEB NATUURLIJK</td>
</tr>
<tr>
<td>37</td>
<td>[but OF ] COURSE YOU HAVE</td>
</tr>
<tr>
<td>38</td>
<td>#een-een-een he?=</td>
</tr>
<tr>
<td>39</td>
<td>a-a-a right?=</td>
</tr>
<tr>
<td>40</td>
<td>→der: der zijn gewoon wel wat afwijkingen te Zien ook,</td>
</tr>
<tr>
<td>41</td>
<td>→the: there are just some abnormalities to be seen too,</td>
</tr>
</tbody>
</table>
The GP’s explanation starts with a confirmation of the patient’s earlier claim that the complaints are unpredictable, and re-appropriates it as medical knowledge (“happens more often,” “spastic colons,” lines 11–12). The GP thus uses information from the patient’s expanded rejection as in accordance with the diagnosis.

Then, in contrast to the history-taking question (extract 1), the potential role of psychosocial concerns in causing the complaints is proposed as a diagnostic explanation (lines 17–19). We previously demonstrated how the GP gradually moved from K- to a more knowing position (Heritage, 2012a) by pursuing acceptance of the first psychosocial ascription. With the explanation format, the GP moves to further establish her role as a medical authority using several interactional features. First, this more “knowing” format tends to invite confirmation and sequence closure rather than projecting sequence expansion (Heritage, 2012a). Second, the claim is supported with a third-party reference to scientific research to lay grounds for the diagnosis (Peräkylä, 1998). Third, instead of referring to “tensions” to formulate the problematic mother–son relationship (see extract 1), the GP switches to emotionele problematiek. The Dutch problematiek is idiomatic and does not translate to English. The term refers to an aggregated level with all emotionally loaded problems in one specific domain, and is often used in psychological or health-related contexts, usually by health professionals. With this, the GP thus (“often,” “generally speaking”). Detached footing also serves another function; it bolsters the GP’s medical authority. Even though the patient may not see the link, the GP draws on medical research to claim that “emotional matters really have a clear influence” (line 18) on the affliction under discussion, hence on the patient’s complaints. The existence of a link between physical symptoms and emotional matters has now become indisputable, and the patient is only able to deny the possible link for her own case.

The patient attempts to contribute to the explanation three times. The first is in the midst of the GP’s explanation (“and if I,” line 13) and remains unattended. Then, the patient seems to initiate disagreement with the contrastive discourse marker “but” (Schegloff, 1987) in line 15 (“yes but-”) and line 22 (“but if I still”). Even though the GP reclaims the conversational floor in both instances, she attends the patient’s contributions by mimicking the patient’s “but,” and explicating scientific (“it seems from research,” lines 16–20) and sensory evidence (“some abnormalities to be seen,” lines 23–25) (Peräkylä, 1998) in support of her psychosocial explanation for the patient’s complaints.

Whereas the patient in extract 2 does not get the opportunity to respond to the diagnostic explanation, the patient in extract 3 could have taken a turn but remains silent. Despite a transition relevant place at the potential ending of the explanation, the patient does not produce a verbal response:

---

Extract 3: Diagnostic explanation format (GP 2)

```
1 GP: •hhhh e:n e::hm (0.9) ja ut-t-t-t tis tis: een e:h (1.3) het is #e:h ja;
   •hhhh a::nd e::hm (0.9) yeah it-t-t-t is: an e:h (1.3) it is #e:h yeah;
2   (0.8) #e-en het vergelyende is (0.9) •pt het is all- is-is
   (0.8) a-and the annoying thing is (0.9) •pt it is all- is-is
3 → dat op het moment dat je je ZORgen maakt over een lichaamsdeel,
   the moment you start WORrying about a body part,
   (0.3) •hh ga je vanZELF dat lichaamsdeel beter waarnemen.
4   (0.3) •hh you will automatically better detect that body part.
5 PT: (1.3) / {(minimal head nods)}
6 GP: “he’ dus je [gaat ]-
   “right” so you [will]-
7   [‘hm;∗]  
8 GP: op het moment dat je zorgen heb over een versleten knie?
   the moment you start WORrying about a worn knee?
9 PT: nou ja;-
   well yea:h;-
10 GP: =ga je die knie beter voelen want daar zit DREIGING in.
   =you will better feel That knee because it’s threatening.
```
and the indefinite “you” refers to how worries affect these sensations for people in general rather than the patient in the consultation room (Teas-Gill & Maynard, 1995). The falling intonation at the end of the GP’s turn creates a transition relevant place where the patient could take a turn.

The patient, however, withholds a verbal response (line 5) which is common in response to GPs’ diagnostic assessments (Heath, 1992; Peräkylä, 2002). By remaining silent, patients orient to doctors’ expert position in the delivery of a diagnosis (Maynard, 1991), and it could serve as a form of implicit resistance to the explanation. The patient’s “well yeah” in line 9 during the GP’s expansion of his explanation (line 6 and 8) suggests that the patient’s prior lack of verbal uptake indeed tacitly displayed her resistance to the explanation (Pomerantz, 1984). The GP does not attend the patient’s attempt to contribute and he continues his analogy between a worn knee and the patient’s complaints (her chest pain). Only later in the consultation, the patient disagrees in a slightly more explicit way by presenting new symptoms that counter the GP’s expansion (data not shown) (Peräkylä, 2002; Stivers, 2007). This extract shows that the diagnostic explanation format of psychosocial ascriptions does not necessarily require patients to respond – at least not as strongly as questions do.

To conclude, we identified two different ways in which GPs relate symptom experiences to potential psychosocial causes in MUS consultations. In line with previous CA research (Hayano, 2012; Heath, 1992; Schegloff & Sacks, 1973; Stivers & Robinson, 2006), we observed that history-taking questions strongly establish a relevance for patients to verbalize a – agreeing or disagreeing – response. They claim a relatively weak epistemic stance toward the potential explanation for the patient’s situation (Heritage, 2012a), and serve to arrive at a diagnosis later in the consultation. Explanation formats of psychosocial ascriptions, on the other hand, generate a weaker epistemic stance toward the potential explanation for patients to respond – at least not as strongly as questions do.

### Preliminary activities

Inherent to psychosocial ascriptions is that psychosocial concerns are presented as a potential cause of complaints. Additional exploratory analyses of our data suggested that, prior to discussing potential psychosocial causes, GPs engage in preliminary activities that create a context of talk about psychosocial concerns. Such activities establish the presence of patients’ psychosocial concerns, usually as a direct consequence of the presented complaints. The causal relationship between concerns and physical symptoms is thus reversed compared to psychosocial ascriptions that are raised later in the consultation. In contrast to psychosocial ascriptions, preliminary talk about psychosocial concerns is rarely met with resistance from patients in our sample. In this section, we tentatively show that establishing the presence of emotional distress may set a basis for discussing it as a cause of complaints later in the consultation. We use examples from two consultations different from the previous extracts.

Preliminary activities often occur during the history-taking phase after GPs have inquired about physical symptoms. For instance, in extract 4, the GP explores the patient’s physical symptoms through a series of question-answer sequences (Boyd & Heritage, 2006), e.g., about the physical sensations of the complaints (line 1). When the GP treats the patient’s contribution to this inquiry as sufficient, she marks the movement to a new topic with “yeah (0.9) okay (1.0)” (Beach, 1995). The question that follows in line 11 as part of the question-answer sequence addresses the emotional consequences for the patient being short of breath:

### Extract 4: Preliminary activity preceding a PA later in the consultation (GP 3)

<table>
<thead>
<tr>
<th></th>
<th>GP: voelt t alsof je een br(\text{\umlaut})t OK in de keel t(\text{\umlaut})ebt? does it feel as if you have a lump in the throat?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PT:</td>
</tr>
<tr>
<td>2</td>
<td>([y\text{\umlaut}A: \text{\umlaut}H.])</td>
</tr>
<tr>
<td>9</td>
<td>“ja” (0.9) “okey.” (1.0)</td>
</tr>
<tr>
<td>10</td>
<td>hhhhh=</td>
</tr>
<tr>
<td>11</td>
<td>GP: “ja” (. ) maakt je dat bang? “yeah ( . ) does it scare you?</td>
</tr>
<tr>
<td>12</td>
<td>PT: Y\text{\umlaut}EAH (0.6) gister zat k gewoon te&lt; kokhalzen omdat geen lucht meer kreeg. yesterday I was gagging ’cause I just couldn’t breathe anymore.</td>
</tr>
</tbody>
</table>

By empathically inquiring whether her complaints scare the patient (line 11), the GP shifts the history-taking activity that thus far concentrated on physical aspects, to the psychosocial domain. In line 12, the patient confirms and elaborates her “being scared”; she describes her physical reaction when she felt unable to breathe, which she legitimizes with several extreme case...
formulations (“gagging,” “just couldn’t breathe”) (Pomerantz, 1986). By corroborating the negative psycho-social impact, the patient thus illustrates the severity of her complaints, and she claims legitimacy of her current complaint (Heritage & Robinson, 2006).

Later during this consultation, the GP inquires “having tensions” as a more general state of mind (see extract 5), which follows after the patient and her mother further elaborated the severity of the patient’s complaints (data not shown). The GP seems to project an explanation that disaffiliates with the mother’s previous turn with the turn-initial “well you know” in line 47 (Asmuss, 2011; Heritage & Sorjonen, 2018). Yet, she self-repairs to launch another history-taking question in line 48, which refocuses the mother’s physical contribution (line 45) to the psychosocial domain:

Rather than feeling “scared” due to the complaints, the GP generally inquires whether she experiences “a lot of tensions lately.” This is denied by the patient as she shakes her head and says “no” (lines 49–50). The GP’s uptake of this denial demonstrates the conflicting interactional goals when establishing the presence of psychosocial concerns. That is, the GP challenges the patient’s denial by emphasizing with extreme case formulations that the symptoms “do really scare” the patient (Pomerantz, 1986). This claim sets the basis for raising it as a cause of complaints later on. The patient, however, minimizes this general implication (“just because”) (Lee, 1987), and she justifies feeling scared as a result of the severity of her physical symptoms (“it is getting worse every time” line 53). She hereby re-invokes the severity, and hence the “doctorability” of her complaints (Heritage & Robinson, 2006).

Extract 5: Inquiring mental state without direct link to complaints (GP 3, continued)

Extract 6: Topicalizing mental states in the summary of complaints (GP 4)
The final example of preliminary activities is taken from a consultation where the patient self-initiates his concerns in relation to the complaints during the history-taking phase. The GP formulates the patient’s worries about the experience of complaints in a summary of the history-taking phase:

The GP marks the shift from history-taking to the diagnostic phase in line 2 with “well what do you have” (Heritage & Sorjonen, 2018). The GP’s formulation first highlights the patient’s reported worries (lines 2–3). He thereby focuses on this specific aspect of the problem, moving away from physical symptoms as the primary focus of the consultation (Antaki et al., 2005). This is made explicit in lines 5–6, where the GP marks the patient’s concerns as the “most striking” of his symptom presentation. Thus, by formulating the patient’s worries at the beginning of the diagnostic phase, the GP marks this formulation as indicative for the diagnostic conclusions. 4

These explorative analyses suggest that preliminary activities of GPs might set a basis for ascribing psychosocial causes to patients’ symptoms. GPs achieve that psychosocial concerns are put “on record” before they are proposed as a potential cause of the complaints. Patients generally confirm feeling concerned due to the experience of complaints. This could endorse the severity of complaints and may also underline the legitimacy of the current visit. The cause-effect relationship is reversed when GPs raise psychosocial ascriptions; psychosocial concerns are then presented as a cause rather than a consequence of complaints. In contrast to preliminary activities, psychosocial ascriptions potentially threaten the visit’s legitimacy, because they would suggest that the problem is “psychological.”

**Building a psychosocial ascription**

So far, we presented short fragments of consultations to highlight specific formats of psychosocial ascriptions and preliminary activities. What the analyses of these short fragments did not show is that psychosocial ascriptions tend to be built up over the course of multiple sequences or phases of the consultation. Furthermore, while various patients in the previous examples resisted the psychosocial ascriptions made by GPs, resistance was not always pervasive in these consultations. Extract 7 shows an entire sequence of preliminary activities leading to a psychosocial ascription. This extract is different from earlier examples (e.g., extract 1), as the patient aligns with the carefully constructed psychosocial ascription. He suffers from tiredness and joint pain, and

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*Extract 7: Psychosocial ascription preceded by preliminary activities (GP 5)*

1 PT: (dan) (0.3) kon die ook zien wat het e:h (0.4) nieuwe medicijn deed. (then) (0.3) he could also see what the e:h. (0.4) new medicine did.

2 GP: [JA.] [YEAH.]

3 → jA (. ) *h *wat spannend; eigenlijk.= yEAH (. ) *h that’s quite frightening actually.=

4 PT: =echt wel. =definitely so.

5 GP: >kan men voorstellen dat je daar ook wel< van schrikt of niet? >I can imagine that this does somehow scare you or not?

6 PT: JA dan ben je wel eventjes [e::h] ja. (.) YES for a moment you are [e::h ]

7 GP: [JA; ] [YEAH;]

8 j:a (0.2) j[a.] yeah (0.2) y[eah.]

9 PT: [ja]: “hij zei dus ook van” e:h, [yea]:h “he also said like” e:h,

10 (1.5) three comma nine en als het naar boven gaat,= (1.5) three point nine and if it goes up,=

11 =dan vinden we dat e:h =then we’re considering it e:h

12 GP: JA. YEAH.

13 PT: (0.7) (?) als het boven vijf en een half en dan moet je geopereerd,= (0.7) (?) if above five and a half and then you need surgery,=


15 PT: [yes.] [ja.]
he recently discovered that he might have an aneurysm that needs surgery. When the patient describes the treatment he received from his cardiologist (new medication, line 1), the GP suggests that this might have caused serious worries in lines 3–15 (i.e. preliminary activities):

The GP establishes the presence of psychosocial concerns in two small consecutive steps (brackets 1a and 1b). First, by formulating “it’s quite frightening” (line 3), she produces an affiliative (Ruusuvuori, 2007) response that assesses the negative valence of the patient’s troubles telling (Prior, 2018). When the patient agrees a brief upgraded second assessment (“definitely so,” line 4) (Heritage & Raymond, 2005; Pomerantz, 1984), the GP carefully (“I can imagine”) inquires how this “may have scared” the patient in line 5. This inquiry invites the patient to provide a more elaborate response in which he confirms and illustrates his reason for being "scared"; i.e. he may need surgery (lines 9–13).

The affiliative assessment of the potential emotional impact of symptoms in lines 3 and 5 serves two functions. First, it validates the patient’s experience of psychosocial concerns. Next, it paves the way to ascribe psychosocial causes to the symptoms in lines 16–18 (bracket 2). The assessment thus leads to a topic shift that helps to complete the institutional task of finding potential causes of symptoms (Beach & Dixson, 2001; Ruusuvuori, 2007). Several hedges (“could it be”), hesitations (e.g., repetitions), and vague references (e.g., generic effect on Ruusuvuori, 2007) assess the effectiveness of the patient’s troubles telling (Prior, 2018). Scholars have shown that, even though doctors would find explaining MUS a challenge (Olde Hartman et al., 2009), “effective” explanations are likely to be the most powerful intervention that exists for MUS (van Ravenzwaaij et al., 2010). Our findings add new insights to previous research about symptom explanations for MUS in three ways. First, scholars have developed a classification of explanation types and their components to support doctors in explaining MUS (Morton et al., 2017). Whereas this taxonomy enables doctors to provide symptom explanations based on different contents, we have shown that different forms of symptom explanations, in specific with history-taking question format, may especially facilitate “effective” explanations.

Second, we demonstrated that GPs interactionally involved patients in diagnostic reasoning by asking them about the role of psychosocial concerns in their symptom experience. Since collaborating with patients would be crucial during symptom explanations (Burton et al., 2015; Salmon, 2007), we provided novel insights in how this can be achieved interactionally. By asking questions, doctors implicitly made suggestions for the potential diagnostic hypothesis, and they left room for the patient to express their ideas. Such practice could contribute to achieving patient-centered care, and stresses the importance for doctors to explore patients’ symptoms, thoughts, and ideas (Houwen et al., 2017).

Conclusion and discussion

Our analysis showed that GPs carefully ascribed psychosocial causes to patients’ symptoms in two ways; with history-taking questions, or with diagnostic explanations. While questions strongly established relevance for patients’ accepting or rejecting – responses, diagnostic explanations did not make relevant such responses. GPs claimed a relatively stronger epistemic authority over the interplay between patients’ psychosocial concerns and physical states with explanations than with questions. The way in which they introduced psychosocial ascriptions to the consultation thus pre-allocated the extent to which patients were accommodated to participate in this important moment in the consultation. Further, we tentatively showed that GPs lay grounds for psychosocial ascriptions by first introducing concerns as a consequence of physical ailments. These preliminary activities enabled GPs to propose psychosocial concerns as a potential cause of physical symptoms later in the consultation.

Two categories of symptoms were identified: diagnostic explanations (Burton et al., 2015; Salmon, 2007), we provided novel insights in how this can be achieved interactionally. By asking questions, doctors implicitly made suggestions for the potential diagnostic hypothesis, and they left room for the patient to express their ideas. Such practice could contribute to achieving patient-centered care, and stresses the importance for doctors to explore patients’ symptoms, thoughts, and ideas (Houwen et al., 2017).
Third, our analysis showed that GPs lay the ground for the delicate relationship between psychosocial issues and physical symptoms by first introducing psychosocial concerns as a consequence of complaints. Prior studies have shown that patients often resist psychosocial explanations (Burke, 2019; Monzoni et al., 2011) as it would make them accountable for their complaints (Robson & Lian, 2017). Preliminary activities, on the contrary, are usually accepted by patients as they underscore the doctorability (Heritage & Robinson, 2006) of complaints. This supports the notion that a “reversed causality” of symptoms leading to psychosocial concerns is better accepted by patients than vice versa (Burke, 2019). So, although these preliminary activities are empathic in validating patients’ concerns (Stommel & Te Molder, 2018), they also pave the way for making psychosocial ascriptions later in the consultations.

Previous research suggests that typically interrogatives are used to discuss psychosocial causes (Joosten et al., 1999), but in our corpus the explanation format was far more common. A potential explanation lies in the moment in the medical trajectory the consultation takes place. Possibly, questions with psychosocial ascriptions are useful for newly presented complaints, while explanations, offering less room for patient responses, may be more apt in subsequent consultations. Previous research also found that patients tend to be resistant to MUS explanations (Monzoni et al., 2011), while some patients in our data agreed with explanations presented by the GP. Patients may be more resistant to potential psychosocial explanations in secondary care environments or in subsequent GP visits. Future research should examine potential psychosocial ascriptions in relation to the medical trajectory beyond single visits.

There are some caveats in our findings that require further research. First, we restricted our analysis to GP-initiated psychosocial ascriptions, but in some consultations, not the physician but the patient claimed their symptoms could have psychosocial causes. Future studies need to examine in which interactional contexts patients self-initiate psychosocial ascriptions. Second, we provide an initial analysis of preliminary activities prior to GPs’ psychosocial ascriptions. The variety and scope of these activities need further examination. Third, we focused our analysis on consultations with patients presenting MUS, but some GPs interpreted the inclusion criteria for MUS more strictly than others, which may have resulted in a relatively diverse sample.

Practice implications

This study highlights that GPs introduce psychosocial concerns as a potential cause of MUS with history-taking questions or diagnostic explanations. Questions (e.g., “could it be that when you hear something like that, that it also has an effect on your body or not?”) invite patients to express their ideas, whereas explanations (e.g., “emotional matters really have a clear influence”) allow doctors to “tell their story” with relatively little patient participation. Questions value patients as experts in their symptom experiences. On this basis, it could be recommended that GPs should collaboratively construct symptom explanations by enquiring a potential link between symptoms and psychosocial concerns. Though GPs run the risk that psychosocial ascriptions are explicitly rejected when they are introduced as questions, explanation formats are just as little effective when they fail to be tuned in with patients’ ideas. In addition, empathically designed preliminary activities first put psychosocial concerns “on record” before they are proposed as a potential cause of complaints. This could be considered a patient-centered practice to validate and better understand patients’ psychosocial concerns. Yet, the potential downside is that GPs use such information against patients to overcome resistance to psychosocial ascriptions later in the consultation. Hence, GPs need to carefully balance between searching for potential psychosocial issues, while at the same time, listening to patients’ concerns and ideas. Tailoring explanations to patients and inviting patients to respond is crucial for providing effective explanations.

Notes

1. Also referred to as “psychosomatic attributions” (Burbaum et al., 2010). We use the term “psychosocial ascription”, since “psychosocial” refers to patient’s psychological (e.g., worries, depression) or social (e.g., family, work) concerns, and “ascription” causally links this to patients’ physical complaints. We also use “ascription” instead of “attribution” to prevent connotations of the psychological construct that underlies the term.
2. We use an example from the same consultation to demonstrate how both formats may occur in the same consultation. See Table 1 for (brief) examples from other consultations.
3. Later in the consultation, the GP provides the following psychosocial ascription: “It also has something to do with, right with the fact that you are very worried about it, that causes stress, which also makes it tense in here ((points to throat)).”
4. The GP (implicitly) ascribes “worries” as a potential cause of her complaints later in the consultation: “you’re feeling your large intestines, that’s obvious. And yeah you are worried about it, which makes you feel somewhat bloated”.

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