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Title:
When patients and clinician (dis)agree about the nature of the problem: The role of displays of shared understanding in acceptance of treatment

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Abstract

Globally, 4.4% of the world's population suffer from depressive disorder, and 3.6% from anxiety disorder. Previous work found considerable negotiation between providers and patients about the nature of mental health problems and frequent patient resistance to treatment. However, how doctor-patient shared understanding of the problem is reflected in treatment recommendations and whether this is consequential for patient acceptance of treatment is poorly understood. This study explored shared understanding of the problem and patient acceptance of treatment using conversation analysis. In 52 U.K. video recorded primary care consultations (collected July 2014-April 2015), 33 treatment recommendations for medication or talking therapy were identified. Shared understanding was explored focusing on: whether the patient presented the mental health problem as their primary initial concern and how they characterised the concern; whether the mental health concern was raised by the patient; and how the doctor aligned with the patient's earlier characterisation of the problem in the treatment recommendation itself. These phenomena were coded for each treatment recommendation and the impact on treatment acceptance was explored. Patients accepted the recommendation immediately in 38% cases and actively resisted in 62% cases. However, two communication behaviors were associated with patient acceptance: recommending treatment for the patient's initial focal concern and doctors' turn design *in* the recommendation itself, i.e., using the patient's earlier words from the initial problem presentation to describe and characterise the problem. Given the global burden of mental health problems and frequent patient resistance to treatment, understanding how professionals can engage more closely with the patient's perspective is important. When doctors use the patient's precise words from the initial problem presentation in the treatment recommendation, this displays an understanding of the patient's perspective and

personalisation of treatment based on the underlying biomedical or social causes, which then impacts on patient acceptance of treatment.

Introduction

Around 8% of the global population has a common mental health problem, with around 4.4% suffering from a depressive disorder and 3.6% suffering from an anxiety disorder (WHO 2017). The risk of becoming depressed is greatly increased by poverty, unemployment, employment conditions (low pay, zero hours contracts, hazardous conditions), other social inequalities and significant life events like bereavement (Allen et al. 2014). Depression is ranked by the WHO as the single largest contributor to global disability, accounting for 7.5% of all years lived with disability in 2015 (WHO 2017). In the UK, over 90% of patients with common mental health problems are managed solely by their General Practitioner (GP) (Goldberg & Huxley 1992) and around 40% of GP visits involve mental health concerns (MIND 2018). Mental health is intimately connected to physical health. People with mental health problems are at increased risk of physical health conditions, and people with chronic physical conditions (e.g. diabetes, chronic obstructive pulmonary disease) have poorer mental health: around 30 per cent of people with a long-term physical health condition also have a mental health problem, most commonly depression/anxiety (Barnett et al. 2012).

The National Institute for Health and Care Excellence (NICE) guidelines for the treatment of common mental health disorders (depression and anxiety) recommend antidepressants and talking therapy (NICE 2009). However, many patients come to the consultation with valid concerns about starting or staying on anti-depressants. Around half of people with major depression disorder do not benefit from initial antidepressant treatment and a different medication is usually tried (Connolly and Thase 2011). Articles in the mainstream press have drawn attention to anti-depressant side-effects including suicidal thoughts, fears about dependency and serious withdrawal effects. Recognising the need for additional treatment options, the Improving Access to Psychological Therapies (IAPT) programme was designed to improve access to talking therapies. While antidepressants were dispensed to almost 8 million people in England in 2019-20 (NHS Business Services Authority), there were also 1.6M referrals to IAPT in England in 2018-2019, set to rise to 1.9M by 2024 (NHS England

2018). Treatment usually consists of a course of Cognitive Behavioural Therapy lasting, on average, seven sessions.

Considerable research has been conducted on shared decision making, ranging from subjective reports of perceived involvement in decisions, to observational studies of decision making in healthcare consultations, to interventions to improve patient involvement in decision making. A systematic review of 86 randomised controlled trials implementing decision aids found that patients using decision aids were more knowledgeable, had a more accurate appreciation of risk and were more likely to have a care plan aligned with their needs and values (O'Connor et al. 2011). In a systematic review of communication practices that encourage shared decision making in recorded healthcare encounters, Land and Parry (2017) found that flagging that a decision needs to be made, eliciting the patient's perspective before proposing a course of action, laying out multiple options rather than a single option from the outset of the decision-making process and exploring reasons for patient resistance increase shared decision making.

Observational studies of shared decision making have focused primarily on the actual decision about a future course of action. Typically, this is when the healthcare professional makes a recommendation for a treatment and the patient is expected to commit, or not, to that treatment. However, as Land and Parry (2017) note, it is reasonable to assume that all communication during the consultation will impact on the decision-making process and patient acceptance/resistance to treatment. Some studies have moved a little further back, before the treatment recommendation is made, to examine preparatory decision-making talk. Eliciting the patient's perspective and views on treatment can bring these to the surface so they can be integrated into treatment recommendations and may be particularly useful in delicate contexts such as communicating an autism diagnosis to parents (Maynard 1991), end of life contexts or where professionals are anticipating patient resistance (Land and Parry 2017). Barnes (2018) investigated 'preliminary' recommendations, communicative

practices which enquire about previous treatments (e.g. "Have you tried anything before?"). They work to 'test the waters' (Clayman 2002), enabling the professional to do advance work and thus avoid making a recommendation that is ill-fitted. Indeed Barnes (2018) found that when GPs use a preliminary recommendation, patients accepted the treatment recommendation more often. In the emergency department, Bergen and McCabe (this issue) also found that patients were more likely to accept mental health treatment recommendations if they followed a preliminary recommendation.

It is also reasonable to assume that a shared understanding of the patient's health problem between the doctor and patient is likely to impact on patient treatment acceptance. Outlining how professional–patient communication influences health outcomes, Street et al. (2009) note that a key goal is that clinician and patient reach a shared understanding of the problem and agreement on the treatment plan. They note that patients and clinicians often see the problem through different lenses, which can manifest in disagreements about the nature, cause and severity of the problem, all of which have implications for treatment decision making.

In primary care consultations for physical health problems, treatment recommendations logically and typically follow diagnoses of the problem. Limited evidence suggests this may be different in mental health primary care consultations with problem presentation and history taking followed by treatment recommendations: typically there is no 'diagnostic moment (Heritage & McArthur 2019) with the labelling of mental health problems more likely to be negotiated between doctor and patient (cf. Ford 2020). Compared to most physical health problems which have demonstrable biomedical causes, the diagnosis of common mental health problems is viewed by GPs and patients alike as a negotiation rather than strictly in the doctor's domain of expertise (Parker et al 2020). For both GPs and patients, there are tensions between understanding emotional concerns as medical conditions or as arising from social stressors: GPs report that they are "reluctant to 'medicalize' patients'

concerns and differentiate between 'real depression' and normal sadness caused by an understandable response to difficult life circumstances" (Parker et al. 2020, p. 436).

The varying conceptualisation of patients' difficulties has consequences for treatment as it gives rise to different patient preferences and treatment offers from doctors. Patients who view their problems as rooted in life circumstances prefer non-medical approaches whereas those viewing their problems as a biomedical condition prefer medication (Johnston et al. 2007). Tate (2020) examined patient problem presentations for mental health concerns and identified two different types of problem presentations that shape the diagnostic outcome. 'Symptoms only' presentations of mental health concerns tend to favour questioning leading towards a physical health diagnosis whereas 'Lifeworld disruption' presentations of mental health concerns describing a causal link between mental health concerns and everyday life disruption (e.g., inability to do normal activities) favour further questioning leading to a mental health diagnosis. Karasz et al. (2012) found that patients' conceptualisations of their problems are further reflected in their narrative problem presentations, which then impact on treatment decisions. They found three different types of narrative problem presentations: a focus on symptoms (depression, feeling depressed); a focus on situation (life events); or a mixed focus on symptoms and situation. When patients presented with a life events narrative, doctors were less likely to offer medication. Moreover, doctors did not usually try to 'correct' patients' understandings and themselves distinguished between depression as 'life problem' versus 'real depression'. Hence, both patients' and doctors' conceptual models and social context play an important role in shaping the treatment plan in depression consultations. Geraghty et al (2019) interviewed GPs about their perceptions of emotional distress presentations and found they varied widely in how they explained emotional distress and whether it reflected a depressive disorder.

In ongoing secondary care for people with severe mental health problems, Bolden and Angell (2017) found that recommending treatment for psychotropic medication in this setting

is a complex course of action that includes building a case for a recommendation and eliciting acceptance in order to manage anticipated resistance, problems with adherence and side-effects. Other studies have examined how patients solicit medication changes in secondary care (Bolden et al. 2019) and decision making more broadly, e.g., in group meetings in a mental health rehabilitation community (Stevanovic et al. 2020). Also in repeat consultations in secondary care, Kushida and Yamakawa (2015) examined how psychiatrists cautiously approach treatment recommendations based on patient readiness for decision making. In particular, they are attentive to the patient's perspective on their subjective state and self-diagnoses. Previous research has found frequent patient resistance to proffered treatments for mental health problems in primary care. For example, Ford et al (2019) found that around three-quarters of recommendations for medication or talking therapy were resisted by patients.

Against the background of patient resistance to mental health treatments and the delicate nature of negotiating about the nature of the problem, what is not yet well understood is how shared understanding of the problem is reflected in mental health treatment recommendations and whether this might impact patient acceptance. This paper unpacks this concept of shared understanding by investigating what the patient orients to as the primary concern in their initial problem presentation, whether the mental health concern is raised by the patient or the doctor and how the doctor aligns with the patient's prior orientation to the problem in the treatment recommendation. I then explore how doctors' displays of shared understanding impact on patient acceptance of treatment.

Data and Methods:

The data come from the One in a Million archive of recorded primary care consultations, collected from 23 GPs in 12 practices in England July 2014-April 2015. Patients were approached before their appointments and, if they consented, their consultation was recorded. 421 patients were approached and 300 (89.8%) agreed to future use by

researchers. Seven recordings failed, yielding 300 consultations. See Barnes (2017) and Jepson et al (2017) for further information on the One in a Million study.

The consultations were screened for common mental health problems, i.e., anxiety, depression, and stress (excluding conditions such as psychosis and memory problems), using the International Classification of Primary Care, Second edition (ICPC-2) codes. This yielded 52 recordings, screened for recommendations for antidepressants or talking therapy. Recommendations responsive to a patient-initiated request for a treatment were excluded. Twenty-three consultations (22 video and 1 audio recording) included 33 treatment recommendations: 16 consultations were with female patients, and seven were with male patients. Fourteen patients had a co-occurring physical condition, e.g., diabetes, heart disease, chronic obstructive pulmonary disorder. Mean patient age was 46 years (standard deviation [SD] 18, range 19–84). Mean consultation duration was 15:28 minutes (SD 0.21, range 7:13-25:51 minutes.

Each treatment recommendation sequence was transcribed in detail to denote micro-characteristics of speech such as pauses, overlap, stress, intonation and pace (Jefferson 2004). The patient's immediate and later responses to the treatment recommendation were coded as immediate acceptance, passive resistance or active resistance (Heritage & Sefi 1992, Stivers 2005, Stivers & Barnes 2018). Recordings and transcripts were used to analyse non-verbal behaviour (head nod, head shake, scrunched up face). Acceptance was indicated by acceptance tokens such as "Okay", "Alright"; "That's fine" with final intonation or assessments such as "Good" (Stivers 2005). Passive resistance was defined as acknowledgments" such as "mm hm", or "yeah" that withhold acceptance (Heritage & Sefi 1992). In the face of such acknowledgements, doctors typically pursed acceptance by adding information about the treatment ("Well it's a slightly different approach"), providing a further rationale (e.g. "You've got a really difficult situation there, anyone would probably feel

anxious, but it's kind of helping you to deal with it and helping you to get through that isn't it?") or issuing a patient view elicitor such as "What do you think?". Active resistance did not accept the recommendation, instead asking questions about the treatment ("What medication are you going to put me on?") or providing a reason not to accept the treatment, e.g., on the basis of preference ("I'm not keen on starting medication at the moment") or previous experience ("I've had that before"). All cases of patient active resistance were identified, either immediately after the recommendation or following initial passive resistance and doctor pursuit of acceptance.

To unpack the concept of shared understanding, I first analysed the transcripts and recordings qualitatively to examine how doctors and patients were orienting to the problem in the problem presentation and treatment recommendation. I started by focusing on what the patient described and what this suggested about causality, in the initial problem presentation (and later if relevant), how the doctor displays that they are attending to the patient's description and characterisation of the concern (in particular how their language matches that of the patient) and whether the patient or doctor raised the mental health problem. If the problem was not raised outright by the patient but rather raised by the doctor, this makes it more complicated for the doctor to address let alone display shared understanding about the problem with the patient. I coded the visits based on these findings, further discussed in the analysis section below.

Results:

In this paper I show how shared understanding is demonstrated or not through how doctors use the patient's language to characterise the problem. I then demonstrate that shared understanding is associated with patient acceptance of treatment. I offer two main types of evidence for this claim. After providing an overview of the dataset, I show qualitatively what (lack of) shared understanding looks like in this context and how patients come to the point of accepting treatment, focusing on how doctors' displays of shared understanding are key

to that. Next, I provide distributional support showing that patients are relatively more likely to accept treatment if the doctor has displayed a shared understanding of the problem through using the patient's language and characterisation of the problem as biomedical or social in origin.

Data

Treatment Recommendations: Across the 23 consultations with 23 patients, there were 33 treatment recommendations for a mental health problem involving 13 GPs. Ten consultations had recommendations for multiple treatments. In this context, the typical pattern was one recommendation for medication and one recommendation for talking therapy. Nine recommendations were to start medication (27%), five to review an existing medication (15%), and 19 to start talking therapy (58%).

Acceptance and Resistance: Patients actively resisted the proffered treatments over half of the time. Table 1 offers a summary of key findings and suggests both how fraught making a mental health treatment recommendation can be and the critical role that patients play in accepting these recommendations. In what follows, I will unpack each of these main findings. Of the 33 recommendations, 11 were immediately accepted. 4 were passively resisted; 8 were initially passively resisted and then actively resisted during further discussion; and 10 were actively resisted. Following active resistance in 18 cases, 10 recommendations were ultimately accepted following single or multiple rounds of patient resistance and doctor persuasion.

Resistance ranged from a single round to multiple rounds of resistance before ultimate acceptance or rejection. When stated, reasons for resisting medication were: wanting to put a brave face on it and not take medication (1), feeling anxious rather than depressed (1), preferring to try talking therapy first (1). Reasons for resisting talking therapy were: not wanting to participate in group therapy (1); having had counselling before and feeling unsure

if it would help now (2); previous negative experiences of talking therapy (2: feeling worse, counsellor thought I was abused and I wasn't); prefer to take medication first so I feel able to talk to someone (1); the problem is too deep-seated to be addressed by talking therapy (1); had student counselling but needs more specialized psychological work due to trauma (1); had cognitive behaviour therapy before and prefers a more person-centred approach; and, preferring a bereavement service (1).

Insert Table 1 here

Lack of shared understanding and resistance

I begin with a detailed analysis where a patient describes her reason for the visit as "vertigo" and "stress", for which the doctor recommends antidepressants and therapy. An analysis of the trajectory from problem presentation, to treatment recommendation, to diagnosis, to the patient's resistance towards the recommendations and diagnosis, reveal the ways in which shared understanding impacts on the patient's response to a recommendation.

In 1a below, the doctor and patient know each other well. The patient presents with a recurrence of vertigo and difficulty coping in lines 3-6.

(1a)
```
1.  Pat:        Right. I may look fine, but I am not.
2.  Doc:        Right.
3.  Pat: →      I've had this vertigo again, and I've done this, you
4.              know, and it does help, what you came and showed me. I'm
5.              just having a job to cope with everything. Had this back in
6.              August when my grandson got married
7.  Doc: →      [(Are y-)] are you feeli:ng:: stressed the:n,
8.                  [ºorº]
9.  Pat: → [(Uh-)   ] Yeah.
10.         Well (.) you know. It's Christmas coming up. I've
11.         got no mone:y I've got no washing machi:ne, .hhhh
12.         I've g(h)ot no (.) f::reezer got no be:d everything-
13.         you know- I'm- (0.5) everything's just (0.5) boiled up.
14. Doc:   Has it?
15.         (0._)
16. Pat:   Yeah. And on Sunda:y I spent the day in bed, .hhh
17.     →  I've just had this (0._) vertigo again, .hhh Which is
18.     →  all (0._) is all (0._) stress.
19. Doc:   Ri::ght.
```

In line 7, the doctor asks if she is feeling stressed: she confirms this and elaborates:

Christmas is coming up, she has no money and no washing machine/freezer/bed. In lines

17-18, she re-iterates she has vertigo again, attributing it to stress. At this point, the patient

has described her primary concern as vertigo and difficulty coping and has agreed with the

practitioner's characterization of her as stressed. Across the first half of the visit, she

continues to describe her health concerns as situational and relating to stress, as opposed

to based in a mental health condition such as depression. The practitioner makes a proposal

to start antidepressants in 1b (lines 2-3).

(1b)

```
1.  Doc:        If: you find you (need-) (0.7) (to think-)
2.     TR→   (yy)you're still feeling anxious the other thing to
3.      →      think about is antidepressants.I kno:w: you're not
4.               keen,
5.  Pat: Rs→ Well (.) the thing i:s (.) once you go on those,
6.  Doc:        Yeah?
7.  Pat: Rs→ Then you're on them (0.6) at least six months.
8.  Doc:        >At least six months.< That's right yea:h.
9.  Pat: Rs→ .hhh (Uh-) (0.9) No I'm- I – I h- I- I don't (.) I
10.            don't know.=I don't know whether I am depressed.
11.            (0.4)
12. Pat: Rs→ This anxi:ety thi:ng,
13.            (0.4)
14. Pat: Rs→ These (0.5) problems I have at the moment.
15.            (0.5)
16. Pat: Rs→ .hh I don't know.
```

He qualifies his recommendation with the recognition that the patient is not keen, as she mentioned earlier not wanting to go on anything long-term. In lines 5 and 7, the patient initially actively resists the proposal with a concern about long-term use of anti-depressants: a six-month commitment to medication would not fit with her perspective, i.e., her symptoms are caused by short-term situational stressors. She continues to resist in lines 9,10,12,14 and 16 contesting the implicit diagnosis - that she is depressed - as the basis for the recommendation, characterising her problem as 'anxiety' in line 34 arising from her current financial and social problems "at the moment". By resisting the recommendation for antidepressants based on a lack of shared understanding about the cause of her symptoms, the patient makes relevant a move to establish shared understanding of the problem.

At this point, the doctor suggests using a questionnaire (the Patient Health Questionnaire – PHQ9) to establish whether the patient is depressed (see Ford et al. 2020). On the basis of the patient's responses, in (1c) the doctor delivers a diagnosis in an epistemically downgraded way "I would say (0.3) you have- (.) you are depressed". "You have-" is cut off and reformulated as "you are depressed" echoing the patient's description in (1b line 10) "I don't know whether I am depressed". Being depressed is described by patients as a

temporary mood state with depression described as a more long-lasting illness. This more cautious formulation ("are depressed" rather than "have depression) may be responsive to the patient's previous questioning of being depressed and her characterisation of her problems as arising from her current financial and social situation "These problems I have at the moment" (1b, line 14). The patient responds emotionally to the diagnosis with long silence, sighing in (h) and out (hx) and looking down (lines 3-7). In line 8, the doctor issues another recommendation "We've got various treatments for that, We've got (0.4) um talking therapies". Before the doctor has finished explaining talking therapies, the patient interrupts in lines 11-15, strongly resisting this recommendation, this time on different grounds, namely that she has already tried talking therapy and has difficulty traveling to attend (lines 19 & 21).

(1c)
```
01  Doc: Dx→  Okay. Well (.) looking at that I would say you (0.3)
02       →    you have- (.) you are depressed.
03                 (5.2) ((Mouse clicking))
04                 (h::)
04  Pat:  →   (°Heh.°)
05        →    (13.5) ((Mouse clicking, patient breathing))
06  Pat:  →   hx:: yea:h. [resigned tone, looks down]
07                 (0.6)
08  Doc: TR→  We've got [var-  ] various treatments for that, We've
09  Pat:           [(What-)]
10  Doc:           got (0.4) u::m we've got talking therapies which ar[:e]
11  Pat: Rs→                                    [ I]'ve
12                 don:e- I've [done that     ] uh:: (.) ((Service)) I've
14  Doc:                    [((Service))   ]
15  Pat:           done that before.
16  Doc:           Okay.
17  Pat:           Yeah.
18                 (0.4)
19  Pat:           I've done that.
20                 (0.6)
21  Pat:           .hhh But the problem is getting up here to do it.
22  Doc:           Sure.
23                 (0.4)
24  Doc:           Sure.
25                 (1.6)
26  Doc: TR→  pt. .hhh Well what do you (.) say to me trying
27                 an antidepressant as well as the valium for a
28                 little while.
29  Doc: Rs→  What antidepressants are you going to give me?
30  Doc:      [.h h h h U::h I ] would suggest using (.) um (0.8) pt.
31                 (1.1) probably (1.1) fluoxetine,
32       Rs→       (1.0)
33  Doc:           It's Prozac?
34                 (0.5)
35  Pat: Rs→  .hhhhha:h No:hhh!
36                 (0.__)
37  Doc: TR→  We could use another one (called- use) citalopram,
38                 (0.__)
39  Pat: Rs→  Are th- are th- are th- are they gonna keep me awake at
40                 ni:ght. Because that was what Doctor [((Name)) said ] to
41                 me once.
42   Doc:                                 [    (Sure.)]
43       TR→   I've got one that doesn't. One which makes you go to
44                 sleep.=You take it at night it makes you feel- (0.__)
45                 [makes you] sleepy. [Would you like to-]
46  Pat:      [Yea:::h. ]      [    See I think] if I could sleep,
47  Doc:      Sure.
48  Pat:      That would help me.
49  Doc:      No problem. Let's give you one that makes you sleep okay.
50  Pat: Ac→  Yes.
```

The doctor makes a second recommendation for an antidepressant in lines 26-28 "What do you say to me trying an antidepressant as well as the valium for a little while?". This is resisted (line 29) with the patient querying the type of antidepressants. On hearing "It's Prozac", the patient rejects this outright with a very loud inhalation and an extended and animated "No:hhhh!". In line 37, the doctor issues a third recommendation for a different antidepressant, also resisted by the patient on the grounds that it might keep her awake at night (lines 39-41). The doctor issues another a fourth recommendation with the offer of a different antidepressant to help her sleep (lines 43-45). By attending to the patient's concern about not being awake at night with an antidepressant that will make her sleepy, the doctor finally secures acceptance in line 50. Although the patient finally accepts antidepressant medication, the patient engages in multiple rounds of resistance which expose the lack of shared understanding about the nature of the problem, with final acceptance based on addressing a specific sub-problem (sleep) rather than depression per se.

To summarise, the patient presents with vertigo due to stress because of her current life circumstances. The treatment recommendation for an antidepressant does not fit with the patient's characterization of her problems as caused by temporary social stressors. This case shows how the words used by the patient in the problem presentation and the doctor in the treatment recommendation reflect different underlying assumptions about the explanatory cause: the patient is seeking a solution for vertigo due to stress so the recommendation for an antidepressant is ill-fitted. The resistance here exemplifies the problems that we see across the dataset when doctors do not sufficiently display that they have a shared understanding of the problem with patients.

Shared understanding and acceptance

Next, I present a detailed analysis of a case in which a patient and doctor jointly establish the patient's presenting concern as "bulimia" for which the doctor then recommends antidepressants and therapy. Analysing the trajectory from problem presentation, to

diagnosis, to the patient's response towards the treatment recommendation, reveal the ways the practitioner was able to demonstrate shared understanding of the problem and how this shapes this patient's acceptance of treatment.

In extract 2a, the patient describes a recurrence of bulimia in her initial problem presentation.

(2a)
1. Doc: What have you booked the appointment about [name]?
2. Pat: I'm an international student and I just got here, in [city],
3.   →   one month ago, to do a Masters. **I've had bulimia** for ten
4.   years, but since I got here, it got really worse and I'm
5.   having this huge crisis.

After the initial problem presentation, the doctor explores the patient's symptoms in more detail and they both use the term bulimia throughout the consultation. Later in (2b), the doctor asks about her bulimia (line 1) in the run up to the treatment recommendation.

(2b)
1. Doc: →   Have you always had **bulimia?** Or did you have anorexia before
2.   bulimia?
3. Pat: →   No. It was always **bulimia.**
4. Doc: **Always bulimia?**
5. Pat: **Yes,** since I was fifteen years old.
6. Doc: Yes, okay fine. Do you have any contact with your
7.   psychologist or your psychiatrist, in [country]?
8. Pat: No, not really anymore.

She asks if she always had bulimia or had anorexia before: the patient accepts the terms of the question and responds affirmatively (Stivers & Hayashi 2010). The doctor accepts the patient's response. In this way, the patient is treated as having epistemic rights over labelling what she is experiencing as bulimia. After an enquiry about contact with professionals in her home country, the doctor moves to recommending treatment, with two treatments worth considering in (2c).

(2c)
```
1.    Doc:  .hhhh So: (.) in (0.4) in this situa:tion th- I guess there
2.             are two thin:gs that are hh probably worth thinking about
3.  →         doing.=One is restarting: medication, Oka[y, .hh]h Uh: th
4.             (.) restarting=
5.    Pat:                                      [Yeah. ]
6.    Doc:  =fluoxeti-=Did you find that helpful¿ [ Befo]re¿
7.    Pat:                                 [Yeah.]
8.    Doc:  Yeah.=
9.    Pat:      =Yeah. [Very.]
10.   Doc:       [  So] we can put you back on that quite easily
11.            but it will take a couple of weeks [to work.     ]
12.   Pat:                          [Yeah I know th]at.
13.   Doc:  Yea[h?]
14.   Pat:    [ I] know.
15.   Doc: →But I think that's probably a good idea do [you.]
16.   Pat: →                                [ Yea]h.
17.   Pat: →   I think so too.
```

The first is restarting medication. The patient accepts this as something worth thinking about in line 5. As the patient has been on medication before, the doctor names the specific medication (fluoxetine) and asks if she found this helpful previously, a practice used to gauge a patient's experience of treatment to tailor the recommendation and increase acceptance (Barnes 2018; Bergen and McCabe, this issue). The patient confirms in line 7 that she found this medication helpful, upgraded to 'very' helpful in line 9. The doctor adds that the medication will take a few weeks to work in lines 10-11 and the patient accepts this based on her previous experience (lines 12 and 14). With these caveats and marking this as an idea to be ratified by the patient ('I think' 'probably'), the doctor proposes in line 15 to proceed with restarting medication. The patient accepts and endorses this idea in lines 16-17 with 'Yeah. I think so too'.

The second treatment recommendation for talking treatment is issued in lines 18-21 in extract 2d. This is accepted in line 24 in an upgraded way with 'I would really appreciate that".

```
(2d)
18. Doc:    And the other thing that might be helpful is that we have
19.  →      (0.4) u:m an eating disorders servi:ce called First Step,
20.         U::m pt. .hh which is tck. for people- mainly for people
21.         With bulimia actuall[y:,      ] Um and I could refer you to
22.     →   them,
23. Pat:                        [ Yea:h.]
24. Pat:→   I would really app[reciate that.]
```

In summary, this case shows how the patient describes and explains her difficulties in the

initial problem presentation using the diagnostic label bulimia. The practitioner follows the

patient's lead in orienting to it in this way and the treatment recommendations reflect this.

There is immediate patient acceptance of both recommendations. By contrast, the previous

case shows how the patient and doctor have different understandings of what the problem is

(vertigo caused by stress vs. depression) and how this impacts on strong patient resistance

to the recommendations for antidepressants and talking therapy. These shared (or different)

understandings are reflected in the specific turn design features, namely using (or not) the

patient's earlier description. This suggests that doctors who recommend treatment using the

patient's earlier descriptions are able to attain acceptance compared to doctors who do not

demonstrate understanding by using the patient's earlier descriptions. This is true even

though mental health problems are associated with high resistance and the presentation is

commonly fraught.

Distributional support for a link between shared understanding and treatment acceptance
I now turn to considering whether the ways that doctors demonstrate shared understanding

might matter to patient uptake. I show that patients are relatively more likely to accept a

treatment if the physician has displayed a shared understanding of the problem. I

operationalise shared understanding as follows: (a) Does the patient present a mental health

concern as the primary concern at the start of the visit and how is this characterised?; (b)

Does the patient initiate talk about mental health?; (c) Does the doctor recommend

treatment for the concern raised by the patient at the start of the visit?.; and (d) How does the doctor display that they have attended to the patient's description and characterisation of the concern in the treatment recommendation? I focus on comparing cases of immediate acceptance (N=11) to the recommendation or active resistance (N=18) at any point in the decision-making trajectory (i.e., immediately or after initial passive resistance).

The patient's orientation to the problem

(a)   Does the patient present a mental health related concern as the primary concern at the start of the visit and how is this characterised? Patients presented with either: a mental health concern as the primary concern (55%), e.g., feeling depressed, anxious or stressed, stress/bullying at work, a recent bereavement, running out of a prescription/sick note; a physical health concern (18%) such as needing a blood pressure check, stomach problems or arthritis; or a mental health and physical health concern (27%) such as knee pain and feeling very down or vertigo and stress (Table 2). As we might expect, when patients hint at a mental health concern but don't bring it up outright, this makes it more complicated for the doctor to address let alone display shared understanding about the problem with the patient.

Insert Table 2 here

(b)   **Does the patient initiate talk about mental health?** The mental health concern was raised by the patient in 61% cases and by the doctor in 39% cases. Hence in just over one-third of cases, the patient was not orienting to the mental health issue as the primary issue. This again can make it challenging for the doctor to reach shared understanding with patients about the mental health issue. When raised by the doctor, patients initially presented with a physical concern. In these cases, the doctor and patient tended to know

each other with the doctor enquiring about mood or noticing the patient becoming tearful when discussing ongoing physical symptoms.

Insert Table 3 here

The doctor's orientation to the problem

(c) Does the doctor recommend treatment for the concern raised by the patient at the start of the visit?.Treatment recommendations targeted a focal mental health concern presented by the patient in their initial problem presentation in 70% (23/33) cases. Case 2b above is an example of this ("Have you always had bulimia?"). Similarly, in (3a) below, the patient presents with dreams that her daughter is being snatched, which she attributes to anxiety.

(3a)
1. Doc: So how can I help?
2. Pat: **Basically I've been having these dreams, like where she's**
3.   **being snatched. I was speaking to my friend's mum and she**
4.   **said that she had a similar thing happen to her. She said**
5.   **she went to the doctors about it and they said it's to do**
6.   **with high anxiety.**

The treatment recommendation (3b) later in the consultation targets the mental health concern as characterised in the initial problem presentation. The doctor uses an assertion format which makes a generalization about the benefit of treatment, *implying* a recommendation without proffering a directive (Stivers et al. 2018). Toerien et al. (2013) and Toerien (2018) have analysed this recommendation format, also describing it as a form of option listing (Toerien et al. 2013) that is oriented to by patients as informing. This format indicates the existence of solutions without making a decision relevant next but is still hearable as recommendation relevant. In this excerpt, the doctor states that there are different ways to address anxiety via medication, talking therapy or practical support. Consistent with Toerien's (2018) observations, the doctor continues to inform the patient

about the practical support and then asks the patient if she is happy to contact the practical

support worker herself which the patient confirms.

(3b)
```
   1. Doc:      Um:.phh I guess I was thinking .hh 'Cos obviously there's:-
   2.      →    there's a couple of ways you- If someone's feeling anxious a
   3.      →    lot .hh there's a couple of ways you can: (0.3) try to help
   4.      →    .hh One is- (0.8) Y:'know broadly, .hh One is kind of I-
   5.      →    going down the medication road, .hhh And the other is
   6.      →    looking at getting: different (.) all diffe°rent° kinds of
   7.      →    support (.) really.=And .hh Or some (.) people to talk to:
   8.           or: .hhh um psychologists to help with techniques to do with
   9.           or .hhh a bit more practical help and support for you as a
   10.  mum, .hhh Um: pt. .hh (0.5) I guess are two angles, .hh I
   11.  would be keener to: (0.3) look at getting you a bit more
   12.  support of different sorts rather than– (0.7) 'Cos it's
   13.      almost like you've got a really difficult situation there,
   14.  anyone would probably feel [a(h)nxiou(h)s] y'kn(h)ow. .hhh
   15. Pat:                       [°°(Aheh)°°  ]
   16. Doc:      but it's kind=of helping you to deal with it and helping you
   17.  to get through that isn't it [and ].hhhh um .hhhh so- and
   18. Pat:                          [Yeah].
```

(intervening talk informing the patient about the practical support)

```
   Doc:        Are you happy to ring her yourself [.hh ] Or would you                    like
me to.
      Pat:                          [Yeah]
```


In 30% of cases (10/33), the doctor recommended a mental health treatment for a problem

the patient did not present with, e.g., counselling when a patient presented with an arthritis

flare-up, counselling when a patient presented with sweating, counselling when a patient

presented with bullying at work, an antidepressant when a patient presented with vertigo. In

(4a), the patient presents for a blood pressure check.

(4a)
```
   1. Doc:      How can I help you today?
   2. PAT: →    I think you were going to do my blood pressure again because
   3.           it was too high.
   4. DOC:      Yes, that's right.
```

Later after discussing the patient's mood which was raised by the doctor, the the doctor makes a recommendation for talking therapy (4b), which does not target the patient's concern in the initial problem presentation.

(4b)
1. DOC: → **Firstly some counselling would be beneficial**, was that
2.   something that crossed your mind?
3. PAT: I had counselling before.

(d) How does the doctor display that they have attended to the patient's description and characterisation of the concern in the treatment recommendation? Doctors typically referred briefly to the problem in the treatment recommendation, so I then identified how the doctor described the mental health concern in the run up to the treatment recommendation, in a preliminary recommendation or in the recommendation itself. In 25/33 cases, the doctor referred to the patient's concern in a way that was consistent with the patient's characterisation of the problem. We saw an example of this in the bulimia case (case 2) above. Doctors also did this by using an anaphoric reference, referring back to a constituent in a patient's prior turn. Anaphora tie the doctor and patient's turns in a sequentially integrated say so that the meaning of the doctor's turn is dependent on a referent in a patient's prior turn (Healey et al. 2008). Doctors used an anaphoric reference to refer to the patient's previous description of their difficulties, e.g., "feeling like this" or e.g. a patient saying "I want help with leaving the house" and the doctor recommending "It might be good to have someone else helping you with _it_ as well" (anaphoric reference 'helping you with _it_') or used a generic formulation (e.g. "your problem"). This also included cases where the problem was not referred to but the recommendation was closely aligned with the concern (e.g. "My mum died last week" in the problem presentation and "bereavement counselling" in the treatment recommendation).

In 8/33 cases, the doctor used another form of words to characterise the patient's concern or did not put forward a closely aligned recommendation with the presenting concern. In some

cases, this was when patients presented with a primary physical concern and
recommendations for mental health problems were issued. We see an example of this in
Case 5 below. In (5a), the patient presents with ongoing stomach problems.

(5a)
   1. Doc: How can I help, Mrs NAME?
   2. **Pat**: →   Well, **I've got problems here [pointing to stomach] again**.
   3.   Two weeks ago, three weeks ago, I was rushed into hospital
   4.   with severe pains. The ambulance came.

The patient became tearful during the consultation, leading the doctor to issue a
recommendation to help with the patient's mood that differs from the patient's primary
presenting concern (5b). Treatment recommendations are oriented to as requiring
acceptance or rejection by both doctors and patients (Stivers 2005). Here, there is a 2.2
second delay (line 3) and the patient does not accept the recommendation, displaying a
moral orientation towards antidepressants (lines 4-5) although she does leave the door open
("I could try something") . The doctor orients to the patient's response as non-accepting and
suggests an alternative treatment, counselling, in line 6.

(5b)
   1. Doc: → **D'you think it might be a good idea: to have somethi:ng to**
   2.   → **pick you u:p a bi:t with your moo:d**.
   3.   (2.2)
   4. Pat: Well I could t- sh- (.) try something.=I mean I'm not on
   5.   to take a loada tablets anyway
   6. Doc: or maybe a bit of ↑counselli:ng?
   7. Pat: .skuh
   8. Doc: cos you've ↑bee:n through a lo:t haven't you
   9. Pat: ((nods)) a lot lot ↑yea::h

Distributional support for a link between shared understanding and treatment acceptance

I now turn to distributional support for the role of shared understanding in patient
acceptance. Firstly, patients accepted the doctor's recommendation when it targeted the
concern presented by the patient in the initial problem presentation in 85% cases versus
44% cases when this was not the case (Table 4).

Insert Table 4 here

Secondly, when the mental health concern was raised by the patient, they accepted recommendations in 68% cases versus 86% cases when raised by the doctor (Table 5). When doctors raised concerns, it appeared that they were more likely to purse acceptance of the treatment recommendation. In these cases, patients did sometimes resist (passively, then actively) but doctors worked through (sometimes multiple rounds of resistance) to overcome the resistance and persuade the patient to accept the recommendation.

Insert Table 5 here

Thirdly, when doctors' turn design demonstrated a shared understanding of the patient's description and characterisation of the underlying cause of the problem in the treatment recommendation (by using the patient's previous words) or put forward a recommendation closely aligned with the concern, patients accepted in 81% cases versus 50% cases when this was not the case (Table 6).

Insert Table 6 here

Thus, these findings support the importance of both attending to the concern the patient treats as primary and to the words the patient uses to describe that concern, particularly what this denotes about the underlying cause of the problem in the patient's view. Although it would have been preferable to conduct statistical comparisons, the small cell counts would make this unreliable. With this caveat, when doctors use these aspects of patients' presentations, these findings provide early evidence that they are more likely to secure acceptance.

Discussion

This paper examined the role of displays of shared understanding in patient acceptance of treatment. It took a novel approach by examining the patient and doctor's orientation to and displays of shared understanding from the problem in the problem presentation to the treatment recommendation. Two communication behaviors were associated with patient acceptance: recommending treatment for the patient's initial focal concern and doctors' turn design *in* the recommendation itself, i.e., using the patient's earlier words from the initial problem presentation to describe and characterise the problem. When doctors use the patient's precise words from the initial problem presentation in the treatment recommendation, this displays an understanding of the patient's perspective and personalisation of treatment based on the underlying biomedical or social causes, which then impacts on patient acceptance of treatment.

When patients are presenting to GPs in the UK with common mental health problems, they raise mental health concerns but actively resist the proffered treatments of medication and talking therapy over half of the time. In just over half the cases of active resistance, they ultimately accept the recommendation or a modified recommendation after persuasion by the doctor. When recommendations are resisted, there can be extensive negotiation about the name of the problem (e.g. stress versus depression), the underlying cause and what this warrants in terms of treatment. This study is consistent with previous work highlighting the importance of negotiating about the nature of the problem in mental health consultations. When discussing subjective experiences like feeling anxious, worried, stressed, depressed, low etc, there is delicacy in how the doctor appropriates the patient's subjective experience. The patient's concerns are elicited in the initial problem presentation. Followed by further history taking and assessment of personal and social circumstances, this provides the basis for the diagnosis or diagnostic moment (if present) and the treatment recommendations. In the case of the patient presenting with vertigo and stress, we can see how this can be problematic as the patient does not think she is depressed. Heath (1992) observed that

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patients typically "relinquish or subordinate their knowledge and opinion concerning the illness and render the co-participant's version as the objective, scientific and factual assessment of the condition". However, the transition from feeling stressed to depressed and in another consultation (not shown) from feeling depressed to "proper depression" elicits resistance and a strong emotional response from the patient. As Goffman (1963) has described, a diagnosis transforms temporary mood or feelings into a more abiding feature, and, as such, can create biographical discontinuity and threaten face and social identity. This presents challenges for doctors in moving from patients' concerns and their perspective on them to securing acceptance for a treatment that is not aligned with the patient's perspective. Perhaps to avoid this, doctors also use generic formulations like "your problem" or anaphoric referents like "it" to avoid presenting a competing or potentially competing characterisation of the problem that differs from the patient's perspective.

In the current data, patients often resisted both medication and talking therapy. Patients cited past and possible problems with talking therapy and not finding them applicable to their situation (e.g. being bullied at work, bereavement). As can be seen in the vertigo and stress case, mental health problems also frequently coincide with social problems and poverty. Children and adults living in households in the lowest 20% income bracket in Great Britain are 2-3 times more likely to develop mental health problems than those in the highest income bracket (Marmot et al. 2010). Hence, there is increasing interest across the U.K, North America, Australia and Scandinavia in alternative approaches such as social prescribing to decrease GP contacts and improve wellbeing: this involves healthcare professionals referring patients to non-clinical, social activities in the community, mostly provided by third sector organisations (Public Health England 2019).

While this paper focused on the role of shared understanding in patient acceptance of treatment, acceptance is also influenced by how the doctor addresses the grounds for resistance which can lead to acceptance. Sometimes this happens after one round of

resistance while sometimes there are multiple rounds of resistance. While we did not show this data in the current paper due to space constraints, this data suggests that strategies that work to increase acceptance are asking the patient what they most want to change, using a patient view elicitor (e.g. "I just wondered what you thought about starting an antidepressant", "How do you get along in groups?") and describing how the proffered treatment can help with specific rather than generic issues that the patient has mentioned, e.g. "goals' for counselling when the patient has mentioned struggling with goals previously or "sleep" for antidepressants when the patient has mentioned trouble sleeping.

In terms of promoting engagement in treatment discussions and acceptance of a treatment recommendation, many aspects cannot be changed by the doctor, i.e., what concern the patient presents with, whether the mental health concern is raised by the patient or whether the patient has a comorbid physical condition. However, doctors can change how they describe and characterise the concern to closely match the patient's problem presentation, which impacts on acceptance. Using the patient's words indicates that the doctor has listened carefully to the patient, which patients report as fundamental to feeling understood (Xanthopoulou et al. 2020).

Strengths and Limitations

The strengths of this paper are a novel approach to operationalising shared understanding that reflect the degree to which the doctor and patient share a common language, and hence, perspective on what the problem is and how it should be treated. This was examined in detail in the problem presentation at the beginning of and during the consultation, and how this was incorporated or not in the treatment recommendation. While this goes a little way towards addressing the dynamic nature of the consultation over time, it did not micro-analyse the full consultation for all cases and the nature of the problem is negotiated and transformed to various degrees during mental health consultations. This was a small study. Future work could also track and code ellipsis and anaphora throughout a consultation to get

a more sensitive picture of how closely aligned doctors and patients are in talking about the problem, how they come to a shared view of the problem (or not) and how it should be treated. This could allow coding on a bigger scale to investigate links with patient acceptance in larger datasets and across other settings.

Conclusions

Given the high global burden of mental ill health and frequent resistance to treatment for mental health problems, understanding how professionals can engage more closely with the patient's perspective is important. Attending closely to the patient's precise words in the initial problem presentation can signal the patient's perspective about the underlying causes, and hence treatment, of these problems. When doctors use the patient's precise words from the initial problem presentation in the treatment recommendation, this displays an understanding of the patient's perspective and personalisation of treatment based on the underlying biomedical or social causes, which then impacts on patient acceptance of treatment.

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