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Article

Consultations Preliminary to Interdisciplinary Chronic Pain Rehabilitation

Patients' and Practitioners' Orientations to the Institutional Significance of a Shared Understanding of the Pain

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Abstract

Before patients with chronic pain enter an interdisciplinary chronic pain rehabilitation programme, a team of various healthcare professionals performs a biopsychosocial analysis of their pain problem. To enhance patients' engagement, the problem analysis is thoroughly discussed with them in order to gain a shared understanding of the nature of their pain problem. This study explores how patients and practitioners talk through their rehabilitation team's hypotheses regarding the psychosocial factors involved in these patients' health situation. Nine consultations were recorded at various Dutch interdisciplinary chronic pain rehabilitation units. The recordings were transcribed and analysed, combining an applied

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conversation analytic research approach with discursive psychology. Patients and practitioners are found to orient to ensuring consensus on the problem analysis as a relevant activity and tend to avoid or minimize the articulation of differences in perspectives. This study also shows that this orientation to consensus involves a delicate management of issues of accountability and blame. Findings can be used by practitioners to consider communication practices that are more likely to encourage patients to voice potential concerns regarding their rehabilitation team's findings.

Keywords

Chronic pain, pain rehabilitation, shared understanding, applied conversation analysis, discursive psychology.

Pain that initially functioned as a signal of tissue damage may in some cases persist after the injury has healed and there is no longer a univocal biomedical cause assignable (Gatchel et al., 2014). When medical pain-reducing treatment options are not effective, patients may be referred for interdisciplinary pain rehabilitation treatment by their general practitioner or medical specialist. Such treatment is aimed at helping patients to increase their functioning despite being in pain, thereby improving their quality of life. The majority of referred patients in the Netherlands have had pain complaints, often in more than one body part, for more than two years (Köke et al., 2017). They are generally referred to pain rehabilitation treatment as a last resort, after they have visited a variety of healthcare professionals (Köke et al., 2017).

Apart from biomedical factors, psychological factors (e.g., emotions and behaviours) and social factors (e.g., social support and cultural norms) play an important role in the development of chronic pain and pain-related disabilities (Gatchel et al., 2014). Interdisciplinary pain rehabilitation programmes take a biopsychosocial approach, taking into account the complex interplay of the biomedical, social, and psychological factors involved in chronic pain and pain-related disability (Gatchel et al., 2014). Various healthcare professionals (i.e., rehabilitation physician, physiotherapist, occupational therapist, psychologist, and social worker) work together in an interdisciplinary rehabilitation team. Before patients enter pain rehabilitation treatment, they are first examined by various members of their rehabilitation team. Together they seek to explore the biomedical, social, and psychological factors that contribute to the patient's pain and pain-related disability and that potentially could be targeted to increase the patient's functioning (Gatchel et al., 2014; Swaan et al., 2019).

Preliminary to interdisciplinary chronic pain rehabilitation treatment, the team's problem analysis is thoroughly discussed with the patient. As patients with chronic pain often tend to approach their pain from a biomedical perspective and dismiss the role of social and psychological factors in their pain complaints (De Oliveira et al., 2020; Kenny, 2004), this discussion is regarded as an important step in preparing them for treatment taking a biopsychosocial approach. In addition, it is considered important that patients and their practitioners develop a shared understanding of the causal and maintaining factors that have contributed, and still contribute, to their pain and pain-related disability (Frantsve & Kerns, 2007; Oosterhof et al., 2014; Verbeek et al., 2004). After all, if patients and practitioners reach a shared understanding about the nature of the pain problem, they are more likely to reach agreement on the treatment goals and the most appropriate treatment plan (see also McCabe, 2021). This does not mean, however, that patients and their practitioners need to agree on each

and every aspect of the problem analysis before treatment plans can be made. However, to be eligible for pain rehabilitation treatment, patients need to be willing to explore the social and psychological factors involved in their pain problem.

Good communication between patients and their healthcare providers about the nature of the patients' problem is essential, especially when there is no straightforward biomedical explanation, as is the case for chronic pain (McCabe, 2021; Tauben & Sullivan, 2022). The advocated patient-centred approach to caring for people with chronic pain (Tauben & Sullivan, 2022) has been found to influence positively patients' adherence to treatment plans, self-management, and well-being (Rathert et al., 2013). Such a patient-centred approach is reflected, amongst other things, in patients' and practitioners' communication (Santana et al., 2018). That is, patient-centred communication involves a process of collaboration, grounded in both the practitioner's and the patient's knowledge, views, and experiences (Santana et al., 2018). However, pain rehabilitation practitioners may experience such collaboration as challenging; for example, when patients cling to a biomedical approach to their pain and/or focus strongly on pain relief. Patients, too, may experience their communication with practitioners as challenging; for example, if they feel that their practitioner is ignoring the somatic cause of their pain.

Both the importance and the complexity of good communication in the context of chronic pain rehabilitation are increasingly recognized in scientific literature and practice. There is, for example, a growing interest in how practitioners can improve their communication through pain neuroscience education (see, e.g., Siddall et al., 2022) and patient-centred communication styles, such as motivational interviewing (see, e.g., Nijs et al., 2020) and validating communication (see, e.g., Edmond & Keefe, 2015; Linton, 2015). Furthermore, more specifically with respect to reaching a shared analysis of the pain problem, Paap et al. (2022) suggest that pain rehabilitation professionals should explore patients' unspoken thoughts more actively, as many of the patients that they interviewed indicated that, although they did not (fully) agree with their rehabilitation team's analysis of their pain problem, they did not discuss this with the team. Such literature on the importance of good communication, however, is not based on empirical analyses of actual interactions between patients and practitioners in the specific context of interdisciplinary chronic pain rehabilitation. Therefore, Stinesen et al. (2019, 2021) propose that, in order to identify points for improvement with respect to communication between patients with chronic pain and their practitioners, it is helpful also to examine actual patient–practitioner interactions directly. Such work has shown, for example, that, when practitioners use particular types of formulations that suggest that patients are not subjected to their pain but have control over their behaviour, this can evoke defensive responses from patients (Stinesen et al., 2021).

This study contributes to the line of research that directly considers how patients and practitioners manage their communication. It specifically aims to increase our understanding of how patients and practitioners talk through the social and psychological factors hypothesized to be involved in the patients' health situation, as this is considered to be a crucial step in preparing patients for interdisciplinary pain rehabilitation treatment. In this article, we present findings from a detailed analysis of patient–practitioner interaction during consultations preliminary to pain rehabilitation treatment. We illustrate how, during such consultations, both patients and practitioners orient to the institutional significance of reaching a shared understanding of the causal and maintaining factors involved in these patients' health situation.

Methods

The Data

Before entering pain rehabilitation treatment, a patient is examined by various members of an interdisciplinary rehabilitation team, after which a problem analysis is formulated. Subsequently, a consultation is scheduled with one team member. During this consultation, this team member and the patient discuss the team's findings with respect to the biomedical, social, and psychological factors hypothesized to be involved in the patient's pain and pain-related disability. Our analysis focuses on this particular consultation, preliminary to the pain rehabilitation treatment.

Our corpus consists of nine such consultations that were audio-recorded at five chronic pain rehabilitation units in the Netherlands, after the first author had conducted a short ethnographic study to become familiar with their institutional practices (e.g., she interviewed practitioners and attended various consultations). Four hours and 18 minutes of audio material was collected. Seven practitioners from various disciplines participated in the study: two rehabilitation physicians, one physician assistant, two psychologists, and two trajectory coordinators (both physiotherapists). The practitioners each audio-recorded one or two of their consultations. All nine patients participating in the study had chronic (i.e., lasting for more than three months) musculoskeletal pain with no univocal biomedical cause assignable. Two of them were accompanied by someone during the consultation (one by a family member and one by a partner). The majority of patients who participated were between 30 and 60 years old and most of them were female; this corresponds with the overall population of patients referred for pain rehabilitation in the Netherlands (see Köke et al., 2017). Table 1 provides an overview of the characteristics of each recorded consultation.

Table 1. Characteristics of the Recorded Consultations

Consultation	Patient Characteristics		Practitioner	Companion Present	Rehabilitation Unit	Duration (min)
	Sex	Age				
1	female	60	psychologist 1	no	1	55
2	female	45	psychologist 2	no	1	43
3	female	46	trajectory coordinator 1 (physiotherapist)	no	2	28
4	female	57	trajectory coordinator 2 (physiotherapist)	no	2	13
5	male	50	physician assistant 1	yes	3	37
6	female	21	physician assistant 1	no	3	30
7	female	23	rehabilitation physician 1	yes	4	16
8	male	44	rehabilitation physician 1	no	4	19
9	female	27	rehabilitation physician 2	no	5	17

Data Analysis

In this study, we examined conversations between patients with chronic pain and their practitioners directly, so as to increase our understanding of how patients and practitioners talk through the social and psychological factors hypothesized to be involved in these patients' health situation. Through empirical observation of patterns in their interactions, we considered how patients and practitioners manage this aspect of their communication. We studied their conversations on a microlevel, because this provides the opportunity to examine the nuances of how patients and practitioners talk through the rehabilitation team's hypotheses. Moreover, doing so generates useful insights for practitioners with respect to their interactions with patients and how they might use language in practice (Kiyimba & O'Reilly, 2016).

We combined an applied conversation analytic research approach (Antaki, 2011; Lester & O'Reilly, 2019) with discursive psychology (Wiggins & Potter, 2017). Traditional conversation analysis examines how participants in interaction perform social actions (such as complimenting, requesting, agreeing, or disagreeing) by zooming in on the structure and sequential organization of their talk and the ways in which their turns are designed to perform some action (Antaki, 2011). Applied conversation analysis draws upon insights and principles of traditional conversation analysis to investigate institutional interactions and/or to offer practical advice to organizations (Lester & O'Reilly, 2019). In this study, we did so taking a discursive psychology research perspective, meaning that we paid attention to how participants in interaction build up and use representations of reality and how they manage issues of accountability and blame (Potter, 1996; Wiggins & Potter, 2017).

To be able to analyse the data on a microlevel, the full corpus was transcribed at word-level accuracy. During the first stage of the analysis, sequences of talk about social and psychological factors involved in the patient's health situation were identified by the first author (who is a discourse analysist). These sequences were then presented to the second author (who is a discourse analysist). Having listened to, and read, the materials, the first and the second author noticed a pattern with respect to the structure and sequential organization of practitioners' turns eliciting patients' confirmation of the team's hypotheses. It was therefore decided to examine more closely how practitioners deliver their team's hypotheses and when and how patients respond to this. For this purpose, relevant sections were transcribed according to Jefferson's (2004) transcription system (a glossary of transcription symbols can be found in the Appendix). The analysis was conducted primarily by the first author. During the course of the analysis, the first and the second author had regular data sessions to support the analysis. In addition, data extracts were presented for open discussion during data sessions with other discourse analysts. Such sessions confirmed our preliminary findings and also allowed for different perspectives to emerge and for additional ideas to be generated (see O'Reilly et al., 2018).

Validating Procedures

To warrant our analytic claims, we have drawn upon discourse researchers' validating procedures described in the literature (O'Reilly et al., 2021; Wiggins & Potter, 2017). First of all, we adopted the *next turn proof procedure* to underpin our analytic claims about the social actions that participants perform. This means that we looked at recipient uptake to assess how the patient and the practitioner themselves display their understanding of each other's talk. Thus, what a turn is doing could be established by examining how it is responded to, in the

interaction itself, by the next speaker. Secondly, we took *coherence* into consideration. First, this means that in order to speak of a pattern – for example with respect to turn design, sequential organization, or participants' orientations – the identified phenomenon needs to emerge recurrently throughout the data. Therefore, we were thorough and re-iterative in our analyses of instances of interest from the various consultations that were recorded. In this way, we could ensure that the analytical patterns that we identified provided an authentic representation of the data. In addition, we compared the coherence of our analytical findings with previously published conversation analysis and discursive psychology studies. Thirdly, we examined *deviant cases* (i.e., exceptions to the analytical patterns identified) to assess the accuracy of our analytic claims. In conversation analysis and discursive psychology, deviant case analysis is an important way of checking the validity of analytic claims. Deviant cases were therefore actively identified and scrutinized to ensure that analytic claims were not made prematurely. Finally, we worked according to the validating principle of *transparency*. In the next section, we present our analytical findings step by step along with data extracts that include the original production of talk in Dutch. Transcript sections reported in this article were translated to English with the help of a native speaker (we opted for a translation that is as literal as possible). The transparency of the data and our analysis enable the reader to assess the validity of our analytic claims.

Ethical Approval

Various ethical aspects with respect to the setup of this research were considered, such as participants' informed consent and privacy. For example, the patient information letter contained simple and understandable language and was supplied one week in advance of the consultation to provide for enough time to make a decision. To protect participants' privacy, only the first and the second author had access to the raw audio data. During data sessions with other analysts, fragments of audio were played only if the relevant participants gave permission to do so. Also, participants were made unrecognizable using voice changing software. In addition, data presented during data sessions and in this article were pseudonymized. The research was approved by an accredited Research Ethics Committee (METC Z, the Netherlands, reference number: 17-N-160), and participants gave written informed consent for their speech to be recorded and analysed for the purpose of this study.

Results

The recordings revealed considerable variation between the consultations. For example, they vary in length and level of detail with respect to the feedback that practitioners provide to patients. However, our analysis showed that a common factor in the consultations is that, in their interactions, patients and practitioners orient to ensuring consensus on the factors hypothesized to be involved in the patients' health situation as a relevant activity. In this section, we illustrate this, using four extracts, of which the first three are representative of how this pattern emerges throughout the data (the fourth extract shows a deviant case). The presented extracts are derived from different consultations (per extract, it will be indicated from which consultation the extract is derived). In our analysis, we also pay attention to how patients and practitioners in interaction build up and use representations of reality and how they manage issues of accountability and blame when talking through the rehabilitation team's hypotheses

with respect to the social and psychological factors associated with the patients' health situation.

Patient Agreement as an Interactional Resource for Building Doctorability

Patients in our dataset regularly display an orientation to agreement as the relevant response to a practitioner's delivery of the rehabilitation team's analysis of their pain problem. In this section, we provide an example of a patient's immediate display of agreement with the rehabilitation team's problem analysis. In our analysis, we specifically focus on how displaying agreement with behavioural factors hypothesized to be involved in their health situation can serve as an interactional resource for patients in establishing their doctorability.

In previous work, Stinesen et al. (2021) have illustrated that, for patients with chronic pain, establishing doctorability entails more than establishing a doctorable *problem* (see Heritage & Robinson, 2006). Chronic pain rehabilitation demands that patients realize that they themselves have an important role in improving their health situation and that they need to be willing to change their behaviour. Therefore, in order to establish their doctorability in interaction with their practitioner, patients also need to establish themselves as doctorable *persons*, who recognize their own role in their health situation and who are motivated to change their behaviour. Extract 1 (derived from consultation 9) illustrates that one way in which patients may do so in consultations preliminary to treatment is by stressing their agreement with their rehabilitation team's findings concerning their behaviour.

We first share part A of Extract 1:

Extract 1A

1. Pr: **.hh dus als we ↑kijken we wij stellen altijd 't- 't kernprobleem op.**
   .hh so if we ↑look we we always formulate the the central problem.
2. Pa: **ja**
   yes
3. Pr: **uh hè (*w*) wat is de es↑sentie van .hh ↓waar we tegenaan kijken.**
   uh right (*w*) what is the ↑essence of .hh ↓what we are looking at.
4. **wat (*w*) wat speelt er allemaal.**
   what (*w*) what is going on.
5. Pa: **[ja**
   [yes
6. Pr: **[.hh en dan zeggen ↑we: een mevrouw met chronische pijnklachten,**
   [.hh and then ↑we: say a woman with chronic pain complaints,
7. **vermoeidheid (.) en die balansstoornissen die je benoemt,**
   tiredness (.) and those balance disorders which you name,
8. Pa: **ja**
   yes
9. Pr: **.hh waardoor conditie en kracht afgelopen jaren (.)**
   .hh due to which for the past years stamina and strength (.)
10. **ver↓minderd zijn,**
    have di↓minished,
11. **doordat ze zichzelf als het ware heeft (.) ver↓waarloosd.**
    because she as it were has (.) ne↓glected herself.
12. Pa: **↑ja ja: dat is wel zo.**
    ↑yes ye:s it is like that.

The extract starts with the practitioner who provides a description of one of the rehabilitation team's routines: ".hh so if we ↑look we we always formulate the the central problem." (line 1). The patient receives the practitioner's prior turn as informative and shows acknowledgement through her minimal response "yes" (line 2), which – as we can see in the next turn – invites the practitioner to continue: "uh right (*w*) what is the ↑essence of .hh ↓what we are looking at. what (*w*) what is going on." (lines 3–4). Overlapping with another affirmative minimal response by the patient in line 5 ("yes"), the practitioner then starts to describe how the rehabilitation team has depicted the patient's health situation: ".hh and then ↑we: say a woman with chronic pain complaints, tiredness (.) and those balance disorders which you name," (lines 6–7). Notice, how the pronoun 'we' underscores consensus on the problem analysis within the team and how, by talking about the patient in the third person, the practitioner (consciously or unconsciously) avoids addressing the patient directly. The patient's minimal response in line 8 ("yes") invites the practitioner to continue: ".hh due to which for the past years stamina and strength (.) have di↓minished," (lines 9–10). She then provides a behavioural explanation for the patient's current health situation: "because she as it were has (.) ne↓glected herself." (line 11). Note that, by using the mitigator "as it were", the practitioner weakens her claim, displaying how cautiously she is dealing with the delivery of specifically this aspect of the team's problem analysis (see also Bergmann, 1992; Monzoni & Reuber, 2015).

After the practitioner has provided the team's behavioural explanation for the patient's health situation, the patient explicitly confirms: "↑yes ye:s it is like that." (line 12). According to Heritage and Raymond (2005), confirmatory response formats like these – which *start* with agreement tokens (in this case, "↑yes ye:s"), followed by confirmation ("it is like that") – are generally to be understood as wholly occupied with agreement. Thus, the patient treats the practitioner's behavioural explanation for her health situation as one that makes agreement relevant (whereas she *could* also have received it as merely informing her about how the team has formulated her central theme, for example through providing another minor continuer or acknowledgement token; see Stivers, 2006).

It should be noted that the untranslatable Dutch word "wel" (line 12) both emphasizes agreement and makes the utterance hearable as a confession, indicating that the patient also orients to the practitioner's claim, and to accepting that claim, as delicate. After all, the team's behavioural explanation for her current health situation carries the inference that she is accountable for her own pain complaints. However, through her agreement, aka confession, the patient manages to display acknowledgment of the role of her own behaviour (i.e., neglecting herself) in maintaining her current health situation. And, as we shall see in Part B of Extract 1, she has thereby paved the way—in co-production with the practitioner—for establishing her readiness to change this behaviour.

After a 1.5 second gap (line 13), indicating that the patient is ready to pass back the turn to the practitioner, the practitioner states: ".hh she ↑realizes (0.2) that with a view to the future, she now should take ↑better care of herself." (lines 14–15). The practitioner then pauses (line 16), providing the patient the opportunity to respond to this statement: "°yes° (1.3) yes that is it entirely," (lines 17–19). Thus, using a similar confirmatory response format as in line 12, Extract 1A (i.e., *starting* with agreement tokens), the patient displays her agreement with the rehabilitation team's description of her current mental state. Moreover, she upgrades the accuracy of the description by stating "that is it *entirely*," (rather than just "that is it,"). Thereby, the patient indexes her epistemic independence and at the same time displays herself as in full agreement with the practitioner (see Pomerantz, 1984; Pomerantz & Heritage, 2012). Thus, by

means of this upgraded agreement, the patient reinforces the team's claim that she realizes that she should now take better care of herself, and thereby works up her readiness for pain rehabilitation treatment.

Extract 1B

13.		**(1.5)**
		(1.5)
14.	Pr:	**.hh ze be↑seft (0.2) dat ze gericht op de toekomst,**
		.hh she ↑realizes (0.2) that with a view to the future,
15.		**nu ↑beter voor zichzelf moet zorgen.**
		she now should take ↑better care of herself.
16.		**(1.6)**
		(1.6)
17.	Pa:	**°ja°**
		°yes°
18.		**(1.3)**
		(1.3)
19.		**ja dat is het helemaal,**
		yes that is it entirely,

"Do You Recognize That?": How Practitioners Pursue Confirmation of Their Team's Findings

In the previous section, we provided an example of a patient displaying immediate and relatively strong agreement with a practitioner's summary of the rehabilitation team's findings. The examined consultations, however, also contain instances when patients initially remain silent or provide only minimal responses after the delivery of the rehabilitation team's findings, which can signal resistance (Monzoni et al., 2011). In this section, we illustrate that, when it remains unclear whether or not the patient is in agreement with the rehabilitation team's findings, practitioners tend to pursue an unequivocal response. We illustrate a pattern with respect to how they design their turns in ways that pre-empt resistance and encourage patients to confirm the rehabilitation team's findings, rather than voicing their own (potentially different) perspectives.

We first consider Extract 2 (derived from consultation 2):

Extract 2

1.	Pr:	**.hhh eh::m: (0.4) >de fysio kwam ook nog met<**
		.hhh eh::m: (0.4) >the physio also came up with<
2.		**ik mag geen ↑ruimte innemen,**
		I must not take up ↑space,
3.	Pa:	**°ja°**
		°yes°
4.		**(1.4)**
		(1.4)
5.	Pr:	**°herken je dat,°**
		°do you recognize that,°
6.		**(0.8)**
		(0.8)

Extract 2 (continued)

7. Pa: **j:a. dat herken ik wel ja.**
   y:es. I do recognize that yes.
8. **'kmaak me altijd een beetje on↑zichtbaar.**
   I always make myself a bit in↑visible.
9. Pr: **hmhm**
   hmhm
10. Pa: **.hh ja ze[ker in groepen of eh-**
    .hh yes cer[tainly in groups or eh-
11. Pr: **[ja**
    [yes
12. **ja**
    yes
13. Pa: **ik kan heel goed verdwijnen. ja**
    I am very good at disappearing. yes
14. Pr: **precies**
    exactly
15. Pa: **ja**
    yes

Extract 2 starts with a practitioner making reference to something as brought up by another member of the rehabilitation team: ".hhh eh:m: (0.4) >the physio also came up with< I must not take up ↑space," (lines 1–2). Seuren and Huiskes (2017) propose that such yes/no declaratives, which recognizably launch a new sequence by addressing a new issue, may be used by speakers to request a recipient's confirmation as well as elaboration on potentially delicate topics, without accountably doing so. It should also be noted how presenting it as a report by someone else, also called distanced footing, decreases the practitioner's personal accountability for this description (see Potter, 1996). In Extract 2, the patient responds minimally with a soft "°yes°" (line 3) after which she remains silent (line 4), indicating that she indeed orients to the practitioner's talk as delicate. As she does not provide any further elaboration, it remains unclear whether her "°yes°" reflects a confirmation of the physiotherapist's suggestion or whether she receives the practitioner's prior turn as merely informative of the physiotherapist's suggestion.

The practitioner treats the patient's response as insufficiently clear, as evidenced in the next turn, in which the practitioner pursues a more unequivocal response from the patient: "°do you recognize that,°" (line 5). Thus, the practitioner orients to the absence of an unequivocal display of agreement with the physiotherapist's notion as noticeable and relevant. She uses a polar question format, which sets up normative constraints for responding, as it makes relevant only two specific response options: "yes" and "no" (Raymond, 2003). She softens her voice and uses a relatively cautious formulation, "°do you recognize that,°", indexing that she orients to the physiotherapist's suggestion as potentially delicate.

After a 0.8 second gap (line 6), the patient confirms: "y:es. I do recognize that yes." (line 7). Remarkably, she now also further elaborates that she "*always*" makes herself a bit invisible (line 8). Thus, she presents the behaviour as recognizable, typical, and routine (see Edwards, 1994). By doing so, she both provides evidence for the physiotherapist's claim and makes relevant the authenticity of her own claim regarding its recognizability (i.e., she is not "just going along" with the physiotherapists claim (see Pomerantz & Heritage, 2012)). Thereby, just

like the patient in Extract 1, the patient shows that she acknowledges the role of her own behaviour. The practitioner's "hmhm" in line 9 invites the patient to further elaborate: ".hh yes certainly in groups or eh-" (line 10). Supported by acknowledgment tokens provided by the practitioner (in lines 11 and 12), she then concludes: "I am very good at disappearing. yes" (line 13). Note how she completes this turn with a final confirmative "yes", thereby further underscoring "being in agreement" with the physiotherapist's claim. With her "exactly" (line 14), the practitioner not only reinforces this being in agreement between patient and physiotherapist, but also works up agreement between the patient and the practitioner in the here and now. Furthermore, this invites the patient to once more confirm "yes" (line 15), adding the final touch to their joint construction of consensus.

We now turn to Extract 3 (derived from consultation 3). This extract provides another example of a practitioner pursuing a clear response by the patient, as it remains ambiguous whether or not she is in agreement with the rehabilitation team's problem analysis. In this extract, the patient displays – at least to some extent – her reservations regarding the team's findings. We show that, even then, both patient and practitioner orient to their project of ensuring consensus, rather than to getting the patient's concerns and perspectives out in the open so as to be able to discuss them first of all.

Extract 3 is part of a consultation during which a practitioner, in a rather monological way, alternately produces elements of the rehabilitation team's problem analysis and the team's advice. For reasons of space, we step in as the practitioner produces a final list of behaviours from which, according to the rehabilitation team, the patient could benefit (lines 1–11, Extract 3A). These behaviours are then contrasted with a description of the patient's current behaviour as observed by the team (lines 12 and 13).

Just like the practitioner in Extract 1, the practitioner in Extract 3 positions himself as talking on behalf of the team by using the pronoun "we" (line 1), thereby working up consensus on the presented analysis within the team of rehabilitation professionals. The practitioner's formulations "automatic pilot", "survival mode", and "plodding along" (lines 12–13) suggest that the patient's current behaviour is not sustainable in the long term, thereby underscoring the relevance of the team's advice as delivered from line 1 onwards. At the same time, just like the practitioner in Extract 1, this practitioner orients to the delicacy of constructing the patient's current behaviour as problematic: by using formulations that mitigate his description, such as "(like) a kind of" (line 12) and "well almost a kind of" (line 13), the practitioner anticipates potential resistance (see Monzoni & Reuber, 2015).

The patient responds with an affirmative, but minimal, "yes" (line 14). It remains unclear whether her "yes" reflects agreement with the rehabilitation team's problem analysis and/or acceptance of their advice, or whether she receives the practitioner's talk as merely informative. In the next turn, we can see that the practitioner indeed treats the patient's response as insufficiently clear: after a 1.5 second pause (line 15), he pursues a more unequivocal response from the patient in line 16, using almost the same question formulation deployed by the practitioner in Extract 2: ".hhh (0.6) do you recognize this?". This specific formulation is in fact frequently used by practitioners in our dataset. It is important to note that, as opposed to alternative polar question formulations like "do you agree?" or "is that correct?", this formulation allows patients to respond affirmatively, without necessarily fully committing themselves to the truthfulness of the practitioner's proposition. Thus, practitioners may choose this formulation over alternative formulations to pre-empt potential resistance.

Extract 3A

1.	Pr:	**.hh e:::hm:. verder hebben we:: 't meer ↑stilstaan.**
		.hh e:::hm:. furthermore we:: have standing ↑still more.
2.		**(0.7)**
		(0.7)
3.		**eh meer ruimte geven aan gevoelens en lichaamssignalen.**
		eh giving more room to feelings and body signs.
4.		**(1.5)**
		(1.5)
		((7 lines of advice giving omitted for reasons of space))
12.		**in plaats van nu: (als) een soort automatische piloot in 'n-**
		instead of no:w (like) a kind of automatic pilot in a-
13.		**.hh ja bijna een soort overleefstand.(0.5) doorbuffelen.**
		.hh well almost a kind of survival mode.(0.5) plodding along.
14.	Pa:	**ja**
		yes
15.		**(1.5)**
		(1.5)
16.	Pr:	**.hhh (0.6) herken je dit?**
		.hhh (0.6) do you recognize this?
17.	Pa:	**jahh dat klinkt ↑g(h)oed(hh)**
		yehhs that sounds ↑g(h)ood(hh)
18.	Pr:	**gaat het [over jou of heb ik 't=**
		is this [about you or am I talking=
19.	Pa:	**[(heh)**
		[(heh)
20.	Pr:	**=ove[r iemand-**
		=abou[t someone-
21.	Pa:	**[n(h)ee d(h)it [g(h)aat (h)over mij ih heheh=**
		[n(h)o t(h)is [(h)is (h)about me ih heheh=
22.	Pr:	**[hhh heh heh .hhh hh**
		[hhh heh heh .hhh hh
23.	Pa:	**=.hh nee dit is heel [herkenbaar ja. heh**
		=.hh no this is very [recognizable yes. heh

Just like the patients in Extract 1 and Extract 2, the patient in Extract 3 starts her response (line 17) as preferred with an agreement token: "yehhs". However, after that, she adds: "that sounds ↑g(h)ood(hh)". Thus, she provides a positive evaluation of the rehabilitation team's advice, but not an unequivocal answer to the practitioner's question as to whether she recognizes the preceding description of the factors involved in her health situation (such as her current behaviour). Potter and Hepburn (2010) have illustrated that, by means of interpolated particles of aspiration such as those in the delivery of the patient's "↑g(h)ood(hh)", speakers may mark their description as potentially problematic.

In the next turn, lines 18 and 20, it becomes clear that the practitioner indeed treats the patient's response as problematic. He pursues a more unequivocal stance with respect to the team's analysis of the factors involved in the patient's health situation, by reformulating his question (yet, holding on to a polar question format): "is this about you or am I talking about

someone-". There is no need to fully complete his turn, as the patient, in overlap, now unequivocally confirms: "n(h)o t(h)is (h)is (h)about me ih heheh .hh no this is very recognizable yes. heh" (lines 21 and 23).

The aspiration particles in the patient's utterance are hearable as laughter and index some kind of interactional trouble. They may be associated with the problem of delivering this confirmation with delay (i.e., after *first* having delivered an inadequate answer) (see Potter & Hepburn, 2010). However, by laughing, the patient also implicitly indicates her awareness of the delicacy of her activity (see also Haakana, 2001). That is, by confirming that the team's description applies to her, she implicitly accepts any unfavourable inferences of accountability and blame that are inherently available in this portrayal. The patient's laughter invites the practitioner to laugh along (line 22). By laughing together, the patient and the practitioner start to remedy the delicacy of the situation, which they continue to do in part B of Extract 3.

Extract 3B

24.	Pr:	**[(want-) maar dit is zegge maar de=**
		[because-) but this is so to speak the=
25.		**=[werkhypothese.=dit is-**
		=[working hypothesis.=this is-
26.	Pa:	**[dit is wel- nee zo zou'k 't niet kunnen omschrijven (h)m**
		[this is- no I wouldn't be able to describe it this way (h)m
27.		**.hh °nee°**
		.hh °no°
28.	Pr:	**dit is eh: dit is niet d'absolute waarheid wijsheid**
		this is eh: this is not the absolute truth wisdom
29.		**maar dit is een soort werkmo[del.=van ku-**
		but this is a kind of working mo[del.=of ca-
30.	Pa:	**[(dit 's jouw feedback)**
		[(this is your feedback)
31.	Pr:	**hie- hier gaan we dan in principe mee aan [de slag,**
		wi- with this we will then in principle get [going,
32.	Pa:	**[ja ja**
		[yes yes
33.	Pr:	**[en dit kunnen we altijd bijstell[en of wijzigen.**
		[and this we can always adju[st or alter.
34.	Pa:	**[ja [ja: is natu-tuurlijk niet**
		[ja [ye:s it's of co-course not
35.		**zo zwartwit (als/dus) en de ene dag is eh**
		that black and white (like/so) and one day is eh
36.		**°>ook sterker dan de andere dag. lijkt mij<°**
		°>also stronger than another day. it seems to me<°
37.		**(0.4)**
		(0.4)
38.	Pr:	**ja**
		yes

Laughter is an interactional device that participants in interaction can use and interpret (Haakana, 2001). In part B of Extract 3, the practitioner attunes to the patient's laughter, as he further remedies the delicate situation. He does so by downgrading the team's problem analysis to "so to speak the working hypothesis." (lines 24–25), which conveys "not the absolute truth wisdom" (line 28), but is "a kind of working model." (line 29), with which they will "in principle get going," (line 31) and that they "can always adjust or alter." (line 33). As we can see in the next turns, he thereby invites the patient – after she mentions that she herself would not be able to describe the situation in this way (lines 26–27) – to join in with the project of downgrading the initially presented problem analysis and thereby manage her personal accountability. That is, she offers several agreement tokens (lines 32 and 34) and counters the sharp contrast previously suggested by the practitioner with respect to her current modus operandi vs. more beneficial behaviours proposed by the rehabilitation team (see Extract 3A): "it's of co-course not that black and white (like/so) and one day is eh °>also stronger than another day. it seems to me<°" (lines 34–36, Extract 3B). It remains ambiguous what precisely it is that she considers to be stronger on one day than another. Nonetheless, the practitioner confirms this statement with a "yes" (line 38) and does not ask further questions that could encourage the patient to further express any specific thoughts or concerns. The consensus established in part A on the problem analysis is safeguarded, at least for the time being.

"What Do You Think of This?": A Deviant Case

In the previous sections, we have illustrated how patients and practitioners tend to orient to ensuring consensus on their rehabilitation team's problem analysis as a relevant activity. We have also shown that practitioners tend to (consciously or unconsciously) deploy discursive strategies that pre-empt resistance and encourage patients to confirm their rehabilitation team's hypotheses, rather than voicing their own concerns and (potentially different) perspectives. In this section, we turn to Extract 4 (derived from consultation 6), in which we see the start of an elaborate discussion, between patient and practitioner, about the accuracy of some of the content of the rehabilitation team's report, as well as about how particular sentences could be rephrased to arrive at a more nuanced description of the social and psychological factors involved in the patient's health situation. Such discussions are not very common in our data, and, as we shall show, this deviant case in fact confirms the normative structure of patients' orientations to confirmation being the relevant and preferred response to descriptions of their rehabilitation team's findings. That is, the way in which the patient in Extract 4 presents her own perspective shows us that she treats doing so as a delicate activity. In addition, this deviant case suggests that an open question format may be more helpful for inviting patients to disclose their own perspectives in consultations preliminary to treatment.

Whereas in Extracts 1–3 practitioners communicate their teams' problem analyses orally, the practitioner in Extract 4 – earlier in the consultation (in an exchange not included in Extract 4) – has asked the patient to read the rehabilitation team's report. Extract 4 starts after the patient has read the report, with the practitioner inviting the patient to respond to it: "what do you think of this Sarah," (line 1). Thus, he uses a format that deviates from the yes/no question format that practitioners in our dataset typically use to elicit responses from patients to their problem analyses. The practitioner's *wh*-question fits with a relatively collaborative and patient-focused communication style, as such questions have been found to invite patients to voice their own perspectives and concerns (Cowell et al., 2021). As we shall see, this is also

the case in this extract. However, before the patient addresses any specific concerns with respect to its content, she first provides a positive evaluation of the report: ".hh yes I believe- it is described ↑really well. I think." (lines 2–3). After a 1.1 second pause (line 4), she adds a positive assessment of reading the report: "and it is also good for me to just read that again" (line 5). Note how, thereby, the patient makes relevant her readiness to look into the causal and maintaining factors involved in her health situation.

Extract 4

1.	Pr:	**wat vind je hiervan Sarah,**
		what do you think of this Sarah,
2.	Pa:	**.hh ja ik denk- 't staat wel ↑echt goed beschreven.**
		.hh yes I believe- it is described ↑really well.
3.		**vind ik.**
		I think.
4.		**(1.1)**
		(1.1)
5.		**en het is ook goed voor mij om dat gewoon weer even te lezen.**
		and it is also good for me to just read that again.
6.	Pr:	**hm[hm**
		hm[hm
7.	Pa:	**[.hh denk wel dat er (0.2) ↓sommige <dingen> (0.5)**
		[.hh do think that (0.2) ↓some <things> (0.5)
8.		**inmiddels minder zijn?**
		are less by now?
9.		**.hhh e:h [zoals]**
		.hhh e:h [like-]
10.	Pr:	**[dat-] kan. vertel,**
		[that's-] possible. do tell,
11.	Pa:	**ja e::hm:. (1.0) waar stond 't nou.**
		yes e::hm:. (1.0) where was it again.
12.		**.hh oh ja verdriet niet toelaten uit angst (*e*)**
		.hh oh yes not allowing grief out of fear (*t*)
13.		**erin te blijven ↑hangen.**
		to get ↑stuck in it.
14.	Pr:	**hm[hm**
		hm[hm
15.	Pa:	**[((snuift)) ik denk dat dat wel (0.5) ↓veel minder is.**
		[((snorts)) I do think that that is (0.5) ↓much less.
16.		**tenminste (0.9) ik laat dat gewoon over me heen komen want ik**
		at least (0.9) I just let that come over me because I
17.		**weet wel (0.2) waar de grens zeg maar ligt?**
		do know (0.2) like where the boundary lies?
18.	Pr:	**hm[hm hmhm**
		hm[hm hmhm
19.	Pa:	**[.hh dus dat is 't ding dat (1.2) minder is=**
		[.hh so that is the thing that is (1.2) less=
20.		**=en afleiding zoe:ke:,**
		=and loo:king for distraction,

In partial overlap with the practitioner's "hmhm" (line 6), she then expresses her reservations: ".hh do think that (0.2) ↓some <things> (0.5) are less by now?" (lines 7–8). Previous conversation analytic research has shown that a positive preface, as produced by the patient in lines 1–3 and 5, is a common feature of dispreferred action (Pomerantz & Heritage, 2012). Furthermore, the pauses, mitigation ("some"), and the rising, questioning intonation of the utterance in line 7 indicate that the patient treats expressing her reservations with respect to the team's problem analysis as dispreferred (see Pomerantz & Heritage, 2012).

There is some overlap of talk in lines 9–10: as the patient provides a cue that she is about to provide an example (".hhh e:h like-"), the practitioner acknowledges that it is possible that the patient considers some of the things described in the report to be less by now ("that's-possible"), after which he invites her to elaborate ("do tell"). The patient then provides an example: "yes e::hm:. (1.0) where was it again. .hh oh yes not allowing grief out of fear *(t)* to get ↑stuck in it." (lines 11–13). Note how the patient displays being engaged in the activity of searching for an example and, thereby, makes relevant that she does not have an example ready right away. Thus, this particular description fits with her previous interactional work of managing the delicate activity of displaying disagreement with some of the team's findings.

Invited by another "hmhm" from the practitioner (line 14), she states: "I do think that that is (0.5) ↓much less." (line 15). Note how the 0.5 second pause, just before characterizing the behaviour in question as "↓much less", indicates some hesitation. Moreover, by individuating her claim ("*I do think* that that is (0.5) ↓much less." rather than just "that is (0.5) ↓much less."), she presents this as her personal judgment, thereby softening the event of disagreement with this aspect of the team's reported problem analysis (see Edwards & Potter, 2017).

She then provides evidence by describing how she deals with grief: "at least (0.9) I just let that come over me because I do know (0.2) like where the boundary lies?" (lines 16–17). It should be noted that the words "at least", the pauses, and the rising, questioning intonation mark the patient's talk as tentative (Wiggins, 2017). Then, supported by the practitioner's encouraging "hmhm hmhm" (line 18), she concludes: ".hh so that is the thing that is (1.2) less" (line 19). After that, the patient brings up for discussion another behaviour described in the report "and loo:king for distraction," (line 20). The patient and the practitioner then continue discussing the accuracy of the descriptions concerning these behaviours in the rehabilitation team's report. Also, they exchange ideas about, and decide, how particular sentences should be rephrased to arrive at a more nuanced description (not included in Extract 4 for reasons of space).

In conclusion, Extract 4 deviates from the identified analytical pattern with respect to the yes/no question format that practitioners in our data predominantly use to elicit responses from patients. It is also deviant from the rest of our data in the sense that, subsequent to the practitioner's question, a relatively elaborate discussion about the problem analysis unfolds, leading to the problem analysis being rephrased. However, even though the regularities that we identified in our data are infringed in this extract, a close examination of the extract corroborates our finding that patients orient to confirmation being the relevant and preferred response to descriptions of their rehabilitation team's hypotheses.

Summary of the Results

Our analysis of nine consultations preliminary to pain rehabilitation treatment shows a pattern with respect to patients' and practitioners' orientation to ensuring consensus on the factors

hypothesized to be involved in the patients' health situation as a relevant activity. The analysis shows that patients regularly display agreement in response to their practitioners' descriptions of how the rehabilitation team depicts the factors involved in their pain problem. However, when patients respond only minimally to these descriptions, practitioners generally pursue confirmation of their team's findings. We have identified a pattern with respect to how practitioners design their turns in ways that pre-empt resistance and encourage patients to confirm the rehabilitation team's findings rather than voicing their own (potentially different) perspectives. More specifically, practitioners tend to mitigate their statements with respect to patients' pain-related behaviours and predominantly use yes/no questions to elicit patients' responses to their team's hypotheses. In addition, our analysis has revealed that patients' and practitioners' joint constructions of consensus on the social and psychological factors (especially behavioural factors) involved in these patients' health situation may function as an interactional resource in managing the patients' doctorability (i.e., their readiness for treatment). At the same time, their talk directed at ensuring consensus about these factors involves a delicate management of issues of accountability and blame.

Discussion

Shared goal setting and decision making about treatment plans are essential elements of patient-centred communication, which is considered a fundamental aspect of the care for patients with chronic pain (Tauben & Sullivan, 2022). The experience of chronic pain is uniquely personal and involves a complex interplay of biomedical, social, and psychological factors (Tauben & Sullivan, 2022). Therefore, patients and their practitioners need to talk through and reach a sufficiently shared understanding of the factors that contribute to the patients' pain and pain-related disability before they can move on to discussing which of these factors could potentially be targeted in treatment and how this could be done. In this study, we examined such preparatory decision-making talk, by empirically analysing consultations subsequent to examination and preliminary to treatment, during which one of the team members discusses the rehabilitation team's problem analysis with the patient. Our analysis shows that, during these consultations, participants treat the problem analysis as a joint responsibility. This is in contrast with findings from various conversation analytic studies in primary healthcare environments, where participants generally orient to diagnoses or problem analyses as primarily within the healthcare professional's domain of responsibility (cf. Heath, 1992; Heritage & McArthur, 2019; Peräkylä, 2006; Stivers, 2006). Thus, this study adds to this body of research and shows that the way in which patients and practitioners orient to the problem analysis may depend on the specific medical context.

From a clinical perspective, it is considered highly important that patients and practitioners agree that the pain problem should be approached from a biopsychosocial perspective (Frantsve & Kerns, 2007; Oosterhof et al., 2014; Verbeek et al., 2004). Moreover, it is considered important that they reach a sufficiently shared understanding of the causal and maintaining factors involved in the pain and pain-related disability before they move on to treatment (Verbunt et al., 2019). Patients and practitioners in our study were found to orient to this institutional norm: they were found to treat ensuring consensus on the factors hypothesized to be involved in these patients' health situation as a relevant activity. Furthermore, our analysis has provided insight into how consensus on behavioural factors in particular may function as

an interactional resource for managing patients' doctorability. Previous work (Stinesen et al., 2021) has illustrated that, in the context of chronic pain rehabilitation, patients need to establish themselves as doctorable persons. That is, they need to show that they are willing to change their pain-contingent behaviour. Findings from the current study are coherent and further support this: we have illustrated that patients regularly respond to behavioural attributions available in the rehabilitation team's problem analysis by displaying insight into, and acknowledging, their own behaviour. By doing so, they work up their readiness to examine their own role in their health situation and establish themselves as eligible candidates for rehabilitation treatment from a biopsychosocial perspective. Patients, however, deal with an interactional dilemma, as showing acceptance of behavioural attributions is a rather delicate activity in which to engage, because such attributions carry implications of accountability and blame.

Patient-centred communication involves (building) a partnership between the patient and the practitioner that enables collaboration, grounded in both the practitioner's and the patient's knowledge, views, and experiences (Santana et al., 2018). In the case of health problems that do not have an unequivocal biomedical cause, the process of collaboratively reaching a shared understanding of the problem tends to require negotiation between patients and practitioners (McCabe, 2021). This means that patients need (to be encouraged) to share their own, potentially different, perspectives. However, in our dataset, instances of patients articulating different perspectives were rare. In fact, our analysis suggests that patients' and practitioners' orientations to the institutional significance of reaching a shared understanding may actually prevent them from articulating differences in perspectives on the factors that cause and maintain their pain and disability. Thus, patients and practitioners may comply with the institutionalized nature of the consultation by "doing being concordant", without actually engaging in a process of exploring differences of opinion and negotiation.

It is, however, important to note that these findings are limited specifically to those consultations in which the rehabilitation team's problem analysis is discussed. It may be that patients and practitioners engaged more actively in a process of articulating and negotiating different perspectives during other conversations, for instance during examinations. Therefore, in order to gain a more complete picture of the process of reaching a shared understanding in the chronic pain rehabilitation context, it would be worthwhile to follow patients and practitioners from the beginning, during each of their consultations.

Previous conversation analytic research (Cowell et al., 2021) on physiotherapy consultations in primary care has indicated that whether or not patients express their own concerns and perspectives can be contingent on practitioners' subtle communication behaviours, such as their question design. Accordingly, we have shown how pain rehabilitation practitioners design their turns in ways that encourage patients to confirm the rehabilitation team's hypotheses regarding the social and psychological factors involved in their pain problem, rather than voicing their own (potentially different) perspectives. They were, for example, found to pre-empt resistance by mitigating their descriptions of the patient's pain-related behaviour. These findings with respect to practitioners' orientations to the delicate nature of addressing a patient's behaviour are coherent with other studies that examined the ways in which healthcare professionals address psychosocial attributions (Bergmann, 1992; Burbaum et al., 2010; Monzoni & Reuber, 2015). Also, practitioners in our study regularly use the pronoun 'we' when they present their hypotheses. This is of course understandable, as they are talking to the patient on behalf of their team. However, it is important to note that working up consensus

within the rehabilitation team through such subtle rhetoric may confine the patient's interactional space to voice different views, as this would imply going against an entire team of medical professionals (see also Engelhardt et al., 2016; Pilgram & Snoeck Henkemans, 2018). Furthermore, particularly when patients' communication practices signalled potential resistance (i.e., when patients remained silent or responded only minimally), practitioners deployed polar question formats that invite confirmation (e.g., "Do you recognize that?"). Previous research has shown that recipients of such yes/no questions generally orient to the principle of avoiding or minimizing disconfirmations in favour of confirmations (Pomerantz & Heritage, 2012). Our finding that patients confirm their rehabilitation team's hypotheses in response to these polar questions, rather than voice their own potentially different opinions, is coherent with this.

Even though pain rehabilitation practitioners may intend to engage in a dialogue on differences in perspective during their consultations with patients, they may unconsciously deploy discursive strategies that actually discourage patients from expressing differing perspectives. In fact, this is only natural, as interaction is regulated by preference principles securing solidarity (Pomerantz & Heritage, 2012) and continuity (Stivers & Robinson, 2006). More specifically, articulating differences poses an interactional risk to the preference for agreement (securing solidarity between participants) and the preference for progressivity (securing the continuity of the interaction) (Te Molder, 2021). Also, from a practical point of view, practitioners may find that there is too little time to discuss the problem analysis in depth. However, it is possible to reach an understanding that is truly shared only if patients open up about any concerns or different perspectives with regard to the factors involved in their health situation. Therefore, it is important that practitioners make an interactional effort to actually encourage patients to make their concerns or even objections explicit, so that these become open for discussion (see also Monzoni et al., 2011; Paap et al., 2022).

Achieving a completely shared understanding of a patient's pain and disability may not always be possible or even entirely necessary. However, an interview study by Paap et al. (2022) indicates that patients' latent disagreement with their team's problem analysis negatively influences their commitment to rehabilitation treatment. Thus, it is important to identify discordances, as this may support patients and practitioners to communicate in ways that result in more effective medical practice (Coran et al., 2013). For example, the patient and the practitioner may then come to agree to certain issues being further explored during the rehabilitation treatment.

Findings from this study can be used by practitioners to reflect on how they can develop communication practices that are more likely to invite patients to express concerns regarding their rehabilitation team's findings. For example, the analysis of a deviant case (Extract 4) suggests that open-ended *wh*-questions are more likely to invite patients to share their own perspectives and concerns. Communication strategies that actively encourage patients to articulate their concerns seem to be especially important when there are signs of potential resistance. In addition, as time constraints may hinder the exploration of differences of opinion, it is also worthwhile to consider whether the limited time available during consultations might be used more effectively. For instance, patients could be asked to familiarize themselves with the team's problem analysis prior to the consultation, leaving more time to discuss the nature of the pain problem during the consultation.

Conclusion

Patient-centred care is an important underpinning of the biopsychosocial approach in interdisciplinary pain rehabilitation (Cowell et al., 2021; Tauben & Sullivan, 2022). Taking the patient's perspective into account is an important component of patient-centred care, which is central to reaching a shared understanding of the factors involved in the patient's pain and pain-related disability. This study has examined how patients and practitioners in interaction manage this aspect of their communication during consultations after the examination phase and preliminary to treatment. It has revealed that, during these consultations, patients and practitioners orient to the institutional significance of reaching a shared understanding of patients' pain and disability and tend to avoid or minimize the articulation of differences of opinion. It has also revealed that patient–practitioner interactions directed at ensuring consensus about the social and psychological factors associated with the patient's health situation involve a delicate management of issues of accountability and blame. This study invites practitioners to evaluate their communication practices. It also offers suggestions for communication practices that are more likely to encourage a joint exploration of differing opinions for the benefit of ultimately reaching an understanding that is truly shared.

Ethical Approval

The research has been approved by an accredited Research Ethics Committee (METC Z, The Netherlands, reference number: 17-N-160) and participants gave written informed consent.

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Conflict of Interest

We have no conflict of interest to disclose.

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Albère J. A. Köke started working in 1984 as a member of the 'pain team' of the University Hospital Maastricht (azM) in the Netherlands. Since then, he has worked primarily as a clinician and a researcher in the field of chronic pain, specializing in the rehabilitation of patients with chronic pain.

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Appendix

Table A. Transcription Symbols Based on the Jefferson (2004) Transcription System

Symbol	Meaning
[ ]	Square brackets indicate overlapping speech
=	Equal signs indicate no break/gap
o o	Degree signs indicate speech that is quieter than the surrounding talk
> <	'Less than' symbols indicate that the bracketed talk is delivered faster than the surrounding talk
< >	'More than' symbols indicate that the bracketed talk is slowed down compared to the surrounding talk
(.)	A dot in round brackets indicates a micro-pause, hearable but too short to measure
(1.6)	Numbers in round brackets measure pauses in (tenths of) seconds
word	Underlining indicates emphasis
:	Colons signal a prolongation of the preceding sound
↑↓	Arrows indicate a rise or fall in intonation
.	A full stop indicates a falling intonation
,	A comma marks a slightly rising intonation
?	A question mark signals a rising, questioning intonation
((writing))	Double brackets refer to transcriber's descriptions of features or non-verbal aspects of the interaction
.hh	A dot preceding (a row of) 'h' indicates an in-breath
hh	(A row of) 'h' indicates an outbreath
heheh	Indicates outbreaths that have vowel sounds (e.g., used to indicate laughter)
w(h)ord	Interpolated particles of aspiration are signalled by 'h' in round brackets
(m)	A parenthesized italicized letter indicates an incipient sound
-	A dash indicates a cut-off
( ), (word)	Empty space between brackets or words between brackets respectively indicate inaudible speech and uncertain hearings