

The Pragmatics of Concealment in Selected Interactions between Terminally-ill Patients and their Caregivers

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DOI: <http://doi.org/10.36892/ijlls.v2i3.322>

Received:

04/06/2020

Accepted:

09/09/2020

Keywords:

Concealment,
Terminally-ill
Patients,
Psychotherapeutic
Context, MCB,
Healing Process

Abstract

Concealment, an act of intentionally withholding information for some purposes, is considered to be often employed by caregivers to veil the terminal status of the patients. This paper therefore investigates the pragmatics of concealment in interactions between terminally-ill patients and their caregivers as it relates to psychotherapeutic process; thereby complementing existing studies which have largely captured attitudes, strategies and structures of such discourses. Seven interactions, capturing cancer, heart disease and kidney failure, were collected through tape-recording and participants' observation at University College Hospital, Ibadan, between February and August, 2016. These were transcribed and analysed using convergence aspect of Gile's Communication Accommodation Theory. Findings show that concealment in this discourse pragmatically configures psychotherapeutic context which bifurcates into palliative psychotherapy and cognitive-behavioural therapy. Palliative psychotherapy, through shared situational knowledge and mutual contextual belief, raises hope of recovery and dislodges fear of death. Cognitive-behavioural therapy, through shared cultural knowledge, facilitates compliance and support in the healing process. The aforementioned findings resonate that the use of concealment in therapeutic discourse psychologically changes the underlying thoughts that contribute to mental depression and modifies the problematic behaviours that result from these thoughts.

1. INTRODUCTION

Concealment, an act of intentionally withholding information for some purposes, has been explored as a discourse strategy in medical discourse. Even in other fields, concealment has been described as the mode of using language to hide information and intentions (Aziz & Al-Duleimi, 2018). Aziz & Al-Duleimi further argue that it is the ability to make something appear as different from what actually is, or does not appear at all. Deducible from the foregoing is the fact that speakers use concealment for certain reasons and to achieve specific aims. Regarding the use of concealment in psychotherapeutic context in medical discourse, it

is believed that it performs the function of giving meaning to the life of the terminally-ill patient and equally offers hope of survival. According to Richman (2000), when terminally-ill patients are offered psychotherapy through information concealment, they are assured of health recovery. This hope of health recovery makes them cooperate with the medical officers and other caregivers in the therapy procedure. Odebunmi (2011) also defines veiling in medical discourse as a means of achieving concealment in communication for the purpose of transmitting unclear information to patients.

To justify the importance of information concealment in medical discourse, Williams (2009) states that the position of the World Medical Association on information concealment is that news can be withheld from patients in certain cases if it is established that they (patients) will harm themselves or commit suicide. The above position then validates why caregivers of terminal patients conceal information from the patients. Terminal illness is one in which, to a reasonable degree of certainty, there can be no restoration of health, and which, absence of artificial life-prolonging procedures, will inevitably lead to natural death (McCartney and Trau, 1990). It is also referred to as a life-limiting illness. Some of the examples of terminal illnesses include the following: lung disease, advanced heart disease and advanced cancer. Terminally-ill patients need psychotherapy that can be provided by a caregiver who could be a medical doctor, nurse or a family member. Family caregivers provide assistance with food and psychological support, which could be in form of communication, to ensure the patients' comfortability.

Nwabueze and Nwankwo (2016), claim that good caregiver-patient communication has the capacity to help regulate patients' emotion and identify their needs, perception and expectations. Interactions between terminally-ill patients and their caregivers result in therapeutic relationship and the patients' willingness to remain in care with the hope of recovery. In the process of achieving this aim, concealment is employed to veil information about their inability to recover from the illness. Therefore, this study investigates concealment as a pragmatic strategy usually deployed in psychotherapeutic discourse. Specifically, the study examines the pragmatic use of concealment in selected interactions between terminally-ill patients and their caregivers with a view to showing the significance of the strategy in the discourse and to complementing existing studies in medical discourse.

2. RELATED STUDIES

Studies have established the strategic use of language in health-related matters. For instance, Adebite and Odebunmi (2006) describe discourse tact in doctor-patient

interactions in English in selected southern-western Nigeria hospitals. The study uses recorded conversations between doctors and patients in the selected hospitals in Nigeria as data. Findings of the study indicate the predominance of doctor-initiated spoken exchanges in which doctors elicit and confirm information and give directives to patients, while the patients give information and attempt to respond appropriately to the doctors' move. There is a nexus between this reviewed study and the current study in terms of the data used. The two studies make use of recorded and transcribed interactions between the actors in the hospital setting in Nigerian medical space. However, while Adegbite and Odebunmi's study does the analysis of diagnosis in medical communication, this study focuses on the pragmatics of concealment in selected interactions between terminally-ill patients and their caregivers.

Boluwaduro (2018) also explores a research on (Non-) adherence in doctor/patient interaction in Nigerian HIV Clinics. The study examines the consultations between female HIV-Positive patients and doctors/counselors in outpatient clinics covering south-western part of Nigeria. For its analysis, the study employs Conversation Analysis and socio-cognitive theory as its framework. Boluwaduro's study and this present one are similar because they both make use of the interactions between doctor and patients in Nigerian hospitals in the south-western part of Nigeria as data. However, this study collects its data from only one hospital which is University College Hospital, Ibadan, Nigeria. Another area of divergence is the difference in their theoretical framework.

Nwabueze and Nwankwo, (2016) also investigate a similar research titled "Ethnicity and Doctor-Patient Communication: An Exploratory study of University of Abuja Teaching Hospital, Nigeria". Their study adopts survey research and focus group discussion methods to ascertain whether ethnicity affects interpersonal communication between doctors and patients. Its findings show that ethnicity of a doctor significantly affects the nature of interpersonal relationship between the doctor and their patient. Nwabueze and Nwankwo's work is similar to this in that they both make use of conversation between medical doctors and patients as their data, thereby making the two studies to be in the purview of medical discourse. However, the two studies are clearly different in terms of the variable of interest in their data (doctor-patient interactions). While Nwabueze and Nwankwo's study considers whether ethnicity affects interpersonal communication between doctors and patients, the present study tracks the pragmatics of concealment in selected interactions between terminally-ill patients and their caregivers at University College Hospital, Ibadan.

Odebunmi (2006) examines pragmatic strategies of diagnostic news delivery in Nigerian hospitals. The findings of the study reveal three strategies used in delivering diagnostic news. Two of the strategies are: “asserting the condition” and “citing the evidence”. The third is named, “mitigating the blunt news through veils and hedges”. Odebunmi adds that the third strategy is largely peculiar to Nigerian hospitals. This third strategy is similar to the thrust of the present study which is about information concealment in medical discourse. Odebunmi (2006) defines veiling in medical discourse as involving inexactitude in language use i.e. non-use of the actual or known medical term for strategic reasons.

Odebunmi (2011) examines concealment in consultative encounters in Nigerian hospitals. He examines concealment items in the interactions between doctors and patients in Southwestern Nigerian hospitals and their pragmatic implications for medical communication in Nigeria. The study discovers nine concealment strategies (jargonisation, veiling, forecasting, mitigating, stalling, normalization, dysphemisation, euphemisation and doublespeak) in consultative encounters to achieve preventive, palliative, culture-compliant and confidential goals. The study concludes by asserting that concealment in consultative encounters takes into account the socio-psychological security needs of patients and attends positively to patients’ cultural expectations. None of the reviewed studies has addressed the use of concealment for psychotherapeutic process between the terminally-ill patients and their caregivers. This study therefore fills this gap by investigating the pragmatics of concealment in psychotherapeutic context.

3. THE THEORETICAL FRAMEWORK

The study adopts Communication Accommodation Theory (CAT). Communication Accommodation Theory as propounded by Giles, (1971) and expanded in Giles, (2006) relates to social identity theory and it is about people adjusting to communicate with other people by minimizing the social differences or gaps that exist between them. It was first referred to as speech accommodation theory which is used to explain the fact that when people talk to each other, they attempt to change the way they talk to align with the way the listeners talk. What can be adjusted to align with the way listener talks include your accent, your speed, your rhythm, your vocabulary, stance and gesture. All these may be done consciously or unconsciously, and it is for the purpose of showing agreement and affinity for another.

The core interest of Giles in this theory lies in the underlying thought processes and emotions that are involved in the use of convergence and divergence during conversations, as accommodation strategies. Gallois, Ogay and Giles (2005) introduce two functions of accommodation and they explain each as displayed below:

A) Cognitive function: cognitive organization.

- Convergence: Speaker (s) converges to Recipient's (R) speech characteristics in order to facilitate comprehension.
- Divergence/ Maintenance: speaker (s) diverges from Recipient's (R) speech characteristic in order to remind R of their non-shared group memberships and hence prevent misattributions, or S diverges in order to encourage R to adopt a more situationally appropriate speech pattern.

B) Affective function: Identity Maintenance

- Convergence: Speaker (S) converges to Recipient's (R) speech characteristics in order to appear more similar and thus more likeable.
- Divergence/ Maintenance: Speaker (S) diverges from Recipient's (R) speech characteristics in order to emphasize distinctiveness, and thus reinforce speaker's positive sense of identity.

It is evident that the theory tries to fill the gap in conversation created by the fact that there is unequal access to linguistic and social resources between the interlocutors. The area of convergence as a strategy of communication accommodation theory, just explained above, was used for data analysis to track how caregivers adjust to align with the way the terminally-ill patients talk in order to facilitate comprehension. This is done in bifurcates of palliative therapy and cognitive-behavioural therapy. The current study uses communicative strategies (convergence and divergence) to signal attitudes and negotiate social inclusiveness

4. METHODOLOGY

Data comprise seven purposively selected interactions between terminally-ill patients and their caregivers, capturing cancer (3), heart disease (1) and kidney failure (3); which were collected through tape-recording and participants' observation at University College Hospital, Ibadan, Nigeria, between February and August, 2016. The researchers became caregivers shortly before one of them lost his father, who was a terminally-ill patient. The researchers were partially allowed to observe core therapeutic treatment involving the medical practitioners but free access to capture interactions between terminally-ill patients and their caregivers. These caregivers include some medical practitioners: doctors and nurses and

family members of the patients. The choice of UCH Ibadan was due to its capacity to handle critical health challenges in Nigeria. The seven interactions were transcribed using Conversation Analysis transcription notations.

The study adopted the descriptive research design method in the analysis of data. Particularly, convergence aspect of Gile's Communication Accommodation Theory was deployed to capture the linguistic expressions projecting concealment in the sampled interactions; while convergence aspect of the theory, indicating Mutual Contextual Beliefs accounted for the contextual dimension of the analysis. It is noteworthy that many of the interactions are very long and only a few instances were carved out used to represent each category because they manifest similarly related contents. The interactions were situated in the psychotherapeutic context which bifurcates into palliative psychotherapy and cognitive-behavioural therapy. Palliative psychotherapy through shared situational knowledge (SSK) and mutual contextual belief (MCB) raises hope of recovery for the patients and dislodges fear of death. Cognitive-behavioural therapy through shared cultural knowledge (SCK) facilitates compliance and support in the healing process. The use of both palliative psychotherapy and cognitive-behavioural therapy results in the cooperation of the terminal patients in the healing process.

5. ANALYSIS AND FINDINGS

The pragmatic use of concealment in this study configures psychotherapeutic context.

Psychotherapeutic Context

This refers to the circumstances that aid the understanding of the use of psychological methods in treating terminally-ill patients for milder depression by telling or discussing their problems. This takes into account: socio-historical context of the interaction and referential communications through which intentions are negotiated. The analysis on this bifurcates into cognitive-behavioural psychotherapy and palliative psychotherapy.

Concealment for Cognitive-behavioural Psychotherapy

Cognitive-behavioural therapy is the treatment given to human mind that guides the person's behaviour. The interactions below capture this situation.

Interaction 1

Background: Interaction between a nurse and patient of severe liver cancer in the hospital ward.

1. **Nurse:** Banji, the only thing you need to do to be discharged is to be taking your drugs as
2. prescribed and be eating your food very well.↑
3. (0.3) In due course you will be fine and return to your workplace↑
4. **Patient:** = I use to take my drugs as prescribed and I eat my food very well;
5. but those drugs are not easy to take. I am just forcing myself to take them.
6. Family members: @ ((in chorus)) you know we told you as well.
7. Thank you for your help, nurse.

The interlocutors in the excerpt above share the cultural knowledge that even though what is needed to be healed as a patient may not be convenient, the caregiver needs to encourage the sick to do it and the patient needs to do it, all for the purpose of ensuring their recovery. That is why the nurse in lines 1, 2 and 3 encourages the patient to be taking his drugs as prescribed and be eating his food normally to ensure quick recovery. The nurse even mentions the patient's name for the purpose of convergence which reduces the social distance and power relation between the duos. This issue of convergence now makes it possible for the patient to cooperate with the medical practitioners in the healing process. The evidence of this cooperation is seen in the response of the patient when he says in lines 4 and 5 that he takes his drugs as prescribed and eats his food normally. The patient adds that he forces himself to take the drugs, asserting that taking the drugs is not easy. The use of concealment as a pragmatic strategy deployed by the nurse to veil the reality of the patient's health status really works on the patient in terms of making him cooperate in the healing process and that is why he (the patient) forces himself to do what is not convenient for him (intake of drugs). The nurse even consolidates her pragmatics of concealment by adding that the patient will not only be medically fine, but also return to his workplace. This goes a long way in raising the patient's hope that he will not only be healthy but also be fit to do the work he used to do even before he became sick.

Interaction 2

Background: A doctor went to the hospital ward to meet a patient of acute renal failure, who appeared to be wealthy based on the kind of care that his family members gave him in the hospital.

1. **Doctor:** Daddy, we will need to do Dialysis for you so that you can be fine.
2. If we do that, your health will be recovered.
3. **Patient:** ((looking anxious))= I am ready. Will you do it now? ↑

In the interaction above, both the doctor and the patient share the same cultural knowledge that medical practitioners have solutions to patient's health challenges. The doctor picks on that to veil the terminal status of the patient by telling him the seemingly sure

solution to his (patient's) health challenge. The doctor in lines 1 and 2 tells the patient that dialysis would be done for him to get well. Dialysis is a means of using machine to extract body waste which the kidney cannot extract due to its failure. Both the doctor and the patient are aware that it is expensive to do dialysis. To show that he shares the same cultural knowledge with the doctor that medical practitioners have solutions to patients' health challenges, he anxiously responds by saying "I am ready. Will you do it now?" The patient's response shows that he is ready for the dialysis, even without asking for further clarification. The patient's response here confirms that he strongly believes that dialysis is the sure solution to his health challenge, thereby making him cooperate in the healing process which is what concealment used is targeted to achieve. Cognitive-behavioural therapy which is the treatment of how brain works in relation to one's behaviour, has also been achieved by the doctor through his use of concealment and that is why the patient seems to be cooperating with the caregiver in the healing process.

Interaction 3

Background: Interaction between a patient of renal failure and his family member in the hospital ward.

1. **Patient:** ((talking authoritatively))=Take me home today. I am ready for whatever
2. happens. Let me go and die in my house. This pain is too much.
3. **Family member:** Yes, you are right, sir. I observed it and when I complained
4. to the doctor, he promised to do dialysis for you today so that you will be fine.
5. **Patient:** ((feels relaxed))=You should have told me this before.

The aspect of divergence in Communication Accommodation Theory is reflected in the opening of the interaction above as the patient disassociates himself from further healing processes ostensibly aimed at ensuring the patient's recovery. The patient and the caregivers (family members and medical officers) share common cultural knowledge that if the patient is not fierce in his request to be discharged against medical advice (Nigerian situation), he will not be discharged; as this can reinforce a written undertaking. They also share the same cultural knowledge that the patient's health is not improving despite the long-time treatment. It is on this basis that the patient expresses his withdrawal from further cooperating with his caregivers in the so called healing process. The expression of the patient's withdrawal is in lines 1 and 2 of the interaction when he says, authoritatively, that he should be taken home on that day. He even adds that he is ready for whatever happens as the consequence of his discharge against medical advice.

In an attempt to conceal, the family member who is with the patient employs convergence, claiming that the patient is right. The family member is of the opinion that by

identifying with the patient, he (the family member) would be listened to and through that he can achieve his target concealment for the purpose of cognitive-behavioural therapy. The family member then says “Yes, you are right, sir... when I complained to the doctor, he promised to do dialysis for you today so that you will be fine”. Saying the patient will be fine after dialysis is done on him is not true. Through this skillful deployment of concealment in convergence communication by the patient’s family member, cognitive-behavioural therapy is achieved and that is why the patient is relaxed and responds that if the family member had given him that information before then, he wouldn’t have expressed his withdrawal from further cooperation in the healing process. This use of concealment by the family member has worked on the thinking of the patient and then affects the patient’s behaviour, by changing from disassociating from to associating with the healing process.

Interaction 4

Background: Interaction between a patient of cancer of the liver and his family member in the hospital ward

1. **Patient:** I am tired of these drugs; I am not taking them again. I have tried.
2. **Family member:** ((after putting a dose of drugs in a morsel of ‘amala’ without the patient being
3. aware))=Let me feed you with this. Now that you don’t take drugs again, you need to eat well.
4. **Patient:** Yes, I can take this; it is drugs that I am tired of.

In the above interaction, the shared cultural knowledge between the patient and his family member who serves as the caregiver is that when one (patient) takes drugs for a long period of time, one could be fed up. In line 1, the patient makes use of divergence aspect of Communication Accommodation Theory by indicating his refusal to continue to take the drugs he has taken for a long period of time. In an attempt to achieve the patient’s cooperation, the family member deploys both linguistic and non-linguistic means of communication accommodation theory. First, (non-linguistic) the family member secretly puts a dose of drugs in a morsel of ‘amala’ (amala in Nigerian context is a meal made from either cassava or yam flour) and secondly (linguistic), he says “let me feed you with this. Now that you don’t take drugs again, you need to eat well”. The family member knows that for him to use concealment on the patient, he (family member) needs to agree with the patient’s opinion so that the patient will have a level of trust in him and that opportunity of trust can be used by the family member to “deceive” the patient. It is on that note that the family member says”... now that you don’t take drugs again...” Hearing this statement, the

patient will develop a level trust in the speaker without knowing that the statement is for an undisclosed target. Having achieved the trust, the family member then says "... You need to eat well". Hearing again that he needs to eat well, since he does not take drugs again, the patient believes eating well is the next thing to do to get well as a patient who has stopped taking drugs.

In line 4 of the interaction, the patient then says that he can take food; it is drugs that he is tired of. Unknowingly to the patient, taking the food given to him by the family member is equal to taking the drugs he believed to have stopped taking. The family member is able to achieve this level of cooperation from the patient due to his skillful deployment of veiling through convergence.

Concealment for Palliative Psychotherapy

Caregivers of terminally-ill patients make use of veiling to provide palliative psychotherapy to the patients. They do this to gradually heal the mind of the patients by raising their hope of recovery through shared situational knowledge and mutual contextual belief. The interactions below capture this.

Interaction 5

Background: A female nurse went to a patient in the hospital ward to measure the patient's blood pressure. In the process, she engaged the patient who was suffering from acute liver cancer in linguistic exchange.

1. **Nurse:** (Putting on a smiling face and holding the patient's right hand)
2. Sir, when you recover and get home, your children will be making a mockery of you because you feel uncomfortable taking injections.
3. **Patient:** @ I trust them; they cannot do that ↑

Using both non-linguistic (putting on a smiling face and holding the patient's hand) and linguistic (Sir, when you recover and get home, your children will be making a mockery of you because you feel uncomfortable taking injections), the nurse is able to instill a level of psychological relief into the patient because the duo have the shared situational knowledge (SSK) and mutual contextual belief (MCB) that in this part of the world, patient who does not adequately cooperate with the healing process by feeling uncomfortable is usually mocked after recovery. It is on this SSK that the nurse bases her common ground to pragmatically produce linguistic palliative therapy for the patient by sympathizing with the patient; because the nurse does not insinuate that there is no need to feel uncomfortable to take injection.

In line (4) four of the interaction, the patient's response shows that he has a shared knowledge with the nurse on the notion that family members make a mockery of the patient who does not adequately cooperate with the healing process and that is why he responds by saying, "I trust them; they cannot do that". As at the time the patient responds, he is a bit relieved from the pains of injections he had taken and any other time that he wants to take the injection, he is likely to remember the statement of the nurse and as a result, he may feel relieved after the injection because he does not want to be mocked after recovery.

Interaction 6

Background: Interaction between a patient of chronic heart disease and his family member in the hospital ward. Another patient who seemingly has a worse health challenge and whose bed is beside the patient in question has just died and moved to the morgue.

- 1. Patient:** ((just waking up from sleep))= Where is the patient on the bed by my side? Did he go to the toilet?
- 2. Family member:** It is because you slept that you did not know. He has been discharged about thirty minutes ago, on the ground of health recovery. We have been jubilating since then.
- 3. Patient:** If that is the case, it means I have hope because the condition of that man is worse.

The question that the patient asks in line (1) one of the interaction is not necessarily because of his concern for the other patient whose bed is beside his, but because he was anxious that if anything bad (death) has happened to the other patient not seen on the bed again, his own hope of recovery may not be real. So, the patient is disturbed and nervous by not seeing the other patient with the similar ailment on the bed again just after waking from a (short) sleep. For the purpose of palliative therapy, the family member around quickly bases his argument on the shared situational knowledge that the patient has just woken up from sleep and he, (the family member) says, "It is because you slept that you did not know. He has been discharged about thirty minutes ago, on the ground of health recovery. We have been jubilating since then". The patient's knowledge of the discharge of the unseen patient and that the people around have been jubilating since then, will, to a great extent, give a level of hope recovery to the patient in question. If the patient has been feeling psychological pains because of his state of health, he could feel a little relieved with the information that a patient with a worse health challenge has been discharged on the ground of health recovery. The belief would be that if it is possible for the other patient to recover, it is also possible for him to recover since they both have a similar health challenge.

Interaction 1

Background: Interaction between a patient of kidney failure who expresses his pain and his friend in the hospital ward.

1. **Patient:** See, I am in pain.
2. **Friend:** Oh! Take it easy. Look at this funny game. ((playing a game for the patient on the phone)).
3. **Patient:** This game is interesting indeed. I can play it as well.

In the excerpt above, the patient expresses his pains due to his health challenge by saying, “See, I am in pains”. To call the attention of the people around to his plight, the patient starts by saying “see”. This is expressed through convergence strategy. The patient wants the people around to empathize and sympathize with him. He wants to minimize the difference between the sick and the healthy for the purpose of being cared for. If this convergence technique is not employed by the patient, he may not get the required attention from the people around him (caregivers). To respond to the patient still in the mood of convergence, his friend that is around says, “Oh! Take it easy”. This statement is to express the fact that the friend associates with the patient even when the patient is in pains. So, the patient gets the desired response (of being cared for).

After showing solidarity, the friend provides palliative therapy to give the patient a level of relief from his pains. To achieve this, the friend says, “Look at this funny game” and he starts to play the game on his phone. The word “look” in the statement is to create convergence in the communication so that the patient would not feel isolated, which may add to the pains. By the time the non-linguistic aspect of communication is used (playing of the funny game), the patient is a bit relieved and at least for the moment forgets his pains. To pragmatically express that veiling used by his friend to make it look as if the funny game is more important than his pains or is the solution to the pains, works, the patient, after watching the game for a while, forgets the pains and instead of expressing his pains as before, he begins to express his enjoyment of the funny game shown to him by his friend.

4. CONCLUSION

Seven interactions, capturing cancer (3), heart disease (1) and kidney failure (3), were collected through tape-recording and participant observation at University College Hospital, Ibadan, Nigeria between February and August, 2016. These were transcribed and analysed using convergence aspect of Gile’s Communication Accommodation Theory. Findings show that concealment in this discourse configures psychotherapeutic context which bifurcates into palliative psychotherapy and cognitive-behavioural therapy. Palliative psychotherapy through

shared situational knowledge and mutual contextual belief raises hope of recovery and dislodges fear of death. Cognitive-behavioural therapy through shared cultural knowledge facilitates compliance and support in the healing process. The aforementioned findings resonate that the use of concealment in therapeutic discourse psychologically changes the underlying thoughts that contribute to mental depression and modifies the problematic behaviours that result from these thoughts. By implication the study complements existing studies on the use of concealment in medical discourse as it relates to caregivers and terminally-ill patients in Nigerian context.

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