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The Therapeutic Role of Language in HIV/AIDS Diagnostic Counselling: A Pragmatic Appraisal

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Abstract

This paper evaluates the pragmatic relevance of counsellor-client interaction in pre and post HIV/AIDS diagnostic counselling. The study establishes to what extent the observation of pragmatic principles either improves or impairs the diagnosis and treatment of this dreadful disease. The analyses reveal that participants involved in counselling flout or uphold the interpersonal rhetoric as well as employ speech acts and implicature in encoding and decoding utterance meaning as the case may be. However, the obliquity arising from hedged performatives does not undermine meaning due to

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contextual factors. The language employed by the participants is, to a large extent, pragmatically adequate and therapeutic as it disposes both the HIV positive and negative clients counselled to respond to the perlocutionary effects of the utterances. This pragmatic appraisal becomes imperative given that "a mere knowledge of technical vocabulary, and even the ability to use that knowledge correctly, are worth nothing, as long as the pragmatic conditions governing the use of that knowledge are not met" (Mey, 1993, p.300).

Introduction

A very distressing aspect of HIV/AIDS is that members of society often view it as a tragedy that people bring on themselves; hence, they stigmatize people living with the disease. Consequently, this wrong perception instils fear in people making discussions on some HIV/AIDS-related issues very sensitive. Many people vehemently refuse to check their status. Some who did check give in to depression when the test result is positive and may even resort to suicide or an emotional disposition that undermines medication. Some even brazenly resolve to endanger others by deliberately and callously infecting them with the disease in an I-don't-want-to-die-alone fashion. Almost everyone who has done an HIV test has a story of fear to tell as HIV screening induces anxiety. This anxiety tendency necessitates pre and post test counselling: to prepare the mind of the patient towards the outcome of the test and to discuss the way forward based on the diagnosed status respectively. In both cases, language is employed and on its efficacy hinges the success of the counselling. This brings to the fore the place of 'talking' in medical interview. Mey (1993) reveals that doctors find themselves in a 'double bind' while dealing with patients, a bind that conflicts with the need to counsel patients with the need to save time (p. 300).

When people talk, they have an intention in mind – an intention which may be explicitly or implicitly conveyed. Whether the speech act is direct or indirect, the speaker expects his hearer to understand the utterance meaning. This awareness is crucial to HIV/AIDS medical

interview where there is a high tendency for the participants to use hedges and derive the meaning of an utterance by implicature owing to the sensitive nature of the topic.

The relevance of language in medical counselling

The relevance of language to the field of medicine cannot be overestimated. Lewis (1972) states that while understanding the language used in some professions may not matter for an 'outsider' it certainly does in medical practice. According to her, it may not matter if a car owner does not understand how a mechanic fixes his car but a doctor cannot 'fix' a patient without the patient's cooperation (p.3). This, points to the instrumental role of language in diagnosis and treatment. A doctor and a patient represent two individuals who have come together to seek a solution to a problem. The patient uses language to give the doctor an insight into his state of health while the doctor on his part uses language to elicit vital information as well as request for one kind of behaviour or the other from the patient. This doctor-patient interaction is communication and its success depends, to a large extent, on the adequacy of the language used.

Remarkably, language and communication lie at the core of medical practice playing a pivotal role in diagnosis and treatment. Without effective use of language, there will undoubtedly be misinformation with its untoward consequences. Despite this fact, inadequacies in communication skills continue to plague medical practitioners, hampering the attainment of their health-oriented goals and bringing them criticism from other professionals. Commenting on the need for effective communication in the field of medicine, Treichler (1992) states that most malpractice suits are predominantly based not on 'what is done' but on 'what is not said' stressing that the vast majority of formal grievances and litigation against physicians and health care agencies could be averted by improving communication in medical practice (p.411).

Shedding more light on the imperativeness of good communication and the appropriateness of language as well as the therapeutic effect of

language in medical practice, Land (2003) observes that doctor-patient interaction provides a window *via* which both can connect to find solutions to a problem. In some circumstances, language tends to give better comfort than medication and if a disease proves too strong or complex for a solution, the same language creates a relationship of trust which can be more comforting than medication for people facing death (p.23). Buttressing the instrumental role of language in medical practice, Rael and Eeva (1992) stress that language is very essential in the practice of medicine. Through language, a physician engages his patient in an interview to ascertain his heath history and condition (p.4). Without this medical interview, therefore, diagnosis will be impaired a great deal. The interaction gives the physician useful insights that inform his decision-making and the solution proffered.

With respect to HIV/AIDS diagnostic counselling, language plays an indispensible role. On its quality and quantity lie successful preventive awareness, emotional stability and status management. Owing to the grave stigma associated with the disease globally, especially in developing countries, no one wants to be infected with the scourge and if, unfortunately, one tests positive to it, one feels as though one's life has come to an end. Thus, conveying a positive test result to a patient is likened to giving the patient a death sentence. The consequent emotional turmoil can lead to suicide if not well managed. Worse still, poor awareness as a result of ineffective counselling can induce depression and frustration that may engender in the victim a resolve to endanger others by infecting them so that the victim will not suffer nor die alone.

It is therefore pertinent to employ a euphemistic approach to relaying such issues to HIV infected patients. Mey (1993) says euphemistic language allows us to talk about negative-laden subjects in terms that deliberately try to pre-empt any negative reaction on the part of our interlocutors. He captures this view succinctly making reference to subjects of cultural taboos such as sex, sickness, death, money, religion, politics and bodily functions (pp.33-4).

All in all, the general business of utterance meaning in counselling, which lies at the core of this paper, falls within the purview of pragmatics. Leech defines pragmatics as the use of language in goal-oriented speech situation in which the speaker is using language to produce a particular effect in the mind of the hearer. Positive and/ or negative results can be attained through language as a tool for diagnosis, prescription, and medication; the efficacy of which this paper centres on. As Mey (1993) points out, Pragmatics is concerned with the use of language in human communication as determined by the conditions of the society (p.6). This suggests that when people use language, social factors and environment influence their linguistic choices. Thus, a client presenting himself for HIV diagnostic counselling is usually on tenterhooks owing to the resultant stigmatization if the diagnosis is positive. To protect himself, he often resorts to linguistic repression by way of giving under dose of information – a practice that flouts the Gricean Cooperative Principles. The counsellor on his part is likewise challenged in the task of conveying the difficult task. This necessitates the use of hedges and other pragmatic devices to douse the tense atmosphere characteristic of HIV/AIDS diagnostic interview.

Methodology

The method of data collection employed is covert and overt participant observation which according to Whyte (1979) is 'a shorthand term for a set of methods including interviewing, since any able field worker will supplement what is learned from observing and participating with some interviewing (p.163). To ensure objectivity, therefore, the researchers employed both covert and overt participant strategies. On the one hand, a covert participant observation was employed as the two researchers involved presented themselves for HIV counselling and diagnosis in four different clinics (two for each researcher) in Jos metropolis. The covert entry into the field was adopted because it was the only way to gain access to undiluted data. One may wonder why this disguise is employed and whether it is ethically justified. Responding to this, Whyte (1979) says,

> the roles of spy and researchers are alike in that both conceals their true objective; they differ markedly in commitment and objectives. The spy is a partisan, working for one side against the other..., gathering information for the purpose of damaging individuals or organizations on the opposing side. The researcher should be committed to the gathering of information to increase scientific knowledge. In reporting the findings, the researcher is obligated to try to avoid damaging the organisation or its members (pp.164-5).

Therefore, what matters here is not the covert method employed but the objective that underlies the method: exposing the therapeutic role of language in HIV/AIDS diagnostic counselling.

On the other hand, in overt participant observation the researchers conducted interviews with ten HIV/AIDS counsellors chosen from the four clinics visited. This becomes necessary considering the ethics of the medical profession. The interview was employed to circumvent the challenge of eliciting classified information regarding HIV positive patients.

Due to limited space, two primary data from the covert participant observation and one data from the overt participant observation are presented.

Presentation of Data and a Holistic Pragmatic Analysis

Data 1

Pre Test Counselling

Researcher: Good afternoon Ma'am.

Counsellor: Afternoon, how may I help you?

Researcher: I want to do a test.

Counsellor: Have you done an HIV test before?

Researcher: Yes, but about nine years ago.

Counsellor: Why do you want to do it again?

Researcher: I have a need for another test.

Counsellor: So, how has your life been since the last test?

Researcher: Anyway, I have been faithful to my husband, but you know HIV can be contracted through other means.

Counsellor: Like from one's spouse?

Researcher: Exactly!

Counsellor: What means of transmitting HIV do you know about?

Researcher: I'm aware it is contracted through sex, sharing of sharp objects, et cetera.

Counsellor: Yes, you are right. The major cause is sex with an infected partner. Has your spouse done the test before?

Researcher: I don't think he has.

Counsellor: What about him?

Researcher: Do you mean his life style?

Counsellor: Yes.

Researcher: Well, I can only vouch for myself.

Counsellor: Will this result make any difference in your life?

Researcher: Hmmm! I don't pray for a bad result at all, but if it turns out bad, what can I do to change it? Nothing!

Post Test Counselling

Counsellor: Congratulations! You are negative.

Researcher: Hmm, Thank you Ma'am.

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Counsellor: Always remember that being negative today does not mean you'll be perpetually negative.

Researcher: So?

Counsellor: You have to preserve and sustain it. Gone are the days when HIV infected persons were rare. They are many now so be on your guard to avoid being infected. You know these our husbands- o-o. They are very important, whether they bring money home or not. If you don't make the home conducive for them, they will go out and the wife suffers the consequences. So handle your husband like gold o-o!

Researcher: Okay, thank you very much.

Counsellor: You are welcome.

Data 2

Pre Test Counselling

Researcher: Good day Sir.

Counsellor: Hello, how may I help you?

Researcher: I am here for test.

Counsellor: Okay come over to this room. So how are you?

Researcher: Fine, thank you.

Counsellor: Have you done the test before?

Researcher: Yes.

Counsellor: When was the last time you came for HIV screening?

Researcher: Three months back.

Counsellor: So why do you want to have one done again?

Researcher: To know my status.

Counsellor: Are you married?

Researcher: Yes, but widowed.

Counsellor: Oh! Sorry. When did this happen?

Researcher: Two years and eight months ago.

Counsellor: Is it this same problem that killed him?

Researcher: No.

Counsellor: Okay, let me collect the sample. I will call you when your result is ready.

Researcher: Okay, thank you.

Post Test Counselling

Counsellor: Do you know how HIV is contracted?

Researcher: Yes, through sex, sharp objects, accidents, mother to child, blood transfusion, et cetera.

Counsellor: Sex with infected partner, infected sharp objects, infected blood.... Do you understand?

Researcher: Okay, yes.

Counsellor: HIV can also be contracted through sharing the same tooth brush with an infected partner.

Researcher: Wow! That is if the gums have wounds?

Counsellor: Of course. What will you do if this result turns out positive?

Researcher: I will accept my fate and take it as one of those things.

Counsellor: Anyway, your status is still Ok my dear. Now that your status is negative, try as much as you CAN to maintain it. I know and I am pretty sure they will come. Fine woman, young like you. Men no

go gree oo! But be wise. God will help you. God allowed whatever happened the way it is. You can remarry since you are just thirty-two. But you have to be careful. Be very very wise. Do you understand? (Patient nods). Don't just start a relationship. Before anything, try to check. God will help you.

Researcher: Thank you.

Data 3: Interview with an HIV/AIDS Counsellor (Partly Presented)

Researcher: Are your clients scared during counselling?

Counsellor: Yes, the anxiety associated with the outcome of HIV test is very high. Most clients are on tenterhooks until a negative result is announced to them.

Researcher: Does counselling drive away such fear from the client?

Counsellor: Yes, to a large extent. It gives them hope and shows them the way forward.

Researcher: Does effective use of language affect the emotional state of a positive client during post test counselling.

Counsellor: Yes, a great deal. Most positive clients are prone to suicide but counselling reduces the tendency drastically. For instance, a policeman brought his girlfriend for HIV screening and when she tested positive, I suggested to the man to get screened too and he obliged. Unfortunately, he tested positive, too. The day he came for the result, I was alone in the office because it was still very early. He was so anxious he arrived before office hours. As soon as I saw him, I sensed he's disposed to commit suicide if he's positive. So I decided to be very tactful in disclosing the result to him. I noticed a pistol in his inner breast pocket concealed by a jacket. Before announcing the result, I began by telling him that there's hope available for HIV positive patients now because drugs are readily available for them and

treatment is free. They can live normal lives as long as possible if they learn how to take care of themselves and so on and so forth. As I talked, his shaky hand was struggling with something in his inner breast pocket, apparently a pistol. The more I talked the calmer and less shaky he gradually became. He was too absent minded to interrupt me. At length, he found his tongue and said: "Do you mean I shouldn't do something stupid now?" I smiled broadly and I said, "There is no need for any stupid act." The future holds so much good for you and you will be a fool to cut it short. I've had patients that tested positive more than ten years ago. They are still hale and hearty today and doing fine regardless of their status. Then he said, "Let me try to believe you" and removed his hand from the breast pocket. Of course, I made a sign of the cross when he left.

Analysis of data 1 and 2

It is worth noting that pragmatic principles and maxims are not only related but interwoven. Any meaningful and pragmatic analysis must take this notion into account, for example, if a speaker hedges an utterance by using a less obvious word to relate it (upholding the Politeness Principle of Tact), the cooperative principle of quantity may be flouted. In this regard, the researcher will incorporate all the pragmatic elements available for analysis.

In both data 1 and 2, the turns open with exchange of pleasantries to create a polite and relaxed atmosphere for successful counselling. By so doing, the agreement maxim of the Politeness Principle (PP) is upheld. The agreement maxim states: 'Minimize disagreement between *self* and *other* and maximize agreement between *self* and *other*' (Leech, 1983, p.131).

It is pertinent to note that turn-taking involves speech acts. Austin (1962) makes a distinction between three kinds of speech acts: a locutionary act (performing the act of saying something), an illocutionary act (performing an act in saying something), and a perlocutionary act (performing an act by saying something). The illocutionary goal of a discourse can be distinguished from other

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social goals – the 'social goals' of maintaining cooperation and politeness among others. The speech act theory is relevant to the study because it establishes the fact that there are a series of analytic connections within the notion of speech acts, what the speaker means, what the linguistic element uttered means, what the speaker intends, what the hearer understands, and what the rules governing the linguistic elements are.

It is observed that both the researchers (Rs) and the counsellor (C) rely on implicature and context in the following statements: 'I want to do a test'; 'I am here for test' which occur in the data. The type of test is not stated but both parties have shared assumptions that the 'test' referred to is HIV screening even though not explicitly mentioned thereby violating the CP maxim of quantity and the Clarity Principle. It follows that the parties involved in the exchange are aware that the clinics are HIV screening centres. The statements that follow denote that the illocutionary goal of the message is not lost. In data 1, C tells R 'Have you done an HIV test before?'- introducing the type of test for the first time. In data 2, C maintains 'test' without stating the type of test in question. C still says 'Have you done the test before?' based on the shared assumption. In data 2, C shows sympathy on hearing the marital status of R: widowed. C says 'Oh! Sorry. When did this happen?' In doing this, C upholds the PP Sympathy Maxim: (a) Minimize antipathy between *self* and *other* (b) Maximize sympathy between *self* and *other*. C however uses tact to ask R 'Is it this same problem that killed him?' C implies that R's spouse died as a result of HIV; as such, R is there to confirm her status within a span of three months (when the test was done last). Still upholding PP (tact maxim) C asks R in data 1 'So, how has your life been since the last test?' It is assumed that C cannot ask R outright if she has been promiscuous. C uses a subtle way to go about her search. C employs a hedge thereby being evasive. In data 1, R in response to C's question- 'So, how has your life been since the last test?' says: 'Anyway, I have been faithful to my husband, but you know HIV can be contracted through other means.' R hedges the response by employing the PP maxim of

approbation that stipulates: Minimize dispraise of *other*. C however implies Rs hedged meaning from what follows. C says: 'Like from one's spouse?' R agrees thus: 'Exactly'.

Furthermore, we observe in both data 1 and 2 that Rs flouted the quantity maxim of CP by failing to give the right amount of information required. Rs in both 1 and 2 say that HIV/AIDS is transmitted through sex, sharp instruments, et cetera failing to note the fact that the virus is contracted through sex with an **infected** partner or **infected** sharp objects. C in both data 1 and 2 corrects Rs. C however does the correction subtly thereby upholding the PP approbation maxim that says (a)Minimize dispraise of *other* (b) Maximize praise of *other*.

In data 1, R, when asked if her spouse has done the test before, confesses that she does not think he has. The CP quality maxim that states: Try to make your contribution one that is true; i.e. do not say what you believe to be false and do not say that of which you lack adequate evidence is upheld. This maxim is further upheld when C asks R a question suggestive of the spouse's possibility of infidelity: 'What about him?' C's question flouts the CP maxim of manner that underscores obscurity of expression. The question is vague but is explicated by the context which accounts for R's response to the hedged question: 'Do you mean his life style?' The clarity principle requires that utterances be made clear (Leech, 1983, 100). It is deducible, therefore, that clarity goes beyond the linguistic units used to the context of use. This maxim is interwoven with the Cooperative Principle in the sense that it is only when a text is free from ambiguity, obscurity, falsity, and disorderliness that it will be clear. C affirms R's implicature by a 'yes' confirmation. R, again, upholds approbation maxim (a) Minimize dispraise of *other* (b) Maximize praise of *other*. R refuses to imply that her spouse is promiscuous but simply says she can only vouch for herself. The CP maxim of quality is also upheld by R's refusal to say what she lacked adequate evidence for. C further asks R whether the result of the test will make any difference in her life. In response, R in data 1 says: "Hmmm! I don't

pray for a bad result at all but if it turns out bad, what can I do to change it? Nothing!" R in data 2 says: "I will accept my fate and take it as one of those things."

Rs responses show resignation to whatever the outcome of the result will be. C intends to know what Rs reaction will be if a positive result is announced. R could possibly want to kill herself like the patient in data 3. C does so with the aim of arming herself for the unforeseen. For instance, C in data 3 presupposes rightly what her patient plans to do - shoot himself. Thus, assured of Rs negative status, C discloses the HIV test result but tactfully warns, in no uncertain terms, that being negative today does not imply being negative forever; precautions are to be taken seriously. In data 1, C upholds the PP Approbation maxim by congratulating R and then tactfully telling R some of the precautionary measures to maintain her status. She goes out of her way to exaggerate that husbands are "like gold". She hedges the fact that no matter how negative R is (since she can vouch for herself), she must not give her husband the leverage to be unfaithful for that will make her unsafe. Again, in data 2, C uses tact to advise R to maintain her negative status by remarrying, considering her age. C uses unnecessary prolixity for emphasis thereby flouting the maxim of manner albeit this flouting is necessary to safeguard R's health. C also stresses *can* and *very* - 'try as much as you can...', 'Be very very wise' because of the presupposition that widows are exposed to multiple partners. As such, they are susceptible to the disease. C tells R in data 2, "Before anything, try to check'. The word *check* is obscure but understood because of the context of situation as well as co-text since there are shared assumptions of the theme of discourse.

Analysis of data 3

The ten interviews conducted generally depict that language plays an indispensible role in both pre and post test counselling as a medium via which counsellors educate their clients on the HIV/AIDS pandemic on a one-to-one basis as well as allay the fears of HIV positive clients by acquainting them with information regarding how

to access medical care and to stay healthy. However, since the paper makes a pragmatic assessment of the language employed in counselling, the salient pragmatic principles observed in data 3, where an encounter with an HIV positive client is related, are hereby analysed. The two participants, speaker (counsellor) and hearer (client) are referred to using S and H respectively.

Before receiving the test result, H rightly predicts his status based on the encyclopaedic knowledge that sex with an infected partner is a high risk factor. S infers H's suicidal disposition from the context of situation. But because S believes, apparently from previous experience, in the therapeutic role of language in counselling, S is unnerved by H's emotional disposition. Thus, S talks on until language does the magic of restoring emotional stability in H as seen in his subsequent body language. Going into an indepth analysis of the body language will lead into another field of language study-semiotics which does not fall within the purview of this study.

Implicature is employed in the discourse. S conveys the grave, positive result to H using indirect speech act. Rather than tell H brazenly that he is positive, S resorts to telling H how to manage an HIV positive status and giving him hope. S draws the implicature that he is positive knowing full well that the extra prolixity employed by S has an illocutionary goal. S does not just flout the sub-maxim of manner (Be brief) but does it on purpose to allay H's fears by educating him on how to manage the positive status. S upholds the approbation maxim of the Politeness Principle by avoiding dispraise of *other,* evident in the indirect conveyance of the result. Similarly, despite S's use of indirect speech act to tactfully convey H's result, the perlocutionary effect of S's utterance is not lost. This is visible in H's first response to the lengthy discourse: 'Do you mean I shouldn't do something stupid now?' Although H's utterance lacks explicitness and flouts the CP's sub-maxim of manner (avoid obscurity), S draws the inference from co-text that 'something' in the utterance means 'suicide'. This implicature necessitates S's response to H's question thus: 'There's no need for any stupid act. The future holds so much

good for you and you'll be a fool to cut it short.' The concluding utterance 'Of course I made a sign of the cross when he left' implies that HIV counselling is not only challenging to clients counselled but also to counsellors themselves on whose shoulders rest the huge task of allaying the often tremendous fear of their clients.

Conclusion

To sum up, some expressions used in the talk exchange obey the pragmatic principles to a higher degree than others, but still all the utterances could be considered cooperative in the exchange as long as other relevant pragmatic tools were used, such as identifying reference and drawing the appropriate implicature. Misunderstanding does not arise in the interaction even in the face of obliquity because of the existence of context. Consequently, the utterances either observed or flouted the pragmatic principles but none of them opted out of or violated them. Speakers opt out of observing the maxim if they decide not to cooperate in a conversation. For example, they may prefer to say 'I don't think I can give you any information about it' or 'I can't tell you' even though they know the truth. The flouting of the maxims happens "when speakers appear not to follow the maxims but expect hearers to appreciate the meaning implied..." (Cutting, 2002, 37), so the speakers deliberately break the maxims while still attempting to be cooperative in an exchange. The violation of the maxims, on the other hand, means the speakers intentionally disobey them, and are fully aware that the addressees will fail to perceive the real truth and interpret the speakers' utterance literally. As a consequence, the hearers falsely assume that speakers are cooperative while in fact there is a large lack of cooperation on the part of the speakers, resulting in misleading interpretation. However, no violation was observed in the analyses.

As observed, utterances that were hedged turned out to be understood as a result of co-text and implicature with the basic assumption that the participants are cooperative. Thus the use of language in HIV/AIDS counselling is pragmatically adequate and therapeutic.

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