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**Research Paper**

# "It will be *scratching me": Increments in STI and HIV medical encounters in Southwest Nigeria

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**Abstract**
This study examines the occurrence of increments in three languages (Nigerian English, Yoruba, and Pidgin) in the medical context in Nigeria with the aim to give a functional classification to increments built upon the conceptual and structural description in the literature. This is a step further from reflecting the manifestation of increments in the monotypic context of mundane interactions to an investigation of the phenomenon in an institutional context. Fifty audio-taped recordings of naturally occurring conversations in selected hospitals in three states in southwest Nigeria were transcribed and analysed using Conversation Analysis. Functional classification of increments in the data revealed six types of increments namely, symptom-motivated, information-motivated, history-related, face-saving, emphatic, and mundane. The increments were mainly glue-ons and very few instances of non-add-ons in the context of history-related increments. Patients were more frequently disposed to designing increments than doctors in STI and HIV consultations in Nigeria. The patients utilized the symptom-motivated increments for the purpose of elaborating on their health concerns and for clarifying the most pressing symptoms. This afforded them the opportunity of unburdening their health concerns and focalising more pressing symptoms. In addition, the sensitive nature of their condition also spurred the deployment of face-saving and history-related increments to handle embarrassing and face-sensitive questions about their condition and lifestyle.
**Keywords:** Increments, Turn constructional unit, STI and HIV medical encounters, Conversation Analysis, Nigerian English

## 1. Introduction

Medical encounters in STI and HIV settings as with other medical settings thrive on communication as communication provides the avenue for doctors to retrieve such medical history from patients as to assist them in arriving at correct diagnosis. As such, the bulk of medical consultations entails question-answer sequences where medical information is elicited and supplied and where each turn at talk orients to the previously produced turn. This study derives its inspiration from the observed propensity of the participants, especially the patients, to provide additions to their turns by either correcting a misconceived health problem or insisting on their most pressing health concerns. The turn additions resonate well with what has been described in the literature as a type of turn expansion called 'increments' (Schegloff, 1996).

Increment has been defined as grammatical extensions of a prior turn (Ono and Couper-Kuhlen, 2002) whereby a speaker provides further talk past the possible completion of a Turn Construction Unit (TCU) (Couper-Kuhlen and Selting 1996; Ford & Thompson 1996; Ono and Couper-Kuhlen, 2002). Increments have been classified into two groups: glue-ons which refer to additions that are grammatically fitted to the end of the host turn construction unit (TCU), and insertables: additions that are not fitted to the end of the prior TCU, but which can be fixed somewhere within it (Couper-Kuhlen and Ono, 2007). The result of an analytical survey of increments in English, German, and Japanese reveals glue-ons as being more prevalent in English conversations, with very few cases of non-add-ons and insertables (Couper-

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Kuhlen and Ono, 2007). The occurrence of increments thrives on an understanding of what constitutes a TCU. A Turn Constructional Unit specifically refers to that size of talk that makes a turn. In English, a speaker may choose to construct a turn with a word, phrase, clause, or sentence. This choice is determined by several principles such as the type of action that needs to be performed, the action performed in the preceding talk, the recipient's turn design, etc. Thus, "each TCU is a coherent and self-contained utterance, recognizable in context as 'possibly complete'" (Clayman, 2013, p. 151).

Previous studies have examined the way in which increment is achieved in different languages such as English, Korean, Finnish, Navajo, and Chinese excluding the previously represented study of increments in English, German and Japanese (Schegloff, 1996; Ford and Thompson,1996; Kim, 2007; Seppanen and Laury, 2007; Field, 2007; Luke and Zhang, 2007). In addition, there have been arguments and suggestions of a reformulation of the criteria for distinguishing increments to accommodate 'increments to do backward-oriented (retrospective) actions but never forward-oriented actions (Auer, 2007). Auer (2007, p.19) specifically argues that "even a more sophisticated and typologically more satisfactory approach to unit expansions runs into problems if it remains on the syntactic plane alone." Thus, according to him, a full typology will have to consider not only prosody and semantics but also action structure and pragmatics at large.

This study examines the occurrence of increments in three languages (Nigerian English, Yoruba, and Nigerian Pidgin) in the medical context in Nigeria with the aim to give a functional classification to increments built upon the conceptual and structural description in the literature. This study is also a step further from the manifestations of increments in the monotypic context of mundane interactions to an investigation of the phenomenon in an institutional context. In the subsequent sections, I will present the methodology and theoretical insights, the analysis, the findings, and the conclusions of the study.

## 2. Methodology and theoretical insights

Audio-taped recordings of fifty naturally occurring conversations between doctors and patients in STI and HIV clinics constitute the data for analysis in this study. The clinics were domiciled in private, state, and federal-owned hospitals in three states (Ondo. Ekiti, and Lagos) of Southwest Nigeria. Ethical approval was granted by the ethics committee or chief medical director in the selected hospitals while informed consent was granted by both doctors and patients who participated in the study. Thereafter, the data were transcribed using the Jefferson Transcription System (adapted from https://www.universitytranscriptions.co.uk/jefferson-transcription-system-a-guide-to-the-symbols/). The transcribed interactions were screened for instances of increments which were analysed using insights from Conversation Analysis.

According to Sidnell (2010, p.1), Conversation Analysis (CA) is "an approach within the social sciences that aims to describe, analyze and understand talk as a basic and constitutive feature of human social life. CA is a well-developed tradition with a distinctive set of methods and analytic procedures as well as a large body of established findings". The definition by Sidnell (2010) gives a clue to one of the roots of CA, one of which is sociology, and the fact that CA offers a robust body of resources and established traditions and methods for its preoccupation. A crucial feature of CA, as rightly observed by Pomerantz and Fehr (1997, quoted in Arminem, 2005), is that it does not study talk in general, but rather specifies in detail, naturally occurring interactional practices, to illuminate the generic properties of talk and social action through which the constitutive nature of social reality is maintained. Methodologically, the objective of CA research into institutional interactions is to reveal the practices through which participants manage their interactions as a specialized form of interaction, for instance as a news interview (Clayman and Heritage, 2002), as doing counseling (Perakyla, 1995), as a medical visit (Heritage and Maynard, 2006; Stivers, 2006; Odebunmi, 2005, 2016; Odebunmi and Amusa, 2016; Boluwaduro, 2020; Amusa, 2016; 2022) and so forth. In such research, CA connects very directly with ethnographic sociology (Maynard, 2003) and offers a distinctive, rigorous, and fruitful methodology for investigating social life's organizational and institutional sides.

## 3. Analysis

The analysis of the types of increments in the STI and HIV/AIDS consultative interactions reveals increments as predominantly glue-ons, thereby aligning with Couper-kuhlen and Ono's (2007) conceptualization. The data shows that the increments are grammatically and syntactically fitted to the end of the host TCUs. The study has functionally identified six classifications of increments namely, symptom-motivated, information-motivated, history-related, face-saving, emphatic, and folk-related (or mundane). Each type shall be discussed shortly in the sections below:

### 3.1 Symptom-motivated increments

Symptom-motivated increments constitute those post-TCU expansions that are triggered by the desire of STI and HIV/AIDS patients to unburden their health concerns. The primary goal of patients visiting the hospital is to receive treatment to make them well. The pattern of the consultative interaction is constituted by question–answer sequences, where the doctor institutionally coordinates the pace of the consultation. Each turn usually makes a Turn Construction Unit (TCU) and a speaker may employ a number of discursive strategies to either design another turn at a Turn Relevance Point (TRP) or give the other participant an opportunity to take the floor (Schegloff, 1996).

In the medical institutional settings generally and specifically, during medical consultations, the doctor displays Aesculapian power which positions them as the pacesetter of the consultation. However, due to the desire of the patient to get well, they sometimes display a possibility to self-select, to expand a prior turn. Many times, this act of

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incrementing is symptom motivated. Symptom-motivated increments in this study are predominantly glue-ons and are sequentially located after the problem presentation phase and sometimes, after the physical examination stage as instantiated in the interactions below. The symptom-motivated increments are in bold fonts.

### Example 1

The interaction below occurs between a doctor and a female patient in the General Outpatient Department (GOPD) of a hospital in Southwest Nigeria. The patient has come for the treatment of a Sexually Transmitted Infection-related ailment, as it concerns some discomforting itching in her genitals. The general terminology used to explain this type of experience among women in Nigeria is "toilet disease". The interaction is presented below:

1. Pat: ((should I go on↓))
2. Doc: ehn↓
3. Pt: I said I'm having scratch inside my private part
4. Doc: oka:y↓
5. Pt: so, as I'm scratching it,
6. the thing is paining me,
7. **peppering me**
8. Doc: okay=
9. Pt:= the:n I still have malaria ( )
10. ((noise))
11. Doc: ( .) sorry. You said, you have toilet disease.
12. How do you know you have toilet disease?=
13. Pt: =even whe::n .mtch. because I travelled home.
14. the::n↑ =
15. Doc:=Is it because you travelled home?=
16. Pt: =No↓ it has been affecting me before↓
17. **I used to scratch my private part.**
18. ***It will be *scratching[ me]* (It will be itching me)**
19. Doc: [do] you have any
20. discharge?=
21. Pt:=no
22. Doc: Does it have
23. Pat: [but ]
24. Doc: [Ehn↑]
25. **Pt:=the thing the body is paining me**
26. Doc:=does it have any stain on your pant?
27. you said you have been having it like that
28. Pt: umm. when I treat it like that, it will still go
29. for many (( ))
30. Doc: do you have diabetes↓=
31. Pt: =no
32. (())

The interaction above begins with the patient's request to continue a prior explanation. The doctor acknowledges the patient's self-initiated repair of a prior inaudible turn in line 2. The patient redesigns her turn as an expression of a health concern which signals the frame of problem presentation in line 3 ("I said I'm having scratch inside my private part"). The doctor then formulates an acknowledgment token with a falling intonation in line 4 ('oka:y↓'), which encourages the patient to continue. In line 5, the patient designs a new turn construction unit (TCU) to describe the feeling that accompanies the itching in her genitals. Following immediately is a further description of a peppery feeling in line 6 ("peppering me'), which serves as an increment to that turn, even though the turn construction unit is very minimally concluded in the initial turn. This increment constitutes a non-add-on increment type (Couper-kuhlen and Ono, 2007); the only instance of such in the current data. The patient's turn is then acknowledged by the doctor in line 8. In line 9, the patient self-selects to design a new TCU to express an additional concern ('= the:n I still have malaria') which is not entirely reflected in the transcription because there was 'trouble', a noise in the background that interfered with the recording. Thus, in line 11, the doctor self-selects to design a turn, using a sorry-prefaced turn design ('(.) sorry. You said you have toilet disease), to foreground a particular health concern which must have been mentioned by the patient simultaneously with the noise in the background. In a latched response, the patient gives uptake to the doctor's Inquiry in line 13 (=even whe::n .mtch. because I travelled home. the::n↑ =). The doctor's request for clarification in line 15 is given an uptake in the succeeding line by the patient. This response is sufficient as a TCU, judging by the semantic content and the falling tune that marks the end of the turn. However, the patient provides further talk past this TCU to further explain her STI symptoms in two turns, in lines 17 and 18: "I used to scratch my private part; *It will be *scratching[ me]* (It will be itching me)", respectively. The increment in line 17 is intended to describe the itchy effect of the infection in the patient's genitals while the increment in line 18 emphasises the discomforting experience of the itching she feels. In line 19, the doctor designs another inquiry to check the symptoms of the patient with her medical knowledge and a projecting of the possible diagnosis. The patient's uptake is a latched disaffirmation, in line 21 ('=no). In line 22, the doctor initiates a turn to further clarify the patient's symptoms, but this

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is interrupted by a self-selected turn by the patient which terminates in an overlap with the doctor's new turn, in lines 26 and 27. The patient thereafter self-selects again to design an incremental turn in line 25 (=the thing the body is paining me), which is not a syntactic expansion of a prior turn, but a semantic and pragmatic one that foregrounds the patient's more pressing symptoms, other than the one for which the doctor sought elicitation. She goes ahead of the doctor, in desperation and anxiety to get well. Her increment, though a violation of Grice's maxim of quantity, reveals compliance with the maxim of relation. It is relevant to the overall consultation. Another interaction is considered below:

**Example 2**

Below is another interaction that occurred between a male doctor and a patient living with HIV. The patient who is an elderly man has visited the clinic for a routine check for HIV-reactive people and to receive treatment for a health concern.

| | | | |
|---|---|---|---|
| 1. | . | Dr: | Good morning sir= |
| 2. | | Pt: | = good morning↓ |
| 3. | | Dr: | you are welcome sir |
| 4. | | Pt: | thank you |
| 5. | | Dr: | S:::::o what can I do for you today sir↓ |
| 6. | | | ( . ) |
| 7. | | Pt: | hmmn mcheww hhhh, I have this itching in my body and ((searching for words)) |
| 8. | | | (.) |
| 9. | | Dr: | itching= |
| 10. | | Pt: | =itching |
| 11. | | Dr: | let me see↓ |
| 12. | | | (( patient opens back for doctor)) |
| 13. | | Dr: | WO::W |
| 14. | | Dr: | how long has this itching started?= |
| 15. | | Pat: | =hm::mn tch let's sa::y, it's up to:: °a week now°= |
| 16. | | Dr: | = A WEEK↓. |
| 17. | | | (.) |
| 18. | | | let me see your tummy |
| 19. | | | ((physical examination)) (0.5) |
| 20. | | Dr: | one week |
| 21. | | Pt: | hun↓ |
| 22. | | | **hhm the other time I came her::e, I explained to the doctor,** |
| 23. | | | **Whenever n I urinate, I will be feeling some pains, then emm, there will be s ,after I** |
| 24. | | | **urinate, I will see some blood,then I when i took some ehnnnn ((BitchamAmpiclox))** |
| 25. | | | **it stopped. but now, whenever I urinate I feel some pains.** |
| 26. | | | **No blood, But I feel some pains.** |
| 27. | | | **After urinating, I feel some pains.** |
| 28. | | Dr: | so that time when you urinate you see some blood there= |
| 29. | | Pt: | = ehn >IT HAS STOPPED< when I took the Ampiclox ↓… |
| 30. | | | **but lately, if I urinate, I will be feeling some °pa::ins°** |
| 31. | | | (0.6) ((doctor writes) |
| 43. | | | (0.5)((11 lines deleted: 32-42)) |
| 44. | | Dr: | Your body is not hot= |
| 45. | | Pt: | =no no no no↓ |
| 46. | | Pt: | ***It *scratches*, (it itches) then after this, after urinating ,** |
| 47. | | | **pains°. That's all** |
| 48. | | | (--) |

In the interaction above (example 2), the symptom elicitation by the doctor in line 14 provides the foundation for the symptom-motivated increments that shall be discussed shortly. The patient designs the expected answers as adjacency pairs to the doctor's questions, up till line 21, where he says "hun" which implies "yes", uttered with a falling tone to signal finality. Afterward, the patient decides to self-select to expand the turn with a catalogue of symptoms ahead of the doctor's pace of symptom elicitation. After providing a history-related increment in line 22 (see the section on history-related increment) in order to specify a previous visit to the clinic, the patient begins an overview of all pressing symptoms from lines 23 to 27 ("whenever I urinate"; "I will be feeling some pains" ; "then ehn there will, after I urinate ; "I will see some blood"; "then I took some ehnnnn ((Bitcham Ampiclox))"; "it stopped"; "but now, whenever I urinate"; "I feel some pains"; "No blood; "But I feel some pains"; "After urinating I feel some pains".

The patient constructs eleven (11) increments simultaneously following a pattern where the description of his physical activities herald the expression of more physiological and medical symptomatic experiences.

In line 28, the doctor designs a turn to isolate certain serious symptoms presented by the patient. This is acknowledged by the patient in his uptake. However, he decides to provide further talk beyond his completed turn construction unit in line 30. The goal of these increments is to redirect the doctor's attention to the more pressing and current symptoms.

The question-answer sequences continue and in lines 32-33 (not shown), the doctor's inquiry on the last visit of the patient at the hospital receives an uptake in line 34 which reveals his uncertainty of the truthfulness of the response. The doctor's turn in line 35(not shown) is an acknowledgment that is given in the form of a repetition of the patient's prior turn. The patient confirms his prior response and thereafter, he self-selects to construct an increment that repairs his previous turns in line 39 ("April, April"). Next, the doctor inquires on the last time the patient did a CD4 count, a test to determine the immunity level of people living with HIV. The patient responds in line 41 after which a brief pause is observed for the doctor to document the information supplied. In line 44, the doctor again elicits information on the

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body temperature of the patient, to which the patient responds in the negative, "no, no" (line 45). This response is sufficient for the current purpose as a complete turn construction unit in the consultation in that it obeys Grice's maxim of quality. That notwithstanding, the patient self-selects to expand the turn with an emphasis on the pressing symptoms previously mentioned in lines 46-47 (*It *scratches*, (it itches) then after this, after urinating, °pains°. That's all). In the next section, another type of increment, information-motivated increments, shall be examined.

### 4.2 Information-motivated increments

Information-motivated increments in the context of medical consultations are a two-way endeavor. Doctors elicit information from patients on their medical history and health concerns. This activity assists them in the correct diagnosis of health conditions, alongside tests and physical examination. Many times, in hospitals in Nigeria, this information elicitation forms the bulk of the diagnostic activity as doctors are often overworked, due to the large turnout of patients in many government-owned hospitals. Consequently, for doctors to attend to more patients in a shorter time, they often resolve to mainly eliciting symptom-related information from patients, especially where the cases are not severe, and where a test may not be necessary.

In the same vein, patients elicit information from doctors about their own health conditions. Due to the institutional awareness of the status of the doctor as expert and caregiver. Separate from the usual information elicitation that occurs as the bulk of activity in the diagnostic context, there is also the propensity of either doctor or patient to construct increments that are information-motivated across the contexts of the consultative encounter. Information-motivated increments in this study are glue-ons and they are sequentially found at the post-problem presentation phase. Below, some interactions shall be examined to reveal this inclination. As such, the discussion will be presented on two planes. First, the doctor-designed information-motivated increments shall be discussed and thereafter, the patient-designed ones. They are taken in turns below:

#### 4.2.1 Doctor-designed information-motivated increments

Doctor-designed information-motivated increments are constituted by such post-TCU expansions that are strategically designed by doctors for the purpose of eliciting the patients' views about their condition or the cause of it. An interaction shall be considered shortly to instantiate this sub-category.

#### Example 3

The interaction below occurred between a male doctor and a young male patient who has visited the General Outpatient Department for the treatment of a perceived sexually transmitted infection.

| | | |
|---|---|---|
| 1. | Doc: | WHEN↑ (.) did you notice that burn::ing sensation |
| 2. | Pt: | last year |
| 3. | Doc: | last year (0.2) again, you used some drugs |
| 4. | Pt: | I used drugs like ((manspan))= |
| 5. | Doc: | =okay, which other drugs?= |
| 6. | Pt: | =only manspan that I can recall |
| 7. | Doc: | but apart from the burn::ing sensation that you feel, |
| 8. | | is there anything that comes out from yo::ur= |
| 9. | Pt: | =no |
| 10. | Doc: | alright, so um . when you go to the do you notice that you urinate frequently↓= |
| 11. | Pt: | =no, it's only that whenever I want to urinate I do get hot= |
| 12. | Doc: | =you get hot.and it burns you |
| 13. | | you're uncomfortable. and maybe before you get to the toilet, |
| 14. | | you probably would have urinated some on yo::ur |
| 15. | | so what do you think is actually the cause of this problem↓= |
| 16. | | =**In your own mind, what do you think↓ =** |
| 17. | Pt: | =I know its sexual, I know its sex::ual |
| 18. | Doc: | you think its [sexual] |
| 19. | Pt: | = [I know↑, it's not that I think] |
| 20. | Doc: | you know. why do you say that↓ |
| 21. | Pt: | uhm↑ |
| 22. | Doc: | why do you say that↓ |
| 23. | Pt: | from the last time, when I had sex with one [girl] I had ( ) |
| 24. | Doc: | [yes] |
| 25. | Pt: | after then, like three weeks later I [noticed] |
| 26. | Doc: | [you were having]= |
| 27. | | =so how many girlfriends >have you<↓ |
| 28. | Pt: | @ |
| 29. | Doc: | No. this is one of the things we should do as doctors, |
| 30. | | to be able to enlighten our patients. |
| | | ((lines deleted: 31-38)) |
| 39. | | so what are your ideas about thi::s this condition↓ |
| 40. | | **What ideas have you↓** |
| 41. | | **Apart from thinking it has to do with e:m sex** |
| 42. | Pt: | that's the only idea |
| | | (Some lines have been deleted) |

The interaction above begins in the diagnostic context where the doctor designs his first turn to request the start of a health concern that has been mentioned previously by the patient. The patient's uptake in line 2 results in more question-answer sequences by the participants as they co-construct the patient's health history (lines 3-13). In line 14,

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the doctor designs a turn, the opinion query of a Perspective Display Sequence (PDS) (Maynard, 1991), to inquire about the patient's thoughts on the cause of his condition. The PDS opinion query is utilized by the doctor as a professional linguistic device to induce more sensitive information from the patient. In the absence of an immediate uptake to this question, the doctor self-selects to increment a repair in line 16 (=In your own mind, what do you think↓ ="). The patient's uptake in line 17 ("=I know it's sexual, I know it's sex::ual") and his subsequent turns ("from the last time, when I had sex with one [girl] I had ( )" line 23; ("after then, like three weeks later I [noticed]" line 25) confirm the doctor's intention for the opinion query.

In his next turn, the doctor asks about the patient's sexual partners in line 27 ("=so how many girlfriends have you↓"). The patient responds with laughter as a way of evading the question and thus, saving face. After offering some advice to the patient on the danger and implications of unsafe sexual practices, the doctor designs a turn in line 39 to inquire about other ideas the patient might have on the condition, apart from its connection with sexuality. Line 40 presents an increment by the doctor that is repetitive of the prior turn, for emphasis and for the desire for an uptake. The increment in line 40 ("What ideas have you↓") is another opinion query that is achieved through an inversion of the doctor's original turn to elicit the patient's "ideas" about his health concern. Again, the doctor designs further talk, in line 41, to specify the scope of the solicited information ("Apart from thinking it has to do with e:m sex"). The patient gives a dis-affirmative response which is indicative of the absence of any other idea. In the next section, the patient's information-motivated increment is discussed.

### 4.2.2 Patient-designed information-motivated increments

Patient-designed information-motivated increments are those post-TCU expansions (increments) that are triggered by patients for the purpose of soliciting information that is related to their current (or other) health concerns. Such increments constitute patients' moves to seek information about the cause of their condition based on their awareness of the medical expertise of the doctor. Most of these types of increments occur in the diagnosis context, not barring possibilities in other contexts. Some instances shall be considered shortly.

### Example 4

The turns at talk below were designed by a young male patient who has visited the GOPD for the treatment of a swollen scrotum. The full transcript reflects the interaction from the point when he is examined for sexually related symptoms. The excerpt below reflects a patient-initiated information-motivated increment-

| | | |
|---|---|---|
| 163. | Pt: | is not paining me (.) |
| 164. | | **but what might cause it?** |

The full interaction reveals a patient who has come to complain to the doctor about a swelling that appeared on his scrotum. He also expresses his fears of contracting HIV as he articulates his concern about his weight loss and frequent sneezing. He enquires from the doctor about the safety of using a condom as a contraceptive. The doctor provides professional advice on these issues and offers to prescribe some antibiotics to address the swelling. Following the patient's turn in line 161(is not paining, *se this thing?) to explain that the swelling on the scrotum is painless. He designs another turn in line 163 (is not paining me (.) to emphasize the previous turn and thereafter, he designs an increment in line 164 ("but what might cause it?). This increment reveals the patient's concern about the swelling and his desire to ascertain its cause. The patient's elicitation is borne out of his recognition of the institutional role, professional training, and expertise of the doctor as a possessor of superior medical knowledge. We shall consider another interaction shortly.

### Example 5

The interaction captured below occurred between a doctor and a patient living with HIV. She has come to her periodic clinic and at the request of the doctor; she gives an overview of her symptoms. She co-constructs her previous experience and immediate medical history with the doctor. While some of the symptoms have been cured from the previous treatment, some other symptoms have evolved.

| | | |
|---|---|---|
| 29. | Pt: | boya kokoro oun lo de tun n je k'owomii ri bi eleyi/ |
| 30. | | I wouldn't know if the Virus is the cause of this swollen hand |

In line 28 (in the full interaction), the patient designs a turn expansion to explain that some persisting symptoms had been cured and she also express a current symptom ("gbogbo e ti lo, amo ti owo mii lo wa ku bayii/ they've all disappeared, except this hand of mine"). The turn expansion manifests as a noun phrase that isolates her swollen hand. In an immediately succeeding turn, she formulates a further increment that serves as an indirect question, in line 29 (boya kokoro oun lo de tun n je k'owomii ri bi eleyi/ I wouldn't know if the virus is the cause of this swollen hand**").** This increment constitutes an information-motivated increment that serves as an indirect inquiry about the connection between her swollen hand and the HIV condition. However, the doctor fails to recognise the force of the inquiry intended by the patient. He merely acknowledges the symptom and moves on to other symptoms.

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### 4.3 History-related increments

History-related increments in this study are so-called because they constitute the patient's illness biography which is volunteered and strategically announced. It is one of the ethical practices for medical practitioners to document the history of patients which is supplied during clinical visits and to record the treatment prescribed to patients at each visit to the hospital. First-visit patients are made to supply their personal and family medical history for doctors to track any possibility of genetic ailments and possible common environmental or family habits that may be causes or contributions to the illness. Aside such history taking activities by doctors, patient in Nigeria sometimes also provide information on their medical history that may be helpful in arriving at a correct diagnosis. Thus, it is not uncommon to find patients expand their turns to track their own history. History-related increments in our STI and HIV data are glue-ons that constitute unsolicited turn expansions by patients sometimes formulated after the test announcement phase or after the physical examination. Some instances shall be considered below:

### Example 6

In the interaction below, a Health Provider (HP) in an STI clinic solicits some STI symptoms from a man who has been invited to the clinic to undergo an STI urine test. His wife had earlier visited the clinic for an STI diagnosis and so the man has come on the invitation of the HP for STI testing.

((several lines have been deleted))

| | | |
|---|---|---|
| 114 | Dr: | so since you said there is no problem, we will ju:::st= |
| 115 | Pt: | =I didn't say there is no problem, but I m:::ean= |
| 116 | Dr: | = you don't feel anything |
| 117 | Pt: | I don't fe:::el |
| 118 | Dr: | since you said there i::s em:: .nothing you feel, |
| 119 | | but you will do the test, |
| 120 | Pt: | Ah no problem, |
| 121 | Dr: | when the test result comes, |
| 122 | | the result will tell us the next line of action= |
| 123 | Pt: | =another thing ma, you can guide me, |
| 124 | | if someone is in this kind of situation, |
| 125 | | what are those things such persons feel |
| 126 | Dr: | @ |
| 127 | Pt: | you can guide me and I would say yes, yes, I could remember |
| 128 | Dr: | the only question that I want to ask i:;s when you urinate, |
| 129 | | do you feel anything?= |
| 130 | Pt: | = no |
| 131 | Dr: | so when you have ehm fun, do you feel anything? |
| 132 | Pt: | hmmnnn as in to pain someone |
| 133 | Dr: | either pain or stomach pain during intercourse |
| 134 | Pt: | no |
| 135 | Dr: | so you will go for test |
| 136 | Pt: | **except that ehn::: ti nba ni fun nigba mii, ehn::: mo ,maa weak and then iyen I think it's associated with my health status /** |
| 137 | **pt**: | **except that ehn::: when I have fun sometimes,** |
| 138 | | **I feel weak ,** |
| 139 | **ehn**; | **I think that is associated with [I think my health status]** |
| 140 | Dr: | [ its normal] |
| 141 | | alright, alright no problem |
| 142 | Pt: | because I am diabetic |
| 143 | Dr: | no problem |
| | | ((Doctor writes, other conversation in the background)) |

In example 6, the patient has disaffirmed all the symptom checklists posed to him by the HP. This outcome has made the HP assume that the patient is being untruthful and uncooperative. This accusation is vehemently denied by the patient who thereafter requests the HP to prompt him on likely symptoms that are experienced by people with STI conditions. In response, the HP proposes to ask him one more question in line 123 ("The only question that I want to ask i:;s when you urinate, do you feel anything?") and his answer is another disaffirmation. A further question is designed in line 125 ("So when you have ehm fun, do you feel anything?"), and again the patient disaffirms. The HP therefore recommends a test in line 129 and at this point, the patient designs an incremental turn to explain his experience of weakness whenever he has sexual intercourse in line 130. He designs a further increment where he associates the feeling of weakness during sex to his health status, in line 132 ("ehn;;; I think that is associated with [I think my health status]"), and yet another increment in line 135, on his diabetic status ("because I am diabetic"). The patient's incremental turns express his idea that his current weakness during intercourse is unconnected to a possible STI. Thus, the patient provides an afterthought medical history, through self-selected incremental turns to justify his current weakness and absolve himself of an STI condition. It is noteworthy that STI in the Nigerian context is culturally linked with an indecent sexual lifestyle, and most of the time, it is women, in their desperation to be cured, who are found visiting the STI clinics. The situation is also compounded by the fact that men are often asymptomatic of STI.

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### 4.4 Face-saving increments

While the concept of face as one´s self-image in relation to as well as in interaction with others is a broad concept (cf: Izadi, 2023), face-saving increments refer to those increments which are designed by STI patients to cope with an embarrassing situation during the consultation. It has been explained in the literature that STI and HIV interactions are intrinsically face-threatening, especially in the Nigerian context (Akinbola, 2012; Amusa, 2016; 2021). Most people do not want to be publicly seen around STI clinics because of the general belief in Nigeria that STIs and HIV are the corollaries of reckless sexual lifestyles. While related studies have revealed the efforts by doctors to mitigate some of the threats to the patient's face using concealment strategies and politeness strategies (Odebunmi 2011, Odebunmi and Amusa, 2016; Amusa, 2016), cultural instincts still prevail over participants in STI and HIV medical encounters (Amusa, 2021). Thus, in these contexts, patients sometimes design increments that are face-saving in the sensitive context of advising. The face-saving increments in this study are glue-ons because they fit closely to the end of their host TCUs, and thus are consistent with the classification in the conversation analysis literature. Some manifestations of face-saving increments in the data are presented below.

**Example 7**

| | | |
|---|---|---|
| 26 | Doc: | so how many girlfriends have you? |
| 27 | Pt: | @ |
| 28 | Doc: | No. this is one of the things we should do as doctors, to be able to enlighten |
| 29 | | our patients. There are some things they don't know that make them exposed to |
| 30 | | some other things. And as much as possible we want to (.) prevent them. Like I: |
| 31 | | was saying, (.) the same way one gets a venereal disease is the same way one can |
| 32 | | get HIV , but if we can get a situation where you can try as much as Possible |
| 33 | | to watch it. Even if you want to do it, we advise that abstinence is the best |
| 34 | | form of protection. But if for some people who cannot discipline themselves they |
| 35 | | should use condom. But the DANGER with that is that it can break. I don't know |
| 36 | | if you have discovered that. you know |
| 37 | | so what are your ideas about thi::s condition? |
| 38 | | What ideas have you? |
| 39 | | Apart from thinking it has to do with em sex |
| 40 | pt: | =that's the only idea |
| 41 | Doc: | Ok. but are there other [things]? |
| 42 | Pt: | **[though this] is my first time of experiencing such** |

**Example 8**

This interaction occurred between a male doctor and a young male patient in his twenties. He visited the GOPD for different health concerns including a sexually related one.

| | | |
|---|---|---|
| 171 | Doc: | ehehn, when was this? |
| 172 | pt: | it has been long o |
| 173 | Doc: | uhnnn.how old were u then? |
| 174 | Pt: | mayb::e 18 |
| 175 | Doc: | 18. Then u have had girlfriends too |
| 176 | Pt: | yes [i] do |
| 177 | Doc: | [@. ]ok |
| | ((several lines deleted)) | |
| 185 | Doc: | how many girlfriends did u have then |
| 186 | pt: | then. |
| 187 | Doc: | uhn |
| 188 | pt: | it was onl::y em let's say just once I have sex. |
| 189 | | **It's only once** |

In examples 7 and 8 above, the patients have come for the diagnosis and treatment of STI-related symptoms. To arrive at a diagnosis, the doctor requests information on general and more personal aspects of the patients' life. In the two interactions, the cooperation of the patients with the doctors on arriving at a diagnosis is secured up till the point where the doctors elicit information on their sexual partners in lines 26 and 185 respectively ("so how many girlfriends have you?" and "how many girlfriends did you have then?"). These come as direct questions that require a cataloguing of their sexual partners and thus, face threatening.

In example 7, the patient's immediate uptake is laughter, which is a face-saving act that is intended to evade response to the question. The doctor observes the patient's embarrassment and invokes the institutional voice to explain his right to such information intended at educating his patients. The patient's withdrawal is observed in his failure to give uptake to the doctor's successive turns (lines 28, 29, 30). In line 31, the doctor designs a second information-eliciting increment which compels the patient to give a brisk response that latches closely to the doctor's inquiry ("=that's the only idea"). And in line 35, the patient constructs a face-saving increment which overlaps with the doctor's attempt to present a perspective display sequence regarding the patient's ideas on his condition. The patient's incremental turn, "[though this] is my first time of experiencing such", projects his effort to defend his moral

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uprightness. Similarly, in example 8, the patient's increment, "It's only once", latches on his prior turn, and it explains his attempt to save face and exclude himself from the cultural stigma of sexual adventures. This increment becomes even more evident because it contradicts his earlier admission of multiple girlfriends in line 176.

### 4.5 Emphatic increments

Emphatic increments are post-TCU expansions that accentuate or stress some previously supplied information. Information giving and receipt is very germane to the success of clinical meetings. As such, the need sometimes arises for the proper acknowledgment of the information supplied either by the doctor or patient. This endeavour usually precipitates the occurrence of certain turn expansions (increments) that are emphatic in function. Emphatic increments are also glue-ons in this study and are sequentially located in the sequence of advice-giving, in the overall structure of the consultations. Below are instantiations of emphatic increments.

### Example 9

| | | |
|---|---|---|
| 53 | D: | But again, the 2nd way to look at it, but the second one, |
| 54 | | like I have said those who can abstain should abstain, |
| 55 | | and if you cannot abstain, use condom. Try and keep to ONE sexual |
| 56 | | partner. Are you getting it? **Very important**. Then if at any point in time, |
| 57 | | the woman HAS anything like sexually transmitted diseases, |
| 58 | | vaginal discharges and all that, it's good to KNOW (line 53) |

### Example 10

| | | |
|---|---|---|
| 128 | D: | no, it's not the best although it's good o but it's not the best. The best is |
| 129 | | abstinence. you get it? Uhn. **The best is abstinence** |

### Example 11

This interaction occurred in the HIV clinic between a male doctor and a female woman who has come for the HIV routine check.

| | | |
|---|---|---|
| 64 | Dr: | if your count is less than 350, |
| 65 | | **the count is less than 350,** |
| 66 | | that is when we will |
| 67 | | start you on drugs but if it is not up to that, if it is above that, |
| 68 | | we won't start you on the HIV drug |

In the interactions above the doctors' turns are designed to provide advice on unprotected sex and the importance of doing a CD4 count to ascertain the immunity level of an HIV patient. "Very important" (example 9, line 56) which stresses the relevance of the medical advice. On the other hand, the third interaction presents an increment ("the count is less than 350") (example 11, line 65) that repeats and emphasises the previous turn. Consequently, it emphasises the salience of the information supplied. HIV patients are placed on antiretroviral drugs based on their immunity level which is measured through a CD4 count test. Those whose count is less than 350 are considered those with low immunity. Such an assessment bears serious implications for patients living with HIV.

### 4.6 Mundane increments

Following the Conversation Analysis (CA) dichotomy of talk into mundane and institutional talk, certain increments have been identified as mundane or folk related. Mundane increments refer to increments that are situated in ordinary conversations or put in another way, those conversations that are in the social and non-professional contexts. In such contexts, the interaction is largely channeled toward the sustenance of the communal culture and enhancing interpersonal relationships. In our STI and HIV/AIDS interactions, mundane increments manifest as glue-on. They are located within the occasional sequence of small talk in medical consultation.

### Example 12

Below is an interaction that occurred in the HIV routine clinic between a male doctor and an elderly woman. She is relatively new to the clinic, and she happened to be from an ethnic group that is resident in the town where the doctor did his National Youth Service Corps (NYSC; this is a required national programme in Nigeria where new graduates are posted to different states in the country for internship for one year) a few years back. The doctor engages the HIV patient in a small talk about her tribal affiliation and they share experiences about the dominant and minority groups in Jos, North-central, Nigeria. The fact that the patient does not speak Yoruba triggered the doctor's curiosity about her tribal affiliation. They engage in talk about the tribal difference in Jos Nigeria, between the Hausas and the Katau people who are believed to be the real indigenes of Jos.

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| | | |
|---|---|---|
| 1. | Dr: | Ekaaro ma/ good morning ma |
| 2. | Pt: | good morning sir |
| 3. | Dr: | X and Y abi? |
| 4. | Pt: | X X |
| 5. | Dr: | Mrs XX, E pele ma /well done ma |
| 6. | Pt: | thank you sir |
| 7. | Dr: | E se e se testi yin abi? /you have just done your tests abi? |
| 8. | Pt: | I can't understand Yoruba sir |
| 9. | Dr: | oh, you can't understand Yoruba= |
| 10. | Pt: | = I don't understand it |
| 11. | Dr: | oh so you are from Zongo-katau |
| 12. | Pt: | Yes |
| 13. | Dr: | Very good. Which side are you Ikulu or Katau |
| 14. | Pt: | I am katau= |
| 15. | Dr: | =You are Katau |
| 16. | Dr: | ehnehn. that is Obaju |
| 17. | Pt: | no. Obaju are different. Katau are different |
| | | ((talking to another doctor)) |
| 18. | Another doc: | boss |
| 19. | Dr: | yes |
| 20. | Another doc: | they said Boko Haram is planning to put poison in suya, |
| 21. | | they said we should not eat suya again |
| 22. | Dr: | ok, it is a lie |
| 23. | PT: | it's propaganda |
| 24. | Dr: | don't mind them, interesting. |
| 25. | | So how long have you down here? |
| 26. | Pt: | It's just last week that I was sick that, |
| 27. | | the doctor asked me to go and do the test I did the test |
| 28. | Dr: | no no , I am saying how long have you been down south |
| 29. | Pt: | okay:: , I am up to:: , I am up to ten years (it is up to ten years) |
| 30. | Dr: | Interesting! Your husband came here or how did you come from zo… |
| 31. | Pt: | yes. my husband was here and my father too |
| 32. | Dr: | Ehen |
| 33. | Pt: | **my father was a soldier** |
| 34. | Dr: | ok. in the army, Okay:::;;;. ok, no wonder. because I worked in zonkwa before |
| 35. | Pt: | OK, those are the bajus |
| | | ((several lines deleted)) |
| 62. | Dr: | like we use one test, we call it CD4 count |
| 63. | PT: | yes, they told me over there |
| 64. | Dr: | if your count is less than 350, |
| 65. | | **the count is less than 350,** |
| 66. | | that is when we will start you on drugs but if it is not up to that, |
| 67. | | if it is above that, we won't start you on the HIV drug |
| | | ((Talking to another doc for a while)) |
| 68. | Dr: | so how are you findi:::ng down- south here? |
| 69. | | Everybody thinks eeh anybody from that side is Hausa abi? = |
| 70. | Pt: | =yes |
| 71. | Dr : | @ |
| 72. | Pt: | that's what they believe, and that we are muslim, |
| 73. | | **that we are muslims** |
| 74. | Dr: | (laughs), |
| 75. | Pt: | some people will hardly believe that ahhh |
| 76. | Dr | so when you say your name is DANIEL, they will be wondering= |
| 77. | Pt: | = Ehn |
| 78. | Dr: | Say how can you be Daniel. Are you not ehn Hausa. |
| 79. | Pt: | °it's true° |
| 80. | Dr: | So everybody thinks everybody from the North is Hausas= |
| 81. | Pt: | = Is Hausa and is Muslim, |
| 82. | | **must be Muslim** |
| 83. | Dr | @ |
| | | ((several lines deleted)) |
| 92. | pt: | one funny thing even is,the REAL HAUSAS, people we call Hausa, |
| 93. | | they are reading their language on in their book, they are Christians |
| 94. | | ((much noise in the background)) |
| 95. | pt: | That is, that is the mabuzawas. |
| 96. | Dr: | eh ehn |
| 97. | Pt: | **They are the real Hausas,** |
| 98. | Dr: | you see |
| 99. | Pt: | they are all Christians |
| 100. | | that is where they use to farm these tomatoes and pepper, onions. because The |
| 101. | | because The muslims, they are between between kano and Kaduna .so:: |
| 102. | | the mulims in Kano reject thems and the muslims in Kaduna , you know, |
| 103. | | they put them in the middle. so they rejected them. so that was where |
| 104. | | there they founded that irrigation farming. and that is what is |

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| | | |
|---|---|---|
| 105 | | Sustaining them over there |
| 106. | | **because they are Christians.** |
| 107. | | They don't give them jobs . in fact, in those days when you go there, |
| 108. | | you see poverty with your eyes because of how those are mistreating |
| 109 | | Treating them. |
| 110. | Dr: | hun |
| 111. | pt: | **and they are the real Hausas** |
| 112. | Dr: | HUN |
| 113. | Pt: | yes |
| | | ((several lines deleted)) |
| 170. | Dr: | @@ |
| 171. | Pt: | you know them o. AH you really studied our people. |
| 172. | Pt: | @ |
| 173. | Dr: | what are you telling me. I spent most of my time working there now. @@@@@ |
| 174 | | @@@@@ |
| 175. | Pt: | I am very happy to meet you |
| 176. | Dr: | abio, you are welcome madam |
| | | ((several lines deleted)) |

The first mundane increment in line 33 was necessitated by the doctor's request to know the circumstances and duration of the patient's relocation to South-west Nigeria. The patient explains that her relocation had to do with marital reasons and the fact that her father was resident in the South. That marked the end of a turn, but then, she self-selects to produce the increment in line 33 ("my father was a soldier") which reveals both the profession of her father and the reason for her relocation down south. The doctor transits to the medical context to discuss the medical business with the patient, but again he reverts to the social context in line 68 when he asks how she is finding down south. Thereafter, they talk about the misconception that people from Jos are Hausas and Muslims. The patient confirms this and then she increments a repair-like confirmation in line 73 (that we are Muslims). This clarifies the misconceived religious identity of the natives of Jos. There is another increment in line 97 (they are the real Hausa) that confirms the Mabuzawas (Katau people) as the real Hausas, and yet another increment to explain that these Mabuzawas were being discriminated upon "because they are Christians" (line 106). Furthermore, in expressing their distaste for the Hausa tribe they recount the way the Hausas had dominated the Katau people and the aggressive nature of the Hausas. The talk continued about the economic life of the two tribes and the unfair treatment that the Katau people suffer in the hands of the Hausas. Both the doctor and patient sustain the mundane talk with their shared experience from having lived in the region at different times until they return to the medical business.

## 5. Findings and conclusion

The analysis of increments in the current study reflects a harmony with the position of Couper-kuhlen & Ono (2007) on the occurrence and prevalence of glue-on increments in English conversations even though the data for the current study were captured in Nigerian English, Nigerian Pidgin, and Yoruba (including the translations in English). Nevertheless, the increments were found to be grammatically and syntactically fitted to the end of the host TCUs, except for very few cases of Non-add-ons (observed in history-related increments).

However, a functional classification of the increments revealed six types of increments namely, symptom-motivated, information-motivated, history-related, face saving, emphatic and mundane. While information-motivated increments were found to be either doctor designed or patient-designed, history-related increments were strictly designed by patients as turn expansions that manifested as non-add-on turn expansions in that they were not grammatically fitted to the end of a previous turn, but most often served as a pragmatic expansion of a disparate turn. These sets of increments reveal unsolicited information supplied by patients about the patient's health history.

Furthermore, it was observed that patients designed face-saving increments that reflected their discomfort with embarrassing questions in relation to their condition. Emphatic increments performed the emphatic repetition of certain crucial information in the context of doctors' professional advice. Mundane increments were designed by both doctors and patients, describing their social world experiences and their views of the physical activities and the psychological behaviour of their referents.

The study therefore concludes that patients are more frequently disposed to designing increments than doctors in STI and HIV consultations in Nigeria. Specifically, patients utilized the symptom-motivated increments for the purpose of elaborating on their health concerns and for clarifying their most relevant symptoms. This afforded them the opportunity of unburdening their health concerns and highlighting the more pressing symptoms. In addition, the sensitive nature of their condition also spurred the formulation of face-saving and history-related increments to handle embarrassing and face sensitive questions about their condition and lifestyle. Thus, increments in STI and HIV doctor-patient interactions in Nigeria are not only structurally relevant to the consultation but also functionally significant.

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## Transcription Notations

• [ ]
[ ] indicating overlap;
• (0.2) indicating elapsed time in tenths of seconds;
• (.) indicating a brief
• ( ), indicating inaudibility
• <> talk said more slowly than surrounding
• >< talk said more quickly than surrounding talk
• @ laughter
• collective laughter
• $ smile
• ::: prolongation
• ↑ ↓ high or low pitch
• (( )) transcriber's descriptions
• WORD (upper case) loud sounds relative to the surrounding talk
• owordo word/utterance indicating that the sounds are softer than the surrounding talk
• = no break or gap
• - - indicate a short or untimed interval without talk
( adapted from https://www.universitytranscriptions.co.uk/jefferson-transcription-system-a-guide-to-the-symbols/)

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