FACE MANAGEMENT IN MEDICAL ENCOUNTERS WITH PATIENTS DEALING WITH MENTAL HEALTH CONDITIONS IN NIGERIA

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Abstract

Patients, particularly those in psychiatric care, expect clinicians to respect their "face" (social self-image) during medical encounters. Despite mental health disorders being a leading cause of global disability, linguistic research on medical interactions in Nigeria has largely overlooked psychiatric discourse in favour of other clinical conditions. Because the negotiation of mental health diagnoses significantly impacts a patient's face, this study examines how face is managed during doctor-patient psychiatric sessions in Nigeria. Guided by Brown and Levinson's politeness theory and Arundale's face-constituting theory, this study examines how the face is negotiated in doctor-patient encounters in psychiatric sessions. The study employed qualitative and quantitative methods to investigate face negotiation in medical encounters with mental health patients in Nigeria. Findings reveal that conversational tokens such as “okay” and “yes” function as critical positive face markers. Furthermore, face support strategies are mainly engaged during phatic exchanges of medical interactions to establish a positive rapport with the patients, while face-stasis strategies dominate medical examinations through routine health status checks. Notably, face threats were entirely absent during the opening phases of the encounters. The study concludes that face negotiation is a fundamental component of effective doctor-patient communication in psychiatric settings, essential for maintaining therapeutic relationships.

Keywords: Face management; face stasis; face support; face threat; patients dealing with mental illness; psychiatric consultations in Nigeria

Introduction

Mental health has been considerably neglected in Nigeria despite the global indicators of the disease (WHO, 2006). World Health Organisation's (WHO's) reports indicate that one in four people in the world is likely to have mental illness in their lifetime, and Nigeria is among the countries with the greatest burden of diseases emanating from mental health disorders (WHO, 2001, 2018). Mental and related disorders are the leading causes of disability in the world, with more than ten per cent of the global population affected by the illness (WHO, 2001, 2018). Five of the ten leading causes of death in the world in 1990 were mental disorders, representing 11% of the total disease burden. As human beings, mental health patients have expectations when they encounter their medical handlers. Mental health patients, including those of Nigerian origin, generally like their face maintained in the progressive stages of meetings, orienting to politeness cues. They expect doctors to maintain their face wants during clinical encounters, as doctors interact with them to diagnose and treat suspected mental illnesses. In Nigerian clinical encounters, the doctor-centred approach is more utilised because the patient relies exclusively on the doctor's direction (Odebunmi, 2017). Nonetheless, both participants are involved in the co-construction of the condition. The manner through which the condition is negotiated has implications for face in medical encounters.

The (dis)respect for the face wants of mental health patients goes a long way in alleviating patients' conditions. When specific basic requirements are not met, the timeliness of recovery is further compromised. Previous studies on mental health have deployed different approaches but linguistics. For instance, Martin (1990) examines patient's mental functioning and behaviour and concludes by emphasising the importance of the assessment as a clinical tool for the diagnosis and treatment of individuals with mental health issues. In another study, Ghosal & Ray (2022) explores the integration of consultation-liaison psychiatrists in primary care practices in Neuchâtel, Switzerland, and concludes that the Consultation-Liaison psychiatrist's integration into primary care brought relief to physicians, improved mental healthcare access and fostered a shared culture of care. Ogunwale et al. (2023) explore indigenous mental healthcare in Nigeria, and conclude that indigenous mental healthcare in Nigeria is a prevalent issue, noting that collaborative shared care is a good

strategy that combines orthodox and indigenous mental health care, and further helps to prevent harm, respect culture, and improve outcomes for patients.

Previous studies on language use for mental health focused on language as part of diagnostic resources for mental health treatment. Some of such studies (Mitchell et al., 2014; Coppersmith et al., 2015a & b) classified mental illness based on language use in social media. Some other studies (Roark et al., 2007, 2011; O'Reilly & Lester, 2017; Akeredolu-Ale, Osisanwo & Chinaguh, 2025) categorise mental distress based on other instances of language use. What is common to these studies is their focus on language in classifying mental disorders, but they overlook language roles, and especially politeness strategies/facework, in the promotion of mental health and the prevention of mental illness. Yet, facework has the potential of providing communicative strategies for the promotion of mental health and prevention of mental illness, especially in Nigeria amidst the COVID-19 pandemic and other life stressors. Odebunmi's (2013) study on greetings and politeness in doctor-client encounters in southwestern Nigeria is particularly relevant to this research. The study shows that doctors and patients jointly negotiate face support and face threat, and that cultural and institutional differences in politeness cues significantly shape medical interactions. However, the focus is on general doctor-patient encounters rather than psychiatric consultations.

The present study, therefore, focuses specifically on face negotiation between patients with mental health conditions and psychiatrists/clinical psychologists. Its significance lies in examining how face wants are preserved or threatened in psychiatric encounters and how politeness strategies can promote mental wellness, prevent distress, and support diagnosis and treatment. This provides useful insights for healthcare professionals, policymakers, and other stakeholders in Nigeria's mental health sector. Accordingly, this study investigates the politeness strategies involved in negotiating face for the promotion of mental wellness, the prevention of mental distress, and the support of diagnosis and treatment in psychiatric encounters in Nigeria.

Face, Facework and Negotiation

Face, as defined by Goffman (1967, p. 61), is the "image of self," while Brown and Levinson (1987) viewed face as the "public self-image" of a person.

Facework is devoted to the negotiation of face needs in human interaction. The conceptualisation of face in linguistics takes off from Goffman's (1967: 5) notion of face as "the positive social value a person effectively claims for himself by the line others assume he has taken during a particular contact" or as "an image of self-delineation in terms of approved social attributes". This notion was expounded by Brown and Levinson (1978, 1987), whose concept was also influenced by the English folk term that ties face to the notion of embarrassment or humiliation, as in the idiom "to lose face" – which means losing the respect of others. The concept of face is thus described by Brown and Levinson as an emotional investment that can be lost, maintained or enhanced; and requires constant attention in interaction, to assume one another's cooperation based on mutual vulnerability of face. Brown and Levinson's (1987) treatment in terms of facework has been the most widely applied and the most widely critiqued (Arundale, 2006).

According to Brown and Levinson (1987), the concept of face has two interrelated aspects, that is, the positive face and the negative face. Whereas an individual's positive self-image is their wish to be liked by others and their wants to be desirable at least to some others, an individual's basic desire to be free from any form of imposition and their actions unimpeded by others is the negative face (Osisanwo, 2009; Osisanwo, 2013). Utterances constitute a threat to face and are termed 'face-threatening acts (FTAs) when threats are successfully expressed with such verbal acts as criticism, requests, complaints, offers, commands and questions. Every person has an emotional sense of self that they want another person to recognise (Osisanwo, 2009; Osisanwo and Ojora, 2021). Brown and Levinson (1987) note that two strategies are involved in doing FTA: the 'off-record' and the 'on-record' strategies. They opine that, in doing an FTA, the speaker could use an avoidance strategy to avoid offending the hearer. This relates to the negative politeness strategy that is preserved to protect the negative face of the interlocutor. Meanwhile, a threat to the positive face could be preserved by avoiding such linguistic acts as complaints, commands, questions, reprimands, criticism and accusations, which damage the positive face – they act as threats to an individual's desire to be liked or appreciated.

Following criticisms of Brown and Levinson's (1987) idea of the face, many other reconceptualisations of face by different theorists have emerged. In

conceptualising face as relational and interactional, Arundale argues that "face belongs to the dyad or social unit, and hence as 'our connection and separation' or 'our face'" (2010, p. 2090). Arundale defines face as one's interpreting of one's relational connection and separation, which is conjointly co-constituted in interactions (Arundale, 2009, 2010, 2013). The reconceptualisation is a departure from the sense of face as a purely cognitive, person-centred phenomenon in the sense of *image* or *concept* of self, but it is interactionally achieved in conversations in the same way as social actions and pragmatic meanings are interactionally achieved. Face, therefore, emerges in relationships and is conjointly co-constituted in interactions.

Arundale's Face Constituting Theory (FCT) is distinct from Brown and Levinson's and other existing face theories because it rests upon two radical shifts in conceptual framing. First, Face Constituting Theory employs a new theoretical model of human communication, whose conceptual commitments are disproportionate to those of existing theories of face and facework (Arundale, 2008). The FCT draws upon current theory in the study of human communication, as well as on research in conversation analysis, to explicate how meaning and action are achieved in everyday talk and related non-linguistic conduct (Arundale, 2010). Second, FCT employs a new conceptualisation of 'face' in terms of the relationship two or more persons form with one another in interaction, using current theory and research in interpersonal communication. This conceptualisation is different from the understanding of face in terms of person-centred attributes like social identity, public self-image, or social wants that characterise existing theories (Arundale, 2006, 2009).

For the current study, therefore, the tenets of Arundale's (2010) FCT which are deployed for analysis are face as interactional achievement of connectedness and separateness dialectic, based on three interactional achievements of stasis face, threatening face and supportive face – in other words, face stasis, face threat, and face support. Stasis face, as defined in Arundale's Face Constituting theory (FCT), refers to a state of stability or balance in a social interaction, where no significant shift in connection or separation occurs between the interactants' faces. It refers to a situation where the participants can maintain their face needs without threatening the other's face. Arundale (2010) describes a supportive

face as the achievement of a positive face, where the participants can support each other's face needs. This happens when the participants' face needs converge or diverge, and the participants' face interpreting for the current utterance is evaluated as supportive of the relationship. Threatening face refers to the achievement of a negative face, where the participants are unable to support each other's face needs and face a potential threat to their face. However, threatening face as conceptualised by Arundale is different from Brown and Levinson's notion of face threat in that Arundale views utterances as not themselves inherently threatening but hinged on the evaluations that the participants make of the projectings or interpretings of connection and separation face that arise as they design or interpret utterances. While Brown and Levinson canvassed for universal or general principles of linguistic politeness across cultures, Arundale's FCT emphasised the role of culture in shaping face. Both perspectives are deployed in this study to identify how face is managed in doctor-patient encounters in psychiatric sessions, allowing for a more nuanced analysis that considers both universal aspects of face want and context-specific nuances in face management, incorporating Nigeria's specific cultural expectations and local healthcare systems.

Consequently, the majority of the face negotiation strategies used in the study were derived from Brown and Levinson's politeness theory. These include face-supportive strategies such as asserting concern, showing interest, using in-group identity markers, and expressing approval. One of the strategies, concealing, was derived from Odebunmi's (2011) categorisation of concealment in medical encounters in Nigeria. The other strategies were inductively derived from the data as shaped by the relevant context of use. For instance, health-status check, providing care, seeking information and conformation align with medical procedures of clinical information gathering, making accurate diagnoses, and developing treatment plans. *Assuring* reflects the doctor's role as a counsellor.

Methodology

Qualitative and quantitative methods were employed to gain an in-depth understanding of face negotiation in selected medical encounters with mental health conditions at the Neuropsychiatric Hospital, Aro, Abeokuta, Nigeria. After securing participants' informed consent, seven medical encounters were

audio-taped. They had an average length of 10:17 min with a range of 2:18 to 29:26 min. Six out of the seven encounters were conducted in the indigenous language of southwest Nigeria, that is, the Yoruba language, while one was conducted in English. The English-medium encounter was transcribed using the Otter AI transcription tool, while the Yoruba-medium tapes were manually translated and transcribed into the English language for data analysis. Five research assistants were engaged to conduct four activities: data collection, translation, data cleaning and categorisation. The data categorisation was done using individual turns within the exchanges in the medical encounters as the unit of analysis. The study combined discourse analysis and content analysis to provide a comprehensive understanding of face negotiation in doctor-patient encounters in psychiatric sessions. Discourse analysis was used to qualitatively examine the contextual and interactional subtleties of doctor-patient communication (considering the cultural values and local healthcare system of Nigeria), alongside content analysis for a quantitative assessment of face-supporting, threatening, or maintaining behaviours in the interactions.

The research assistants involved were native speakers of the source language and holders of doctoral degrees in English. We facilitated ongoing communication, clarification sessions, and quality assurance checks to ensure consistency. They were also given access to translation resources, such as the Yoruba Dictionary website (https://www.lexilogos.com/english/yoruba_dictionary.htm), Nigerian dictionary site (https://nigeriandictionary.com/translate), and Google Translate. The cleaned data transcripts were combined into a corpus of 4,891 words and visualised with the Voyant tool with a vocabulary density of 0.179, readability index of 5.743 and average words per sentence of 9.9. Aspects of two theories – Brown and Levinson's Politeness Theory and Arundale's Face Constituting Theory – were deployed to guide the identification of face negotiation in doctor-patient encounters in psychiatric sessions.

Consistent with the research ethics guidelines of the International Ethical Guidelines for Biomedical Research Involving Human Subjects (2002), the guidelines for submitting applications for ethical reviews of research protocols were followed. As part of the research ethics protocols, the Principal Investigator did courses and obtained the following certificates from TRREE and the Clinical Trials Centre of the University of Hong Kong: Research Ethics Evaluation, Informed Consent, Public Health Research Ethics, Training in the

National Code for Health Research Ethics. Application forms and an Anonymised Informed Consent form, among other documents, were submitted as part of the application process and approvals were obtained from the National Health Research Ethics Committee of Nigeria (NHREC), Abuja Federal Capital Territory, and the Neuropsychiatric Hospital Ethical Research Committee, Aro, Abeokuta, Ogun State, both in Nigeria.

Results

The analysis explores face negotiation during medical encounters, particularly in a mental health setting. Mental health communication is a holistic approach to care management that extends beyond treating symptoms. It takes into account the unique nature of mental health issues and how a patient's social and psychological needs can affect their mental well-being. The analysis examines how this impacts the negotiation of face in medical encounters between mental health professionals and patients. The analysis proceeds from the general visualisation of the corpus of mental health professionals and patients during medical encounters to the segmentation of the encounters for deeper analysis. In examining face negotiation in the study, face stasis, face support and face threat are operationalised in the analysis by integrating analytical categories from Brown and Levinson's universal politeness strategies or facework and Arundale's context-specific face constituting strategies.

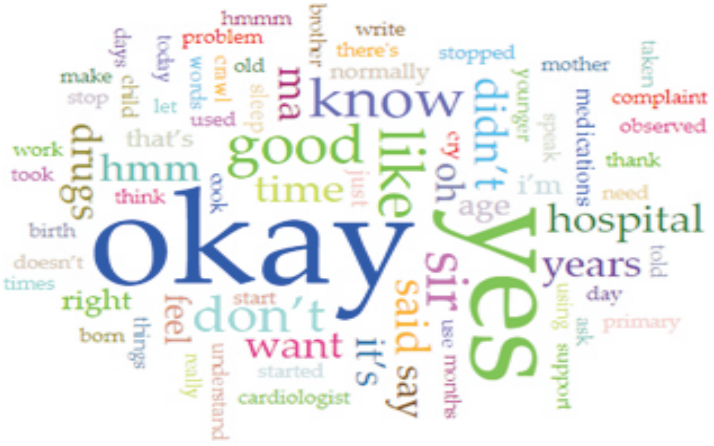

Figure 1: Visualisation of the corpus of mental health professionals and patients' medical encounters

Figure 1 represents a visualisation of the corpus of mental health professionals and patients' medical encounters. The word cloud was created by compiling all words from the transcribed medical encounters and using the Voyant software tool to visually represent the frequency of words. The more frequently a word appears in the text, the larger it appears in the cloud. This provided an initial, broad overview of the linguistic landscape of these interactions before they are subjected to contextual analysis guided by the theoretical framework (derived from Brown and Levinson's politeness and Arundale's face-constituting theories).

The corpus presents the most dominant words to be the conversational tokens "okay" and "yes", which provide brief responses as politeness markers, and besides indexing (empathetic) acknowledgement as minimal responses, they have also been found within the context of their use to subtly signal deeper facework categories, such as agreement and confirmation in medical encounters as exemplified in the following text instances.

Text 1:

Doctor: Did you observe while she's going up if a boy in the community or an old man sexually abuses her?
Patient's mother (PM): No o.
Doctor: Like if she was sexually abused?
PM: No o.
D: She wasn't sexually abused?
PM: No o. I don't leave her alone anyhow too.
D: **Okay**. She hasn't known a man
PM: No.

Text 2:

D: But do you sleep very well?
P: Yes, I do sleep but since a week now, I do wake up around 5a.m.
D: Hmm hmm. So when you wake, what do you do?
P: At times, I will sleep again later or watch video.
D: **Okay**. How about the drugs? Are they suitable for you (your body)?
P: Yes. They are suitable for me.
D: So they are okay and need no adjustment?
P: They are okay.

D: **Okay**. But make sure you're using the drugs, and don't think that nothing is happening to you anymore.
P: **Okay** ma.

Text 3:

D: But you know... do you think there are some words that shouldn't be spoken to her?
PM: Yes.
D: Okay. Okay. What do you think would be the outcomes/consequences of such words?
PM Such words may make her worse than the way she is.
D: Okay.

Text 4:

P: I noticed I was having some stomachache one day. Then I went home where I was being treated, but I didn't know anything was wrong with me.
D: Okay…
P: It's from home I was brought to this place where I got to know of my mental illness or something.
D: Okay, okay.

The analysis highlights that "okay" and "yes" are not merely repetitive conversational fillers but play significant roles in facilitating face negotiation in medical encounters. The conversational token "okay" is used to signal a positive face and connectedness in the doctor-patient interaction, appearing in contexts where it goes beyond mere acknowledgements. For instance, in Text 1, the doctor's use of "okay" serves as an acknowledgement of the patient's mother's narrative, indicating understanding and engagement. Similarly, in Texts 3 and 4, "okay" is employed to demonstrate empathy and build rapport. Its repeated usage in these texts highlights the doctor's active participation in the dialogue, showing a willingness to delve deeper into discussions and to empathetically engage with patients' experiences. The next dominant word is the token "yes", with a relative frequency of 0.0035. It is largely used by the patients as a face co-constituting device while responding to the doctors' questions or statements. Its functions exceed a simple affirmative response; thus, it plays a crucial role to

voice connectedness during medical encounters, indexing agreement (in texts 2 and 3) and confirmation of case history – which indicates understanding and assuring cooperation.

Text 5:
D: You said she spent 11 months in the womb before you gave birth to her.
P: Yes.
……
D: Did she cry when she was born?
P: She didn't cry.
D: She didn't cry?
P: Yes.

The "yes" token in Text 2 is discursively engaged by the patient as a face co-constituting device voicing connectedness. It serves as an affirmative response to the doctor's inquiries, embodying both compliance and collaborative engagement in the medical interaction. The patient's response not only signals agreement with the doctor's assessment of sleep patterns but also demonstrates a supportive stance towards the proposed treatment plan by confirming the drugs' suitability. This response fosters connectedness between the patient and the doctor and opens avenues for further conversation, allowing the patient to elaborate on sleep habits and medication efficacy. This interactive dynamic enhances the overall quality of the diagnostic and therapeutic exchange, underpinning the principles of face management and connectedness in medical communication. In Text 3, where the patient speaks in proxy (through the PM), the PM's first turn voices agreement with the doctor through the conversational token "yes", to agree that there are certain words that should not be spoken to the patient. Such words that are to be avoided are trivialising words, derogatory words, negative language and labelling language (American Psychiatric Association, n.d.; *Rogers Behavioral Health*, 2019).

In Text 5, the patient's use of "yes" serves a crucial role in affirming and clarifying the doctor's inquiries drawn from prior information about the patient's extended gestation period. The patient's affirmative response with "yes" not only confirms the details shared by the patient's mother but also assists the

doctor in clarifying specific aspects of the patient's medical history. Further along, "yes" punctuates the end of an interaction, particularly when the doctor seeks confirmation about the patient's post-birth reaction. Voicing connectedness with the doctor, the PM co-constitutes a confirmation of the information and clarification for the doctor's understanding, indicating a similar pattern of compliance and collaborative engagement in the healthcare decision-making process.

Opening/Phatic Exchange

The first part of a medical encounter, known as the opening or phatic exchange, is when the medical professionals build a rapport with patients, earn their trust, and make them feel at ease. This exchange typically involves greetings, small talk, and polite conversation that serve to establish a positive relationship between the doctor and the patient. To achieve this conversational goal, sometimes non-medical subjects like the present state of the weather, current affairs, or any other relevant conversational topic may be discussed during the opening/phatic discussion. This seemingly unrelated exchange is driven towards providing face support or face enhancement to establish the necessary social foundation for a productive doctor-patient interaction.

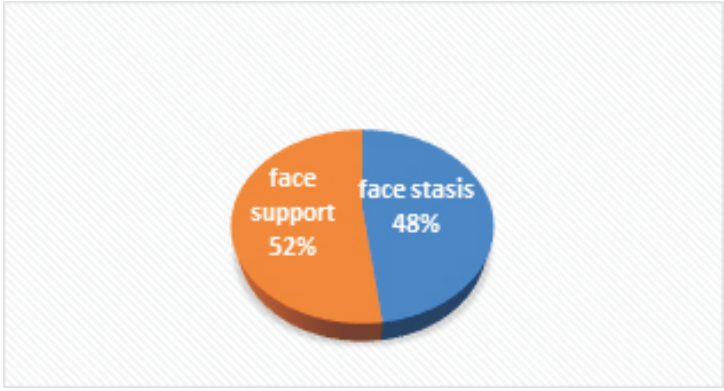

Figure 2: A pie chart showing the percentage distribution of face management in opening exchange of medical encounters

Face support (52.0%) is predominant in the opening exchange when compared to face stasis (48.0%) as illustrated in Figure 2 above. The high distribution of face stasis indicates that in many instances the interactions were conducted to maintain face, without necessarily infusing face-enhancing tokens and preventing potential face-threatening acts. The lack of face threats in this opening exchange further indexes mental health professionals' expertise, as consistent with their training, which predisposes them to build rapport with their patients and take cognizance of patients' vulnerability. In the opening exchange, face support is managed through showing interest, asserting concern, in-group identity marker and expressing approval; while face stasis is projected through a health status check, seeking confirmation, acknowledgement and apology, as illustrated in Figure 3.

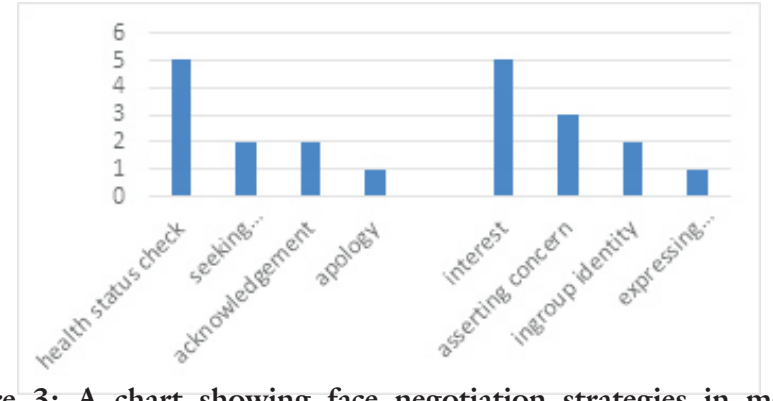

Figure 3: A chart showing face negotiation strategies in medical encounters

Figure 3 shows the frequency distribution of face negotiation strategies in the medical encounters between psychiatrists and patients. The figure indicates that health status checks and interest are the most dominant, which reveals that, in the phatic exchange between doctors and patients, the face management strategies of the doctor mostly oscillate between the face stasis strategy of checking the health status of the patient as they come into the consulting room, and paying attention to their interests, needs or wants to build a rapport with the patient to create a suitable setting for the encounter. Asserting concern, which comes next in representation, is another face support strategy and it is exhibited by the doctors to demonstrate their empathy to affirm their positive

face. Seeking confirmation indicates instances where the doctors ask questions or make utterances that are directed towards confirming certain information about the health condition of the patient. Acknowledgement is a face stasis strategy that seeks to preserve the face by recognising or affirming information. In-group identity markers are words that indicate a shared identity, which are used in the data to further enhance the patient's face. Apology surfaced in the data to mitigate face threat over a missed appointment. Expressing approval, which is one of the least distributed strategies, is a face-support device that provides positive feedback on a patient's proposition.

Face Stasis in Doctor-Patient Opening Exchange

Face stasis (FSt) in doctors' turns are framed through a health status check (HSC), seeking confirmation (SM), acknowledgement (Ac) and apology (Ap), as demonstrated in the following interactions.

Text 6

1. Doctor A: How are you now? (FSt – HSC)
2. Patient A: I'm fine.
3. Doctor A: Are you here alone today? (FS SI)-
4. Patient A: Huh?
5. Doctor A: Are you here alone today? (FS – SI))
6. Patient A: Yes.

Text 7

1. Psychiatrist: Okay, mummy, (FS – IGI) good morning ma. (FS – IGI) How is your health condition? (FSt – HSC)
   Patient: We thank God.
2. Psychiatrist: Please, don't be offended that we could not meet last Thursday. And that is why we had to postpone it to this day (FSt – Ap)
3. Pt: …yes…okay…

Text 8

1. Doctor B: So, how is his health? (FSt - HSC)
   Patient B: He is okay
2. Doctor A: Why is he smiling? Has he behaved somehow lately? (FS – Con)

Patient B: Well, I don't know…maybe it's about what you told us

3. Doctor: oh…okay.

Text 9:

1. Doc: There is no complaint, right? (FSt – HSC) Patient: No.
2. Doc: Everything is okay. (FSt – SC)
   Pt: Yes.
3. Doc: But the last time you came you said your legs were swollen. (FSt – SC)
   Pt: Yes.
4. D: Has the swollen reduced or there's no difference at all? (FSt – HSC)

Pt: It has reduced a bit, but the legs are still swollen.

Texts 6-9 are different openings extracted from selected interactions. What is evident in these openings is that they are not first meetings and there is an HSC in the first turns, tracking the health status of the patient since their previous meetings. So, this update tracker may be regarded as a routine assessment of a patient's current health and well-being during follow-up appointments. It is mostly couched as broad open-ended interrogatives, like "How are you now?" or close-ended confirmatory interrogatives with question tags, like "There is no complaint, right?". Status confirmation (SC) is another face stasis strategy in opening exchange, and as demonstrated in text 9; it frames a close-ended confirmatory statement or interrogative, as a follow-up turn to an HSC turn. As shown in the 9th interaction, the SC "Everything is okay" is a confirmatory follow-up assertion, which is uttered with a doubtful tone as a reaction to the patient's negative claim to the HSC proposition "There is no complaint, right?" This means the HSC query itself suggests that the doctor did not expect there should be a complaint, probably based on the previous treatment given; but the SC in turns 2 and 3 further contextualise the exchange as oriented towards assessing the patient's current health condition.

Face stasis is further negotiated in the opening exchanges through acknowledgement and apology. Doctors used Ac as conversational tokens to mark that they are listening to patients' disclosed information about their health, as with "oh, okay" in Text 10 as lucidly demonstrated with the "okay" token,

which has been established as the most frequently used in the encounters. There is an instance of an apology placed to mitigate face threat in the opening interaction. On getting into the consultation room, the patient's face needs might have been impeded by the doctor for missing the previous appointment. To prevent this face loss from affecting the ongoing interaction, he rendered the apology "Please, don't be offended that we could not meet last Thursday". This presupposes that the doctor took responsibility for the action (Holmes, 1990), and made an attempt to remedy the act by rescheduling the appointment: "And that is why we had to postpone it to this day".

Face Support in Opening Exchange

Face support in the opening exchange of doctor-patient interactions is calibrated through the following strategies: showing interest, asserting concern, in-group identity marker and expressing approval. Showing interest in the patient's needs and wants is a mental health professional's approach to initiating a sincere and empathetic interest in the patient's concerns, emotions, and experiences, in order to build trust and rapport building from the opening exchange.

Text 10

1. Doc: What about your children? (FS – SI) Hope you have been hearing from them? (FS – SI)
   Pt.: I was with them a week ago.
2. Oh, you went to Lagos? Oh, that's good, that's good. So, how is Lagos?
   Patient: I want to go back to Lagos.
3. Doc: Oh, you want to go back to Lagos? Why?
   Pt: I really don't like where I'm currently living.
4. Doc: So, have you explained to your children?
   Pt: I only told one of them.
5. Doc: So, what did the person say?
   Pt: He said I should still stay here for a while.
6. Doc: Oh…okay. So, how often do they come here to check on you?
   Pt: One of them is even here with me.
7. Doc: Oh…okay. Do their children often come to spend the holiday with you?
   Pt: Only one of them has a child for now.
8. Doc: Oh, okay. Okay. So, how many of your children did you pay a visit

when you travelled to Lagos?
Pt: Just a few of them. Like, I used two days with one, and two with another

9. Doc: That's good. So, what did they say about your health when they saw you?
Pt: They were happy
10. Doc: Oh, they were happy! That's good. So, they are aware of the things you complained about from the onset…Glory be to God. Hope you have no complaint today?
Pt: no problem. I only want to show you some of my medications maybe…

Text 11

1. Psychologist: You speak Yoruba, right?
Mother: yes
2. Psychologist: good afternoon ma, and you are welcome ma (Switching to Yoruba)
Mother: thank you, sir.

Showing Interest (SI) is abundantly explored in Text 10, as the doctor engaged in small talk with the patient, enquiring about the patient's children. Mothers, or parents generally, often feel valued and appreciated when others show interest in their children. This can be measured by the proposition in the patient's response in the first turn. She provided more information than required, that she had visited the children the previous week. The proposition bears the implicature that the children are fine, as an indirect response to the question. The answer reflects the patient's level of comfort, showing that the face support strategy has effectively helped relax the patient. This yielded follow-up questions, which built rapport between them and set the stage for the medical interaction. SI is engaged in Text 11 to pay attention to the patient's ability to express herself better. The question demonstrates an interest in the patient's linguistic background and culture, which can foster a comfortable and supportive relationship.

The face support approach of the doctors in their opening communication with the patients is further enriched through in-group identity markers and

expressing approvals at intervals during their interactions. In-group identity markers, like "ma" indexing respectful tone and the more endearing one "mummy" show patients' inclusion as the doctor's hypothetical mother. The appellation "mummy" for a non-relative is a common cultural practice in Nigeria that demonstrates inclusion and hospitality. It is typically used to address someone older. It communicates a sense of community, and familiarity, and creates an immediate sense of belonging. Drawing on this cultural repertoire, the doctor attunes to the cultural sensitivity of the patient to foster an inclusive and therapeutic alliance.

The insertion of EAs to reward patients caps up an effective endeavour to facilitate face support to the patient. This is evident in the doctor's 2nd, 9th and 10th turns in Text 10 to reinforce the patient's attempt to visit her children (an important social support). The doctor's interjection "Oh, they were happy!" in the 10th turn just before the EA (That's good), emphasises the significance of the reward ("they were happy") given for the positive feedback received from the patient's children regarding her health. As an upgrade to the face-maintaining discourse token "okay", EA both acknowledges and validates the patients' agency and commitment to improving their health recovery. It thus has the potential to empower patients in their healthcare decisions, boost their emotional well-being, and improve overall interpersonal communication and cooperation.

As the interaction in Text 10 progressed, the doctor can be seen showing concern about the patient's need to be around her children. This impinges on social support, which is perceived to be an essential factor in maintaining good mental health (Herandi, Taghinisab & Naveri, 2017), and has the potential to protect one from stressors and reinforce coping strategies (Turner & Brown, 2010). How the doctor switched from exclusively family-related questions to obtaining feedback about the patient's health can be traced in the interaction, thus effectively juggling the two face support strategies of SI and AC to deepen positive rapport in the opening exchange.

Face Negotiation in Medical Examination

Medical examination constitutes the medial and core exchanges in the medical encounters between doctors and patients. It involves seeking and gathering information about a patient's clinical history, current medications and physical

health conditions. In psychiatric consultation, the assessment stretches across mental status examination, psychiatric interview and history taking, and cognitive evaluation where necessary (Martin, 1990; Ghosal & Ray, 2022). The examination focuses on assessing medical as well as psychiatric and neurological causes of psychiatric symptoms for informed diagnosis and management. In Nigeria, like in many African countries, there is a lack of awareness and acceptance of mental health problems leading to stigmatisation and discrimination. So mental health practitioners are required to be more sensitive during psychiatric consultations, as indicated by their face management of the encounters reflecting cultural *syntonicity* (Ting-Toomey & Oetzel, 2003; Hwang, 2016; Ogunwale, Fadipe & Bifarin, 2023). This is illustrated in Figure 3 as extracted from the data.

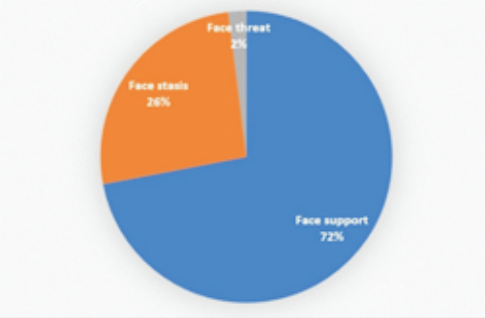

Figure 4: A pie chart showing the percentage distribution of face management in medical examination exchange

Face stasis (72.0%) is the dominant facework during the psychiatric consultations covered by the study, as illustrated in Figure 4, highlighting that doctors generally maintained the patients' face during the consultations. The low distribution of face support (26.0%) further indicates that the encounter is more business-like, similar to general medical consultation, which has also been found to show high deployment of face stasis but low distribution of face support (Adegbite & Odebunmi, 2006). The statistics, however, indicate that, in at least one in every four moments of the interaction, the doctors used communicative behaviours that were supportive of the face of their patients. Meanwhile, the encounters were not entirely free of face threats, used very minimally (2%).

Face Stasis during Medical Examination

Face is maintained during medical examinations as the physicians conduct medical assessments of patients' health conditions by gathering information, confirming information and providing/reviewing care. The frequency of their use is calibrated in Figure 5, which depicts seeking and confirming (medical) information as what practitioners mostly do during consultation.

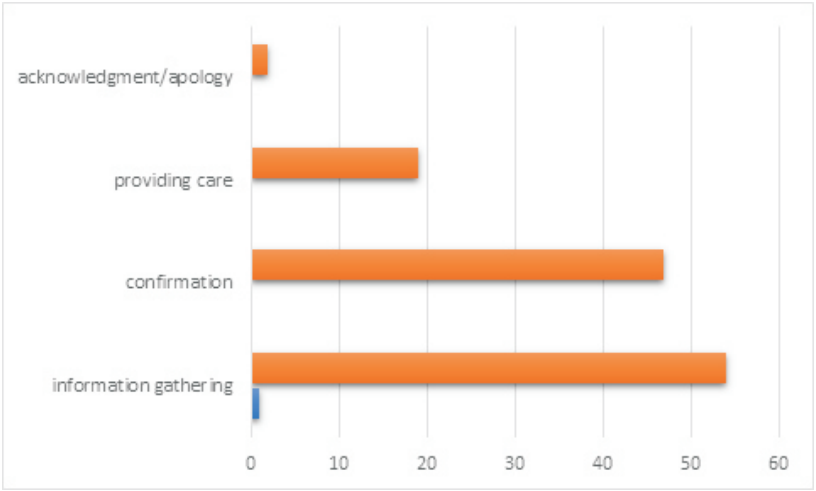

Figure 5: Face stasis in medical examination

Information gathering refers to the process of collecting information about the patient's medical history, symptoms, and health conditions. It is a major part of medical examination, as represented by the above chart. The information seeking usually takes the form of open-ended questions to maintain neutrality and avoid putting the patient in an uncomfortable state. It can also be reflective, to indicate attentiveness. For instance, new information is elicited through these questions: “Have you got any concern today?”, “any complaints today?” The question format allows the patients to share any complaints they might have without restricting them to a simple "yes" or "no" response. It gives patients the opportunity to fully express themselves, yielding more elaborate and insightful responses.

Text 10 exemplifies how a doctor navigates between different question formats to gather information while preventing face loss.

Text 10

1. D: There is no complaint right? (SInf)
   P: No.
2. D: Everything is okay. (Conf)
   P: Yes.
3. D: But the last time you came you said your legs were swollen. (SInf)
   P: Yes.
4. D: Has the swollen reduced or there's no difference at all? (Conf)
   P: It has reduced a bit, but the legs are still swollen.
5. D: Okay. Is it the two legs?
   P: Just one (points to the leg)

The doctor seems to have combined close-ended and open-ended question formats while being sensitive to the patient's feelings to maintain her face. The exchange starts with a close-ended question that seems to ascertain whether the patient has any complaints and to establish a baseline understanding. There is a follow-up close-ended question in the second turn, "Everything is okay", to confirm the overall well-being of the patient. Although a question, it is a declarative tone to retain the doctor's tact towards the patient, to avoid expressing a strong emotion that could threaten her face. There is an open-ended question in the fourth turn to confirm P's health status after referencing her previous complaint in the third turn. This indicates an overlap of FSt token Seeking Confirmation (SC) with Seeking/Gathering (SI) as tools for arriving at an accurate diagnosis for effective management of P's health.

Besides being used as a discourse device, SC can be used as a medical token during medical examinations. In that case, it is deployed to validate or rule out suspected symptoms as the doctors assess patients' health conditions while engaging in diagnostic reasoning and decision-making. The medical slant in SC is exemplified when a doctor asks specific questions like "Do you normally have sound sleep?", "Doctor: okay, do you normally feel refreshed when you wake up?", and "Do you eat regularly?" to assess the sleeping and eating habits of the patient to confirm or refute a provisional diagnosis.

Providing care in the data captures aspects of new treatments, treatment review, and prescription and review of (current) medications. The relatively lower

frequency of providing care (19 times) indicates that the consultations involved more information gathering and confirmation rather than immediate treatment decisions. Additionally, it usually takes less time and words than seeking information or seeking confirmation. Texts 11 and 12 are extracted exchanges from the data that respectively depict two aspects of medical examination – medication review and physical examination.

Text 11

1. Dr: Okay. How about the drugs? Are they suitable for you (your body)?
   Pt: Yes. They are suitable for me.
2. Dr: So they are okay and need no adjustment?
   Pt: They are okay.
3. Dr: Okay. But make sure you're using the drugs, and don't think that nothing is happening to you anymore.
   Pt: Okay ma.

Text 12

1. Dr: Okay. But these kinds of shoes that you wear may let your leg gets swollen. You can see the shoes tighten up your legs. Be wearing shoes that are free a bit.
   Pt: Okay.
2. Dr: Do you understand? (positive politeness; seek agreement)
   Pt: Yes.
3. Dr: Be wearing shoes that are free.

Text 11 is a medication review by the practitioner, which considers the patient's perspective, giving regard to their autonomy or (negative) face needs. Having secured the Pt's face maintenance and comfort, Dr goes ahead to give medical advice by emphasising medication adherence. Text 12 provides another instance of caregiving, capturing physical examination, which takes into consideration how Pt's footwear could affect her health. This maps the doctor's expression of concern provisionally reflecting face support until it is vitiated by the directness of the doctor's communication – which down-tones the supportiveness of the communication. The last part of the chart bears acknowledgment/apology, which each appears once.

Face Support during Medical Examination

Face supportive communication during medical examinations stretches around the following positive facework tokens: being attentive to patients' interests or needs, asserting concern towards them, being inclusive and using in-group identity markers, expressing approval, assuring and concealing. Their distributions are represented in Figure 6.

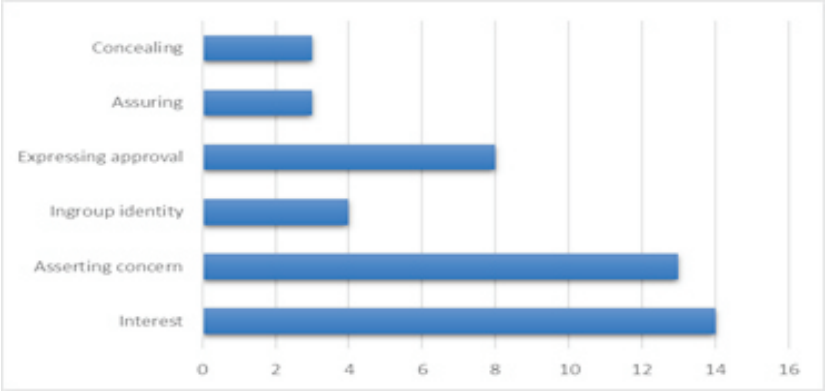

Figure 6: Face support during medical examination

Paying attention to patients' interests and asserting concern towards them are mostly relied on to provide face support to patients. Paying attention to hearers' interests, wants or needs enhances their positive face. It is engaged in medical assessment as doctors demonstrate their attentiveness to patients' health conditions by listening to their narratives or by asking more about their medical history, as exhibited in Text 13.

Text 13

1. Dr: How many months was she when you gave birth to her?
   PM: Around 11 months.
2. Dr: Around 11 months? Was she your firstborn?
   PM: No. Third born.
3. Dr: She is the last born, right? She has two elder siblings?
   PM: Yes.
4. Dr: Male or female?
   PM: The two are female.
5. D: What's their age and what do they do?
   PM: The two of them are at work.
6. D: They have finished schooling and working at the moment?
   PM: Yes. They've graduated. One of them has a master's degree.

Text 13 presents a case of consultation-liaison, where the patient's health condition is assessed through the mother. The doctor asked questions to obtain information about the patient's family history. The questions represent the Dr's increased attention to the patient's needs and the patient's mother seemed to have grown more comfortable and trusting of the doctor by providing more details than required, including that one of the patient's older siblings has a master's degree. In addition, the examination captures Drs' indication of concern towards patients' needs either by expressing the need for social support as demonstrated by the doctor's first turn in Text 14 or by other means that would positively impact their well-being as in text 15.

Text 14

1. Dr: I wouldn't know if it will be possible for us to see any of your relatives? Because it's been a while we saw them.
   Pt: I will inform the person that is presently with me
2. Dr: oh, very good.

Text 15

1. Dr: so, has he been doing any work?
   PF: I didn't allow him to do any work
2. Dr: ah…why?
   PF: I don't want that thing to do him.
3. Dr: hmm, he can still be engaged

The doctor's concern about his patient's well-being is apparent in text 15, Line 1, when the doctor enquires to know if they have become socially active – 'so, has he been doing any work?'. This hallmarks the doctor's empathy and emotional support towards Pt. Meanwhile, the entire gamut of the physician face support is anchored through the infusion of approvals at intervals to provide positive feedback to a patient's cooperative health conduct like Pt's

second turn in text 14 promising to comply with the doctor's observation. Consequently, the remark "Oh, very good" to praise the patient's effort Dr may also reward milestones along the path of recovery.

There was less use of in-group identity, indexing minimal use of inclusion or shared identity during medical assessment. This manifests in some of the doctors' willingness to speak Yoruba, the language of the environment, to help patients communicate more freely. Despite the low statistics, it is important to state that all but one out of the consultations were held in Yoruba, indicating that there was a global inclusion in the psychiatric consultations. At the lower rung lies Assuring and Concealing, both occurring 3 times each. Assuring is engaged as counselling thrust to provide continued care for a patient as evident in this doctor's assurance: "(Please, don't abandon her. She needs your support) and we will also do our best here", following Dr's request to a patient's mother for social support to the patient. Assuring is also used here "Don't worry, everything will be okay ma" to alleviate the worries and concerns of the patient's father, who was present in liaison for the patient. The use of the honorific or respect-bearing in-group marker "ma" within the assurance expands the face support net to deepen the rapport between them and trust in the treatment plan.

Concealing strategy is used in the doctors' examination of the patients by being indirect and restraining from full disclosure of health conditions to Pts to save their positive face. Concealing is a pragmatic strategy that involves withholding some information from the hearer, either intentionally or unintentionally. As observed by Odebunmi (2011), the major goal is preventive, which bars the Pts from having full knowledge of their health condition to forestall "crises". Text 16 provides more clarity about the use of Concealing in the data.

Text 16

1. Dr: but…hmm, you may need to see a cardiologist because there was a finding here that one side of your heart…your heart has four chambers of which one is a bit bigger than normal... so…
   Pt: (cuts in) and is that frightening?
2. Dr: no no no…it is not too frightening. I just feel it's something a cardiologist should look into.

Concealment is deployed in this dialogue by the doctor to downplay the severity of the patient's health condition, by trying to hide or withhold some information from the patient about the seriousness of the heart condition. The doctor uses vague and ambiguous language, such as "a finding", "one side of your heart", and "a bit bigger than normal", to avoid giving specific details or diagnoses that might alarm or upset the patient. The doctor also uses a euphemism, "(it is something a cardiologist should) look into", to imply that the problem is not urgent or severe and that it can be easily solved by a specialist.

Face Threat in Medical Examination

The high distribution of face-supportive or maintaining acts reflects the deliberate steps taken to mitigate face-threatening acts in medical examination, the only segment of the medical encounters it has so far featured. Nevertheless, face threats are barely present in the medical exchange, having only 2% as previously captured in Figure 3. Text 17 illustrates how it is used in the data.

Text 17

1. Dr: what's that? (FT)
   Pt: nothing, I only want to call someone
2. Dr: wait wait…is that not a flash?
   Pt: I'm only taking a picture of something
3. Dr: please delete it. No no, delete it. It's someone else' details
4. Dr: I will add some medications to the ones prescribed for you already.
   Pt: sorry, is it anxiety
5. Dr: Yes, something like that.

The doctor's interrogative posture in the first turn threatens the patient's (negative) face by interfering in Pt's desire to take a snapshot of the file and freedom to use their phone as they please. However, Dr's action is consistent with his professional duty to protect the privacy and confidentiality of other patients. Dr is implying that Pt is doing something inappropriate and tries to prevent him from taking pictures of the file. Pt can be seen slyly deflecting the pre-emptive move by saying: "nothing, I only want to call someone", but was given away by the phone flash. It is notable to emphasise Dr's respective tone while requesting that the pictures be deleted. He might have realised how his move, even though professionally justified, was face-threatening and posed a

potential risk to the success of his ongoing medical examination. So, he changed the topic in the 4th turn. The focus switched back to the patient, who indeed needed care.

It is important to note that the face threats in the conversation would have exceeded the current occurrence if the practitioners had not applied discourse tact in the assessment of the patients' health conditions. As a doctor-initiated encounter, which reposes some degree of authority in physicians while eliciting information about the patient's health state and giving directives for their health management, medical examination tends to threaten Pts' face (Robins & Wolf, 1988; Adegbite & Odebunmi, 2006; Nimmo, & Stenfors-Hayes, 2016; Takele, 2020)? However, doctors adopt different facework strategies, as explained above, to guard against this tendency.

There is also the likelihood of patients provoking doctors to commit face-threatening acts, either by their non-adherence to a treatment plan or certain indiscretions. An instance of medication non-adherence is implied in the 3rd of Text 12 as Dr admonishes Pt: "But make sure you're using the drugs, and don't think that nothing is happening to you anymore." The reiteration of the advice in a follow-up turn, "So be using them", affirms this directive act as prompted by the Pt's non-cooperation, most probably based on her perceived gesture to the medication. Notwithstanding the provocation, Dr engaged face maintaining communication to avoid threatening the patient's face. An instance of patients' indiscretion can be seen in Text 17, with the patient taking an image of another patient's health details, in violation of medical ethics and privacy regulations.

Face Negotiation in Closing Exchange

The closing exchange of a psychiatric consultation is the final stage of the consultative encounter between a psychiatrist and a patient. It may entail a situation where the psychiatrist sums up the clinical findings, gives feedback and recommendations, and discusses the treatment/follow-up plan with the patient. Effectively navigating the nuances of face negotiation in the closures of psychiatric consultations would ensure that the conversation concludes harmoniously and preserve the rapport built during the interaction. A miscue intact may erase or reverse all the positive outcomes or improvements that have

been achieved during the psychiatric consultation, which could impact on the patients' mental health outcomes.

Structurally, the closing exchanges are mostly used as bound exchanges to medical examination. In such an occurrence, the closing exchange does not have an initiation move but is rather linked to the previous (medical assessment) exchange.

Text 18

1. Dr: okay, by the grace of God, we shall still meet in a month's time. Take this medication slip and get it at the same place where you normally get it. Thank you very much ma. The Lord be with you, ma.
   Pt: thank you, Sir.

Text 19

1. Dr: very good then. Please, don't abandon her. She needs your support and we will also do our best here.

Text 18 is a closing conversation, where the psychiatrist employs face supportive communication to close the conversation politely and respectfully. The use of phrases such as "by the grace of God" and "The Lord be with you" shows a level of respect for the patient's beliefs and customs. By acknowledging the patient's faith and showing reverence, the doctor validates the patient's identity, ensuring a face-supportive atmosphere. Additionally, the doctor addresses the patient with the honorific term "ma," signifying politeness and respect. This choice of address elevates the patient's status and demonstrates deference, contributing to a face-supportive communication style.

Text 19 combines several face support tokens, like approval and asserting concern, to deepen empathy and rapport with the patient. The phrase "very good then" is used as a transitional marker to signal the end of the medical assessment exchange and the beginning of a closing exchange (signaling a bound exchange). The doctor acknowledges the information shared during the assessment and signals a shift in the conversation's focus. The phrase is the doctor's positive reinforcement to the patient's mother's response "I know it can't help. It can't help. Besides, there is no reason for me to abandon her." to the

Dr's question "What do you think abandoning her without speaking with her can cause?" in the preceding (medical examination exchange). It thus acknowledges the information shared during the medical assessment and provides a positive evaluation of the situation.

Discussion

This study set out to examine how face is negotiated in doctor-patient encounters in psychiatric sessions, focusing on the politeness strategies for negotiating face in promoting mental wellness and supporting the diagnosis and treatment of mental distress. It explored mental health communication which is distinguished by the unique nature of mental health issues, giving a holistic approach to care management, extending beyond treating symptoms and considering how patients' social and psychological wants could affect their mental well-being. This was done with particular emphasis on how this impacts the negotiation of face in medical encounters between mental health professionals and patients.

The study was divided into four segments for ease of analysis and deeper appraisal of aspects of facework for doctor-patient encounters in psychiatric consultations. The first part was a holistic visualisation of the word cloud in the data corpus using the Voyant tool, which identified a vocabulary density of 0.179, a readability index of 5.743 and average words per sentence of 9.9. The findings highlight that "okay" and "yes" are not merely repetitive conversational fillers but play significant roles in facilitating face negotiation in medical encounters. The discourse marker "okay" is used to signal a positive face and connectedness in the doctor-patient interaction, appearing in contexts where it goes beyond mere acknowledgement. Similarly, previous works have identified the diverse discourse functions of "okay" in medical interactions, which include acknowledging and reinforcing closure, terminal exchange initiation, transitioning between topics, and serving as a pre-closing signal and subtle preclosing tool (Schegloff E. & Sacks, H., 1973; Beach's, 1993, 1995; Drew & Holt, 1998; Allwood et al, 2017). As emphasised by Beach (1995), the use of "okay" is nuanced and can have significant implications for the effectiveness of doctor-patient communication. "Yes", on the other hand, was largely used by the patients as a face co-constituting device while responding to the doctors' questions or statements. It functions beyond being a simple affirmative

response, playing a crucial role to voice connectedness during medical encounters. These findings are consistent with the work of Albl-Mikasa et al. (2015), which also highlighted the importance of discourse markers, particularly phatic tokens and hedges, in medical personnel's presentation of their interactional, trust-building, diagnostic, and therapeutic intentions. The study identified these expressions as essential communication elements geared at building patients' compliance and establishing doctors' safeguards.

The second part of the analysis reveals important aspects of face negotiation strategies during the opening exchanges of medical encounters, particularly in psychiatric consultations. The findings showed the predominance of face support, followed by face stasis, in doctor-patient initial exchanges, driven towards establishing rapport with the patients, as well as maintaining their social image. The dominant face management strategies at this stage were "health status checks" and "expressing interest", which indicate that doctors balance between maintaining the current social value of their patients and enhancing it by paying attention to their health as well as their interests and needs. Other engaged strategies were asserting concern and in-group identity, which demonstrated more empathetic and personalised doctor-patient interaction. The study provides a unique contribution to the literature on medical communication, particularly in the field of psychiatry, by detailing the frequency and types of face negotiation strategies used by mental health professionals. The finding's emphasis on empathy and rapport building aligns with Pollock's (2007) research on "Maintaining face in the presentation of depression", which asserts both doctors and patients actively engage in face work strategies to manage social image and interaction success, impacting the detection of psychosocial distress and overall effectiveness of medical consultations. However, this finding challenges some aspects of traditional medical communication models that prioritise information exchange over relational aspects.

The third part of the analysis focused on face negotiation strategies during medical examinations. The key findings from this section border on the prevalence of face stasis in medical examinations, marked by doctors' medical information gathering and confirmation, and provision of medical care to patients. The study demonstrates a minimal presence of face support, a business-like encounter akin to conventional medical consultations, thus

corroborating Adegbite and Odebunmi (2006). However, the study also reveals that the doctors showed face-sensitive communication in a quarter of the interactions, reflecting the empathy and sensitivity required in psychiatric consultations. The minimal presence of face threats in these encounters emphasises the delicate balance healthcare professionals maintain in preserving patients' face needs during medical consultative encounters. This finding is particularly relevant in understanding how to balance power and relational dynamics during medical consultations, especially in psychiatry. The fourth and final part of the analysis revealed that there was minimal interaction in the closing exchange, which identifies its structural embeddedness as a bound exchange to the medical examination exchange. Nonetheless, the study recognised it as an essential part of the encounter given the importance attached to a harmonious closure to preserving rapport. A tactless closure may undo or harm the positive outcomes or improvements achieved during the consultation and affect the patient's mental health outcomes. This finding supports Heath's (1986) emphasis on bringing consultations to a "satisfactory closure" and aligns with the paper of Allwood et al. (2017) on "How healthcare professionals close encounters with people with dementia in the acute hospital setting". Allwood et al. observed that healthcare professionals providing acute care to Older People wards prioritise closing medical encounters that leave patients contented.

The study's findings suggest that cultural norms and values have a significant impact on the communication strategies used by healthcare providers in Nigeria. In particular, the Yoruba emphasis on respect for elders, as seen in the use of the honorifics like "ma" and "mummy", and communal harmony significantly influenced patient-doctor interactions, fostering a tendency towards deferential and supportive communication styles. These communication strategies align with local cultural values and help build trust and rapport, which is crucial in mental health care. The study also reveals how communication strategies are tailored to meet cultural expectations. The switch to Yoruba in one interaction shows sensitivity to linguistic preferences, which is crucial in a multilingual country like Nigeria. This linguistic shift is not just about language, but also about respecting and acknowledging the patient's cultural identity, which is crucial for effective healthcare delivery in diverse settings. Additionally, the constraints of the local healthcare system, marked by resource limitations and high patient-doctor ratios, could have impacted the

dynamics of face negotiation, often leading to more direct and less patient-centred exchanges in the medical encounters studied.

Conclusion

This study examined the negotiation of face in psychiatric consultations in Nigeria. The study provides a unique contribution to the literature on medical communication, particularly in the field of psychiatry, by detailing the frequency and types of face negotiation strategies used by mental health professionals. The findings highlight how medical professionals tactically use language to manage patients' social needs. These findings contribute to a deeper understanding of the complex communication strategies employed in medical settings, underscoring the importance of empathy, tact, and respect for patient autonomy in medical practice. We, therefore, submit that face is an important aspect of doctor-patient communication in psychiatric settings and that the doctors balance between maintaining rapport and achieving their professional goals. Consequently, the study highlights the need for ongoing training and awareness among medical professionals regarding effective communication strategies that balance clinical objectives with the social value, integrity, respect, and other face needs of patients catering for their emotional and psychological well-being.

Limitations of the study

The study is limited to examining face management and strategies in medical encounters with patients dealing with mental health conditions in Nigeria, through the prism of discourse and content analysis. As such, it does not account for non-verbal cues or the broader socio-economic factors influencing these interactions. Its focus on specific linguistic and cultural contexts within Nigeria may not be generalisable to other regions or healthcare settings. Additionally, the study's reliance on audio-recorded data may not fully capture the complexity of in-person dynamics.

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