linguistic relativity and the diagnosis of schizophrenia*

Sandra Shamis

Occasionally I am asked what prompted my initial interest in the linguistic behavior of schizophrenics. I think it is now time to share the incident that sparked my research.

In 1971, when I was teaching at California State University, Hayward, a social worker from Highland Hospital was referred to me by the Linguistics Department at the University of California, Berkeley. Her problem: She needed some "practical advice" on how to cope with a female Samoan patient who had originally been hospitalized for gynecological reasons.

However, this Samoan patient had refused treatment. After she had been operated on—against her will—she walked out of the hospital, only to be found and returned by the police. This behavior struck the social worker as odd. It had never occurred to her that the patient could not understand English well and had no idea what was being done to her. Nor had anyone tried to explain.

On second thought, moreover, the social worker began wondering about other odd aspects of the Samoan's behavior, and their ramifications: Was she, for example, capable of rearing her children? Should hearings be held to decide whether they should be made wards of the court? What about a conservatorship for a woman who did not even care enough about her health to accept the necessary medical attention?

Apart from the woman's erratic behavior, the social worker cited what she considered the major evidence for insanity: The patient could not even distinguish between men and women; she used the pronoun "she" for all instances of third person singular.

What the social worker did not know, however (though I was fortunate enough to), is that all Austronesian languages—perhaps better known as Malayo-Polynesian—throughout the vast Pacific, from Java to Hawaii and Easter Island, do not distinguish gender in pronouns at all; they have only one third person singular, "sa." This absence of gender distinction in the personal pronouns persists despite a distinction that exists biologically, is recognized culturally, and is expressed in other ways linguistically.

It does not take a linguist to figure out that "sa" sounds much closer to English "she" than to either "he" or "it." What this woman was doing is standard procedure for individuals unaccustomed to speaking a particular second language: she was substituting the similar sounds of a word in her native language (that had a similar or related meaning) for a word in the unfamiliar language.

I wish I could end this tale happily; but I was never allowed to speak to the patient myself, even though I had arranged for an interpreter from the large Samoan community in San Francisco to come and talk to both the patient and social worker. No one was allowed to see the patient after my conversation with the social worker, even though I sent some of my students in various guises to Highland Hospital. I later found she had been transferred to a psychiatric ward.

Recently, I have been faced with diagnostic problems involving two patients whose cultural backgrounds most of us on the diagnostic staff were unfamiliar with—one whose native language none of us could speak. Neither patient belonged to an esoteric minority, however; the first being a Mexican-American from Laredo, Texas, the extent of whose English language skills were pivotal to a diagnosis; the other, a first generation Filipino-American, born in Vallejo.

When faced with incidents such as these, one begins to question the validity of any universal or standard bases for diagnosing mental illness in an individual that do not allow for linguistic differences and, by extension, any bases that eliminate cultural factors from the diagnosis. While all cultures I know of have definitions of what constitutes odd or bizarre (crazy) behavior, and ways of coping with the individual exhibiting them, how is it possible for the diagnostician not acquainted with a patient's culture to decide if the individual is actually ill or culturally deviant (the two need not accompany one another), or simply not accustomed to interacting within the sociocultural expectations of the diagnostician? As a linguist concerned with establishing linguistic criteria for diagnosing schizophrenia, I am confronted with this difficulty as well.

I think this notion of universal diagnostic criteria as we presently approach it—that is, as an interactional definition—in many ways sets an impossible task; and my initial recommendation is that we become acquainted with the resources in our community for mediation between the hospital and the patient, or we shall all be derelict.

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Most of the major ethnic groups in California have trained personnel who could be of assistance, not only in translating the language when linguistic skills are the problem, but also in translating the culture when cultural norms are different or unfamiliar, or whenever ignorance of them can prejudice our diagnosis.

However, I would like to inject a note of optimism here, for I believe that concerned diagnosticians and therapists can, and must, develop certain perceptions, or skills, which can often prevent them from slipping into a faulty prejudgment of the patient because of their own cultural prejudices or ignorance.

I think the first thing to realize (and that is the only other point I shall make here) is that categories of behavior are universal; it is only that cultures exhibit their own expressions of them, and often this cultural behavior is expressed linguistically: hence, the basis of my initial interest.

For example, all cultures have means of expressing evasiveness, impatience, politeness, and deference, among other attitudes. While often these forms may be expressed "kinesically"—that is, through such nonverbal means as establishing physical distance between speaker and hearer—they can also be expressed linguistically. The first step is to try to derive, when possible, the medium, verbal or nonverbal, of these universal emotions or modes of expression. Often the two—our cultural expectations and the cultural behavior of the patient—are isomorphic; in such cases we are in luck. How does one tell? When our behavior elicits either expected normal or expected pathological response in the patient.

What I must emphasize is that often we cannot judge the appropriateness of a response—our intuitions fail us. I wish to urge that when this occurs, an individual acquainted with the patient's culture be employed to facilitate proper diagnosis and adequate treatment. In addition, a history taken from a close relative—who should not, however, serve as the facilitator with the diagnostician—should be used to supplement the diagnosis and aid in prescribing the treatment.

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