AN ANALYSIS OF LANGUAGE FORMS OF THOUGHT DISORDERS : A STUDY OF LANGUAGE PRODUCTION IN INCOHERENT COMMUNICATION OF SCHIZOPHRENICS IN MENTAL HOSPITAL IN PADANG

THESIS

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ABSTRAK

Sari, Zahara Gustiara. 2011. 'An Analysis of Language Forms of Thought Disorders: A Study of Language Production in Incoheherent Communication of Schizophrenics in Mental Hospital'. Skiripsi. Padang : Fakultas Bahasa, Sastra dan Seni. Universitas Negeri Padang.

Bahasa adalah suatu media untuk menyampaikan ide dan pola pikir dalam berkomunikasi baik lisan maupun tulisan. Namun, jika bahasa yang dihasilkan abnormal pastilah ada kesalahan baik di dalam pikiran itu sendiri maupun jiwa. Jika seseorang mengalami keguncangan jiwa, seperti schizophrenia yang pola pikir gangguan jiwa ini pada umumnya tidak sesuai dengan kenyataan, pastilah susah bagi orang didekat mereka untuk menangkap ide dalam bahasa yang dihasilkan oleh penderita gangguan jiwa ini.

Penelitian ini membahas bentuk bahasa yang dihasilkan oleh pasien schizophrenia dalam melakukan terapi komunikasi dengan para perawat di salah satu rumah sakit jiwa di Padang. Penelitian ini memiliki 10 informan pasien schizophrenia yang terdiri dari tiga orang pasien laki-laki dan tujuh pasien perempuan. Metode yang dipakai di dalam penelitian ini adalah kualitatif deskriptif karena mendiskripsikan bentuk-bentuk bahasa abnormal yang dihasilkan oleh pasien schizophrenia tersebut.

Hasil dari penelitian ini menunjukkan bahwa masing-masing informan dari 10 pasien schizophrenia memiliki $\pm$ 5 bentuk bahasa abnormal. Bentuk bahasa abnormal yang mayoritas ditemukan adalah 'poverty of content of speech' isi pembicaraan yang diperoleh sedikit. Begitu juga kelompok bahasa abnormal yang dihasilkan berbeda baik dalam satu kelompok yang sama ataupun berbeda pada tipe-tipe schizophrenia yang diderita.

Ketidak koherenan bahasa yang dihasilkan oleh 10 pasien schizophrenia tersebut tidak hanya dipengaruhi oleh faktor gangguan mental mereka namun juga dipengaruhi proses berkomunikasi yang dilakukan oleh orang-orang didekat mereka. Kesabaran dan perhatian adalah kunci untuk dapat menangkap maksud pembicaraan yang dihasilkan oleh penderita gangguan ini.

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The writer

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CHAPTER 1
INTRODUCTION

A. Background of the Problem

People do communication to get information. The speaker demonstrates something and hopes the listener responds it. The respond is based on the background knowledge between the speaker and listener. The respond will not happen if the speaker or listener do not have the same background knowledge. That is how incoherent in communication happened because the speaker or listener has lack of knowledge that is probably caused by brain damage. Brain damage can affect to the quality of speech, that is language loss.

Language loss is caused by neurological damage in language areas in brain, Broca's and Wernicke's, that is called aphasia. People with Broca's aphasia frequently speak in short phrases that make sense but are produced with great effort. The patients of Broca's aphasia typically understand the speech fairly well. This kind of brain damage attacks the patients of stroke and stuttering.

On the contrary, people with Wernicke's aphasia may speak in long sentences that have no meaning, add unnecessary words, and even create new words. As a result, it is often difficult to follow what the person is trying to say. The patients of Wernicke's aphasia usually have a great difficulty understanding speech, and often unaware of their mistakes as well. Wernicke's aphasia usually attacks children, elder people, alcoholic, and psychological disorders.

One of the patients of Wernicke's aphasia is psychological disorders. The most severe form of psychological disorder is schizophrenia. The comprehension of schizophrenia is noticeably poor.

Schizophrenia is characterized by psychotic thinking or impaired contact with reality, at least during its active phases, which often takes the form of hallucination (most commonly hearing voices) or delusion (often bizarre or persecutory in nature) or both and disorganized thinking and speech. One of the most characteristic features of schizophrenia that can easily be noticed by other individuals is language impairments. Smith et all (1986) explain Schizophrenics are often unable to communicate in a coherent way with others, and their thought patterns are confused. Their thoughts and verbal behavior are filled with irrelevances and it is difficult make sense out of their stream of talk. Schizophrenics have difficulty in communicating loss because their emotional responses are usually inappropriate. This is the result of a blunting of the emotions and of an arbitrary dissociation of feeling from verbal expression.

The study was conducted at one of Mental Hospital in Padang for the patients in West Sumatera, Riau, and South Sumatera. The result of first observation of researcher done on 3rd of June at 10.45 a.m in Gelatik room as preliminary research, It was found that there were incoherent communications of one of Schizophrenics. The communicants were a principle of supervisor, a nursing student and a schizophrenic,Mr. H. The patient was, 28 years old, diagnosed to have hallucination and violent. Here is one of the examples of incoherent communications:

1. Nurse: "*Oh….tadi Pak Hanif kan mendengar suara –suara. Kalau boleh saya tahu suara apa yang Bapak dengarkan ?"*
   'I see… you said that you heard strange voices. May I know what Voices you heard?'
   Patient :" *Kadang adzan, kadang ini, kadang itu*"
   ' Adzan sometime. This one or that one sometime'
   Nurse: " *Contohnya* ?"
   'Could you give the example?'
   Patient : "(*Pegang kedua telinga) akbar, bismillahirrahmanirrahim. Itu pernah juga saya dengar*"
   (Hold his ears) 'Akbar, bismillairrahmanirrahi. This voice I have ever Heard as well'
   Nurse: "*Oh…kapan waktunya*?"
   'Oh….when was it exactly?'
   Patient : "*Dulu"*
   'It was'
   Nurse : *"Kapan?"*
   'When?'
   Patient : *"Dikampung"*
   'In my village'
   Nurse : "*Berapa kali sehari Bapak mendengarnya*?"
   'How many time did you hear it ? '
   Patient : "*Malam"*
   'At night '
   Nurse: "*Berapa kali?"*
   'How many time*?'*
   Patient : (*pikir) "empat"*
   *(*Thinking) 'Four times'

Here, the nurse tried to get the information from the patient, a schizophrenic, but it took a little bit long time in order that the patient was comfortable to tell his problem. The incoherencies of this communication found when the nurse asked when the voice came to the patient. The patient answered them correctly but inappropriate place for the answers. It seems that the patient needs time to answer it correctly and appropriately. Circumstantiality one of the forms of language disorders can be investigated from the answers of schizophrenic above. Blocking is also included in this process because the patient stoped for some minutes to answer the question. To do communication to the

patients, the nurse use therapeutic communication. It is used for making good relationship between client and nurse. The nurse must have skill in communication process for helping the patients to solve their problem.

From the phenomena and explanation above, the researcher is interested to find the other forms of language disorders of schizophrenics produced in therapeutic communication that is used by nurse or doctor in the mental hospital. It has stunt atmosphere to research their communication also for the researcher herself. Even though, it is a great number of people think that they never do communication as if they are not any body. This factual can be seen that there are many mental illness disorders found on road and people are afraid to socialize with them. The schizophrenics are also human that need language to communicate for delivering their idea, but they have different interpretation to do communication. Schizophrenics have many words for one object in their mind that makes them difficult to deliver their answer.

B. Identification of the Problem

There are many effects in Wernicke's aphasia. The effects usually are the problem of language input, such as speaking and writing problem, incoherence communication, comprehension problem, and meaningless speaking value. On the other hand, the patients of Wernicke's aphasia tend to attack the children, older people, alcoholic, and psychological disorder.

According to Davison (2000) psychological disorder can be associated into 6 major disorders, namely *anxiety* – a feeling of apprehension is in stressful

situations. This disorder has problems in which anxiety impedes daily function. Some categories of anxiety disorder are generalized anxiety, panic, phobic, absessive compulsive, posttraumatic stess disorder. *Somatoform* – the psychological leads to the physical. This kind of disorder has psychological difficulties displayed through physical problem. An emotional problem is turned, then, into a physical ailments that acts to relieve the sources of the original emotional problem. *Mood* – feeling is wrong. Emotions of depression or euphoria that are so strong they intrude on everyday living. *Personality* - problems that create little personal distress but that lead to an inability to fuction as a normal member of society. *Dissociate disorders* - a person displays characteristics of two or more distinct personalities. The splitting apaart of crucialparts of personality that are usually integrate. *Schizophrenia disorders* – reality is lost.

Language loss creates some impairments in language. Language impairments are common features of schizophrenia. Language impairments can be studied from the language forms and language srtuctures of thought disorders. The language form of thought disorder can be seen from incoherence communication categories. Meanwhile, Language structures of thought disorders can be studied from phonetics, syntax, marphology, semantic, pragmatic and lexical access.

C. Limitation of the Problem

The researcher is interested in studying language forms produced by one of psychological disorders, schizophrenia, that have some incoherences in

communication. So far there have not been descriptions in this language loss of schizophrenia patient coming from minangkabau society seen from incoherent communication can impact in meaningless speaking value.

D. Formulation of the Problem

The problem of this study is formulated as follow “What are the forms of incoherent communication produced by schizophrenics in Mental Hospital in Padang?

E. Purpose of the Study

Based on the research question above, the main purpose of this study is “To find out the forms of incoherent communication produced by schizophrenics”

F. Significant of the Study

The writer hoped this research can be the contribution as a basic in analyzing of language loss for schizophrenics for the next researcher. It is also hoped the research can give contribution to the field of pragmatic, morphology, syntax, semantic, lexical acces, and psycholinguistics itself.

G. Definition of the Key Terms

Language loss : Some problems in language input and out-put which is caused by neurological damage in language areas

in brain so that the language produced has some impairments .

Incoherent communication: Inability to speak coherence in communication so that the patients have meaningless value in their speech.

Schizophrenia : One of psychological disorders that have hallucination, delusion and disorganized of speech.

Schizophrenics : The patients who have schizophrenia diagnosed.

CHAPTER 2
REVIEW OF RELATED LITERATURE

A. Language Loss

There must be beginning and ending in life. It means, there must be also language acquisition and language loss. Language loss is caused by neurological damage in language areas in brain, Broca's and Wernicke's, that is called aphasia. These language areas may damage because of four factors, as Scovel (1998) explains the brain damage factors are unhappy accident and traumatic event in personal life, on the other hand, non- brain damage factors include age and unfortunate roll of genetic dice.

Aphasia is a study of language and speech deficits pursuant to brain injury. Aphasic language production, which can differ from normal speech in a variety of different ways, highlights the number and complexity of the elements that constitute normal language. Bock in Gaskel (2007) reports that an approximate rate of normal speech errors as one in one thousand words. That makes some disticntions to the language or speech of aphasia with normal speech which may exhibit marked reductions in fluency, may have enermous difficulty producing words to express meaning, may produce fragmeted uttereances interrupted by numerous pauses, and may produce words that do not express what they intended to say.

According to Harley (1997) aphasia is a condition caused by neurological damage or disease, in which a person's capacity to understand or express language is impaired. And an addition explanation comes from Herbert et all (2003) aphasia

is a disorder that results from damage to portions of the brain that are responsible for language. It is clear enough that the left hemisphere of the brain damage causes language disorder.

There are two classic types of aphasia; they are Broca's and Wernicke's aphasia. According to Gaskel (2007) speech output of Broca's aphasics is typically non-fluent and often agrammatic and the production of the sound structure of language are compromised. Broca's aphasia is categorized by speech and writing which are slow, very hesitant, and in severe cases, completely inhibited. The patients may mostly understand the meaning of words and know how to respond. However, the patients have difficulty finding the words to say. Their words are forced out slowly and with great effort, sometimes interrupted by expletives. The patients for Broca's aphasia are stroke and stuttering. Herbert et all (2003) find that most patients of Broca's aphasia are unable to write the words. He sees the phenomena of patients for stroke.

On the contrary with Broca's aphasia, the speech production and writing are pretty much intact however language input has a problem. Patients afflicted with Wernicke's aphasia tend to ramble somewhat incoherently. The patients' inability to process conversation feedback due to the problem they comfort in comprehension. Clark (1977) says that the patients of Wernicke's aphasia have difficulty understanding spoken and written language. The patients usually speak fluently and with a natural rhythm, but the sentences out as garbled, confused strings of words. It sometimes referred to as word salad. The speech of Wernick's aphasia tends to be semantically empthy and includes inappropriately juxtaposed

words and grammatical structure. The main point for this view is the patients may not know that they are speaking nonsense.

Wernicke's aphasia shows the significant priming effects. That is, the response latencies are not slow down as is the case of for neurologically intact individuals, but the patients of Wernicke's apahsia are faster for lexical targets presented in the context of stimuli that had onset competitors. Patients with Wernicke's aphasia may produce many paraphasic word production language output. That is supported by Gaskel (2007) the patients appears largely unaware that they are incomprehensible that prevents from monitoring their speech production errors in thier fluent speech.

Scovel (1998) mentions that damage to Wernicke's aphasia usually attacks children, elder people, alcoholic, and psychological disorders. The patients of neurological damage have a trouble in speech and language.

When a person is unable to produce speech sounds correctly or fluently, or has problems with his or her voice, then he or she has a speech disorder**.** Scovel (1998) mentions that autism and stuttering are examples of speech disorders. Both autism and stuttering have articulation problem that is probably because of neurological and social problem. Scovel (1998) puts there are two variations of explanation for stuttering itself. In Johnson theory states that stuttering originates from traumatic events occurring in early childhood when overly sensitive parents. The opposite extreme theory is from Orton / Travis explains that stuttering, also referred to stammering, is caused by the absence of unambiguous lateralization of speech to the left hemisphere.

Meanwhile, when a person has trouble understanding others or sharing thoughts, ideas, and feelings completely, then he or she has a language disorder**.** Nelson (2008) conveys that a language disorder is impairment in the ability to understand and/or use words in context, both verbally and nonverbally. Some characteristics of language disorders include improper use of words and their meanings, inability to express ideas, inappropriate grammatical patterns, reduced vocabulary and inability to follow directions.

The definitions above show that speech and language disorders refer to problems in communication and related areas such as oral motor function. These delays and disorders range from simple sound substitutions to the inability to understand or use language or use the oral-motor mechanism for functional speech and feeding. Some causes of speech and language disorders include hearing loss, neurological disorders, brain injury, mental retardation, drug abuse, physical impairments such as cleft lip or palate, and vocal abuse or misuse.

One or a combination of these characteristics may occur for mental illness disorders that are affected by language learning disabilities or developmental language delay. One of the patients of mental illness is schizophrenia. The patients may hear or see a word but not be able to understand its meaning. They may have trouble getting others to understand what they are trying to communicate.

McKenna and Tomasino (2007) gives some theorits who explain what makes schizophrenics speech difficult to follow. First, it comes from Kraepelin and Bleular stated that the patient’s mental association often have that peculiarly

bewildering incomprehensibility, which distinguishes them from other forms of confusion and constitute the essential foundation of incoherence of thought. Second, Cameron picked out three factors which were distinct enough to justify separate discussion, namely : asydentic thinkng – the substitution of loose clusters of tems for well- integrated concepts, metonomic distortion- the use of word approximations, and interpenetration of themes- it could be fragmens of different themes. Third, Wing reported that schizophrenics have poverty of content of speech. Fourth, Harrow explored bizzare- idisyncratic thinking for thought disorder. And last, Andreasen had some language disorders of schizophrenics and become modern syntahesis. This research use some forms of language disorders related to Andreasen's recommendation.

B.Language Forms of thought Disorders

Eugen Bleuler, who named schizophrenia held that its defining chracteristics was a disorder of thinking process. Thought disorder applies specifically to the presummed disruption in the flow of conscious verbal thought that is inferred from spoken language.

Patients with schizophrenia often display unusual language impairments. This is a wide ranging critical review of the literature on language in schizophrenia. There are several types of Language di produced by schizophrenia. Videbeck (2008) categorizes the language forms of schizophrenia into 7 groups, they are:

1) Clang Association

In psychology and psychiatry, clanging or clang association refers to a mode of speech and logical association to two or more words primarily based upon word sounds when no logical association between the words exists. For example, rhyming or alliteration may lead to the appearance of logical connections where none in fact exists.

For instance: *" Saya akan minum pil kalau saya mengendarai mobil dan saya tidak akan usil "*
'I am going to take some pill, if I drive a car I will not be mischievous'

The example above, schizophrenia who produces clang association creates the similar ending sounds "ill " in each of their sentences.

2) Neologism

In psychiatry, the term neologism is used to describe the use of words that only have meaning to the person who uses them, independent of their common meaning. This is considered normal in children, but a symptom of thought disorder (indicative of a psychotic mental illness, such as schizophrenia) in adults. People with autism also may create neologisms.

Neologisms are often created by combining existing words or by giving words new and unique suffixes or prefixes. Neologisms also can be created through abbreviation or acronym, by intentionally rhyming with existing words or simply through playing with sounds.

For instance: " *Saya takut terhadap grittiz, jika ada grittiz disini saya akan lari*"
'I am afraid of grittiz, If there is grtitiz here I will run away'

Schizophrenia creates a new words that exactly she/ he knows it well, however, the listener is difficult to understand what the new words means.

3) Verbigeration

Verbigeration is Obsessive repetition of meaningless words and phrases of schizophrenia. It is likely to have meaning or not for the listener.

For instance : " *Saya ingin pulang, pulang, pulang*".
' I want to go home, go home, go home'

The repetitions of word above are likely to have meaning for schizophrenia. The assumption of words" pulang " are probably the patients are boring or the patients do not want to disturb now.

4) Echolalia

Using a mechanical, robot like speech pattern, an individual with certain mental disorders may repeat words or phrases spoken by others. It is known as echolalia, this behavior is observed in children with autism, Tourette's syndrome, schizophrenia, and certain other brain disorders.

For instance: Nurse: " *Dapatkah Anda mengatakan kepada saya bagaimana perasaan anda* ?"
Client : "*Dapatkah Anda mengatakan kepada saya bagaimana perasaan anda* ?"
' Could you tell me how you're feeling now?'

Schizophrenia who repeats the words produced by the nurse are exactly no idea or difficult to interpret the question to answer it well.

5) Stilted Language

The patients of schizophrenia tend to over speaking to deliver their idea. It is called stilted language.

For instance: " *Dapatkah Anda memberi saya sedikit minuman mungkin dalam bentuk air segar yang jernih* "
' Could you give me a little of drink that is probably in natural and fresh of water please? '

The example above conveys that one of language forms of schizophrenia to request something. Not all schizophrenia can do it well, and this phenomenon is extinct to find.

6) Perseveration

The patients keep continuing one topic in conversation even though the nurse has tried to look for other topics to her client. Perseveration is not a unitary phenomenon but rather manifests itself in various forms and across all modalities of response output.

For instance : Nurse : " *Bagaimana tidur Anda akhir-akhir ini* ?"
Client : " *Saya rasa ada orang yang terus mengikuti saya* "
Nurse : " *Apa yang Anda lakukan pada waktu luang* ?"
Client : " *Tidak ada, ada orang yang terus mengikuti saya* "
' Nurse : "How is recently your sleep ? "
Client : " I feel there is somebody always follows me"
Nurse : "What are you going to do in spare time ?"
Client : "Nothing. There is somebody keep following me'

The client above is probably anxiety for someone who has a terrible historical for him /her.

7) Schizophasia

In the mental health field, schizophasia, commonly referred to as word salad, is confused, and often repetitious, language that is symptomatic of various mental illnesses. It is usually associated with a manic presentation and other symptoms of serious mental illnesses, such as psychoses, including schizophrenia. It is characterized by an apparently confused usage of words with no apparent meaning or relationship attached to them. In this context, it is considered to be a symptom of a formal thought disorder.

Schizophasia refers to a defect in processing and organizing language, as opposed to the ability to create a nonsense word which happens to conform to a very specific set of rules.

For instance : " *Jagung, kentang, melompat, lemari* "
' Corn, potato, jumping, cupboard '

This language forms tend to incoherent in communication. The answer is not appropriate sometime.

Other informations about forms of language disorders produced by schizophrenia comes from Nancy Andreasen, in Mckenna and Tosmasino's book *Schizophrenic Speech (2007),* who has broken down into subcategories of disordered speech associated with formal thought disorders, namely:

1) Poverty of speech

It can be seen from poverty of thought and laconic speech. Poverty of speech tends to occur in severe depressive states. The inability to start or take part in a conversation, particularly small talk. The replies of

questions tend to be brief, concrete and uneleborated. However, it may be monosyllabic. This is a very common symptom in schizophrenia and prevents people with this condition from taking part in many social activities. When confronted with this speech pattern, the interviewer may find himself frequently prompting the patient to encourage elaboration of replies.

For instance: Nurse : " *What do you think about this place*?"
Patient : " *Bad* "

2) Poverty of Content of Speech

The categorizes of this language disorder are poverty of thought, empty speech, alogia, and verbigeration. Speech that lack meaning, or where speech quantity is far greater than necessary for the message conveyed. The patient who has verbigeration always repeat some words continously. Meanwhile, if the consonant of the words or phrase does not clear enough or tends to whisper so that the speech of patient goes to alogia. The language in this speech pattern tends to be vague, often over-abstract or over concrete, repetitive and stereotyped.

The interviewer may recognise this speech pattern by observing that the patient has spoken at some lenght, but has not given adequate information to answer the question. Alternatively, the patient may provide enough information to answer the question, but require many words to do so. Furthermore, a lenghty reply can be summarised in a sentence or two.

Sometime the interviewer may characterise the speech as empthy philosophizing.

For instance : Patient: "*I feel quite well, but I keep expecting to get well. You know, every day I put in. But I would like to be you,feel well in myself and I would like to be talking more to people and socialising and all that kind of thing"*

3) Pressure of Speech

It shows that an increase in the amount of spontaneous speech compared to what is considered customary. This may also include an increase in the rate of speech. Alternatively may be difficult to interrupt the speaker, the speaker may continue speaking even when a direct question is asked. The voice of the patient tends to loud.

4) Distractible Speech

During mid speech, the subjects is changed in response to a stimulus nearby. The stimulus can be the people around the patients or an attractive item they see. Firstly, in mid speech, the patients switch the subject due to getting stimulus around them.

For instance: Patient : " *Then I left San Fransisco and moved to....where did you get that tie?"*

5) Tangentiality

The patients reply to questions in an oblique, tagential or unrelated idea. The reply may be related to the question in some way, or the reply may be unrelated and seem totally irrelevant.

The concept of tangentiality has been partially redefined so that it refers only to questions an not to transitions in spontaneous speech.

For instance : Nurse : “ *What city are you from?”*
Patient : “*Well, that’s a hard question. I’m from Iowa. I really don’t know where my relatives came from, so I don’t know if I’m Irish or French”*

6) Derailment

The ideas slipp off the track on to another which is obliquely related or unrelated. A sequence of loose associations or extreme tangentiality where the speaker goes quickly from one idea to another seemingly unrelated idea. To the listener, the ideas seem unrelated and do not seem to repeat. The answers od derailment tends to spontaneous. Loose association and flight of ideas can be categorized in this form. the speech of the patient are confuse, vague, slow and the ideas are not related each other. This patern is loose association, and it is almost similar with flight of ideas, however, the words or phrase produced are rapid.

There may be a vague connection between the ideas;at others, none will be apparent. Perhaps the commonest manifesttation of this disorder is a slow, steady slippage, with no single derailment being particulary severe. Furthermore, the speaker gets farther and farther off the track with each derailement, without showing any awareness that his reply no longer has any connection with the question that was asked.

For instance : Patient : “ *The next day when I’d be going out you know, I took control, like uh, I put bleach on my hair in California”*

7) Incoherence

Speech that is unintelligible because, though the individual words are real words, the manner in which they are strung together results in

incoherent gibberish. Incoherence is also called words salad in which all words in phrases or sentences are not related each other. Paragmatism is roughly synonymous with word salad.

A pattern of speech that is essentially incompreensible at times. The incoherence is due to several different mechanisms, which may sometimes all occur simultaneously. Sometimes the rules of grammar and syntax are ignored, and a series of words or phrases seem to be joined together arbitrarily and at random. Sometime the disturbance appears to be at a semantic level, so that words are substituted in a phrase or sentence so that the emaning seems to be distorted or distroyed. Sometime 'cementing words' (conjuctions such as 'and' and ' although' and adjectival pronouns such as 'the', 'a' and 'an') are deleted. Sometime portions of coherent sentences may be observed in the midst of a sentence that is incoherent as a whole.

For instance : Nurse : " *Why do people comb their hair?"*
Patient : " *Because it makes a twirl in life, my box is broken help me blue elephant. Isn't lettuce brave? I like electrons. Hello,beautiful"*

8) Illogicality

The conclusions are reached that do not follow logically. The patient conclude something based on faulty premises without any actual dellutional thinking. Illogicality may take the form of faulty inductive inferences.

Illogicality may take the form of non sequiturs, in which the patient makes a logical inference between two clauses that is unwarranted or

illogical. Illogicality may take the form of faulty inductive inferences. Illogicality may also take the form of reaching conclusions based on faulty premises without any actual delusional thinking.

For instance: Nurse : " *Do you think this will fit in the box?"*
Patient : " *Well, duh, it's brown isn't it?"*

9) Clanging

This form goes to the sounds rather than meaningful relationship appear to govern words, so that the intelligibility of the speech is impaired and redundunt words are introduced. In addition to rhyming relationships, this pattern of speech may also include punning association. So that a word similar in sound brings in a new thought. the patient who has clanging in her or his speech tends to have knowledge in prose subject.

For instance : Patient : " *I am not trying to make noi<u>se</u>. I'm trying to make sen<u>se</u>. if you can't make sen<u>se</u> out of nonsen<u>se</u>, well have fun"*

10) Neologism

It is new word formations produced by schizophrenics. Neologism is defined as a completely new word or phrase whose derivation can not be understood. The listener does not understand what the new word mean produced by schizophrenics because the new word is only understood by the patients themselves. This may also involve ellisons of two words that aresimilar in meaning or in sound. These may also involve ellisions of two words that are similar in meaning or in sound.

For instance : Patient : " *I got so angry I picked up a dish and threw*

it at the geshinker"

11) Word Approximations

Old words used in a new and unconventional. It can be categorized of metonym and paraphasia; phonemic and semantic paraphasia. Phonemic paraphasia tends to mispronounctiation, syllables out of sequence. On the other hand, semantic paraphasia tends to substitute the inappropriate word.

Metonym is a figure of speech used in rhetoric in which a thing or concept is not called by its own name, but by the name of something intimately associated with that thing or concept. The meaning of word approximation will be evident even though the usage seems peculiar or bizarre (i.e, gloves refered to as 'handshoes'). Sometimes the word approximations may be based on the use of stock words, so that the patient uses one or several words repeatedly in ways that give them a new meaning (i.e, a watch may be called a time vessel')

For instance : Patient : " *His boss was a seeover"*

12) Circumstantiality

Speech that is very delayed atreaching its goal. Speaking about many concepts related to the point of the conversation before eventually returning to the point and concluding the thought. However, the answer is sometimes correct in last questions.

A pattern of speech that is very indirect and delayed in reaching its goal idea. In the process of expalining something, the speaker brings in many tedious details and sometimes makes parenthetical remarks.

Circumstantial replies or statements may last for minutes if the speaker is not intterupted and urged to get to the point. Interviewers will aften recognise circumstantiality on the basis of needing to interrupt the speaker to complete the process of history taking within an alloted time.

For instance : Nurse : " *What is your name?"*
Patient : " *Well, sometime when people ask me that I have to think about whether or not I will answer because some people think it's odd name, but yeah, it's Tom"*

13) Loss of Goal

The subject is going to be asked to schizophrenic is not there in her or his answers. Commonly, all the answers of schizophrenic are not irrelevant manner. Failure to follow a chain of thought through to its natural conclusion. This is usually manifested in speech that begins with a particular subject wanders away from the subject and never returns to it. The patient may or may not be aware that he has lost his goal.

For instance : Nurse : "*Why does my computer keep crashing?"*
Patient : "*Well, you live in a stucco house, so the pair of Scissors needs to be in another drawer"*

14) Perseveration

Perseveration tells about persistent repetition of words or ideas and all the answers tend to similar. Persistent repeatation of words, ideas, or subjects, so that one patient begins a particular subject or uses a particular word. The patient continually returns to it in the pocess of speaking.

For instance : Patient : " *It's great to be here in Nevada, Nevada,Nevada*"

15) Echolalia

The patient has this langauge form echo of one's speech or other people's speech that may only be commited once, or may be continous in repitation. This may involve repaeting only the last few words or last words of the examiner's sentences. Typical echolalia tends to be repetitive and persistent. The echo is often uttered with a mocking, mumbling or stacco intonation.

For instance : Nurse : " *Can we talk for a few minutes?"*
Patient : " *Talk for a few minutes"*

16) Blocking

The patients often keep silent for a few second to minutes. It is signed with interruption of train of speech before completion. Interruption of atrain of speech before a thought or idea has been completed. After a period of silence lasting from a few seconds to minutes, the person indicates that he can not recall what he had been saying or meant to say. Blocking should only be judged to be present if aperson voluntarily describes losing his thought or if on questioning by the interviewer he indicates that was his reason for pausing.

For instance : Nurse : *" Am I early?"*
Patient : " *No, you're just about on...(silent)"*

17) Stilted Speech

Speech excessively stilted and formal. Stilted speech may seem rather quaint or outdated, or amy appear pompous, distant or over polite. The stilted quality is usually achieved through use of particular word

choices, extremely polite, or stiff and formal syntax. The patient is such an educated man.

For instance: Patient : " *The attorney comported himself indecorously"*

18) Self-Reference

Patient repeatedly and inappropriately refers back to self. The first interviewer did not answer the question asked by the nurse. However, when the nurse gives the same question to second interviewer, the first interviewer answers it.

A disorder in which the patient repeatedly refers the subject under discussion back to himself when someone else is talking and also apparently neutral subjects to himself when he himself is talking.

For instance : Nurse : " *What's the time?"*
Patient : " *It's 7 o'clock. That's my problem"*

The researcher also found some words or phrases that can be categorized in new form of language disorders from Andreasen which has not published yet in Meckanna book, it is Evasive interaction. It attempts to annunciate ideas and /or feelings about another individual comes out as evasive or in a dilluted form.

For instance : Patient:"*I..er ah you are uh..i think you have..uh..acceptable erm..uh..hair"*

Language disorders from the definitions given by Videbeck and Andreasen are commonly similar. All definitions above show that it is clear enough that schizophrenics have their own uncommon languages that make people surrounding confuse to catch the idea of schizophrenics' speech. However, the

listeners are likely to understand a little bit if they are patient to listen their communication.

B. Schizophrenia

Schizophrenia is a mental illness which may affect brain and cause wrong thinking, perception, emotion , movement and bizarre. Davison (2006) explains that Individuals with this disorder may develop significant loss of interest or pleasure. Likewise, some may develop mood abnormalities (e.g., inappropriate smiling, laughing, or silly facial expressions; depression, anxiety or anger). Often there is day-night reversal (e.g, staying up late at night and then sleeping late into the day). The individual may show a lack of interest in eating or may refuse food as a consequence of delusional beliefs. Often movement is abnormal (e.g., pacing, rocking, or apathetic immobility). Frequently there are significant cognitive ondtaion, impairments (e.g., poor concentration, poor memory, and impaired problem-solving ability).

The majority of individuals with Schizophrenia are unaware that they have a psychotic illness. It is supported by Karger (1990) this poor insight is neurologically caused by illness, rather than simply being a coping behavior. This is comparable to the lack of awareness of neurological deficits seen in stroke. This poor insight predisposes the individual to noncompliance with treatment and has been found to be predictive of higher relapse rates, increased number of involuntary hospitalizations, poorer functioning, and a poorer course of illness. Depersonalization, derealization, and somatic concerns may occur and sometimes

reach delusional proportions. Motor abnormalities (e.g., grimacing, posturing, odd mannerisms, ritualistic or stereotyped behavior) are sometimes present.

Karger (1990) adds that the life expectancy of individual with Schizophrenia is shorter than that of the general population for a variety of reasons. Suicide is an important factor, because approximately 10% of individuals with Schizophrenia commit suicide - and between 20% and 40% make at least one suicide attempt. There is an increased risk of assault and violent behavior. The major predictors of violent behavior are male gender, younger age, past history of violence, noncompliance with antipsychotic medication, and excessive substance use.

A person diagnosed with schizophrenia commonly suffers among adolescents and young adults. In free encyclopedia (wikipedia) accounts that recently number of schizophrenia patients are late adolescence and early adulthood. In 40 % of men and 23 % of women diagnosed with schizophrenia before the age of 19. The statements are supported also with the data got from medical room in Mental Hospital in Padang that the totals of hospitalized schizophrenics in August 2010 were approximately 53. Meanwhile, mostly the patients were still 25 – 44 years old about 36 numbers of schizophrenics. And the second position was 12 numbers of 15 – 24 years old of schizophrenics. Men were more diagnosed for this mental illness about 39 than the number of women about 14. These are critical periods in young adult’s social and vocational developments.

1. Symptoms of Schizophrenia

The symptoms of schizophrenia are likely to have any disturbances of thinking, perception, and behavior. Videbeck (2008) in her book *Psychiatric Mental Health Nursing.* She explains that the positive symptoms of schizophrenia are:

1) Hallucination. Hallucinations are the projection of impulses and experiences into projection images in the external world. Hallucinations can be associated with any of the sense of organ – sight, hearing, taste or touch. Schizophrenics report voices either perusing orders or accusing them terrible crimes or actions. Not all auditory hallucinations are accusatory or unpleasant. The voices sometimes give comfort and companionship.

2) Delusion. Delusions are essentially a faulty interpretation of reality to which the individual tenaciously clings despite evidence to the contrary.

3) Echopractic : imitate the movement and gesture of someone observed by client.

4) Flight of ideas: the patients jump one topic to other topic in conversation continuously.

5) Reconciliation of interpretation: the external event has a special message for the patient.

6) Ambivalent: to keep holding the wrong faith or feeling which are contradictive with individual and event.

These Positive symptoms are mostly having of schizophrenic. And then for the negative symptoms are: (1) Apathy: the patients do not care enough for

individual, activity and event. (2) Allogia : poor of conversation. (3) Flat affect: there is no expression or mood in their face. (4) Blunt affect: limited expression or mood. (5) Anaerobia: The patients feel joyless in doing activity. (6) Catatonia: immobility of patient such as very cheerful or there is no movement. (7) Less ambition: there is no ambition to do their daily activity.

The negative symptoms tend to have low quality of life. The patients do not have spirit and incapability for their activity. Mostly the patients rarely socialize with other people.

2. Type of Schizophrenia

A class of schizophrenia disorders characterized by severe distortion of reality, resulting in antisocial, silly, or obscene behavior, hallucinations and disturbances in movement. Fenton and McGlashan in Schiller (1991) inform that the distinctions between the several types of schizophrenia are not always clear-cut. Moreover, people with schizophrenia may vary over time.

There are five major types of schizophrenia based on the symptoms, namely:

1. Disorganized schizophrenia: Inappropriate laughter and giggling, silliness, incoherent speech, infantile behavior, strange and sometimes obscene behavior.
2. Paranoid schizophrenia: Delusions and hallucinations of persecution or of greatness, loss of judgment, erratic and unpredictable behavior.
3. Catatonic schizophrenia : Major disturbances in movement; in some phases, loss of all motion, with patient frozen into a single position,

remaining that way for hours and sometimes even days; in other phases, hyperactivity and wild, sometimes violent, movement.

4. Undifferentiated schizophrenia : Variable mixture of major symptoms of schizophrenia; classification used for patients who can not be typed into any of the more specific category.
5. Residual schizophrenia : Minor signs of schizophrenia following.

In addition, there are the most widely used standardized criteria for diagnosing schizophrenia come from the American Psychiatric Association's Diagnosed and Statistical manual of Mental Disorders in fourth edition, DSM- IV-TR, namely : (1) Disorganized schizophrenia. The way of their speech is disorganized, incoherent in communication, combining the similar sounds, and create the new words that makes less understanding for the listener. (2) Catatonic schizophrenia. The patients like imitating the nurse's speech, screaming, talking stop less, and hyperactive. (3) Paranoid schizophrenia. The patients are always anxiety, argumentative, mad, and emotional.

From categorizing of schizophrenics above makes easier for the researcher to take some informants of schizophrenics as well as the researcher must be careful to get the data in order that the informants of schizophrenics feel comfortable during in therapeutic communication go on.

C. Relevant Studies

At the previous research, there are two researchers who have researched about schizophrenia. They are Solovay et all (1987) surveyed schizophrenic

language level by level, from phonetics through phonology, morphology,syntax, semantics and pragmatics. There are at least two kinds of impairments, which is not probably fully distinct, thought disorder or failure to maintain a discourse plan and schizophasia, comprising various dysphansia- like impairments such as clanging, neologism, and unintelligible utterances. From their research explain clearly that the patients with schizophrenia often display unusual language impairments.

M. Harrow and M. Prosen (2000) assessed bizarre verbalization elicited from 37 schizophrenics nad 16 non schizophrenics. They researched about bizarre schizophrenic language result from patients intermingling material from past and current experiences into their verbalization. This intermingled material comes from many different problem areas rather than one central emotional complex. It does not arise from emotional overesponsiveness, overinvolved thinking, or delutional ideation. So that there are two factors hypothesized as responsible for bizzare schizophrenic language are the schizophrenic's monitoring problems and difficulty maintaing perspective about his own behavior.

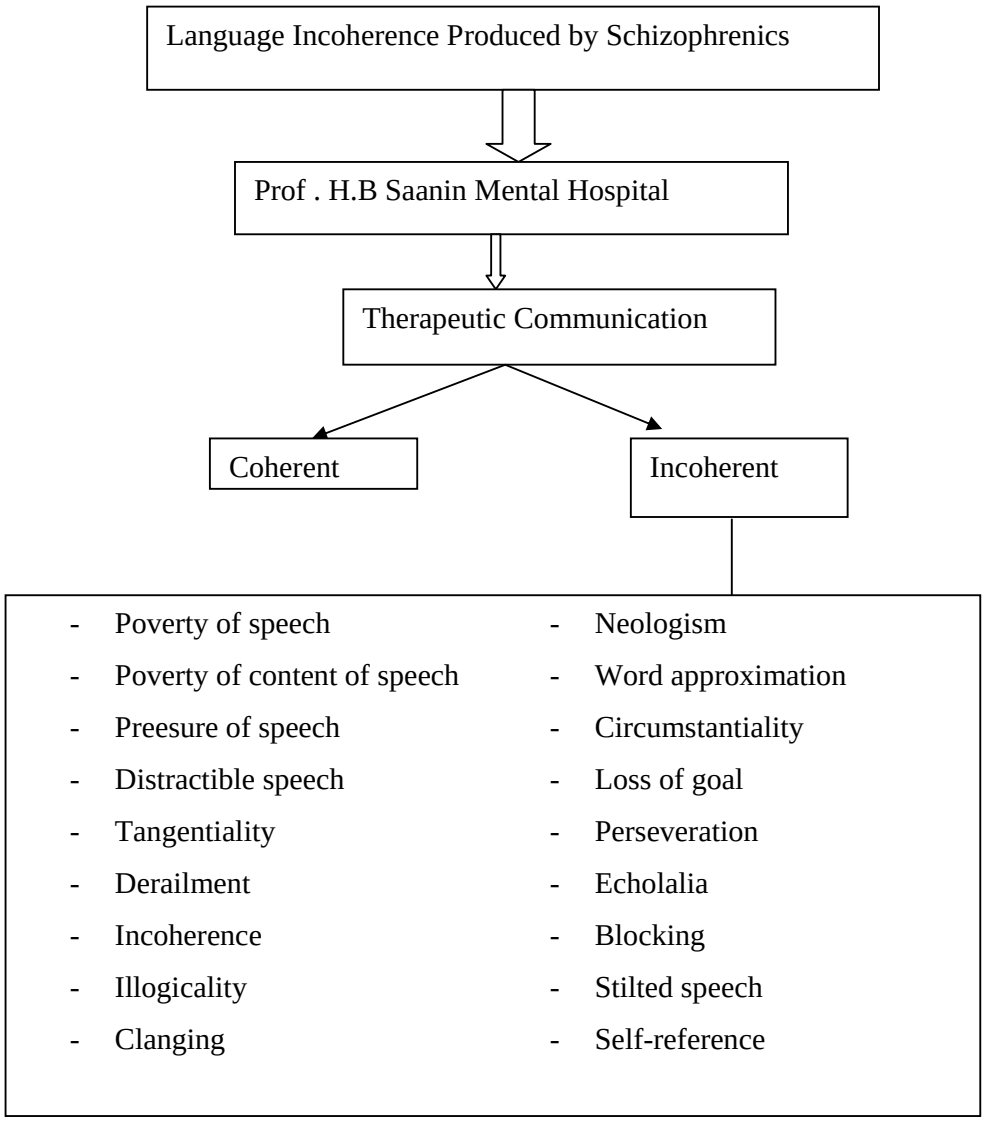
From the relevant studies above show that there is no reserach about the forms of thought dosorders. However, the studies above are going to help to know more about schizophrenics related to thought disorder.

D. Conceptual Frame Work

This research is going to analyze the language forms used by schizophrenics. The researcher is going to record the communication done

between nurses and schizophrenics in Prof. HB. Saanin Mental Hospital in Padang and analyze the the language forms produced by schizophrenics then.

The conceptual frame work of this research as follows:



CHAPTER 5

CONCLUSION AND SUGGESTION

A. Conclusion

In this research the process to get schizophrenics speech is through therapeutic communication. Therapeutic communication is a therapy which has many advantages for schizophrenics in order to be able to socialize with other people and be independent as the main purpose of therapeutic communication.

The speech of schizophrenics have enermous difficulty producing to express meaning. They produce fragmeted utterances interrupted by enermous pauses and produce words that do not express what they intended to say. The languages produced by schizophrenics affected psychological problem they have as well the process of communication done between schizophrenics and nurses. Furthermore, the speech of schizophrenics are difficult to follow and the communication does not run very well.

This research finds that a schizophrenic produces more than one forms of thought disorders. Some patients have loss of goal in their speech. The answers are really different from the questions given by the nurses. The most of the language forms they produced is poverty of content of speech. The quantity of speech they produced is far greater than the message conveyed. The content of their speech is poor, so that the listener can catch a little bit idea from their speech. Then, the schizophrenics like repeating some words or phrases which is in verbigeration subcategory of poverty of content of speech .

Derailment also appears in schizophrenics speech. The idea can jump to another idea in their speech. Furthermore, in one sentence or phrase has more than one main idea. Schizophrenics also have other interpretation of something or someone which are almost relevant to the objects. The listener can catch their idea if they have the knowledge about what the schizophrenics described about something in their speech.

Word approximation is the third position of occurance of the forms of thought disorder. The patients of schizophrenia have semantic and phonemic problem. Word approximation in this research, however, is very low realibility.

Andreasen's and videbeck's theories are commonly similar. The theories about the language forms of thought disorders can be found in this research. However, this research does not find the examples of pressure of speech, self reference and clanging which are produced by 10 informants of schizophrenia.

Meanwhile, this research also finds some examples of figure of speech in schizophrenic speech. This category shows that the schizophrenics substitute something or someone to other irrelevant objects. Figure of speech, however, is not mentioned both in Videbeck's or Andreasen's theories

Schizophrenic speech can be found in some children speech as well. The children like speaking in short one which is no subject and complement in their sentences. The children also like changing one idea to another idea. Children is imitated creature. They like imitating what they hear and see. The researcher can make a short conclusion that the speech of schizophrenics are almost similar with speech of children.

Something more important to know that schizophrenics are not strange creatures that we must afraid of. Schizophrenics are unlucky man who have psychological problem but normal peple must not eliminate the schizophrenics existence in social environment. To catch the idea for what the schizophrenics speech is only need patient and care. It also like what normal people do to their children.

B. Suggestion

The research can be contribution for next reseracher who is interested in researching about schizophrenic speech through therapeutic communication. The research can also give contribution to language structure to the field of pragmatic, morphology, syntax, semantic, lexical acces, and psycholinguistic itself.

After observing the subject in field and analyzing the forms of language disorders, the researcher found that the language disorders happened was not only due to internal factors of schizophrenics but also external factors of people surround them.

Here are some suggestions can be contributed by researcher to some nurses in mental hospital and society as well.

1. Use concrete message. Message is noun is used as pronoun. The characteresitic of concrete The patients of schizophrenia have anxiey to process the cognitive skill. The words in concrete mesaage is explicit in which does not more interpretation. That is why the use of concrete

message for svhizophrenic needed in order that they undrstand for the quetions and comfortable to tell their problem.

2. Interpret the signal. Signal is a verbal or nonverbal message that is a clue for the nurses. Nurses need to know the signal given carefully. If the patients are difficulty to continue the conversation and change to another topic or flight of idea, the nurses have to listen and join thier topic. From the signal, the nurses will know when they pause or even stop the therapeutic comunication.
3. Therapeutic communication has many purposes for schizophrnics. This therapy has applied very well by the nurses. Do this therapy continously to schizophrenics, but do not force schizophrenics to solve their problem in one day. We can do it again in the next day.

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