The Use of Language by Schizophrenic Patients in the Amaudo Home for the Destitute

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ABSTRACT

Schizophrenia is a severe mental disorder, which negatively affects the entire personality of an individual including the speech. This paper, therefore, examined the pattern of language use by the schizophrenic patients in the Amaudo Home for the Destitute with a view to noting that early identification and intervention can increase the chances for recovery and even prevent warning signs of psychosis from progressing. The data were collected primarily through interviews, and direct observation of 9 schizophrenic patients (subjects) with deviant communication patterns in the home. Using a descriptive method of data analysis, the paper observed that the patients have problems in understanding the communication content of others; they rarely respond and participate in conversation appropriately. It further revealed that the linguistic features such as semantics, pragmatics and syntax of the patients are disordered. The study also showed that medication alone cannot effectively take care of all the symptoms that confront the schizophrenic patients; hence the work encourages an incorporation of many initiatives involving identification, testing, psychosocial therapy, language therapy, etc. Early intervention is key to preventing a further episode of relapse, and a strategy to encourage a return to normal vocation and social activity. Although this study does not claim to be exhaustive, it is believed that it may serve as a useful introduction for those unfamiliar with communication patterns of schizophrenia.

KEYWORDS: Schizophrenia, semantic disorder, pragmatic disorder, syntactic disorder, Amaudo Home for Destitute.

Introduction

Schizophrenia is a health condition that affects the patient's mental state. It is seen 'as mental disorder in which a person is withdrawn from reality' (University of Michigan, Department of Psychiatry, 2013). In terms of its characteristics, World Health Organization (WHO) (2015) states that schizophrenia is a severe mental disorder characterized by profound disruptions in thinking, affecting language, perception and the sense of self. WHO (2015) further observes that it involves psychotic experiences, such as hearing voices or delusions as well as impair functioning through the loss of an acquired capability to earn a livelihood, or the disruption of studies. Although schizophrenia is not as common as other mental disorders, the symptoms can be very disabling as it comes with additional mental health problems such as anxiety, depression, or substance-use disorders (National Institute of Mental Health (NIH) 2016).

The term 'schizophrenia' is coined from the Greek roots ***schizo*** 'split' and ***phrene*** 'mind' by Bleuler (1911) to describe the fragmented thinking of people with the disor der. He notes that such split thought is reflected in the way the schizophrenics use language. Language is a human medium of communication, which distinguishes man from other animal creatures in the world (Fromkin & Rodman 1998:3, Samovar, Porter & McDaniel, 2007:164, Emenanjo & Ojukwu 2012:2). It therefore calls for concern when an individual cannot use language to communicate effectively with his fellows or when communication becomes somewhat fragmented. When there is a breakdown in communication there is urgent need to find a solution where possible. This study is a move towards sensitizing family, friends and the general public on the importance of early identification of the communication patterns of the schizophrenics for early management.

Heinrichs (2003) notes that the history of Schizophrenia is a complex one and has been a hard nut to crack. At some point, the people suffering from the illness are excommunicated or locked up somewhere because they are seen as people possessed by unclean spirits and demons. Even as technology has advanced and researches are carried out to unravel the mystery behind its causes, schizophrenia continues to confront both health professionals and the public. The array of symptoms and the odd behaviour associated with it makes it even more complicated to understand. Schizophrenia as a disease does not respect origin, age, social class or culture as anyone can be a victim. This study, therefore, is necessary as it can be used to strongly emphasize that early identification and intervention are major potential steps for partial or full recovery.

Review of Literature

This section gives a brief review of types of schizophrenia, the communication content characteristic of a schizophrenic person and the language use of the schizophrenic as treated by scholars.

Types of Schizophrenia

There are five types of Schizophrenia. They are catatonic, paranoid, disorganized, undifferentiated, and residual Schizophrenia. This study, however, focuses on the three basic types such as catatonic, paranoid and disorganized schizophrenia that are observed in our data.

a. Catatonic Schizophrenia

Catatonic schizophrenia is a type of schizophrenia in which the patients experience severe loss of motor skill to the point of being purposeless and unresponsive to instructions. Fink & Taylor (2003) state that catatonic schizophrenia may manifest stupor, which is characterized by immobility, inability to speak, as well as showing repetitive movements. According to them, catatonic patients may repeat meaningless phrases or speak only to repeat what someone has said. People with catatonic schizophrenia are generally insensitive to the world around them.

b. Paranoid Schizophrenia

Paranoid schizophrenia is a type of schizophrenia in which the patient displays false beliefs of being persecuted by someone. Such persecutory false beliefs are usually accompanied by hallucinations, particularly of hearing voices and perceptual disturbances (Mayo Foundation for Medical Education, 2013). Although patients with paranoid schizophrenia may have a better

functional ability to work than those with other types, Mayo Foundation for Medical Education (2013) observes that the characteristic symptoms of paranoid schizophrenia can have a huge effect on functioning and can negatively affect quality of life. Patients with paranoid schizophrenia may have higher quality of life if their health condition is properly treatment.

c. Disorganized Schizophrenia

Although, schizophrenia is generally characterized by disorganization of thought processes; reality distortion (delusions and hallucinations), and psychomotor poverty (lack of speech, lack of spontaneous movements and blunting of emotion), disorganized schizophrenia is an extreme expression of the disorganization of thought processes (Liddle, 1987). What this means is that patients with disorganized schizophrenia are emotionally unstable and have impairments in virtually every aspect of their daily activities such as brushing of teeth, bathing, dressing and the like.

Generally, people with schizophrenia are not perpetually incoherent or psychotic, that is to say that, chances are that they can recuperate and live a normal life like every other normal human being if treated and cared for. Schizophrenia can be effectively managed. Recovery is possible to most, and although many effective treatments exist, more research is needed to promote greater understanding, more effective treatment and the potential for a cure for schizophrenia and other mental illness.

Communication Content Characteristic of a Schizophrenic person

In considering whether an individual has thought disorder or not, Bleuler (1911) suggests that a close observation of the speech pattern of the individual, which may be characterized by poverty of speech (alogia), derailment, distractible speech, tangentiality, blocking, circumstantial speech, clanging, evasive interaction, echolalia, among others, must be checked. Although it is normal to exhibit some of them during times of extreme stress, but its degree, frequency and the resulting functional impairment is what will show if the person being observed has schizophrenia or not (Bleuler 1911). Some of these speech patterns are observed in the speech of the schizophrenics in our data and they are presented later in this study.

The Language Use of the Schizophrenic

Debra (2010) notes that schizophrenia is a brain-based disease whose diagnosis arises in large part from clinical observations of how and what people communicate through language. The study of schizophrenic language disorder by linguists began with Chaika (1974:257-276). He observed the following abnormalities of schizophrenic use of language to include:

a. failure to utter the intended lexical item,
b. distraction by the sounds or senses of words, so that a discourse becomes a string of word associations rather than a presentation of previously intended information,
c. breakdown of syntax and/or discourse, and
d. lack of awareness that the utterances are abnormal.

Similar to Chaika's (1974) observation, Tenyin (2002) notes that the schizophrenics have difficulties in the decoding of violations of conversational implicative as the core deficit in the disorder is around social cognition, theory of mind and pragmatic language use.

On his part, Michael (2005) examines the language structure of the schizophrenics. He identified a number of unusual language impairments displayed by patients with schizophrenia. Michael (2005) surveyed schizophrenic language level by level, from phonetics through phonology, morphology, syntax, semantics and pragmatics. He observed that thought disorder and schizoaphasia are the two kinds of impairments perhaps not fully distinctly exhibited by schizophrenia.

Working on the schizophrenic language function, Rachel (2005) highlights the importance of right hemisphere language functions for successful social communication and advances the hypothesis that the core deficit in psychosis is a failure of segregation of right from left hemisphere functions.

Indeed, schizophrenic language disorder is fundamentally a loss of voluntary control over the speech generation process. According to Chapman (1966:112), patients sometimes say in retrospect that, this is exactly what happened – they couldn't control their speech. The foregoing show that schizophrenic patients have problem using language and this study is aimed at identifying some of those observed in the speech of patients in the Amaudo Home for the Destitute.

Methodology

This study adopts the descriptive survey method and also looks at the content of schizophrenic communication pattern. The data were collected primarily through interviews, and direct observation of the schizophrenic patients (subjects) with deviant communication patterns in the Amaudo Home for the Destitute. The data on caregivers were collected through a set of questionnaires designed to elicit the opinions and peculiar problems that challenge caregivers in the Home. Nine Schizophrenic subjects (six male and three female), who best suit the purpose of the study, were interviewed out of the forty-five patients in the home. The second author further extracted relevant pieces of information about the schizophrenic subjects from the five caregivers/adult workers at the destitute home. While four of them are male, one is a female and they fall within the age range of 25 to 45 years. Qualitative approach, which is largely descriptive was employed in the analysis of the data collected.

Data Presentation and Analysis

This section presents data collected from both the caregivers/adult workers at the Amaudo Destitute Home as well as the schizophrenic subjects.

Background on the Caregivers

Data were collected from five adult workers/caregivers at the Amaudo Destitute Home. Four of them are male, while one is a female who have worked for a period of 2 years and above. They fall within the age range of 25 to 45 years. The caregivers at the Amaudo Home for the Destitute comprise three (3) health providers and two (2) teachers. They are paid adult workers who assist the patients in a way that enables them to live as independently as possible. Caregiving is most

commonly used to address impairments related to old age, disability, a disease or a mental disorder.

Responses from the Caregivers

The necessary pieces of information needed for the research on the schizophrenic patients were provided by the caregivers and they are summarized in Table 1.

Table 1: Responses from the Caregivers

Questions	Options	Respondents	
		Three (3) Health Providers	Two (2) Teachers
1. What in the language of a person will make you think that he is schizophrenic?	a) Poverty of speech/alogia b) Inappropriate sentences, blocking, c) Incoherence, Echolialia d) Distractible speech, etc.	There is a possibility of a schizophrenic having all the symptoms	Option a, b, & c
2. Do you think that the social condition of the patient will improve with better communication interaction?	a) Yes b) No c) No idea	The three health providers answered 'YES'	Two teachers said 'Yes" (option 'a')
3. What means do you use to spot people with the communication disorder associated with schizophrenia?	a) Professional training b) Experience c) Interaction	They responded affirmatively to all the options	The teachers said Yes to option a, b, & c.

4. What are the challenges you encounter in managing these people?	a) They are violent and aggressive. b) Lack concentration/unresponsive to instructions. c) Social withdrawal/Abscondment d) Not insightful to their illness	Options a, b, c,& d	All the options

From the responses of the caregivers in Table 1, the language of schizophrenic patients are characterized by poverty of speech or alogia, inappropriate sentences, blocking, incoherence, distractible speech, etc. Despite the fact that the schizophrenics are violent and aggressive, lack concentration and are unresponsive to instruction, etc., there is hope that their social interaction and communication with others can improve.

The Schizophrenic Subjects

At the time of data collection for this study, there were forty-five (45) inmates of different kinds of psychotic illness at the Amaudo Home for the Destitute in Bende Local Government Area of Abia State, Nigeria. Out of the 45, nine (9) were identified as schizophrenic by the health providers based on the symptoms observed in them. Apparently, the Destitute Home Caregivers have the equipment they use to find out a particular ailment, as was the case with the nine (9) schizophrenic patients in the home. The nine subjects selected for the study were adults from the ages of 18 to 40. Our choice of this age group was formed by the fact that an adult's speech should be completely intelligible, understood, appropriate, meaningful and socially useful, but when it is not, then there is a problem in communication that needs investigation and urgent intervention. Details of the subjects are recorded in Table 2.

Table 2: Status of the Schizophrenic subjects

S/N	Name	Sex	Age	Disordered communication behavior	Type of schizophrenia	Duration of Condition
1.	Ifeoma	F	35	Difficulty speaking and expressing emotion - Unintelligible sentences	Catatonic	2years
2.	Ogonnaya	M	28	Mutism, rigid and problem with attention	Catatonic	1year
3.	Emeka	M	30	Talk off point, unending speech and jumbled	Catatonic	4years

				sentences		
4.	Victor	M	28	Uncoordinated utterances, haphazard sentences	Paranoid	3years
5.	Okechukwu	M	29	Problem with attention, memory and organization (Pauses, unstable, chaotic voice problems)	Paranoid	3months
6.	Stephen	M	29	Disorders of movement, monotonous speech, pauses, memory loss, bizarre behavior, inappropriate utterances	Paranoid	3years
7.	Chinonso	F	No information on her age	Bizarre behavior	Disorganized	3years
8.	Joy	F	22	Disorganized speech	Disorganized	6months
9.	Linda	F	24	Unusual thoughts or perceptions	Disorganized	1year, 6months

Table 2 gives a brief summary of the statues of the schizophrenic patients at the Home. In what follows, we present and analyse the data collected from the subjects through interviews.

Data from the Subjects Based on the Types of Schizophrenia

This section presents and analyses data elicited from the patients through personal interview and observation. The data are arranged based on the types of schizophrenia to which the subjects are identified.

Subjects with Catatonic Schizophrenia

Three subjects are identified with catatonic schizophrenia. They are presented in Cases (1)–(3).

Case 1: Interview with Ifeoma

Ifeoma is a 35-year old woman diagnosed with schizophrenia. She was spotted wandering around Umuahia Metropolis, and was taken to Amaudo Destitute Home for proper care/treatment. On admission in the home, she was reported to have decreased in energy exertion, violent, irritable mood, unintelligible utterances, muteness and poverty of speech, indicating that there is hope of restoration of the health of a schizophrenic. Ifeoma was interviewed in Igbo as shown in Table 4.3 because she could not express herself in English:

Table 3: Interview with Ifeoma

S/No.	Questions	Subject's Responses
a.	Gini bu aha gi? 'What is your name?'	Silence!
b.	Ole otu I di taa? 'How are you today?'	I … I … (Paused)….Ify
c.	I ma ihe mere iji bia ebe a? 'Do you know why you came here?	Eehn. 'Yes'
d.	O! Ọ dị nma. Ngwa, gwa m ihe mere I ji bia ebe a. 'Ok! It is alright. Tell me why you came here?'	No response
e.	I riela nri taa? 'Have you eaten today?'	Ahu oku na eme m. 'I have fever'. Ofu nwa ka m muru, precious, precious. 'I have only one child , Precious Precious'
f.	Aunty Ify, I na amukwa aka oru na ebe a? 'Aunty Ify! Are you learning any hand work here?'	Hmnnnn…..eeehn…anam … amu Precious 'Hm … yes … I am … learning … Precious'

The interaction with Ifeoma in Table 4.3 shows that she rarely responded to some of the questions asked and when she attempted to do so, her thoughts and language are disordered. Her language is characterized by pauses, poverty of speech, muteness and wrong responses. Ifeoma requires someone to talk to always in order to improve her communication skills and help her social life too. This is because she was observed as being active during the interview section. She also wanted to keep the conversation on as long as possible. She was not angry when been corrected as others instead she wanted to continue in the conversation.

Case 2: Ogonnaya

Available records on Ogonnaya reveal that he is suffering from an acute catatonic schizophrenia. Ogonnaya looked very cheerful but was very lost from reality. He was quite unresponsive and rigid. Efforts made to retrieve pieces of information from him proved abortive as he could not mutter any word. He was neither deaf nor dumb but was totally lost as illustrative in Table 4:

Table 4: Interview with Ogonnaya

S/No.	Questions	Subject's Responses
a.	What is your name?	No response
b.	Where are you from?	No response
c.	Do you know why you are here?	No response
d.	How long have you been here?	No response

e.	What treatment are you receiving here?	No response
f.	Have you worked before?	No response
g.	Do you like this place?	No response
h.	Have you learned any hand work since you came?	Smile

The interview in Table 4.4 shows that Ogonnaya was completely unresponsive to all the questions asked, and was emotionally flat. It is a mark of being purposeless and increasingly eccentric and unmotivated. Ogonnaya's condition portrays a sign of dysfunction in the motor activity of the brain (Thompson 2000). As a matter of necessity, he needs people around him who will initiate discussion to take him out of solitary state. Leaving Ogonnaya alone may worsen his condition.

Case 3: Emeka

Emeka is a 30-year old man diagnosed with schizophrenia. He is from Owerri in Imo State of Nigeria. Emeka has been in the destitute home for 5years, and will soon be reunited to his family. For these years, he has been under serious medical and therapeutic treatments. Emeka has been certified ok, because he can read now and engage in conversations without going bizarre. Emeka can do things he was not able to do before, like bathing himself, brushing his teeth and barbing his hair. In addition, Emeka learnt crop growing; he also engaged himself in petty business (Buying and selling), which is what he does currently in the destitute home as at the time of his interview. See the interview with him in Table 5:

Table 5: Interview with Emeka

S/No.	Questions	Subject's Responses
a.	What is your name?	Emeka
b.	Where are you from?	Owerri
c.	Do you know why you are here?	I don't know, my brother carry me come here
d.	How long have you been here?	(Pause) … as if thinking … then said; 5 years
e.	What treatment are you receiving here?	(laughed … then said)…head medicine, my head is hot when I come…but now it's cold
f.	Have you worked before?	Do you know who I am? Are you mad? I cannot work before and work now.
g.	Do you like this place?	(Smiled … then said), I need to go to the store to buy some eggs. I read an article about how expensive

		AIDS drugs are. People take too many street drugs. The streets should be clean from the rain today".
h.	Have you learned any hand work since you came?	Smile! Yes! Farm work … I go to farm everyday … I fetch water-leave and vegetable and use it to cook soup. The water is green and the pepper is hot.

Although the responses in Interview (4.5a) – (4.5b) demonstrate that Emeka could give correct answers to some of the questions, other responses show that he still has symptoms of disorganized thoughts, speech hesitation and pauses, which are cognitive problems associated with schizophrenia. His thoughts, behaviour and actions are not well integrated, but the Destitute Home Coordinator believes that he will be better when he mixes up again with his family since he can do most what he was not able to do initially. Currently Emeka is the head of their choir in the destitute home, he sings wonderfully well.

The foregoing interviews with the subjects suffering from catatonic schizophrenia demonstrate that their language is characterized by poverty of speech, inappropriate responses to questions, total lost to reality, unresponsiveness, speech hesitation, disorganized thoughts, muteness, smiles or laughter, etc. Thus, any of our neighbours exhibiting such symptoms require urgent medical attention for early intervention.

Subjects with Paranoid Schizophrenia

Instances of paranoid schizophrenia are given in Cases (4) – (6).

Case 4: Victor

Victor could not remember his place of origin. There is no background information on him. As most of them were picked from the street, it was always difficult to trace their place of origin, especially for such a severe case as Victor. He is highly paranoid, irrational, violent and unfriendly as shown in Table 6:

Table 6: Interview with Victor

S/No.	Questions	Subject's Responses
a.	What is your name?	My name is Victor Adiele. A native of St. Andrews Anglican church, Airports of Nigeria West Africa, North Star Kano, North star insurance President Goodluck Jonathan.
b.	Where are you from?	(Paused) A …bia. But why are you asking me? Do you want to kill me?
c.	Do you know why you are here?	Yes …(hesitates) sickness bring me come
d.	Oh! That's good, so	I live in Umuahia, then I left Calabar and moved to

	tell me why you are here	Abuja. Did you see me yesterday? Where did you get that phone? (Pointing at my phone). My computer spoiled and my radio is talking too much.
e.	How long have you been here?	1, 2, 3, 4, 5, 6, (counting his fingers) months … years? (paused) I don't know. Leave me alone.
f.	What treatment are you receiving here?	Medicate
g.	Where do you live before you came here?	I live in Umuahia, then I left Calabar and moved to Abuja. Did you see me yesterday? Where did you get that phone? (Pointing at my phone). My computer spoiled and my radio is talking too much.

The interview with Victor in Table 6 shows that Victor's condition is a clear case of Paranoid schizophrenia. His response in (4.6b) reveals that Victor is suspicious of his interviewer. Although his response in the first sentence of (4.6a) is correct, the additional information he supplied about his place of origin is totally unrealistic and full of confusion. In fact, most of his responses are characterized by repetition of utterances, inappropriateness and unrelated answers to the questions. He was violent, panicking when interviewed, showing signs of delusion, derailment and lost. Our communication recommendation is that even though Victor appeared dangerous, he needs friends, people he can engage in conversations as often as possible. This will enable him understand that people take turns to talk while in conversation. Also, with the aid of professional caregivers and therapist, the tendency for repeating himself will be handled. He needs people around him to reduce his anxiety and restiveness. Seclusion as we saw at the home is not going to help him recover instead it can go from mild to severe and then to worse as a result of seclusion.

Case 5: Okechukwu

Okechukwu is a 29-year old man from Umuahia. He was doing well in business until the last six months as at the time of this research when he began to change, becoming increasingly paranoid and acting out in bizarre.

Table 7: Interview with Okechukwu

S/No.	Questions	Subject's Responses
a.	What is your name?	Okechukwu
b.	How are you?	Am fine I, are? I want to go to Lagos. Sokoto is my name. My job is to watch over you and help you get well. I am not crazy, I threw myself on the pillow and I need to get out of here now

c.	How old are you?	My age is old … emm (pause) … old is here, are you seeing old age
d.	Where are you from?	Mbaano village … (hesitated and continued) … Chima (his neighbour) came into the shop and then he opened the wall. He switched on the light and then looked into every corner for the snake.
e.	Have you eaten today?	(pause as if thinking … then he said) Yes! She cooked a bag of bread and I drink bread and water. But … I don't understand why Chima is spying on me through that television … (pointing at one end).
f.	How do you feel?	I am very fine. I plan to escape from this prison tomorrow, will you go with me? I want to go back to my shop.

The use of language by Okechukwu in Table 7, demonstrates symptoms of disorganized thoughts, hesitation and pauses which are characteristic of schizophrenia. Even though Okechukwu stated his name correctly as in (4.7a), he still claims that his name is Sokoto and instead of seeing himself as being looked after, he now assumes to be looking after his interviewer. He lacks insight of the condition he is into. Those who are developing schizophrenia are unaware that they are becoming sick. Okechukwu's response to the questions are expectedly meaningless as observed in the response in (4.7c), *My age is old ... emm ... old is here; are you seeing old age?* Nevertheless, Okechukwu's condition could improve if given the adequate care he needs. Our assessment is that he can to an extent engage in conversation and do other little things for himself if guided, loved and encouraged properly. But due to his paranoid state that sometimes overtakes him; he is being isolated for violent reasons.

Case 6: Stephen

Stephen is a good looking adult and a graduate. He was violent and unfriendly. In fact, his case was so severe that the interviewer was advised to trade with caution and be brief.

8: Interview with Stephen

S/No.	Questions	Subject's Responses
a.	What is your name?	No response
b.	How are you?	Laughs out loud … hahahahhaha, hohohohoho
c.	Have you taken a bath today?	He gave me money because I am blind and deaf, I cannot talk and my uncle lives in the back
d.	Why do you say that?	You are mad, give me back my money

In the interview in Table 4.8, it is observed that Stephen was totally lost to reality. He is not only unresponsive to questions but also uses laughter as part of his response to certain questions. Attempted responses to some other questions depict inappropriate utterances. In other words, Stephen deviated from the topic of discussion to an unrelated topic.

Generally, the interviews in Cases (4) - (6) show that the language of patients with paranoid schizophrenia is marked with repetition of utterances, false beliefs of being hurt by others, inappropriate and unrelated answers to questions, meaningless responses, total lost to reality, disorganized thoughts and the like.

Subjects with Disorganized Schizophrenia

The subjects that are recognized as showing the features of disorganized schizophrenia are as shown in Cases (7) – (9):

Case 7: Chinonso

No bio-data was collected on Chinonso, because she could not even remember her own name.

Table 9: Interview with Chinonso

S/N	Questions	Subject's Responses
a.	What is your name?	Silence
b.	How are you?	Smiles
c.	Have you taken your bath today?	(Paused) … soap finished, water is in the tap and I am not going to make it hot. My head is already hot. People around don't talk and I am lonely.
d.	What brought you to this place?	My head (she touched the hair)
e.	How is life here?	Oh! Life inside bush is super. You hear birds cry and you eat sweet bitter things.
f.	Do you comb your hair every day?	My hair is strong and painful to comb. My box is broken. Help me bring the elephant. Is cucumber not brave? I like banana.
g.	Do you enjoy spending time with your friends	I don't like that time and how can time be my friend …. go and call time for me.
h.	Are you a table? (This question was asked because the second author wanted to know if she understands that she is a human being and not an object. Unfortunately, she could not	Yes.

	differentiate).	

Table 9 shows that Chinonso has frequent loose association of thoughts. This means that one thought does not logically relate to the next. For example, to the question: *How is life here?* Her responses are: *oh! Life inside the bush is super. You hear birds cry and you eat sweet bitter things.* She misrepresents her environment to be a bush even if it is a home. Her response in affirmation to the question, *Are you a table?,* in (4.9h), indicates that she has lost consciousness of the fact that she is a human being and not the object *table*. The interview also shows that Chinonso is very lonely; a widespread problem of mental illness affecting almost half of the people suffering from schizophrenia (SANE, 2015).

Case 8: Joy

Joy is a 26-year old young lady from Akwa Ibom State. Prior to the interview, the second author was informed that Joy was totally lost in her thoughts and from reality; she did not want any disturbance with human contact. Joy neglected self-care, i.e., personal hygiene, clothing, and bathing. Her appearance was shabby during the interview. Joy wore a blank, vacant facial expression. She appeared desire less; i.e., seeking nothing, wanting nothing. At the period of this interview, Joy had difficulty understanding English. Thus, the interview was conducted in Pidgin as illustrative in Table 10:

Table 10: Interview with Joy

S/No.	Questions	Subject's Responses
a.	Wetin be your name? 'What is your name?'	Joy.
b.	How you dey today? 'How are you today?'	I no no.
c.	Wetin be your age? 'How old are you?'	No.
d.	You don marry? 'Are you married?'	Wetin you dey talk? (paused) … I never chop.
e.	You don born pikin? 'Do you have children?'	Emmh, na only one.
f.	Do you like this place?	(shook her head to mean) NO.
g.	Oh! You mean am? Oya, tell me wetin make you no like the place. 'Do you mean it? Ok, tell me why you don't like this place.'	(She hesitated … and then murmured softly) na me be her mother. I dey here for medicine. My son come bring me for here. Do you know my son?
h.	No! Where is your son?	Abeg, leave me alone.

The interaction in Table 10 demonstrates Joy's monotonous responses to some of the questions as well as inappropriate answers to some others, thus indicating affective flattening. Most people with affective flattening as Joy may reflect severe anhedonia (loss of interest in everything in life). In order to keep Joy mentally alert, she should be encouraged to engage in some physical and mental activity. For instance, a walk through the neighborhood or a visit to a park can help improve the mental and physical condition of a patient, depending on his/her condition.

Case 9: Linda

Linda could not say her age but she has spent 3 years in the destitute home. Information has it that she gave birth to a child on arrival to the home and the child was taking to a motherless babies' home. Whenever Linda is asked about her baby, she immediately becomes moody and starts ranting; *my baby ooh! My baby ooh!* as presented in Table 11:

Table 11: Interview with Linda

S/N	Questions	Subject's Responses
a.	What is your name?	Linda
b.	How are you?	Hungry is inside my belly
c.	How old are you?	I no fit know that one
d.	What is the name of your baby	Baby ooh! My baby ooh! Give me back my baby. Na my own and take your own baby.
e.	Are you married?	My baby ooh! Hmmmm, My baby ooh! (She stopped … then said) I no get am for plenty children. Yes! You don take my baby … come am want to go out to the workshop.
f.	Linda, tell us about yourself	My name is Linda, I am from Akwa-Ibom state. The next day when I go out, I took control, I dey like orange! (paused), I put Omo on my hair and I took the keys and I come back from market

In Table 11, it is observed that Linda has problems expressing her thoughts correctly. She seems to be deeply affected by the absence of her baby to the extent that she bemoans her baby even when the question is unconnected to the baby. Thus she responded in an abstract and tangential manner. She needs people around her, she needs strong support from family and friends to be able to gain greater independence, and lead fulfilling life.

Interviews recorded in Cases (7) – (9) illustrate that the language of subjects with disorganized schizophrenia frequently reflects monotonous and inappropriate responses to questions. They display acute loose association of thought, meaning that one thought does not logically relate to the next. Disorganized schizophrenics may also not be able to recognize the fact that they are human beings and in fact, they misrepresent their environment

Interpretation

It is obvious from the data elicited from the subjects based on the different types of schizophrenia in Cases (1) – (9) that generally, the language of the schizophrenics is marked with serious traces of disorganized thoughts, inappropriate responses to questions, and lost to reality. This means that there is no neat dichotomy among the different types based on our data even though certain peculiarities exist in each of them. Thus, as a matter of peculiarity, the language of the catatonic schizophrenic patients manifest poverty of speech, speech hesitation, smiles or laughter, unresponsiveness to questions, emotional flatness and the like. The language of patients with paranoid schizophrenia is marked predominantly with suspicion of people around them, false beliefs about self, repetition of utterances, unrelated responses to questions, etc., while that of the disorganized schizophrenic subjects often show acute loose association of thought and sometimes, inability to recognize the fact that the patients are human beings, and they seem to be unaware of their environment.

Language Use by the Schizophrenic Subjects

This section reveals the communication area and linguistic features that often characterize the pattern of deviation in the language of the schizophrenic patients. They are discussed under the communication content and disordered linguistic features of the schizophrenic subjects.

Communication Contents of the Schizophrenic Subjects

From the background information of the subjects in our data, it is clear that schizophrenic patients at the Amaudo Home for the Destitute have difficulty speaking and expressing themselves. Most of them are completely lost to reality. They cannot differentiate what is real (reality) from what is imagined; often times they are not aware that they are sick and need help, consequently their communication or language is characterized by disorganized sentences, unintelligible utterances, inappropriate sentences, pauses, unusual behaviour and perceptions. Their speech samples as recorded in the data obviously shows a deviation from the normal communicative pattern. They manifest features such as poverty of speech (alogia), derailment, distractible speech and tangentially as given in the following subsections.

Poverty of Speech (Alogia)

Poverty of Speech or alogia, according to Andreason (1986:474-482) is a general lack of additional, unprompted content seen in normal speech. As a symptom, it is commonly seen in patients suffering from schizophrenia, and it is considered as a negative symptom. People with alogia also slur their sentences and have difficulty pronouncing some of the consonants in certain words. An example of alogia in the speech of the subject in Table 4.3 is renamed here as Table 12.

Table 12: An Example of Alogia

S/No.	Questions	Subject's Responses
a.	Gini bu aha gi? 'What is your name?'	Silence!
b.	Ole otu I di taa? 'How are you today?'	I … I … (Paused)….Ify
c.	I ma ihe mere I ji bia ebe a? 'Do you	Eehn. 'Yes'

	know why you came here?	
d.	O! Ọ dị nma. Ngwa, gwa m ihe mere I ji bia ebe a. 'Ok! It is alright. Tell me why you came here?'	No response
e.	I rie la nri taa? 'Have you eaten today?'	Ahu oku na eme m. 'I have fever'. Ofu nwa kam muru, precious, precious. 'I have only one child, Precious Precious'
f.	Aunty Ify, I na amukwa aka oru na ebe a? 'Aunty Ify! Are you learning any trade here?'	Hmnnnn…..eeehn…ana m … amu Precious 'Hm … yes … I am … learning … Precious'

The data in Table 12a-d and 12f show that people with the negative symptom, 'alogia' rarely respond to questions and when they do as in 12e, the response is usually very brief, signifying that they do not have the capacity to make spontaneous additions to the responses of the questions asked. The response is also inappropriate. The authors, therefore, advise that if such symptom is noticed in a person, even if other behaviour of that person is normal, the candidate MUST be checked properly for traits of Schizophrenia.

Derailment (Loose association or knight's move thinking)

Derailment or loose association is a thought disorder characterized by speech comprising a sequence of unrelated or only remotely related ideas. It is a situation where the speaker derails from the topic of discussion to another which is obliquely unrelated (Blueler 1950:147). We observed a lot of derailment in the responses of our subjects. A typical example is taken from part of the interview with Linda in Table 4.11renamed here as Table 4.13:

Table 13: An Example of Derailment

S/No.	Question	Response
a.	Linda, can you tell us a little about yourself?	My name is Linda, I am from Akwa-Ibom state. The next day when I go out, I took control. I like orange..! (Paused). I put Omo on my hair and I took the keys and I come back from market

Linda actually started off on the right track to the question in (13) by stating her name as well as her state of origin. She, however veered off to other topics unrelated to the question such as … *I like orange…*; *I put omo on my hair…I come back from market*. Schneider's (1930) record of a schizophrenic has similar symptom with our subject Linda. To his question, *Do you like to dance?,* the patient responded thus, "*The traffic is rumbling along the main road. They are going to the north. Why do girls always play pantomime heroes?* Thus, our data lend credence to the fact that patients with derailment wonder from one topic to another which is not related to the subject matter.

Distractible Speech

Distractible speech is a situation where the speaker finds it extremely difficult to maintain a topic of discussion due to distractions from nearby stimulus (Hopkins, 2017). It is a kind of distractions of train of thought to ideas that are associated with external stimulus. An example is seen in part of Table 4.6 with Victor renamed here as Table 4.14:

Table 14: An Example of Distractible Speech

S/No.	Question	Response
a.	Where do you live before you came here?	I live in Umuahia, then I left Calabar and moved to Abuja … Did you see me yesterday? Where did you get that phone (pointing at my phone). My computer spoiled and my radio is talking too much.

The different utterances produced by Victor in response to the question in (4.14a) demonstrate a clear form of distractible speech. Victor's response contains about four (4) ideas in one; none of which is related to the other. It is observed that he changes topic of discussion in response to a stimulus, particularly, when he was querying the source of the phone in the interviewer's hand.

Tangentiality

Tanner (2003) observes that tangential speech or tangentiality is a communication disorder in which the train of thought of the speaker wanders or shows lack of focus, never returning to the initial topic of conversation. Prior to diagnosis, tangentiality is significantly associated with low IQ. An example is seen in the interview with Okechukwu in Table 4.7 renamed here as Table 15:

Table 15: An Example of Tangentiality

S/No.	Question	Response
a.	Okechukwu, where are you from?	Mbaano village … Chima came into the shop and then he opened the wall. He switched on the light and then looked into every corner for the snake.

Similar to Linda's response to the question in Table 13a, Okechukwu succeeded in stating his place of origin but instead of concluding it at that point or supplying more pieces of information that would make it easier for one to locate his home, he introduced other topics and never returned to give further information concerning his home. The foregoing are some of the speech patterns characteristic of schizophrenic observed in our data.

Disordered Linguistic Features of the Schizophrenic Subjects

From the interviews with the schizophrenic subjects, we observed certain disorders reflecting the semantic, pragmatic and syntactic features in their use of language. They are highlighted in the following subsections.

Semantic Disorder in the Schizophrenic Speech

Semantics is the aspect of linguistics concerned with the meaning of words, phrases and sentences (Lobner, 2002:3; Saeed, 2003; Ejele 2014:144) as well as using them appropriately in speech. Schizophrenic patients with semantic disorder have problems understanding the meaning of what other people say and their inappropriate use of speech makes it difficult for the listener to comprehend exactly what they mean. An example of this is observed in some aspects of Chinonso's speech on Table 9.

The subject's response to the question in Table 9e reveals the use of contradiction as in ... *you eat sweet bitter things*. Something cannot be *sweet* and at the same time *bitter*. Semantically, the subject is seen recounting her life experiences in the home as *sweet bitter*. The word *sweet* in this context could be said to mean her earnest desire to be well again and be united back to her family, whereas the *bitter* aspect could be referring to the taste of the drugs or the pain of the injections she receives daily in order to get well; the emotional trauma, and the loneliness she has to deal with in the course of the illness. She does not know how to harness the opposing experiences she encountered in the home. It is further noted that Chinonso misinterprets the idiomatic expression *spend time* in the question, *Do you enjoy spending time with your friends?* Her response is *I don't like that time and how can time be my friend ... go and call time for me.* Chinonso has also lost touch to her personal identity as a human being. She could not differentiate between an object and a human being. No wonder she responded *yes* to the question, *Are you a table*?

Semantic disorder is also observed in Stephen speech in the expression … *I am blind and deaf, I cannot talk ...* in Table 8c. To the best of our knowledge during the period of data collection, Stephen was not blind neither was he deaf nor dumb. He could not be blind and still saw the interviewer, or be deaf and heard the questions asked, neither was he dumb and still responded to the questions even though not appropriately. Thus, his utterances give a wrong picture of who Stephen is. These and many more, therefore, account for the semantic deviations that are characteristics of the schizophrenic.

Pragmatic Disorder in the Schizophrenic Speech

Pragmatics is an aspect of linguistics that studies language from the user's point of view (functional perspectives) in terms of the choices he makes, the conditions that influence his use of language in social interaction (Anyanwu & Ndimele 2001:23, Mey 2001:6, Yul-Ifode 2001:23). People with pragmatic disorder have a great difficulty using language socially in ways that are appropriate. They are not conscious of the fact that people take turns to talk when communicating with one another and they interrupt indiscriminately talking about inconsequential matters.

A typical example of pragmatic disorder is found in Table 3 of the interview with Ifeoma. To the question, *I riela nri taa?* 'Have you eaten today?' Ifeoma's response was *Ahu oku na eme m* meaning 'I am feverish'. She followed it up with *ofu nnwa ka m mụru* 'I gave birth to one child'. Both the first and second responses addressed the question wrongly; there is no direct link between the question and the response. Thus, Ifeoma's response to this question is pragmatically inappropriate and unacceptable in the context of use. She lacks the pragmatic language skills to function appropriately in conversations, hence the breakdown in the pragmatic functioning.

Likewise, part of the expression of Chinonso in Table 9f has a wrong collocation. A part of Chinonso's responses to the question, *Do you comb your hair every day?* is '… *Help me bring the elephant*'. This is obviously wrong as the majority of Nigerians have not seen an elephant physically except perhaps in the zoo. It is not a common animal in our environment and the size is not what can be brought in the manner in which the subject expressed it. It means that the patient is oblivious of her request.

A similar expression that has a pragmatic disorder is the response **'…** *Is cucumber not brave?,* as part of Chinonso's response to the question, *Do you comb your hair every day?* in Table 4.9f. Bravery is an attribute that collocates with human being or animals and not a vegetable like cucumber. Pragmatically the patient may have imagined cucumber as human for her to qualify it with bravery. An edible vegetable as cucumber cannot be brave and does not have the quality to act brave because it is an inanimate object.

The foregoing examples of pragmatic disorder in our data reflect the fact that the relationship between language and context is obviously disordered in schizophrenic patients' speech, despite the fact that the utterances may be grammatically correct.

Syntactic Disorder in the Schizophrenic Speech

Although, schizophrenic speech often does not make sense, its syntactic structure appears to be normal even when it is difficult to understand the meaning or purpose of it. Schizophrenic patients tend to simplify the complexity of the sentences they produce and also have difficulty in understanding complex structure sentences. To this, Morice & Ingram (1982:11) affirm that schizophrenic speech is accompanied by a reduction in syntactic complexity and impairment in syntactic comprehension. Consider the following conversation with the subjects in our data.

In Table 7c, Okechukwu used the expression, *My age is old. Old is here. Are you seeing old age?* to answer the question, *How old are you?* This is a typical case of syntactic disorder in the speech of the schizophrenic. Although the responses are simplified as much as possible by the schizophrenic, they failed to give correct answer to the question and are grammatically and semantically unacceptable. For instance, the word, *old* in *old is here* is an adjective that lacks the appropriate noun it should modify in the subject position to make it acceptable and meaningful. Okechukwu also tends to personify the phrase, *old age* in *Are you seeing old age?* As if it is an object that can be seen. In fact, the entire expression demonstrates utter confusion and meaninglessness in the use of language by the schizophrenics

Furthermore, the expressions, *She cooked a bag of bread and I drink bread and water. But I don't understand why Chima is spying on me through that television* is syntactically unacceptable in grammar. Bread cannot be cooked rather it is baked. You don't also drink bread but you eat it. More so, you don't spy on people through the television, you watch their reflection(s) on the television, particularly, if it is switched on as was the case in the Destitute Home on the day of the interview. It cannot be said to be a case of the television serving as a mirror to show the reflection of people in the room because the television was turned on and there was no one known by the name Chima in that room. Observe that the disorder is characterized by moving from one idea to an unrelated one without returning to it. These and many more are the syntactic disorder observed in the speech of the schizophrenics.

The Role of the Clinical Linguist

There is need for the schizophrenic to regain some of the skills he has lost in course of the illness to a reasonable extent. To function as a member of the society, he needs the help of a clinical linguist. Although the management of the symptoms of the schizophrenic is the primary domain of the pharmacotherapy with the use of antipsychotic medication, the clinical linguist has some roles to play. Thus, this study can act as a guide to the clinical linguist on how to help the schizophrenic regain or rebuild his social skills, thinking skill, planning skill, emotional skill, pragmatic skills, etc. The clinical linguist will help to discuss topics that can help to rebuild the pragmatic skill of the patient; guide the family members on how they can communicate with the patient. Counselling, job or skill training, and social rehabilitation can also be adopted alongside to help the schizophrenic live a meaningful life.

Summary of Findings

Language is a communication medium. The act of communication is only complete when a person can understand others and express himself appropriately. It is evident from this study that the schizophrenics cannot properly engage in any meaningful discussion with others and this poses a huge challenge to the individual, family members and the society. It is observed in this work that the schizophrenics lack the ability to provide communication content necessary for normal conversation. They are unable to maintain topic of discussion due to distraction from nearby stimuli. The schizophrenics lack focus and do not return to topic of conversation. They wonder from one topic to another that is unrelated to the subject matter.

Considering the linguistic features that make it difficult for the schizophrenics to communicate effectively, the paper noted semantic disorder, pragmatic disorder and syntactic disorder. Semantically, the subjects rarely understand the meaning of what people say, while on the other hand, their listeners find it difficult to comprehend exactly what they mean due to inappropriate use of speech. In terms of pragmatic disorder, the schizophrenics hardly use language in the right context. They have a great difficulty using language socially in ways that are appropriate. Thus they often provide wrong responses to most of the questions asked. Syntactically, the schizophrenics have difficulty understanding complex structure sentences. While the structure of their sentences may be simple and correct to some extent, the schizophrenics do not understand the purpose of it. Thus, they are unable to connect effectively with others for meaningful conversation.

During the period of data collection, some issues were observed in the home. One is that the Amaudo Destitute Home has no speech therapist, language clinician or remedial language teacher to support these patients when they go bizarre in communication. Also, the home is privately owned and do not have resident doctors to adequately care for the patients. Furthermore, the destitute home management depends basically on drug treatment to arrest all the symptoms of schizophrenia, neglecting the verbal communication abnormality that comes with the illness which needs the attention of a language therapist. The presence of these professionals in the home would have facilitated a better improvement of the patients.

However, we noted a sign of improvement in the Amaudo Home for the Destitute despite the absence of the speech therapist, language clinician, or remedial language teacher. A typical example is Emeka in Case (3). After receiving medical and therapeutic treatments for five years,

Emeka was certified okay to reunite with family and friends even though he is not completely free from the symptoms. Emeka needs to continue with his medication at home, signaling that the treatment may last for a long time.

Conclusion

This study provides a kind of situational report on the language use of Schizophrenics in the Amaudo Home for the Destitute. From the work, it is evident that schizophrenic patients are faced with huge difficulty using language and communicating appropriately. The fact that these challenges can be identified is a step towards the possibilities of having a solution. Early interventions aimed at improving the condition and engagement of schizophrenic patients in social activity is a priority to prevent further episodes. The paper observed that there are no capable language teachers or clinical linguists to help patients in their struggle to communicate and be understood. The services of other professionals like the clinical linguists would facilitate the improvement of the patients' health, particularly, that of Emeka, who was certified fit to reunite with his family but was still manifesting disorder in his speech. Thus, medication alone cannot handle language and communication impairments of schizophrenics but a combination of different kinds of treatments can.

Recommendations

Observing that the Amado Home for the Destitute is privately owned and its management depended basically on drug treatment to arrest all the symptoms of schizophrenia neglecting the verbal communication abnormality associated with the illness, it is recommended that:

1. Government should provide a community base mental health care services; integrate mental health care totally into the primary health care system and undertake a periodic review of the legislation governing the care of mental illness.
2. Services of the speech therapist, language clinician or a remedial language teacher should be employed to assist the schizophrenic patients when they go bizarre in communication.
3. The public should be sensitized on the symptoms of schizophrenia for early identification, intervention and lifesaving opportunities to be possible and available.

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