Language and psychiatry

Language matters and, it seems there isn't a day in which psychiatrists do not concern themselves with issues of how they and others use language. They strive for an ever-better way of phrasing things both globally, for example, in diagnostic manuals, or locally, in conversations with their patients. I want to offer the comments of a linguist interested in "discourses of psychiatry". My comments are focused on three parts. First, on the 'nature of the message'; second, on who communicates it; and finally, on how to make sense of that message.

Let me start with a linguistic truism: there is no neutral language. No matter what you say or write, you always do it from a particular point of view. Every form of language use carries with a host of assumptions about the world, the interaction you are engaging in, the person you communicate with or indeed yourself. The never-ending discussions about nouns (often referred to as labels) used in psychiatry are not discussions about using neutral language, but, in fact, about what kind of (ideological) assumptions are preferred when speaking or writing. Should we say "patient", "service user" or "survivor" is not at all a question of language, as is not the choice between "commit suicide" as opposed to "die by suicide". These are discussions about preferred worldviews, which, incidentally, I find very rarely explained in detail and argued for in all their nuance and complexity.

For a linguist therefore, language is never a transparent window into the reality it represents. Language constructs reality, invites a view which can never show the "whole picture", no matter how much we try. But this lack of transparency extends further, and so, let me ask the question of who speaks.

Now, let's consider a very simple exchange:

> Doctor: Hello, Dariusz!
> Me: Hello, Doctor!

This apparently innocent interaction constructs our relationship. When you decide to call me by my first name, you take a stance as to where you want to position yourself regarding me, and vice versa. My response also situates me in our relationship, as I complete setting this up, in terms of power and asymmetry. As we speak, we situate ourselves with regard to each other, forging our relationship both socially and communicatively. A similar situation to asymmetry in how we address each other occurs, if you can ask me questions, sometimes very intimate, about me, my life, and my experiences; you can tell me to do things, but I cannot reciprocate.

Putting it in a different way, every act of communication is also an act of positioning of the speaker and addressee in terms of what kind of rights and duties they have with regard to themselves and each other. The question of context should not therefore be asked only in terms of the social roles such as "doctor" or "patient" but also, and perhaps primarily, in terms of whom you construct yourself to be, doctor, as you speak to me, your patient.

What it looks like from the patient's point view, can be rendered well by the following excerpt from a research interview with a patient with the diagnosis of depression (ICD F33). The interview took place immediately after the initial assessment interview of a patient by a psychiatrist on the ward. I present a translation from Polish here:

> Researcher: What did you talk about with the doctor?
> Interviewee: I didn't talk with the doctor.
> Researcher: ???
> Patient: The doctor asked questions, I answered. We didn't talk.

Though we have no access to what actually happened in the interaction between the patient and the doctor, the exchange above constructs the interaction in terms of asymmetrical positions inhabited by the medic and the patient. It is the doctor who is only constructed as authorised to initiate communication (asking questions), while the patient has only the right to respond. This asymmetry is constructed so strongly that the patient is unable to call the interview a conversation, ie, an event where all participants are on equal footing and can contribute to it at will. There is therefore no sharing of experience, no telling of stories, the channel of communication is open by the psychiatrist and closes when the patient answers the question.

The reflection on who you are in relationship to me, your patient, should, I think, go hand in hand with considering what you do when you speak to me. What do you want to achieve?

When I talk to clinicians, whether psychiatrists or psychologists, about the way they speak to their patients, I often ask:

> Why did you say this?

and, consistently, I am surprised with the absence of a meaningful answer.

Communication is a goal-oriented activity. When we say something to somebody, we want to achieve something. When we promise, inform, request, warn, or ask questions, we want to achieve commitment, knowledge, compliance, or get information, respectively. Moreover, we might also want to get our addressees to laugh, to get angry, to go on a date, or to think we are knowledgeable. We might also want to pass time, as we chat with a complete stranger stuck on a long-haul flight. In fact, this very article has quite many complex communicative, social, professional and, indeed, personal goals which I want to attain, which go far beyond passing offering comments to my readers.

The question of what goal psychiatrists want to attain when they say something to their patients is therefore a question of communication basics. And yet, whenever I pose this question to clinicians, more often than not it is met with bewilderment. When I insist on answers, I get either pronouncements of seeking some clinically relevant information or, less often, a perhaps slightly more sincere 'I don't know'.

And so, I would like to suggest that, in contrast to the dominant perspective, clinical communication, should not be viewed in terms of skills which are employed, but primarily in terms of goals attained through it. It is considerably more important that you can tell me *why* you paraphrased or mirrored what the patient said than *that* you did it. This is because whenever you speak, doctor, you achieve things, from my response, through building our

relationship, all the way to me feeling listened to. Or, as the case may be, you fail to do so. It is understanding *what you want to achieve* that makes you a conscious deliberate communicator, who is aware of your role in the particular interaction in which you find yourself. And an account of your use of communicative skills must be seen as secondary and ancillary to such awareness.

Consider now another excerpt (again in translation from Polish) which is part of a longer exchange about the patient's relationship with the father of her child:

> Doctor: So, half a year after the child was born, you split up.
> Patient: Is it relevant?
> Doctor: Oh, simply, just family history. Just an interview.

The patient challenges the question she is asked, arguably, questioning its justification. I would speculate that the challenge results from a suspicion that the doctor takes liberties in being too nosy about the patient's life. Interestingly, however, the doctor does not answer the patient's question! But what is crucial here is that the physician implicitly asserts her right to ask her question because…it is an interview. Again, it is unclear at all whether the clinician was actually aware of why she had asked the question; the patient's challenge caught her off guard. Or perhaps she really did want to insist on her right to ask any question.

Communication between the doctor and the patient breaks down precisely because the implied question "Why do you say this?" gets no answer. The patient does not know why the doctor asks her the question and the doctor doesn't explain. It is also worth noting that in the interaction that follows (unquoted here) the patient changes the topic and does not provide an answer to the doctor's question.

And herein lies my final point here. Instead of wondering about 'language', I would prefer much more worry about how one particular doctor speaks to one particular patient, in a myriad of configurations of individual doctors and individual patients. Here and now, why do you say this? How useful is what you say to you, to your patient, to both of you? This approach to communication, further, lets you prioritise your objectives, from clinical, through social, to institutional and to probably many others.

There are two (explicit) goals of what I have written above. First, I wanted to comment on what I see as a current preoccupation of psychiatry (and psychology, incidentally) with language. The quest for ideal, or simply better language is doomed to fail as such discussions are not, in fact, linguistic, but political. They are about preferred worldviews, forever leaving some people outside.

Second, I wanted to suggest a perspective which, in my view, is more useful insofar as it encourages self-reflective communication, which consciously sets out to achieve communicative, social, or therapeutic goals. I suggest that clinicians should be seen in terms of rights and obligations which are constructed through what they and their patients say. I also propose that clinical communication should not be seen as a toolbox of communication skills which are used by doctors, but, rather, as a goal-directed activity. The question of why something is said, what you want to achieve when you speak with me, is, in my view, considerably more important than that a particular "skill" is used.

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