Language as a Determinant of Psychosocial Health

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Language is the fundamental tool of communication, and it is generally assumed that the ability to communicate is a fundamental human attribute that allows the individual to function productively in society. However, linguistic issues are often overlooked in situations where an individual or group is experiencing difficulty integrating into or functioning appropriately in some social context. This paper will consider the role of language as a determinant of psychosocial health. Specifically, it will outline some of the psychosocial impacts of inability to communicate in the majority language and the potential health effects of communication problems that arise from linguistic factors (as opposed to physiological factors arising from abnormal language development). The inability to communicate fully in the society of residence has been associated with a wide range of psychosocial health issues and represents a fundamental element in social exclusion, which has also been shown to be a great significance in overall mental and emotional health. The issues raised here are especially relevant to Indonesia, where a majority of individuals are second language speakers of the national language of which high levels of mastery are required for full participation in modern society and the life of the nation and, at the same time, there are some 700 local languages in use by Indonesians in various parts of the country. To date, the impact of variable mastery of the national language at the population level has not received much attention as an educational, political or social issue not has its health impacts been considered.

It should perhaps not be surprising that language is a very important factor in psychosocial health. Language determines the way in which we think, express out ideas, and understand our experiences. These perceptions differ, depending on the language in question and the nature of the society that uses it. This linguistic relativity explains many of the differences in perception between different groups using different languages (see Kay and Kempton, 1984, for discussion on the evolution of linguistic relativity). Nonetheless, there are many common elements of the relationship between language and psychosocial health that are experienced by human beings, regardless of the language they speak and the culture in which they live.

Language and Identity

Language is central to identity because it represents a common, uniting element that links all the speakers of the language in question no matter where they are. This means that, no matter how many other differences there may be between individuals and subgroups within that language community, the way in which speakers of the same language share fundamental cognitive features in the way in which they understand and express their perceptions. Speaking a language provides an automatic link to others who speak the same language, even if their experiences are very different. This is the reason

there are commonalities between native English speakers, regardless of whether they are American, Canadian, British, or Australian, that will not exist between those same speakers and speakers of Indonesian or French or some other language.

For this reason, the loss of a person's native language can have very serious psychosocial consequences that are very detrimental to health. If a person is separated from the community that uses his or her native language, the need to interact in another language can be very stressful, even if the individual involved has a high level of fluency. In many cases though, it is difficult for people to master a second language to a high level, and they may experience some degree of linguistic isolation. Linguistic isolation described the situation where a person does not have the opportunity to use his or her first language and experiences difficulty using the language of the community. This situation is not uncommon and is often experienced by refugees, immigrants with low levels of education, people displaced due to conflict or disaster, the elderly, and people from very small language communities (Ward and Styles, 2003; Kerswill, 2006). In a multilingual context like Indonesia, linguistic isolation in varying degrees is surprisingly common because of the inaccurate but widespread assumption that everyone can speak Indonesian along with the very large number of local languages in active use across the nation.

Linguistic isolation is often dependent on context. For example, there are individuals who use their first language at home with family members but are unable to use the language of the place they live to the degree required to interact fully and effectively in the public environment. Others may have reasonable fluency in the majority language but little or no contact with speakers of their first language. Still others may have few opportunities to use their first language but have little or limited fluency in the majority language of the community. All of these situations may have serious psychosocial impacts on the people involved and contribute to a reduced state of health overall (Extra and Verhoeven, 1998).

The issue of linguistic identity is inseparable from a person's association with an ethnic group based on ties of heredity and tradition. Language then is part of the cultural background people inherit from their elders that links them to the customs and culture of their ancestors. Every person possesses this kind of background, even though most people are not consciously aware of it. The question of linguistic identity has frequently arisen in the context of political demands for recognition by individuals whose language and culture differs from the mainstream in the location where they live. In 18th and 19th century Europe, hereditary language was an element of the rising nationalist movements, and the modern European nations are very much defined by the language spoken by the majority of the public (see Barbour and Carmichael, 2000). In multicultural nations like Australia, several hundred languages are in use and are associated with immigration (see ABS 2007). In Indonesia and a number of other nations that gained independence following World War II, a large number of indigenous languages are in use and may exist alongside national and official languages established as part of the nation-forming process.

An important element of language use relates to the social markers contained in the speech of different individuals. All speakers are consciously or unconsciously aware that there are certain features of language use that align with social characteristics, such as geographic origin, educational level, social position, gender, age, and a range of other characteristics. The majority of speakers are quite sensitive to these social cues and subconsciously use this information to categorize other speakers as well as to adjust their own language. Every speaker has the ability to use the multiple codes and registers in his or her first language. For this reason, native speakers can switch codes instantly and correctly (in a social sense) based on the context (Crystal, 1997).

The ability to switch codes and use different registers gives native speakers flexibility in communication and provides a great deal of information about other speakers and the social context (Coulmas, 2005). If people are deprived of this information, either because they do not speak the majority language or do not speak it well enough to grasp its social nuances, they will be socially isolated and will also experience psychosocial impacts because they cannot communicate fully. These effects include depression and anxiety but also frustration, inability to form meaningful relationships, and boredom and isolation from the mainstream culture (Miller and Rascoe, 2004). Much of human social experience is mediated by language, and an understanding of the language in use provides enormous insight into other people and the social environment. It is also important to recognize that, in addition to these direct psychosocial impacts, linguistic isolation has many indirect effects that affect the psychosocial state of the individual. These include the impact of being unable to work, inability to fit into society, inability to make use of available services, and difficulty developing and maintaining social networks (see Amezquita et al, 1995; Alzpura and Fisher, 2008).

Language in the Context of Health

Language is a complex cognitive process and involves thinking, comprehension, aural ability, imitative ability, logic, time sense and many other aspects of the interpretation of individual and collective experience. Health and illness are integral parts of the human experience, and health care professionals rely on being able to obtain information from patients or clients that will help them treat the individual in the most effective way. Communication breakdown often occurs, however, when the cognitive frameworks of patient and provider are different.

The nature of a person's first language determines what is considered a symptom of illness, what situations require professional advice and assistance, how that advice will be understood and accepted, and whether and to what extent it will be implemented by the individual in question. In addition, ability in the majority language determines whether a person is able to explain their problem and how and to what extent any advice he or she receives will be interpreted. It is not just the verbal features of language that are significant in this context but also non-verbal mannerisms, such as facial expression, manner, tone of voice, and so forth.

Communication breakdown is, in fact, common in the healthcare context. It may occur when the health professional uses a different code or register than the patient or client. That is, the healthcare provider uses words and expressions to talk about health that are unknown to members of the general public, even if they speak the same language. Healthcare professionals tend to talk about their field using a jargon that marks them as members of their occupational group but that is not understood by people outside of that field. Communication breakdown occurs when meaning is constructed differently by health providers and their patients or clients. This is a situation where the cognitive framework is different, and the individuals involved categorize health information in different ways. An interesting example of this is use of the word 'cancer' in English. To members of the health professions, 'cancer' is a disease with specific and recognizable symptoms. There are treatments and approaches to managing cancer, and many types of the disease are now curable. This is a fairly new situation, however, and this ancient disease is terrifying to many members of the general public. In fact, before the mid 20th century when chemotherapy began to be available for the treatment of cancer, many English speakers felt it was inappropriate to even mention the name of the disease (see Mukherjee, 2010, for a history of cancer in human society). Generally, euphemisms were used instead, and it was common for people to go to great lengths to avoid mentioning this condition. The euphemism that someone died 'after a long illness'

is still widely used in obituaries and refers to death from cancer. This traditional understanding of the disease persists in English-speaking societies. In recognition of these social understandings, there are sets of guidelines for doctors about how to present a cancer diagnosis to patients, and a considerable body of research has developed that focuses on people's reactions to the language used by health professionals to discuss this condition (see, for example, Butow et al, 1996; Mitchell, 1998; Ellis and Tattersall, 1999; Chapman et al, 2003).

Finally, communication in the healthcare context can fail if the first language of the person seeking treatment does not have words for their condition, and they cannot conceptualize what the health professional is trying to tell them. This may occur when the patient speaks a language that does not have a tradition of internal medicine or is very different from the language in which the interaction is taking place. An example of this conceptual mismatch is the difference between *jantung* (anatomical heart) and *hati* (heart, as in a Valentine; anatomical liver) in Indonesian. An Indonesian speaking individual trying to express the conceptual difference between *sakit jantung* and *sakit hati* might well lead to great confusion if the health interaction took place in English, where *sakit jantung* must refer to 'heart disease' but *sakit hati* means 'upset'. There is no colloquial way to talk about 'liver disease' in Indonesia, likely because a conceptualization of the function of internal organs is absent in the languages of the region, and loan words are widely used in discussing this condition in the medical and healthcare context. For this reason, the meaning of *hati* that refers to the metaphorical 'heart' takes precedence in the cognitive framework of Indonesian speakers and represents a serious mismatch with English.

Communication breakdown in the healthcare context has great potential to result in psychosocial impacts because health concerns are naturally anxiety-provoking and may be matters of some urgency. The kinds of anxiety, frustration, anger, and other negative emotions that characterize inability to communicate appropriately and effectively in other contexts are likely to be magnified in the healthcare environment, and the effect of these emotions of the individuals involved are likely to be significant and severe.

Discussion

It is perhaps not surprising that language mastery and ability to communicate in the majority language is at the root of a set of psychosocial impacts that are linked to a wide range of health and social problems. As noted above, these psychosocial impacts include loneliness, depression, inability to form meaningful relationships, boredom, anxiety, frustration, embarrassment, alienation, and disconnection. Research has identified many health issues that relate to these affects in connection with language. They include:

- Immigrants to many countries report higher levels of drug use that decrease with acculturation (Grusser et al, 2005; Reimer et al, 2007; Prado et al, 2008);
- Foreign born children in the US tend to be healthier than US born children living in linguistically isolated households (Lucas et al, 2005);
- 40% of elderly Asians in New York have symptoms of clinical depression;
- Asian women aged over 65 have a suicide rate more than double that of white women of the same age (Treas and Mazumdar, 2002);
- The hepatitis infection rate among linguistically isolated Asians in the US is 15-20% but only 0.4% for the population as a whole (Levy et al, 2005);

- Linguistically isolated women experience domestic violence at a rate of 30-50%, as compared to only 16% for women in general (Pan et al, 2006);
- Children whose parents are linguistically isolated experience developmental, academic, behavioral, and social problems that persist into adulthood and may be passed from generation to generation (Yu et al, 2009).

Work in Australia has shown:

- High levels of acculturative stress are experienced by Sudanese immigrants due to linguistic isolation among other issues (Milner and Khawaja, 2010);
- Older migrant males from Italy experience depression at twice the rate of the non-migrant population of the same age and gender (Stanaway et al, 2010);
- Arabic speaking, Muslim migrants to Australia, especially females, suffer from depressive and anxiety conditions in direct proportion to their linguistic isolation and separation from their culture of origin (Khawaja, 2007).

All of these observations have been associated with linguistic isolation or ability to use the majority language at the level required to take part in ordinary interaction. However, it must be remembered that, while there may be numerous commonalities in the experience of different groups in different locations, it is necessary to take into account the specific characteristics of the society and culture the group originates in as well as those of the society they are living in. It must also be recalled that the impact of linguistic isolation is significant, not only in health, but also in education, employment, and other domains, each of which may be indirectly related to an individual's psychosocial state and overall health.

In the case of Indonesia, individuals may be linguistically isolated, despite living in their region of origin because of the domains for Indonesian and local languages, as well as the dynamic nature of developing varieties of language. For example, it is not unusual for older Indonesians to experience linguistic isolation that prevents them from using the media, including television, to the full extent because they cannot understand the informal, urban variety of Indonesian that is commonly used in entertainment and on the internet (see Fanany and Fanany, 2019, for discussion of this). More generally, the issue of mastery of Indonesian has rarely been studied, and the majority of Indonesians, including policymakers and education professionals, tend to assume that mastery of the national language is high (see Fanany, 2015). At the same time, it is frequently noted that mastery of local languages seems to be declining among younger speakers due to pressures from Indonesian and English that make these languages more desirable. The widely discussed *Perda Bahasa* are, in part, intended to address this observation (see, for example, Setyono, 2019). If not addressed, it is likely that psychosocial impacts associated with linguistic isolation will be increasingly felt in Indonesia and may represent an unanticipated source of mental and physical health problems among various groups with different levels of risk. These issues remain understudied, however, and it is not now possible to estimate their extent and potential impact, beyond the certainty that such issues do exist and seem to be increasing in seriousness.

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