

**THE EFFECT OF THERAPEUTIC ‘REALITY VALIDATION’ ON THE  
‘SCHIZOPHRENIC DANCE’: A PRELIMINARY STUDY**

**BY**

**BONNY WINT CAMERON**

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Supervisor: Prof. C. Vorster

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**DECLARATION**

I, Bonny Wint Cameron, hereby declare that the work on which this dissertation is based, is original (except where acknowledgements indicate otherwise and that neither the whole work nor any part of it has been, is being, or is submitted for another degree at this or any university or tertiary education institution or examining body.

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**B.W. CAMERON**

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**DATE**

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## ABSTRACT

The aim of this study was to determine the effect of therapeutic ‘reality validation’ on the ‘schizophrenic dance’ based on the principles of a therapy outcome study. The objective of this study was to reduce the observable degree of psychosis in the schizophrenic patient and to facilitate the patient into entering a closer relationship with the therapist through the use of a new therapeutic approach called ‘reality validation’. This was done using a qualitative, exploratory research design. The research was conducted by examining transcribed video recordings of the administered therapeutic ‘reality validation’ by a trained clinician with patients diagnosed with schizophrenia.

The analysis of the video recorded data was conducted independently by three trained clinicians who were each given the recordings along with the transcriptions of the recordings. The clinicians each gave a clinical description of each the patient’s behaviour separately during the sessions according to predetermined questions which were all indicative of the effect of ‘reality validation’ and were asked to conclude whether it had resulted in a reduction in symptomatic behaviour.

The analyses of the six ‘reality validation’ sessions showed promising results. Based on five of the conducted sessions, there were clear indications that with ‘reality validation’ there was a reduction in symptomatic behaviour. In three of the sessions ‘reality validation’ had been at times incorrectly conducted, impacting on the outcome of the study. In two of these three sessions reductions in symptomatic were less evident yet still clearly present. In one session ‘reality validation’ was conducted so inaccurately that it appeared to maintain or increase the patient’s symptomatic behaviour.

Despite the shortcomings in this study there was evidence to suggest that therapeutic ‘reality validation’ when used accurately can be an effective intervention, resulting in a reduction in symptomatic behaviour.

## **CHAPTER 1**

### **INTRODUCTION**

The study of abnormal behaviour is, according to Sue, Sue & Sue (2000), a journey into the known and unknown territories of the mind and body and has as its purpose the description, explanation, prediction and control of behaviours that are strange or unusual. Abnormal behaviour is defined essentially as deviations from what is considered normal or most prevalent in a sociocultural context and can manifest in a vast array of symptomatic behaviour ranging from mild stress to behaviour that deviates to a large degree from the norm, such as schizophrenia (Sue et al, 2000). Those studying abnormal behaviour, are trained to do so from multiple perspectives, including amongst others, biological perspectives and a number of psychological perspectives, which each provide a unique description and understanding of abnormal behaviour.

The perspective on which the current study is based is the general systems theory (Vorster, 2003). This theory provides a unique look at abnormal behaviour from a relational perspective. In other words, the theory describes abnormal behaviour in terms of how it manifests and is maintained within the person's relationships, especially the family relationships. Applied systems theory has enabled the therapist to move to an increasingly scientific approach to psychotherapy and to formulate solutions to behavioural problems from an inter-psychic rather than intra-psychic approach (Vorster, 2003).

Don Jackson was one of the pioneers of the interactional or inter-psychical approach to psychotherapy (Vorster, 2003). He focused on the observable patterns of interactions between individuals rather than focusing solely on the individual. From this perspective Jackson, together with Bateson, Haley and Weakland proposed a theory about how ineffective communication patterns between individuals could lead to the development of symptomatic behaviour patterns. The symptomatic behaviour patterns, in which they showed particular interest, were those of schizophrenia,

otherwise called the 'schizophrenic dance' (Vorster, 2003). They believed that like other symptomatic behaviour, schizophrenia was functional and adaptive to its context. Haley (1959) explains that through the behaviour characteristic of schizophrenia, the individual denies or avoids his relationships, thus creating a large interpersonal and emotional distance. According to Sullivan (1953), this symptomatology was an attempt to cope with anxiety within interpersonal relationships, while Watzlawick, Bavelas and Jackson (1967) explain that symptoms are developed to define, regulate and maintain relationships and in so doing enable the schizophrenic to regulate the emotional closeness or distance in relationships. This regulation in the schizophrenic relationship is of such an extreme nature that in effect the relationship is denied or negated.

From a societal point of view, this behaviour which renders individuals with schizophrenia largely unreachable, is a severely disabling mental disorder impacting heavily on the lives of the individual diagnosed with schizophrenia and those around them, such as friends and family. There have been many attempts to address schizophrenia from the various theoretical models, for example, the medical model which uses medication as the primary treatment for schizophrenia. However, the successes of most of these interventions have been limited and variable and the general view on outcome for those with schizophrenia remains pessimistic. This view goes right back to Kraepelin who believed that it was unusual for an individual diagnosed with schizophrenia to return to a complete premorbid functioning and that it was so rare that if an individual did indeed return to his premorbid level of functioning, he would question the initial diagnosis (Sue et al., 2000).

Within the context of psychotherapy, a particular difficulty posed is the fact that the schizophrenic seems to have learnt to perceive his world in terms of distorted communication (Bateson, Jackson, Haley & Weakland, 1956). As such, the schizophrenic has difficulty in distinguishing between what is real and what is not. This inability manifests itself in the form of hallucinations and delusions experienced by the schizophrenic as described by the Diagnostic and Statistical Model for mental

disorders, Fourth Edition (DSM-IV) (American Psychiatric Association (APA, 1994). Described differently by Freud (Bellak, Hurvich & Gediman, 1973), the individual has difficulty with reality testing. Yet, reality testing is not the only significant factor taken into consideration when studying the behaviour of the schizophrenic patient. Another important, yet mostly overlooked factor is the impact that empathy has on the schizophrenic patient.

The levels of empathy in the therapeutic relationship seemingly have a significant effect on the functioning of the schizophrenic patient. Oyston (1999) varied the intensity of empathy in the relationship with the schizophrenic patient and proved that there was a correlation between high levels of empathy and high levels of emotional distance in the relationship; whereas low levels of empathy correlated with higher levels of emotional closeness. Thus as the schizophrenic's relationships are characterized by 'distance', the use of high levels of empathy would render the therapeutic relationship ineffectual and the patient unreachable. From this it can be deduced that an approach with low levels of empathy may be necessary to create the basic conditions in which to work with the schizophrenic patient.

With these characteristics of the individual with schizophrenia in mind, it has become evident that an approach low in empathy, which simultaneously provides 'reality testing', may provide the therapist a small window of opportunity to gain access to the ever elusive schizophrenic in the initial stages of therapy. Thus the aim of the current study is to explore the effects of a non-invasive therapeutic approach called therapeutic 'reality validation'.

Chapter two will provide the literature review covering some of the relevant information pertinent to this study. It will include a brief outline of the history of schizophrenia and its treatments and outcomes, as well as the theoretical background to General Systems Theory and how this theory relates to schizophrenia.

Chapter three will present the investigation.

Chapter four will provide the research findings, the interpretation of the findings, as well as a discussion of these.

The last chapter, chapter five, will conclude with an overview of the findings and the limitations of the study together with considerations for possible future research.

## **CHAPTER 2**

### **LITERATURE STUDY**

#### **2.1 INTRODUCTION**

The term schizophrenia is one which stems from a history of documented behaviour which was initially labelled ‘dementia praecox’ in the early 1800s (Cancro, Fox & Shapiro, 1974). From its beginning, the literature on the subject has grown at an enormous rate and calls for some selective examination. The purpose of this chapter is to become acquainted with some understanding of the roots of schizophrenia as a concept, and to provide an understanding of the dilemma that schizophrenia poses to the individual, their families, the mental health care system and society at large. This chapter will also provide an outline of General Systems Theory which provides an interrelational perspective on schizophrenia. This will be followed by an examination of some of the intrapsychic theory relevant to the possible therapeutic tool being proposed in this study, namely ‘reality validation’.

#### **2.2 AN HISTORICAL OVERVIEW OF SCHIZOPHRENIA**

The literature on schizophrenia and behaviour patterns which fits with what today is called schizophrenia goes back many, many years. There have been many theories on schizophrenia, each of which provides a unique description and understanding of this phenomenon. However, when studying the literature and the unique descriptions which each provides and their interpretations of the phenomenon, they all appear to describe the very same thing, and that is that there is a great ‘distance’ which the schizophrenic puts between himself and the rest of the world (Vorster, 2008). In the following passages, a brief overview of some of these theories will first be provided, followed by an illustration of how these theories are in essence each describing a crucial element in the description of schizophrenia, which is ‘distance’ in the individual’s relationships with others.

The term schizophrenia was initially introduced by Bleuler in the 1900s, however the descriptions of behaviour which seemingly are parallel to what is today called schizophrenia goes back to ancient times when it was believed that individuals showing symptomatic behaviour were being possessed by evil spirits and were hailed as witches and the creators of evil magic and suspicious curses (Karon & Vandenbos, 1981). Other indications that ‘schizophrenia-like’ symptoms existed many years ago, even as far back as biblical times, are also present. For example, Cutting and Shepherd (1987) indicate that one of the earliest documented references of insanity is a biblical record in the first book of Samuel which describes an evil spirit troubling King Saul during his reign between 1020 BC and 1000BC. Even though there is no clear indication that King Saul did indeed have schizophrenia, there appears to be consistency between what he was presenting and some of the ‘schizophrenic’ symptoms described in current literature. Symptoms of schizophrenia as described by Sue et al. (2000) such as ‘delusions of persecution’, which is the belief that others are plotting against, mistreating, or even trying to kill oneself and bizarre behaviour, may have been misinterpreted as ‘evil spirits’ troubling individuals since at the time there were perhaps no alternative explanations for the bizarre behaviour. These descriptions suggesting that schizophrenia may have existed as far back as ancient times seem, however, to be inconsistent and it was only later that more comprehensive descriptions of this bizarre behaviour were formulated. One of these was given by Emil Kraepelin in his description of dementia praecox (Cutting & Shepherd, 1987).

### **2.2.1 Dementia Praecox/Pre-emptive thinking**

The term dementia praecox, which later became known as schizophrenia, was first formulated by Kraepelin in 1896 who provided a classical description of the disorder. He used this term to label what he described as “... the development of a simple fairly high grade state of mental impairment accompanied by an acute or sub acute mental disturbance” (Cutting & Shepherd, 1987). Kraepelin realized that symptoms, such as hallucinations, delusions, and intellectual deterioration were all characteristic of a particular disorder which he termed dementia praecox (Sue et al. 2000). Regarding

prognosis, he maintained that it was rare to see a significant reduction in symptoms and thus Kraepelin believed that these individuals had very little chance of ever recovering (Cutting & Shepherd, 1987). He divided the condition into three subcategories which he believed were subcategories of the same entity. The first was hebephrenia which was characterized by ‘aimless, disorganized and incongruous behaviour’; the next was catatonia in which those diagnosed presented as ‘negativistic, motionless or even stuporose’ and finally dementia paranoidis which mostly featured ‘delusions of grandeur and persecution’ (Warner, 1994). During this time dementia praecox was regarded primarily as a brain disease and was only considered different from other neurological conditions since there was a lack of any observable evidence of pathology during a post-mortem (Cutting & Shepherd, 1987). Kraepelin’s belief in natural disease entities with an independent existence was strengthened by progress in understanding the so-called infectious diseases: the finding that single micro-organisms, with an independent existence, were responsible for certain clusters of phenomena. Kraepelin accepted unquestioningly that the behaviour of asylum inmates was a manifestation of biological events, just as were the fevers, rashes and at times odd behaviours of those infected with various micro-organisms (Boyle, 2002). Thus, although the theory of this time indicated that perhaps schizophrenia was a ‘brain disease’, they had no evidence to confirm this and as such the description ‘mental disturbance’ can best be understood in terms of Kraepelin’s categorical descriptions of these individuals which painted a grim picture for the prognosis of these individuals.

Otto Gross wrote about the same condition in 1904 proposing that it be termed ‘dementia sejunctiva’. He suggested that dementia meant the process of dementing and that ‘dementia sejunctiva’ was a disorder of consciousness (Cutting & Shepherd, 1987). He spoke of disturbances in conduct and behaviour which he portrayed as inappropriate, perverse or senseless, which interrupts the execution of commonplace acts and might consist of perseveration, inhibition, or behaviour such as singing, biting or belching. He added that at the same time those with ‘dementia sejunctiva’ could carry out some other complicated action, such as counting, and that part of the patients behaviour can be put

down to an 'irregular lability of attention'. He theorised that this behaviour was due to loss of inner consistency (Cutting & Shepherd, 1987).

Thus far although there was no clear consensus on what to call this behaviour, the theories all describe behaviour which was strange or unusual with a poor prognosis which left the individual diagnosed with schizophrenia largely 'untreatable' or put differently 'untouchable'. It was not until Bleuler (1908) wrote his theory that the term 'schizophrenia' was introduced to describe this phenomenon.

### **2.2.2 The introduction of the term 'Schizophrenia'**

Eugene Bleuler (1908) moved away from descriptions of dementia praecox as being a disease-entity, instead he introduced the concept of a group of disorders which had certain symptomatic characteristics in common. He introduced the term schizophrenia in his article "The prognosis of dementia praecox: the group of schizophrenia's", translated by Cutting and Shepherd (1987). He described the phenomenon as a mental debility which follows an acute attack and continues to increase for some time after the acute symptoms have lessened. This 'mental debility' then reaches a relatively 'stable state', with longer or shorter periods of fluctuation. Bleuler de-emphasised 'poor prognosis', however he maintained that the fact that it was a relatively stable state was an important feature of the syndrome. One of the most relevant descriptions he made regarding the disorder was that it was a "lack of continuity in the associations between the patient's thoughts and a restricted or incongruous expression of emotion" (Warner, 1994). According to Bleuler, the fundamental symptoms were numerous and overlap one another. The central ones, however, are the disturbances of association and affectivity, the predilection for fantasy rather than reality, the inclination to divorce the self from reality (autism), and the experiencing of mutually contradictory impulse, wishes, or ideas (ambivalence) (Chapman & Chapman, 1973). He emphasised 'ambivalence' in his description of the group of disorders. One can imagine that ambivalence in relationships might have the impact creating 'distance' in the relationship. Also with a restricted

expression of emotion it may be possible that relationships with this characteristic are lacking in depth and can therefore be described as ‘distant’.

Departing significantly from these formulations, Freud provided his theory on schizophrenia during the same period; however he placed a greater emphasis on the intrapsychic factors. He provided a dynamic view of the inner struggle between the ego and reality, putting emphasis on the pathologic exaggeration of normal defence mechanisms (Cancro et al., 1974). According to Freud, schizophrenia was not a brain disorder; instead he theorized that it was a disturbance in the unconscious caused by unresolved feelings of homosexuality (Dolnick, 1998). Interestingly, he maintained that psychoanalysis would not work with schizophrenics because he believed they ignored the therapist’s insights and were resistant to treatment.

These early descriptions of schizophrenia provided the groundwork for more recent descriptions and theories on the subject.

### **2.2.3 Development of theory on schizophrenia**

During the 1930s, Kleist maintained that psychiatric symptoms necessitated neurological interpretation and sought out comparisons between functional disorders in psychosis and a corresponding deficit in brain damaged subjects. He attempted to explain schizophrenia in terms of the language and thought disturbance which occurred in aphasic subjects with recognizable brain damage (Cutting & Shepherd, 1987). Once again, unusual behaviour which separated these individuals from others, in the form of language and thought disturbance was being described.

Despite the great contributions of Kleist and the forerunners of theories on schizophrenia such as Kraepelin and Bleuler, there was as a large departure from the point of view on the nature of this ‘disease’ during the First and Second World Wars. During this period most schools of thought in different countries had their own opinion, which were mostly different from Kraepelin’s original theory (Cutting & Shepherd, 1987). This change

stemmed mainly from the absence of any detectable physical abnormalities and changed the focus to a social formulation due to the clear social deterioration rather than intellectual weakening.

However, somewhere in between this change, focus was turned to genetic factors as a causal feature in schizophrenia. Studies on genetic factors are an ongoing pursuit in the research on schizophrenia. Studies of blood relatives, twin studies, adoption studies and studies of high risk populations were and are currently being conducted in the quest to determine the aetiology of schizophrenia. Results from previous studies indicated reasonably strong support for the involvement of heredity in schizophrenia, however methodological problems were and continue to be pointed out in these studies (Sue et al., 2002).

Jackson (1960) also questions the over-generalization that there is overwhelming factual evidence for a strong genetic component in the aetiology of schizophrenia. Although it appears likely that hereditary factors do play a part in at least some of the schizophrenias, it remains to be established in what forms, and how vital a 'hereditary "vulnerability"' is. According to Jackson (1960) genetic studies in mental illness have not been of the calibre of investigations in certain other areas of medicine.

Despite the beginning of research in genetics as a causative factor, psychological and social theories during the 1950s and 1960s continued to evolve. These became so powerful that many came to believe that schizophrenia was just a label used to call those who did not fit into society 'mad', and that these people were not ill at all (Cutting & Shepherd, 1987). The newer social formulation paved the way to a new way of framing schizophrenia and is closer to the current description of schizophrenia as being 'distance' in the relationship.

Theodore Lidz spoke of 'schizophrenic thought disorder' as follows: "Schizophrenic reactions are a type of withdrawal from social interaction, and the thought disorder is a specifically schizophrenic means of withdrawal... the schizophrenic escapes from

irreconcilable conflict and unbearable hopelessness by breaking through these confines (of logic and meaning as defined by the culture) by using his own idiosyncratic meanings and reasoning” (Will, 1974).

Based on interpretations such as Jackson’s and Lidz’s, theorists such as Laing, Szas, Cooper, Scheff and Goffman, helped created a socio-political movement, which had as its intention the redefinition of psychosis as a social/interpersonal phenomenon rather than a problem or medical disease (Mosher, 1974). This movement toward a less linear – causal epistemology goes back to Sullivan whose ideas stemmed from his work in his earlier years which was focused primarily on schizophrenics (Oyston, 1999). During this period, in which Kraepelinian theory still had a large influence which held that schizophrenia was an untreatable and irreversible organic deterioration, Sullivan provided his theory which held that the real problem with those diagnosed with schizophrenia was a disturbance in the individual’s ability to relate to and connect with other people, which was a result of social interactions (Sullivan, 1954).

One study illustrating this difficulty in the schizophrenic’s relationships, found that fifty percent of schizophrenia patients had persistent deficits in social skills over a one year period, while eleven percent did not differ from non patient controls, and the remainder showed variable performances (Mueser, Kuipers, Sensky and Green, 1991).

The move toward an interpersonal theory which will be discussed in more detail in the next section, draws attention to the important and essential characteristic of schizophrenia pertinent to this study, which is ‘distance’ in the relationships of those diagnosed with schizophrenia. The way in which Sullivan frames schizophrenia helps make it clear that there is a large interpersonal distance in the schizophrenic’s relationships with others. However, when examining the literature discussed thus far, it becomes evident that there is a common thread between the different theories and perspectives on schizophrenia. The theory describes schizophrenia as having a poor prognosis and as being untreatable or very difficult to treat. From these descriptions, a picture is painted of individuals who are untouchable or unreachable in many ways, i.e. they have proved difficult to treat, they

isolate themselves from society, and they make use of exaggerated defence mechanisms and are ambivalent and lacking in expression of emotion in their relationships. Thus, despite the numerous attempts at treating or at least trying to gain access to these individuals, they appeared to maintain a large ‘distance’ between themselves and society.

This can best be illustrated by reading an unusual account of how an individual diagnosed with schizophrenia experienced his ‘illness’. This is quoted by Sir Aubrey Lewis in 1967, and was written by a boy of 18 years who had been ill for at least a year (Frith & Johnstone, 2003):

“I am more and more losing contact with my environment and with myself. Instead of taking an interest in what goes on and caring about what happens with my illness, I am all the time losing my emotional contact with everything including myself.... I sink into an almost oblivious existence”.

This interpersonal distance proves to be a stumbling block for those trying to relate to individuals diagnosed with schizophrenia and is the focus of the current study. In order to identify a possible procedure by which to overcome this large interpersonal distance, it is necessary to try to understand the relationships of the schizophrenic patient, and the best way to do this is by examining systemic interpretations of schizophrenia.

### **2.3 SCHIZOPHRENIA FROM A SYSTEMIC PERSPECTIVE**

Thus far most of the theories discussed have focused primarily on the individual, whether it is on a biological or psychological level, despite some shifts in focus toward the individual’s relationships. Family systems theory primarily focuses on the relationships that the individual has with others. The focal point is on the family which is considered to be enmeshed in a network of interdependent roles, statuses, values, and norms (Vorster, 2003).

Jackson, one of the pioneers of the interactional or interpsychical approach to therapy, emphasised the importance of the relationship context in which the individual participated, maintaining that the individual's characteristic behaviour patterns were forged in this context (Vorster, 2003). According to Weakland (1978), everyone has had opportunities to note that how one person deals with another, by actions and by words, may influence that other strongly, and at many levels, his thinking, feeling, speaking, and other behaviour, and that how the other responds in turn similarly influences the first, and so on indefinitely in any ongoing relationship.

This theory goes further to provide an explanation for how abnormal or symptomatic behaviour manifests in relationships. Weakland (1978) deliberately and persistently, in terms of the interactional explanatory model, tried to relabel schizophrenia as behaviour, and to look at its enviroing context of communication and interaction. Proponents of systems theory indicate that schizophrenia stems from interactions with family members and that family communication patterns can be so contradictory and intensely controlling that the person who is the target develops schizophrenia (Bateson, et al. 1956). This type of communication pattern is called "double-bind" communication and it is this form of communication pattern responsible for the interpersonal 'distance' in the schizophrenic's relationships. Bateson et al. (1956) explain the double bind as follows: a person in an important relationship which is deemed necessary for his survival receives two messages which are on different logical levels and which contradict each other. The person finds the contradiction difficult to detect and as such cannot comment on the inconsistency. This person finds him or herself in a double bind since no matter how he reacts he is punished regardless. Since the person exposed to this type of communication is unable to leave the situation because he is dependant on it for survival and he is unable to comment on the situation, the only way to respond to this type of communication is paradoxically, i.e. to communicate that you are not communicating (Haley, 1963).

The person exposed to long term interactions of this kind, learns to accommodate such interactions through symptomatic behaviour characteristic of schizophrenia. When an individual exposed to double bind communication has learned to perceive their universe

in terms of contradictory messages from the environment, the individual is no longer dependant on these mixed messages to perceive the world as such. Instead, the person exposed to communication of this kind for long periods begins to generalize all input from the environment as conflicting and becomes unable to differentiate between different levels of communication and use context to assign meaning to behaviour. The individual would then begin to experience problems in his relationships, since he sees all communication as paradoxical. Over time, this inability begins to manifest itself as the symptomatic behaviour (paradoxical behaviour) typical of the person diagnosed with schizophrenia, such as flattened affect, delusions and hallucinations, and incoherent thinking and speaking (Bateson et al., 1956). Vorster (2003, p.10) provides examples to illustrate this point and to indicate how this behaviour is adaptive to the context:

“...therefore he could present as obsessed with finding vital clues to give meaning to his experiences and as a result be diagnosed as displaying paranoid schizophrenia by a psychiatrist. He could also react literally to messages, declining to display any independent thinking and thus not distinguish between what was trivial or important, as is the case in undifferentiated schizophrenia. He could on the other hand choose to withdraw from interaction and relationships through hypo- or hyperactivity and be viewed as displaying catatonic schizophrenia.”

The effect that this behaviour has on the relationship is interpersonal/emotional distance as one gets the feeling that the symptomatic individual is unreachable. This unreachable symptomatic behaviour in systemic terms can also be called the ‘schizophrenic dance’. Explained differently the essence of the individual manifesting schizophrenic behaviour is that he denies his relationships since he communicates that he is not communicating (Haley, 1963).

Haley (1963) explains that normal people work toward a mutual definition of a relationship and manoeuvre each other toward that end; however the schizophrenic seems to avoid that objective and works toward the evasion of any definition of his relationship

with another person. The schizophrenic does this by negating what he says and invalidating any definition of a relationship by using qualifications that deny his communications. Haley (1959) describes four ways which the schizophrenic uses to avoid his relationships. First of all, Haley indicates that any message from one person to another can be broken down into four essential subdivisions:

- 1) I
- 2) am saying something
- 3) to you
- 4) in this situation

To avoid defining his relationship, the schizophrenic can negate any of these four elements by:

- 1) denying that he said something,
- 2) denying that something was communicated,
- 3) denying that it was communicated to the other person,
- 4) or, denying the context in which it was communicated.

An example of someone who denies that he has said something is an individual who maintains that what he says is not being said by him but by aliens speaking through him, likewise an individual who denies that something was communicated may negate what he said or done by saying that he does not remember saying or doing an action that he had in fact said or did. Thirdly, an example of someone who denies that he communicated a message to someone else may do so by indicating that he is talking to himself or indicate that he is talking to someone else by addressing the person who he is talking to by another name, such as the president. Lastly, an individual who denies that what is being said in this situation may indicate that he is in another place such as government offices, denying his presence in the current relationship. From the examples, one can see that the different ways in which the individual avoids defining his relationships are the symptomatic behavioural characteristics of the schizophrenic patient. According to Haley

(1963), the schizophrenic not only avoids defining his relationship with another person he also can be exasperatingly skilful at preventing another person, from defining his relationship with him. It is such responses which give one the feeling of not being able to reach the schizophrenic.

Watzlawick et al. (1967) in their description of the schizophrenic's behaviour, sum it up clearly. According to them the patient develops symptoms in order to define, regulate and maintain a relationship, and in so doing the patient regulates the emotional closeness or distance in a relationship. The schizophrenic does this in such an extreme manner that the relationship is in essence denied or negated.

Oyston (1999) attempted to validate the theory that the schizophrenic appears to regulate the emotional closeness/distance in his relationships. His study consisted of five men and women who had been diagnosed with schizophrenia. The subjects were each involved in a clinical interview in which a trained clinical psychologist attempted to vary the levels of empathy from extremely low levels to extremely high levels. Oyston's (1999) study indicated a significant inverse correlation between the variable emotional distance and levels of empathy suggesting that the 'schizophrenic' regulates the emotional distance within a therapeutic in a relationship.

This 'denying of the relationship', despite the numerous labels which it has been given over the years, such as 'dementia praecox' or 'schizophrenia' has been cause for concern for clinicians since the identification of this behaviour and it has been subject to numerous treatment methods over many years.

In the next section, a brief discussion of some of the methods used in the treatment of schizophrenia will be discussed.

## 2.4 TREATMENT OF SCHIZOPHRENIA

Some of the earliest treatments of schizophrenia were quite brutal in their approach. Motivated by fear of the unknown and the belief that these individuals were possessed by evil spirits, many of these individuals were swiftly disposed of (Cancro, 1974). Other later treatments were also somewhat radical in their approach, this included “warehousing” of psychiatric patients in asylums which were overcrowded and surgical procedures, such as prefrontal lobotomies. These treatments stemmed from medical concepts, of which the remnants can still be seen today since many of the currently operating state hospitals were founded between 1850 and 1900 (Mosher, 1974). The philosophy during that period was that “...isolation in a pleasant climate at some distance from the home, to avoid infecting others, was an effective form of treatment” (Mosher, 1974, p.282). However, these procedures were abandoned in the 1950s in favour of antipsychotic medication. To this day antipsychotic medication is the method most commonly used in the treatment of schizophrenia by those favouring physiological etiologies of schizophrenia.

The medication of schizophrenic patients is based on studies on the possibility that neurochemical factors cause structural changes in the schizophrenic brain. Johnstone in his study of schizophrenic patients found, with the use CAT scans, that many of the patients studied had enlarged cerebral ventricles (Henn, 2001). In more recent neuropathological studies, these findings are supported when examining post mortem samples of schizophrenic brains. Findings from these studies show that, on average, schizophrenic patients show larger ventricular volume than control populations and that there is the impression of cell loss (Henn, 2001). The idea that these anatomical differences are a result of neurochemical effects stems primarily from the dopamine (DA) hypothesis. Experiments on the effects of neuroleptics and amphetamines on DA receptors provided the basis of this theory and showed a strong link between psychotic symptom formation and dopamine (Henn, 2001). From this perspective on schizophrenia it is suggested that a toxic reaction takes place in early adulthood during which cells die and the schizophrenic process is triggered (Henn, 2001). However, the question still

remains and is largely debated as to whether the anatomical changes found in schizophrenic patients are caused by neurochemistry, medication, developmental defects or other environmental factors.

Despite some of the reported successes of this form of treatment, side effects such as Tardive Dyskinesia or late-appearing abnormal movement in chronic schizophrenics has been pointed out by as being a growing problem in patients, mainly chronic schizophrenics, who require prolonged maintenance antipsychotic drug therapy (Cole, 1980). Movement disorders are among the most common side effects; however there is also concern about others, such as agranulocytosis, sudden death and the tendency of antipsychotic drugs to be associated with convulsions, lupus erythematosus and breast cancer.

Atypical neuroleptics are a more recent introduction in terms of pharmacotherapy. These antipsychotic drugs when compared to typical neuroleptics have a better balance of antipsychotic efficacy when taking into consideration the extrapyramidal side-effects (Moller, 2001). However, despite these important advances, Lehman (1974) points out that pharmacotherapy cannot cure schizophrenia any more than insulin can cure diabetes; neuroleptic drugs can only suppress the manifestations of the schizophrenic pathology.

Despite the drawbacks in the medication of patients, such as the severe side effects of some of the medication and the difficulty in getting patients to comply with the treatment, most current treatment programmes focus on providing medication to reduce symptoms. These treatment programmes are, however, usually done in combination with some form of psychosocial therapeutic approach such as supportive counselling and behaviour therapy (Brenner, Boker & Genner, 2001). Many researchers and clinicians tend to agree that this combined approach has proved in the past to be the most beneficial treatment for schizophrenia.

Moving away from purely anatomically based treatments, the stimulus barrier theory on schizophrenia provides the basis for one form of psychological intervention (Eggers,

2001). This theory stipulates that early childhood experiences gained from personal interactions with caregivers are crucial for the normal development of the brain and in particular, the corticolimbic interactions. Treatment based on this theory emphasises the need for the psychotherapist to provide the experience of continuous mental concern for the patient without the threat of overwhelming mental pain. Psychoeducation is encouraged by those who base their treatment on the principles of the stimulus barrier theory, with the aim being to gradually enable the patient and relatives to develop better problem solving abilities and to handle interrelational conflicts more adequately (Eggers, 2001).

Cognitive behavioural therapy is an often used therapeutic approach in psychiatric hospitals where the focus is on addressing the patient's "delusional" thought patterns. One such programme by Beck begins with relaxation techniques followed by questioning of the patient regarding the delusional beliefs. A study on this therapeutic technique on schizophrenic patients by Kingdon and Turkington (1952) found no significant difference between outcomes of those treated by cognitive behaviour therapy when compared to the implementation of a control befriending group, which consisted primarily of a non-directive discussion around neutral topics. Another study indicating the use of a cognitive behavioural technique provides us with a description of a patient with paranoid schizophrenia, who began to understand his psychotic symptoms through the use of a variety of simple techniques (Kingdon & Turkington, 1952). An examination of the stressful antecedents of the emergence of his psychotic symptoms helped the patient to understand their origins. Thereafter, an appropriately paced use of reality testing techniques was used to chip away at the edges of a systematized persecutory delusion. Behavioural homework exercises were used to back up the in-session questioning techniques.

The importance of belief modification as opposed to confrontation in cognitive behavioural techniques is illustrated in Kingdon and Turkington (1952). They indicate that any form of confrontation, no matter how communicated, to the deluded schizophrenic, appears to further entrench and exacerbate delusional intensity and

distress. Instead, the simple ‘peripheral questioning’ should be used which would not directly challenge the basis of the delusion, but merely assist the patient in gathering information concerning related issues.

Various studies have been conducted to determine the effects of psychological interventions on schizophrenia. A thorough examination of all the literature is impossible due to the sheer amount of studies. However, a couple will be mentioned here. One study consisted of 212 patients from various institutions. The results showed that approximately three quarters of those who responded to a questionnaire indicated that individual therapy brought a positive change in their lives (Wykes, Tarrier & Lewis, 1998).

Another study focusing on group therapy with schizophrenics compared two types of group therapy which did not show any differences in therapeutic efficacy, but patients receiving either type of group therapy showed significant improvement in interpersonal functioning compared with controls (Wynne, Cromwell & Matthysse, 1978).

Despite the successes of some of the psychological interventions, there is still widespread pessimism about the usefulness of such interventions, i.e. psychological interventions (Bental, 1990)

Much of the theory thus far has focused on the interpersonal approach and as such a description of some of the treatment methods based on this theory is necessary. Haley (1963) gives a description of treatment methods used based on his theory that the schizophrenic aims to avoid any definition of a relationship. Prior to describing his treatment methods, Haley (1963) emphasises the context in which psychotherapy with a schizophrenic patient would usually take place. Traditionally, the schizophrenic patient would be treated in the context of an institution in which the patient’s life is circumscribed by the people in authority over him. Everything, including what the patient eats, what the patient wears, and when and where the patient sleeps is determined by the institution authority and within the context the therapist attempts therapy with the patient through individual conversation with him. Haley (1963) emphasises this point because it

frames whatever is said between the two people. Although the therapist may not have complete control in this context due to administrative needs, according to the patient the therapist is part of the staff hierarchy and thus is in control of what is to be done to him.

Haley (1963) explains that psychotherapy with a schizophrenic patient needs to be of a particular nature since the schizophrenic is unwilling to indicate that what he does is in response to the other person. Therefore, the focus of therapy is to persuade the patient to indicate a type of relationship and as such the therapist must gain control of the patient's responsive behaviour. Briefly, one way to do this is to force a relationship by essentially trapping the patient so that he is following the therapist's directions in whatever he does and he is therefore participating in a relationship (Haley, 1963). An example of this is that of a patient who once heard "voices" and improved. The therapist insisted that he hear the voices again. If the patient had heard the "voices" again on command, he would be following the direction of the therapist and therefore responding in a relationship with him, and if he did not, he would also be following the direction of the therapist since on a different logical level the therapist is encouraging the patient to stop hearing voices (Haley, 1963). Despite some of the success this approach has had, it has been the subject of much criticism with some believing this approach to be manipulative with too much emphasis on control in the relationship (Vorster, 2003). Thus a therapeutic approach which would also have as its goal 'to assist the patient in defining his relationships with others or at least taking his first tentative steps into entering the relationship' may provide those searching for ways to gain access to the schizophrenic patient with a platform to do just that.

## **2.5 TOWARD 'REALITY VALIDATION'**

The concept 'reality validation' is the culmination of a number of research projects and theories that have helped to explain schizophrenia and provide the groundwork for a new therapeutic technique. As discussed previously, systemic theory has helped us to understand the concept 'distance' in the schizophrenic's relationships which is the nodal point of focus for 'reality validation'. Before continuing with 'reality validation', the

theory by Glasser (1965) and his therapeutic approach which he called 'reality therapy', is distinguished from 'reality validation', while providing important theory on schizophrenia significant to this study. The concept 'reality testing' will then be explored followed by a comprehensive description of 'reality validation'.

### **2.5.1 Reality Therapy**

In order to enrich our understanding of the concept 'reality validation', a discussion on a particular approach to therapy called Reality Therapy, which closely relates to the subject will be presented. Also a distinction between the two concepts Reality Therapy and 'reality validation' is necessary to avoid confusion. Glasser (1965) was the founder of Reality Therapy. This approach is based on the theory that all patients have one thing in common and that is that they are all unsuccessful in their attempts to fulfil their needs, no matter what behaviour they choose to employ. According to Glasser (1965), these individuals deny the reality of the world around them. In their unsuccessful efforts to fulfil their needs, no matter what behaviour they chose, all patients have a common characteristic: they all deny the reality of the world around them. Glasser (1965) states that, whether it is a partial denial or the total blotting out of reality of the schizophrenic patient, the denial of some or all of reality is common to all patients. The similarity between this statement and the earlier description of the schizophrenic who 'denies the relationship' is evident.

Glasser (1965) maintains it is necessary with these individuals to assist the patient in giving up on denying the world and in aiding the patient to recognize that reality not only exists but that it is important for them to recognize this in order to fulfil their needs. A therapist who ignores reality by allowing blame to be put on the patient's family members or past, may temporarily aid in making the patient feel better, yet does not address the patient's ability to satisfy his or her own needs (Glasser, 1965). This approach is based on the principle that realistic behaviour is when the consequences of an action, produce satisfaction and that unrealistic behaviour is when the consequences of the action such as pain and suffering, exceed the amount of satisfaction gained from the action.

Thus it appears that the capacity to choose between two courses of action can be deemed 'reason' and is essential to the individual's ability to fulfil his needs. Based on these principles, Glasser (1965) introduced Reality Therapy, which has as its primary objective to support and strengthen the functioning of the individual's conscience or ability to act based on the reality of a situation and its consequences, as well as tackle the 'tangible' and 'intangible' aspects of the world successfully. This therapy can be described as a therapy toward 'reality'. According to Glasser (1965), the patient has basic needs which he maintains are fulfilled when an individual is involved with other people. These people, or at least person needs to be a person who we care about and who likewise cares about us. Without such an essential person (who is himself in touch with reality) we are unable to fulfil our needs. The needs fulfilled in such a relationship can be described as being able to love and be loved in return (Glasser, 1965). In other words, in a relationship individuals need to be able to affirm and be affirmed in their actions. An example is of someone who is unable to love. Such a person may shun other individuals in an attempt to avoid the pain associated with being in contact with those who he cannot admit to himself that he needs because he is afraid of rejection. The problem in this case is the individual's inability to behave in a manner so that he can give and receive affirmation. In this case it becomes important to him to become motivated to change his behaviour because as long as he shuns people, he is unable to fulfil his needs and will continue to live in isolation or suffer and in order to do this the patient must first gain or regain involvement with others, first with the therapist and then with others (Glasser, 1965).

According to Glasser (1965), psychiatry should be concerned with two basic psychological needs: the need to love and be loved and the need to feel that we are worthwhile to ourselves and others. Throughout our lives, our health and our happiness will depend upon our ability to do so. When we cannot satisfy our total need for love, we will without fail suffer and react with many familiar psychological symptoms, from mild discomfort through anxiety and depression to complete withdrawal from the world around us, since if we are unable to love, we may shun people to avoid the pain of being in contact with those we need, and we cannot admit to ourselves that we are afraid of

rejection. Thus, according to Glasser (1965), to obtain help in therapy the patient must gain or regain involvement, first with the therapist and then with others. The question then arose as to how the therapist can become involved with a patient so that the patient can begin to fulfil his needs? The therapist has a difficult task, for he must quickly build a firm relationship with a patient who has failed to establish such relationships in the past (Glasser, 1965).

Parallels between Glasser's theory on schizophrenia and the literature thus far discussed are evident, since the nodal point identified by Glasser, as is in the rest of the literature, is the lack of involvement of the patient or 'distance' in the relationship. However, Glasser's therapeutic technique addresses more than the 'distance' in the schizophrenics relationships, his therapy goes further by focusing on aspects such as 'acting responsibly' in the relationship (Glasser, 1965). This therapy is primarily a long term therapy and takes many consultations to change the ingrained behaviour patterns of the individual. The difficulty in accessing the schizophrenic patient in the initial stages of therapy, however, has already been discussed and is the point of departure for the proposed 'reality validation'. Thus Reality Therapy would be proposed as a possible long term therapeutic approach to the schizophrenic patient, whereas 'reality validation' can best be described as the beginning point of therapeutic input which aids in providing the first stepping stones to gaining access to the schizophrenic patient, which could then be followed by a more in depth therapeutic approach, such as Reality Therapy. It would appear that these two approaches would work well together. In other words, assisting the patient in coming into contact with reality, or assisting him to define his relationships with others.

### **2.5.2 Reality Testing**

In order to understand the meaning of 'reality validation', a comprehensive description of reality testing and how it relates to schizophrenia needs to be provided.

Freud initially defined the concept 'reality testing' as a learned procedure for the differentiation of internal (idea or memory) from external (reality). Freud assigned judgement a central role in reality testing, stating that an 'impartial passing of judgement' was necessary to determine whether a given idea was consistent with reality by comparing it with memory traces of reality (Bellak et al, 1973). Schafer illustrates this through the question asked by those experiencing difficulty with reality testing, "Is it real or did I only imagine it?" (Bellak et al., 1973). Thus reality testing is most often described as an individual's ability to distinguish between what is real and what is not real.

Freud (1930) summarized his view of the mechanism of reality testing as a learned procedure of deliberate direction of attention and suitable motor action for the differentiation of internal from external. He posited that reality testing could come about if the organism had the opportunity to determine whether an impression could be made to disappear following motor activity.

However, the differentiation between what is subjective and what is objective can be problematic. The reproduction of a perception as a representation is not always a faithful one; it may be modified by omissions, or changed by the merging of various elements. In that case, reality testing has also to ascertain how far such distortions go. Rubinfine (1961, p.80) describes reality testing as the distinction between inner and outer. However, he highlights that this is more difficult when external perceptions are not available and when mobility is restricted (the latter because motor movement will affect the perception of an outer event but not of an inner event).

Balint (1942, p.211) distinguished four aspects of the process of reality testing: (1) the decision whether stimulation originates within or outside the organism, (2) drawing inferences from the stimuli or sensations about what is causing them, (3) discovering the stimulus significance, (4) and finding the correct reaction to the perceived sensations. He illustrated this scheme by classifying psychopathological conditions in relation to it. Thus an incorrect decision or solution at step one would result in hallucinations, at step

two in melancholia, at step three (ascribing an incorrect meaning), in phobias and paranoia; and step four (incorrect reaction), in hysteria, obsessional, and anxiety neurosis.

Weis (1950) summarized relevant factors involved in the apprehension of external reality and its testing, in terms of direct perception (seeing, hearing, touching, tasting, smelling); indirect perception (information and facts about reality from parents, school, books); thinking (i.e. logical conclusions from direct perceptions or from memories); and experimentation and testing to affirm or refute the reality status of data (such as the origin of a sound heard in a dark room where one believes he is alone).

Schafer (1968) sees reality testing as involving varying degrees of the processes of perceiving, feeling, remembering, anticipating, forming concepts, reasoning, paying attention, concentrating, and the directing of interest to internal events and the external world. For Schafer, the crucial factor in the maintenance of adequate reality testing is a self-awareness variable he terms reflective self-representation: the awareness by the person that he is the thinker of the thought. When such awareness is not present, there is no basis for distinguishing between a thought and the concrete reality to which it refers, resulting in a drop in the level of reality testing.

The question thus arises: What is reality? Erikson (1962) first provides his description of reality and distinguishes it from actuality by stating that it is the world of phenomenal experience, perceived with a minimum of idiosyncratic distortion and with a maximum of joint validation.

However, this idiosyncratic distortion which Erikson speaks of seems inevitable taking into account cultural, religious, scientific and social contexts. That an evaluation of reality testing must take into account the cultural and scientific context in which the person lives, is demonstrated in Sachs' (1937) account of the life of John Charafambira. Sachs, an analyst trained in Europe, considered Charafambira to be normal. Yet he was described by Sachs as having a primitive notion of cause and effect, since Charafambira believed that most diseases (and insanity) were caused by poisoning from afar, and held

many other ideas based on witchcraft. These beliefs which he held can be attributed to his cultural and scientific context.

In the South African context, this point is relevant since in Africa witchcraft has become a topical issue in conversations as all kinds of misfortune are often attributed to witches. In South Africa, specifically in the Northern Province and Mpumalanga and the former Transkei of the present Eastern Cape, incidents of witchcraft accusations reported are abundant (Osei, 2003).

According to Silverman (1964), attention is an important factor in reality testing. He concludes that schizophrenics whose symptoms prominently include delusions (and thus poor reality testing) differ in the amount of scanning behaviour, and that schizophrenic patients who appear to be withdrawn from their surroundings and apparently directing attention away from the environment are actually engaged in minimal scanning (i.e. anchoring attention on dominant objects in the stimulus field) and /or in a global or poorly articulated attending to sensory input. He also attributes judgement a role in reality testing as it involves two types of decisions; one is affirming or denying that something has a particular property; the other is deciding whether a particular image exists in reality.

Similarly, Rappaport (1951) hypothesized a close connection between, and overlapping of reality testing, judgement and reflective awareness.

According to Vorster (2008), the essence of the psychotic process is that the psychotic individual is out of touch with reality and is therefore not partaking in effective 'reality testing'. The hallucination is as real and vivid as any other perception of the environment. No effective distinguishing between the two is in essence the psychotic state.

### **2.5.3 Reality Validation**

The fact that reality testing is such a key variable in respect of psychosis or schizophrenia gave rise to the question of active enhancement of a patient's ability to get in touch with

reality or to engage in effective reality testing (Vorster, 2008). If this process could somehow be enhanced or facilitated, the groundwork for a psychotherapeutic intervention in cases of diagnosed schizophrenic patients could perhaps be developed. Clinical observation showed that people tended to “test” their respective perceptions with each other whenever they found themselves in unfamiliar or threatening situations, e.g. if a sudden loud noise would unexpectedly occur, a typical reaction amongst those who had heard the sound would be to take a look at each other, enquiring whether the others have also heard the strange noise (Vorster, 2008). In other words, they will actively validate each other’s perceptions and interpretation under such circumstances. If this principle were extrapolated to the therapeutic relationship a typical scenario would be for the therapist to ask the schizophrenic patient to identify or name a particular object in the therapy room, such as an electric fan, a book, or some other object (Vorster, 2008). Once the patient has actually named the object, the therapist would then actively confirm the perception by agreeing that it is indeed a fan and so on, that the patient had identified. This could continue on a concrete factual level with the therapist and patient even leaving the therapy room and going for an outside walk while continuing the process of ‘reality validation’. Theoretically, a patient should become increasingly confident and certain of him or herself regarding reality testing and should as such be ‘pulled out’ of the psychotic condition (Vorster, 2008).

‘Reality validation’ is believed to have a very specific impact on the schizophrenic patient and takes into account what has been learnt from the literature thus far. This approach takes into account ‘empathy’ and its effect on the emotional distance in the relationship since the schizophrenic regulates the closeness/distance in the relationship. Since ‘reality validation’ has as a characteristic a minimal amount of empathy, it is proposed that there will be a higher level of emotional closeness as demonstrated in Oyston’s (1999) study and seen in the reduction in symptomatic behaviour. ‘Reality validation’ also addresses the individual’s ability to distinguish between what is real and what is not. The ‘reality validation’ directly influences the patient’s reality testing ability since the patient is able to test his perception of reality against the clinicians. Also importantly and possibly most importantly, is the impact on the schizophrenic’s ability to

avoid any definition of a relationship. During the ‘reality validation’ which provides the patient with a non threatening environment, the schizophrenic is required to respond to the therapist and thus, if he does so in a logical, systematic and congruent manner, he is defining or entering into a relationship and thus lessening the emotional/interpersonal ‘distance’. And finally, this approach has another impact on the patient, which is the important experience of being validated which is often lacking in the experience of the schizophrenic. This experience reinforces the patient’s attempts at entering into a relationship.

In summary, according to Vorster (2008), the essence of ‘reality validation’ is that it aims at the facilitation of the patient into taking his first steps in entering a relationship and the world around him.

In the next chapter these ideas will be tested, however before doing so it is necessary to discuss the current diagnostic criteria for schizophrenia, since it is this criterion which will be used to identify suitable research candidates for this study.

## **2.6 DSM-IV CRITERIA FOR SCHIZOPHRENIA**

The current diagnostic criteria for schizophrenia is illustrated by the Diagnostic and Statistical Model for mental disorders, Fourth Edition (DSM-IV) (American Psychiatric Association (APA, 1994). This classification system provides us with the diagnostic criteria for schizophrenia and points out the different categories that schizophrenia is divided into.

The Diagnostic and Statistical Model for mental disorders, Fourth Edition (DSM-IV) (American Psychiatric Association (APA, 1994) provides one of the most recent classification systems for mental disorders and provides the following set of criteria in order for a diagnosis of schizophrenia to be made:

A. At least two of the following symptoms lasting for at least one month in the active phase (exception: only one symptom if it involves bizarre delusions or if hallucinations involve a running commentary on the person or two or more voices talking with each other).

1. Delusions
2. Hallucinations
3. Disorganized speech (incoherence or frequent derailment)
4. Grossly disorganized or catatonic behaviour
5. Negative symptoms (flat affect, avolition, alogia, or anhedonia)

B. During the course of the disturbance, functioning in one or more areas such as work, social relations, and self-care has deteriorated markedly from premorbid levels (in the case of a child or adolescent, failure to reach expected level of social or academic development).

C. Signs of the disorder must be present for at least six months.

D. Schizoaffective and mood disorders with psychotic features must be ruled out.

E. The disturbance is not substance induced or caused by organic factors.

It should be noted that schizophrenia often appears markedly different from individual to individual, which is recognized by the DSM-IV and thus is divided into five distinct categories, namely paranoid schizophrenia, disorganized schizophrenia, catatonic schizophrenia, undifferentiated schizophrenia and residual schizophrenia.

It is however important to note that although diagnostic criteria are set out by the DSM-IV in order to diagnose an individual with schizophrenia, it provides a limited perspective on schizophrenia since it is used primarily as a classifying system and only provides a brief account of the interrelational aspects of schizophrenia.

In the next chapter, the investigation will be presented.

## **CHAPTER 3**

### **THE INVESTIGATION**

#### **3.1 INTRODUCTION**

In this chapter the research design which entails the plans for the approach and the method which consists of a report on the procedure that was followed during the research process will be presented.

#### **3.2 RESEARCH DESIGN**

The research design is the plan which is put into place to outline how the research is intended to be conducted. In this step, the visualized ideas for the research are transformed into a design or blueprint (Mouton, 2001). Included in the research design is the aim, the hypothesis, the research methodology, the procedure, the sample, method of data collection and data analysis.

##### **3.2.1 Aim**

The aim of this study is to determine the effect of therapeutic ‘reality validation’ on the ‘schizophrenic dance’.

##### **3.2.2 Hypothesis**

It is hypothesized that the observable level of psychosis in the diagnosed schizophrenic patient will decrease when therapeutic ‘reality validation’ is employed.

- The patient will reduce the emotional distance between him/herself and the therapist
- Overt indications of hallucinations will diminish or disappear
- The patient will communicate more logically and systematically
- The patient will exhibit higher levels of confidence and assertiveness

- The patient will communicate more congruently
- Volume of speech will increase

### **3.2.3 Qualitative versus Quantitative Research**

Qualitative research approaches are important in the social sciences disciplines (Marshall & Rossman, 1989). According to Denzin and Lincoln (1994), qualitative research means different things to different people and focuses on multiple methods. It involves an interpretive, naturalistic approach to its subject matter and involves the studied use and collection of a variety of empirical materials such as case studies, personal experience, introspection, life story's, interviews and observational, interactional and visual texts. Qualitative research emphasizes the interpretation of data that is collected by the researcher in the form of spoken or written language, or in the form of observations which are recorded in language (Terre Blanche & Durrheim, 1999). This data is analyzed by the researcher for the purpose of finding and categorizing themes. Coolican (1994) acknowledges that it is not possible to give precise guidelines on the analysis and presentation of qualitative data, however there are several specialized methods of analysis which have been developed. One of these is 'categorizing' in which themes are extracted from the data. According to Kirk and Miller (1986), qualitative observation identifies the presence or absence of something, and as such the observer must know what qualifies as that "thing".

In contrast to qualitative research methods, quantitative research isolates and defines variables and variable categories which are linked together to frame hypothesis before the data is collected and tested (Brannen, 1992). According to Newman and Benz (1998), researchers following this type of research to investigate do so in the following manner. It begins with statements of theory from which research hypothesis are derived. This is followed by the establishment of an experimental design in which variables in question are measured while controlling for the effects of selected independent variables. These procedures contribute to the scientific knowledge base by theory testing (Newman and Benz (1998).

This study is a preliminary/exploratory one since the area of research for this study is relatively unknown. It will be a therapy outcome study which according to Nolen-Hoeksema (2001) is appealing because it involves helping people while at the same time providing information. Thus it is based in the social sciences discipline and makes use of interviews and observation of subjects, which according to Marshall & Rossman (1989), helps in interpreting or reconstructing the depth, richness, and complexity of an identified social phenomenon. For these reasons a qualitative research design will be used in this study.

### **3.2.4 Procedure**

Once the research proposal has been reviewed and accepted, permission will be requested from the concerned parties at the George Mukhari Hospital. A meeting will then be held with a residing psychiatrist at the hospital who will assist in finding suitable candidates for the study and arranging the session times with the candidates. The sessions based on therapeutic 'reality validation' will be held in a predetermined room and video recorded. These recordings will be transcribed and given to independent clinicians to analyse the data according to themes. The findings will then be reported.

### **3.2.5 Experimental Variables**

According to Neuman (2003), researchers who focus on causal relations usually begin with the effect, and then search for its causes. However in this research study the inverse is true because the study is focused on the effects of a particular therapeutic input. The cause variable is the independent variable and the effect variable is the dependant variable (Neuman, 2003). In this study the proposed independent variable is 'reality validation' and the dependant variables are changes in symptomatic behaviour i.e. level of emotional distance between participant and therapist, overt indications of hallucinations, patients ability communicate logically and systematically, levels of confidence, levels of congruence, volume of speech and levels of assertiveness.

### **3.2.6 The Setting**

The sessions will be held in a designated consulting room in the Psychiatric Unit at Dr. George Mokhari Hospital. Each session will be held there to maintain standardization. The physical contents of the room will also be predetermined to maintain an acceptable level of standardization and control for nuisance variables. The items are also purposefully chosen to create variety, prevent boredom and inspire interest. The physical contents will include:

- a coffee table
- car keys
- two chairs
- four books
- a stack of magazines
- pens and pencils in a container
- a fan
- a video recorder
- a bottle of water
- a coffee mug
- a teddy bear
- a lamp
- a mirror
- a handbag
- a newspaper

### **3.2.7 The Intervention**

Once suitable candidates have been identified the research will proceed as follows:

- Consent for the research will be requested from the research participants by the referring psychiatrist who will also put the patient into context. The participants will be informed that it is research on a therapeutic intervention in which they are participating. They will also be informed and give consent regarding the video recording.
- The ‘reality validation’ will be conducted by a trained clinician and will be conducted in the following manner:
  - The patient will be directed to a predetermined seat on which the camera will be focussed.
  - Once the patient is seated the patient’s attention will immediately be drawn toward one of the predetermined items in the consulting room i.e. the teddy bear.
  - The therapist will ask the patient to identify or describe that item.
  - Once the patient has identified or described the item, the therapist validates the patient’s description. Any accurate observations that the patient makes are validated in a loud and clear manner. The following validations are suggested, however slight variation is recommended to avoid repetitiveness:
    - “Yes, I agree with you that is a.....”
    - “That is an accurate observation”
    - “That’s exactly it, it is an...”
    - “A....., yes, I agree, it is a.....”
- When no further observations are made and validations are given, the patient’s attention is drawn to another of the predetermined items.
- This process is continued at a fairly unhurried pace and in a relaxed and congruent manner (this is to reduce any possible stress and stimulate trust in the relationship).
- The sessions will all be approximately 10 – 15 minutes in length (this time frame is long enough to get a clear indication of the effects of ‘reality validation and short enough to prevent boredom).
- Each session will be video recorded with the video recorder placed in a position to capture the subject’s entire range of behaviour, both verbal and non-verbal.

### 3.2.8 Sample

Purposive sampling is a method used to get all possible cases that fit a particular criterion, the goal is to select candidates based on their relevance to the study rather than their representativeness (Neuman, 2003). This type of sampling method is often used to select difficult to reach or specialized populations, such as those diagnosed with schizophrenia. According to Drummond (1996), this method of sampling usually has its place in preliminary or pilot studies such as the present study. For these purposes and the difficulty posed in finding suitable candidates who fit all the criteria for this study, purposive sampling will be used. The sample will consist of five selected patients. This number has been chosen since this study is preliminary and exploratory. It is also qualitative in nature and as such should be sufficient to achieve saturation of data to permit generalization of findings. The patients will be chosen from the Psychiatric Ward of Dr. George Mukhari Hospital who have met the criteria for a diagnosis of 'schizophrenia' according to the DSM-IV. A meeting will be scheduled with a residing psychiatrist at the hospital who will assist in identifying and referring suitable participants to the researcher for the study.

In order to standardise the sample the following criteria are proposed for the selection of the sample.

Inclusion criteria:

- Participants will be inpatients at the Psychiatric Ward of Dr. George Mukhari Hospital.
- The participants will be patients diagnosed with 'schizophrenia', according to the DSM-IV by the subject's residing psychiatrist.
- Participants will be chosen from those patients on first admission and will be seen on the first or second day after admission. Patients will be seen after the patients have received the prescribed medication by the residing psychiatrist.

- The patients selected will be chosen from those patients actively displaying any of the symptomatic behaviour characteristic of schizophrenia despite being on medication. The symptomatic behaviour are those included in the DSM-IV, i.e.
  1. Delusions
  2. Hallucinations
  3. Disorganized speech (incoherence or frequent derailment)
  4. Grossly disorganized or catatonic behaviour
  5. Negative symptoms (flat affect, avolition, alogia, or anhedonia)
- Participants need to be fairly proficient in English, as the interviews will be conducted in English.
- The participants will be between the ages of eighteen years and twenty-eight years.

### **3.2.9 Data Gathering**

According to Drummond (1996) interviews are considered to be a method of data collection rich in information and can be used in exploratory research. For the purpose of this study five separate interviews will be conducted, made up of one interview per participant. The interviews are all to be conducted by one trained clinical psychologist. These sessions will be video recorded for data analysis where the video recorder will be positioned in order to capture the subjects' entire range of behaviour, both verbal and non-verbal.

### **3.2.10 Data Analysis**

Data analysis involves familiarization with the data, breaking the data down and restructuring the data in ways which provide new understanding of the data (Terre Blanche & Durrheim, 1999). The video recorded sessions will first be transcribed to ensure the natural history of data. The recordings and transcriptions will then be sent to three independent clinicians who will assist in providing a clinical description of each of the recordings according to specific themes.

The analysis of the video recorded data will be conducted independently by three trained clinicians. The clinicians will each give a clinical description of the patient's behaviour during the recordings. The descriptions will be according to the following themes:

Does the schizophrenic's symptomatic behaviour increase, decrease or stay the same? i.e.

- Does the patient reduce the emotional distance between him/herself and the therapist during the process of "reality validation"?
- Do overt indications of hallucinations diminish or disappear?
- Does the patient communicate more logically and systematically?
- Does the patient exhibit higher levels of confidence?
- Does the patient communicate more congruently?
- Does the patient's volume of speech change?
- Do the patient's levels of assertiveness change?
- Any additional clinical observations.

The clinical observations made by the three independent clinicians will first of all be organized according to the above categories, then discussed after which conclusions will be drawn.

### **3.3 METHOD**

In this section, the implementation of the research design is documented, together with all the changes that occurred during the process.

#### **3.3.1 Aim**

The aim as stipulated in the research design on page 31 in section 3.2.1 remained the same.

#### **3.3.2 Hypothesis**

The research hypothesis remained as described in the research design on page 31 in section 3.2.2

#### **3.3.3 Procedure**

The procedure as described in the research design on page 33 in section 3.2.4 remained the same.

#### **3.3.4 Experimental Variables**

The experimental variables as described in the research design on page 33 in section 3.2.5 remained the same.

#### **3.3.5 The Setting**

The setting as described in the research design on page 34 in section 3.2.6 remained the same apart from the following:

More predetermined objects were added to the original list due to the nature of the predetermined room. In order to reproduce this study, these additions are included:

- A bed
- Curtains
- A sink
- An air conditioner with files on top
- A fridge with cutlery, crockery and plastic containers on top
- Three chairs instead of two
- A side desk with a number of books and file on top
- A frame with a picture of a woman and child

These items remained the same across all sessions.

### **3.3.6 The Intervention**

The intervention as described in the research design on page 34 in section 3.2.7 remained the same apart from the following changes:

- At one point in session 4, the patient requested to go to the toilet, which was allowed.
- In session 5 and session 6, what could be deemed judgements instead of validations were used on two occasions. For example the word 'good' instead of 'that's correct' was used, which could impact on the outcome of the study.
- In session 4, the therapist tried to dissuade the patient from picking up an item, interrupting the flow of the session.
- The length of the sessions varied between +- 8 and 18 minutes in length.

### **3.3.7 Sample**

The selection of participants as described on page 36 in section 3.2.8 went according to the proposed selection criteria with the exception of two aspects. First of all the ages of the participants varied from eighteen years old to thirty five years old instead of the initial plan of eighteen to twenty eight years old. This was due to difficulty in finding suitable participants who met all of the criteria. Secondly, six instead of five participants were used due to availability.

### **3.3.8 Data Gathering**

The data gathering took place as described on page 37 in section 3.2.9 under the research design.

### **3.3.9 Data Analysis**

The method of data analysis was executed as described on page 37 in section 3.2.10 under the research design.

The results and discussion will be presented in the next chapter.

## **CHAPTER 4**

### **RESULTS AND DISCUSSION**

#### **4.1 INTRODUCTION**

In this chapter, the results of the study will be presented and discussed.

#### **4.2 AIM**

The aim of this study was to determine the effect of therapeutic ‘reality validation’ on the ‘schizophrenic dance’.

#### **4.3 HYPOTHESIS**

It was hypothesized that the observable level of psychosis in the diagnosed schizophrenic patient will decrease when therapeutic ‘reality validation’ is employed.

- The patient will reduce the emotional distance between him/herself and the therapist
- Overt indications of hallucinations will diminish or disappear
- The patient will communicate more logically and systematically
- The patient will exhibit higher levels of confidence
- The patient will communicate more congruently

#### **4.4 RESULTS**

##### **4.4.1 Qualitative analysis**

A clinical description of each candidate given by the referring psychiatrist prior to ‘reality validation’ will be provided. The analysis will then be presented in order of the interviews that took place, i.e. all three clinicians’ analysis of each candidates interview will be presented together. An integrated analysis will be provided by first indicating which answers to the standardized questions all three of the clinicians agreed on, then

indicating answers which two clinicians agreed upon and then indicating answers indicated by only one of the clinicians. This will be followed by an integration of any additional clinical observations made by the clinicians and finally the conclusion on each interview/session will then be presented.

The analysis was conducted according to the following questions:

- 1) Does the patient reduce the emotional distance between him/herself and the therapist during the process of ‘‘reality validation’’?
- 2) Do overt indications of hallucinations diminish or disappear?
- 3) Does the patient communicate more logically and systematically?
- 4) Does the patient exhibit higher levels of confidence?
- 5) Does the patient communicate more congruently?
- 6) Does the patient’s volume of speech change?
- 7) Do the patient’s levels of assertiveness change?
- 8) Any additional clinical observations.
- 9) Conclusion: Does the schizophrenic’s symptomatic behaviour increase, decrease or stay the same?

#### 4.4.1.1 Candidate 1

##### CLINICAL DESCRIPTION:

According to the patients file, the patient had been in the hospital for a period of exactly one month before ‘reality validation’ was employed. On admission the patient was not interviewable due to aggressive behaviour and had been restrained. She presented with the following initial symptoms:

- restricted affect;
- irritable mood and
- persecutory delusions

The patient was put on a course of Risperdal and Disipal.

Over the following week, the patient’s behaviour appeared to worsen with the addition of more ‘psychotic features’ such as bizarre and grandiose delusions. Epilim and Ativan were included in her course of treatment. The patient continued to display symptomatic behaviour for the rest of the duration with variations in her symptomatic behaviour (such as the objective observation by staff that she was hallucinating and psychomotor agitation), however, there was no apparent decrease in any symptomatic behaviour. During this period the residing psychiatrist changed the dosage of Risperdal (first increasing, then decreasing and once again increasing the dosage) to no apparent effect. On the day prior to ‘reality validation’ the patient presented with bizarre delusions and maintained that she was experiencing auditory hallucinations.

The table below contains the analyses done by three independent clinicians after the therapeutic intervention.

**ANALYSIS:**

(Superscript numbering has been used to cross reference the analysis with the common answers to the standardized questions identified in the next section)

<b><u>CLINICIAN A</u></b>	<b><u>CLINICIAN B</u></b>	<b><u>CLINICIAN C</u></b>
<p>1. Towards the middle of the interview the patient’s non-verbal communication becomes more congruent which leads to <sup>5</sup><u>decreased distance</u> between therapist and patient.</p>	<p>1. This is unclear as the analyst <sup>7</sup><u>did not observe emotional distance</u> on the part of the patient. A degree of uncertainty was observed, which the analyst hypothesises was due to partaking in an unfamiliar task.</p>	<p>1. Yes the patient <sup>5</sup><u>does reduce the emotional distance</u> between herself and the therapist during the process of ‘‘reality validation’’. This was evident particularly by the patients manoeuvre for closeness when sharing with therapist about her</p>

<p>2. <u><sup>1</sup>No indication of overt hallucinations</u></p> <p>3. The patient spoke in a logical and systematic manner throughout. Her last description (of the chair) was evident of an <u><sup>6</sup>increase in logical and systematic communication.</u></p>	<p>2. This is unclear as the analyst <u><sup>1</sup>did not view any overt indications</u> of hallucinations to begin with, nor did any signs of hallucinatory behaviour become apparent during the course of the interview.</p> <p>3. This point is unclear as the analyst <u><sup>8</sup>did not observe any point during the course of the interview when the patient did not communicate logically or systematically.</u> At one point during the course of the interview, the patient</p>	<p>hospital tag on her arm. Initially the patient accepted the validations by the therapist and as the session progresses she increasingly expanded by giving more of her own appropriate elaborations (manoeuvres to impress), while also looking for confirmation from the therapist (engaging in the relationship).</p> <p>2. There were <u><sup>1</sup>no overt indications of hallucinations</u> during the session.</p> <p>3. As the session progresses the patient's responses became <u><sup>6</sup>more logical and systematic.</u> Initially her answers were vague and consisted of reading things on books but as the session progresses her answers became clearer and more</p>
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<p>4. Her levels of <sup>2</sup><u>confidence increased markedly</u> in the middle of the interview – this also lead to more congruence between verbal and non-verbal communication.</p> <p>5. The patient’s levels of <sup>9</sup><u>congruence increased</u>.</p> <p>6. An <sup>3</sup><u>increase in the volume of speech</u> is evident.</p>	<p>jumped logical levels, but I hypothesize that this may be due to her not being entirely sure of what was required of her when she was asked to describe the magazine.</p> <p>4. The patient did exhibit <sup>2</sup><u>higher levels of confidence</u> during the course of the interview.</p> <p>5. This is <sup>10</sup><u>unclear</u>.</p> <p>6. The patient’s <sup>3</sup><u>volume of speech seemed to increase</u> as her confidence level increased.</p>	<p>accurate.</p> <p>4. It appeared as though the patient <sup>2</sup><u>became more confident</u>, because she willingly expanded on validations and manoeuvred to impress the therapist as the session progressed.</p> <p>5. There were <sup>11</sup><u>no incongruencies</u> in the patient’s verbal and non-verbal behaviour in the session. Initially the patient was reluctant to follow the therapist but this definition was promptly accepted by the patient.</p> <p>6. Yes the patient initially speaks in a soft and high pitched tone as the session progresses <sup>3</sup><u>she progressively speaks louder</u></p>
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<p>7. An <sup>4</sup><u>increase in assertiveness</u> was evident when she was misunderstood by the therapist and then clarified it.</p>	<p>7. The patient's level of <sup>4</sup><u>assertiveness did increase</u> during the course of the interview. This was evident in the fact that the patient started to offer information on her own accord, without being prompted by the researcher. I hypothesize that the patient has worked out what it is that the researcher is looking for and the patient is consequently trying to please the researcher.</p>	<p><u>and clearer.</u></p> <p>7. Yes, refer to question 4. In addition to increasing manoeuvres to impress at times in the interview/session the patient challenged what was perceived to be inaccurate validations made by the therapist and corrected the therapist with accurate observations. This could be indicative of <sup>4</sup><u>increased assertiveness</u> by the patient. Consequently, the patient exhibited less need for confirmation which could be indicative of higher confidence on her part.</p>
<p>8. A confused facial expression was evident from time to time. This does not seem to be related to something the therapist said. I hypothesize that it's a <sup>12</sup><u>manoeuvre for distance</u> in the relationship between the therapist and patient.</p>	<p>8. No.</p>	<p>8. It seems as though the patient resorts to content (reading labels on the books, newspaper ect.) at times during the interview as an attempt to <sup>12</sup><u>maintain some distance</u> in the relationship.</p>

<p>9. There seems to be a <sup>13</sup><u>decrease in symptomatic behaviour.</u></p>	<p>9. This is <sup>14</sup><u>unclear</u> as the patient's symptomatic behaviour was not apparent during the course of the interview. It appeared as though the patient's <sup>15</sup><u>confidence levels increased</u> during the interview, but as far as the actual symptomatic behaviour is concerned, this behaviour was not apparent. As a result, the analyst would need to state that the behaviour remained the same.</p>	<p>9. Taking all the above factors into account e.g. Decreased emotional distance, slight manoeuvres to impress, increases in volume of speech, higher confidence and assertiveness and the fact that there were no overt indications of hallucinations it can be concluded that the <sup>13</sup><u>symptomatic behaviour of the patient decreased.</u></p>
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INTEGRATION:

*Answers to the standardized questions common in analysis by three clinicians:*

All three clinicians observed that there were <sup>1</sup>no overt indications of hallucinations throughout the session. This is significant given the pre-clinical picture since the patient had been experiencing auditory hallucinations.

All three clinicians also agreed that during 'reality validation' there was an <sup>2</sup>increase in confidence, an <sup>3</sup>increase in volume of speech and an <sup>4</sup>increase in assertiveness in the patient's behaviour, which are all indicative of a reduction in symptomatic behaviour.

*Answers to the standardized questions common in analysis by two clinicians:*

Both clinicians A and C indicated that there was a <sup>5</sup>decrease in emotional distance and an increase in <sup>6</sup>logical and systematic communication.

Clinicians A and C concluded that overall there was a <sup>13</sup>decrease in symptomatic behaviour. Clinician B is <sup>14</sup>unclear on this point yet <sup>15</sup>acknowledges an increase in overall confidence levels.

*Answers to the standardized questions in analysis by one clinician:*

The patient's <sup>9</sup>congruence levels were noted to be increased by clinician A whereas clinician B was <sup>10</sup>unclear on this point. Clinician C indicated that there was <sup>11</sup>no incongruent behaviour throughout the session, this is also significant given the nature of the patient's delusional beliefs (her belief that she was married to the psychiatrist was highly incongruent to the context and indicates high levels of incongruent behaviour).

Clinician B indicated that <sup>7</sup>no distance and <sup>8</sup>no illogical and unsystematic communication was observed at all in the session.

*Additional clinical observations:*

Both clinicians A and B added that despite the above factors the patient <sup>12</sup>maintained some distance in the relationship. Thus, it appears that there was still evidence of some lingering symptomatic behaviour with this patient. However it is implausible to think that within such a short duration, with a 'condition' which is considered largely untreatable, that the patient's symptomatic behaviour will completely disappear, and thus any change at all is highly significant.

***Conclusion: effectiveness of therapeutic ‘reality validation’***

The conclusion as to whether ‘reality validation’ was effective in this session in reducing symptomatic behaviour is based on both pre- and post-clinical descriptions as well as indications that during the short period of ‘reality validation’ changes in the individuals behaviour were evident.

Firstly, regarding the pre-clinical picture, the patient had continuously displayed symptomatic behaviour such as disruptive behaviour, restricted affect, and persecutory, bizarre and grandiose delusions and was observed to be objectively hallucinating. None of these symptoms were observed during the course of ‘reality validation’. In addition, all three clinicians agreed that there were no indications of hallucinations during the course of ‘reality validation’. It is at least evident based on these observations that during the course of ‘reality validation’ the patient was somewhat symptom free.

Remarkably, when reviewing the patients file, it was noted by the residing psychiatrist that on the day of ‘reality validation’ post treatment, the psychiatrist was unable to elicit any symptomatic behaviour on questioning, including the patients unshakable delusions. It was the first time since the patient had been admitted that she appeared symptom free. The following day the symptomatic behaviour was once again observable. Thus it appears that ‘reality validation’ had a profound effect on the patient on the day of the treatment, which was somewhat short-lived. This, in light of the fact that it was a treatment of a very short duration, highlights the possible effects of the same treatment for extended periods of time.

During the session it is evident based on the analysis of the clinicians that there were clear shifts in the patients overall symptomatic behaviour. These changes, in particular the increase in confidence and the reduction in emotional distance, are indicative of a reduction in overall symptomatic behaviour and thus, the conclusion can be made that ‘reality validation’ was significantly effective in this session.

#### 4.4.1.2 Candidate 2

##### CLINICAL DESCRIPTION:

The patient had been in hospital for a period of three days prior to 'reality validation'. On admission the patient showed inappropriate behaviour such as undressing and provoking others. He was psychomotor agitated, unkempt and talkative. The patient was sedated and put on a course of Haloperidol. On the day prior to 'reality validation' no clear description of the patient was given other than that the patient admitted to auditory hallucinations and that he presented with alogia (a lack of meaningful speech). It appears that the symptomatic behaviour had decreased somewhat as the patient was no longer talkative, but still symptomatic since he admitted to auditory hallucinations.

The table below contains the analyses done by three independent clinicians after the therapeutic intervention.

##### ANALYSIS:

<b><u>CLINICIAN A</u></b>	<b><u>CLINICIAN B</u></b>	<b><u>CLINICIAN C</u></b>
1. <sup>4</sup> The <u>emotional distance is slightly decreased</u> towards the end of the interview.	1. <sup>5</sup> <u>No emotional distance was observed</u> on the part of the patient to begin with, therefore it is not possible to state whether or not there was a decrease in emotional distance during the course of the interview.	1. <sup>4</sup> The patient did <u>reduce the emotional distance</u> between himself and the therapist at some instances in the interview/session. The patient accepted validations made by the therapist, but he did not expand on them. The emotional distance was

<p>2. <sup>1</sup>There is <u>no indication of overt hallucinations</u>.</p> <p>3. The patient's <sup>3</sup><u>way of communication remained the same throughout</u>. An increase in logical and systematic communication was not evident.</p> <p>4. An <sup>6</sup><u>increase in confidence levels was not evident</u>.</p> <p>5. A <sup>8</sup><u>slight increase in levels of congruency</u> was</p>	<p>2. <sup>1</sup><u>No indications of hallucinations</u> were observed during the course the interview, therefore the analyst is unable to state whether or not the hallucinations diminished or disappeared.</p> <p>3. This is unclear as the analyst <sup>2</sup><u>did not observe any point during the course of the interview when the patient did not communicate logically or systematically</u>.</p> <p>4. The patient's <sup>6</sup><u>confidence levels appeared to remain constant</u>.</p> <p>5. This is <sup>9</sup><u>unclear</u>.</p>	<p>therefore slightly reduced but still remained large. (Slight manoeuvres for control)</p> <p>2. <sup>1</sup>There were <u>no indications of hallucinations</u> during the interview.</p> <p>3. The patient <sup>2</sup><u>communicated logically</u>, but because he didn't elaborate responses weren't systematic.</p> <p>4. Yes the patient did exhibit <sup>7</sup><u>higher levels of confidence</u>; this is indicated because he made a request to the therapist (to open the fridges).</p> <p>5. Yes the <sup>8</sup><u>patient's verbal and nonverbal behaviour</u></p>
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<p>evident.</p> <p>6. Excitement and enjoyment (laughter) became evident and there was a <sup>10</sup><u>slight increase in the volume of speech.</u></p> <p>7. There was <sup>12</sup><u>no marked change in the levels of assertiveness.</u></p>	<p>6. The patient's volume of speech appeared to remain <sup>11</sup><u>constant.</u></p> <p>7. The analyst did <sup>12</sup><u>not observe a change in the patient's level of assertiveness.</u></p>	<p><u>became slightly more congruent</u> (he states to the therapist when he can't describe something e.g. The psychology books, because he hasn't read them). The patient's non-verbal behaviour such as closing his eyes, leaning on his hand, looking away by turning his face communicated that he did not want to be there/communicate with the therapist, yet he did answer questions.</p> <p>6. The patient spoke in a monotonous, soft tone, the volume of speech fluctuated in the session between being soft and <sup>10</sup><u>slightly louder and clearer as the session progressed.</u></p> <p>7. Refer to question 4. The <sup>13</sup><u>patient becomes more assertive</u> by making request more clearly to the therapist. This also indicates assertiveness, and his</p>
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<p>8. The patient was very <sup>14</sup><u>distantiated</u> to the point of looking irritated. This didn't change as the interview went on.</p>	<p>8. No.</p>	<p>volume of speech also increased.</p> <p>8.The patients non-verbal behaviour in the beginning and at the end of the session indicates that he is bored (for example, he closes his eyes, turns his head, pauses for long periods, lying on his arm), this <sup>14</sup><u>self isolating pattern/manoeuvres</u> for distance do decrease in the middle of the session.</p> <p>There seemed to be a few communication distortions, the patient seems to answer questions on a slightly different logical level (e.g. Can you tell me what this is? Patient answers: it's next to a mirror). This made validations difficult as the patient is correct, but not fully. The impact of such communication was frustration and immobilisation on the part of the therapist.</p>
<p>9. There was a slight</p>	<p>9. As was stated with</p>	<p>9. The patients</p>

<p><sup>15</sup><u>decrease in symptoms</u> but not markedly so.</p>	<p>Interview One, this is unclear as the patient's <sup>16</sup><u>symptomatic behaviour</u> was not apparent during the course of the interview. As a result, the analyst would need to state that the behaviour remained the same.</p>	<p><sup>15</sup><u>symptomatic behaviour (especially manoeuvres for distance)</u> did slightly <u>decrease</u> during the "reality validation" process and taking into account that there were no overt hallucinations during the interview symptomatic behaviour did decrease.</p>
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INTEGRATION:

*Answers to the standardized questions common in analysis by three clinicians:*

All three clinicians made the observation that the patient showed <sup>1</sup>no overt indications of hallucinations during the session. This is significant in light of the preclinical picture which indicates that the patient had been experiencing auditory hallucinations.

*Answers to the standardized questions common in analysis by two clinicians:*

Both clinician B and clinician C indicated that the patient <sup>2</sup>communicated logically and that this did not change throughout the session. This is significant, since the patient was described as having alogia.

Clinicians A and C indicated a <sup>4</sup>decrease in emotional distance.

Clinicians A and B both maintained that the level of <sup>6</sup>confidence remained constant.

The patient's <sup>8</sup>congruence was reported to have increased by clinicians A and C.

His <sup>10</sup>volume of speech increased according to clinicians A and C, whilst clinician B indicated that it <sup>11</sup>remained constant throughout.

Clinicians A and B maintained that the patient's level of <sup>12</sup>assertiveness remained the same throughout.

Both clinicians A and C indicated an overall <sup>15</sup>decrease in symptoms. Clinician B observed that there was <sup>16</sup>no apparent symptomatic behaviour throughout the session.

***Answers to the standardized questions in analysis by one clinician:***

Clinician B indicated that there was <sup>5</sup>no emotional distance observed throughout the session.

Clinician C maintained that there was a <sup>7</sup>increase in the patient's confidence levels.

Clinician C indicated that there was some <sup>13</sup>increase in assertiveness.

***Additional clinical observations:***

<sup>14</sup>Both clinicians A and C noted that despite some of the changes noted above, he was still somewhat distanciated. Once again it is important to note that although a complete turnaround has not occurred, any change is evident of progress in the direction change.

***Conclusion: effectiveness of therapeutic 'reality validation'***

When taking into consideration the pre-clinical picture it appeared that the patient's symptomatic behaviour was already decreasing possibly due to the sedation. However, the patient still indicated that he experienced auditory hallucinations. That no indication of hallucinations was evident during 'reality validation' is significant. In addition, the patient was described as having alolia, meaning a lack of meaningful speech. During the

course of 'reality validation' the patient communicated logically which is inconsistent with alogia. However, since it is difficult to determine the extent of reduction of symptoms prior to 'reality validation', the focus here is on what occurred during the course of 'reality validation' and not a pre- and post- clinical comparison.

Thus, based on the analysis of the clinicians which clearly indicate reductions in many areas of the patient's symptomatic behaviour, the conclusion can be made that 'reality validation' was effective in this session resulting in a reduction of symptomatic behaviour.

#### 4.4.1.3 Candidate 3

##### CLINICAL DESCRIPTION:

The patient had been in hospital for a period of approximately two weeks prior to 'reality validation'. On admission he presented with the following symptomatic behaviour;

- Perceptual distortions (auditory, visual and tactile)
- Persecutory delusions,
- Disruptive behaviour.

During this period he was put on a course of Haloperidol and was tested for substance abuse which turned out negative. His symptomatic behaviour remained largely constant with slight variations in presentation. Prior to 'reality validation' the patient was still exhibiting fixed, unshakable delusions.

The table below contains the analyses done by three independent clinicians after the therapeutic intervention.

ANALYSIS:

<b><u>CLINICIAN A</u></b>	<b><u>CLINICIAN B</u></b>	<b><u>CLINICIAN C</u></b>
<p>1. There is no evidence of a decrease in emotional distance between the patient and the therapist. The <sup>12</sup><u>distance remains the same.</u></p> <p>2. <sup>1</sup><u>No overt hallucinations</u> were evident.</p> <p>3. The patient's <sup>3</sup><u>communication remains the same.</u></p>	<p>1. <sup>13</sup><u>No emotional distance was observed</u> on the part of the patient to begin with, therefore it is not possible to state whether or not there was a decrease in emotional distance during the course of the interview.</p> <p>2. <sup>1</sup><u>No indications of hallucinations</u> were observed during the course the interview, therefore the analyst is unable to state whether or not the hallucinations diminished or disappeared.</p> <p>3. This is unclear as the analyst <sup>2</sup><u>did not observe any point during the course of the interview when the patient did not</u></p>	<p>1. Yes, the patient <sup>14</sup><u>does reduce the emotional distance</u> between himself and the therapist during the process of “reality validation”. The patient accepts validations, but he does not expand much on validations thus maintaining some distance in the relationship.</p> <p>2. <sup>1</sup>There are <u>no overt indications of hallucinations</u> during the session.</p> <p>3. Patient's responses are short and brief, but appear <sup>2</sup><u>logical and systematic.</u></p>

<p>4. The patient's <sup>8</sup><u>confidence levels remain the same.</u></p> <p>5. There's a slight <sup>4</sup><u>increase in congruence</u> between verbal and non-verbal communication. The patient expresses his emotions more congruently.</p> <p>6. The <sup>6</sup><u>volume of speech remained mostly the same.</u></p> <p>7. There was <sup>10</sup><u>no marked change in assertiveness levels.</u></p>	<p><u>communicate logically or systematically.</u></p> <p>4. The patient's <sup>8</sup><u>confidence levels appeared to remain constant.</u></p> <p>5. This is <sup>5</sup><u>unclear.</u></p> <p>6. The patient's <sup>6</sup><u>volume of speech appeared to remain constant.</u></p> <p>7. The analyst <sup>10</sup><u>did not observe a change in the patient's level of assertiveness.</u></p>	<p>4. As the session progresses the patient does seem to exhibit <sup>9</sup><u>higher levels of confidence</u> by decreasing the time he takes to respond to questions as well as speaking louder and clearer.</p> <p>5. Yes, initially the patients smiles inappropriately, but as the session progresses his verbal and non-verbal behaviour matched, indicating a <sup>4</sup><u>increase in congruence.</u></p> <p>6. The patient initially speaks in an unclear, soft, stuttering manner, these characteristics change slightly with <sup>7</sup><u>speech becoming slightly louder, clearer</u> and less stuttering.</p> <p>7. There appears to be a <sup>11</sup><u>change in confidence levels</u> as described in question 4. In terms of</p>
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<p>8. It struck me that the therapist did not give the patient accurate feedback when he named the camel a 'puppy'. Although it may be the patient's reality that it is a 'puppy' he received <sup>15</sup><u>false feedback</u> from the environment (therapist) with regard to his observation. This may on the long run increase symptomatic behaviour.</p> <p>9. <sup>16</sup><u>No marked change in symptomatic behaviour</u> was evident.</p>	<p>8. No.</p> <p>9. As was stated with the previous interviews, this is unclear as the patient's <sup>17</sup><u>symptomatic behaviour was not apparent during the course of the interview</u>. As a result, the analyst would need to state that the behaviour remained the same.</p>	<p>assertiveness the patient respond <u>assertively</u> to questions he doesn't answer by saying 'no' or 'nothing else'.</p> <p>8. There seems to be little expansion or elaboration on validations from the patient. Although there are slight changes in communication the <sup>19</sup><u>distance still seems large</u> because there is little interaction from the patient's side. <sup>20</sup><u>Non-verbal behaviour did seem to change; he made more movements and became more expressive</u>.</p> <p>9. Taking all the above factors into consideration, the fact that there were changes in his communication, and that the patient exhibited no hallucinations indicates that the schizophrenic <sup>18</sup><u>symptomatic behaviour did decrease</u>. The changes are significant when</p>
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		looking at the changes that occurred and taking the short time frame of the interview into consideration.
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INTEGRATION:

*Answers to the standardized questions common in analysis by three clinicians:*

All three clinicians indicated that there were <sup>1</sup>no overt indications of hallucinations.

*Answers to the standardized questions common in analysis by two clinicians:*

Both clinicians B and C indicate that the <sup>2</sup>patient communicated logically and systematically.

There was an <sup>4</sup>increase in the patient's levels of congruence according to clinicians A and C. Clinician B was <sup>5</sup>unclear on this point.

It was noted by clinicians A and B that the patient's <sup>6</sup>volume of speech, <sup>8</sup>levels of confidence and <sup>10</sup>levels of assertiveness remained constant, while clinician C indicated a slight <sup>7</sup>increase in speech volume, <sup>9</sup>levels of confidence and <sup>11</sup>levels of assertiveness.

*Answers to the standardized questions in analysis by one clinician:*

In this session clinician A indicates that the <sup>12</sup>emotional distance remained constant. Clinician B noted that there was <sup>13</sup>no apparent emotional distance at all, so was unable to comment on any changes, while clinician C indicates a <sup>14</sup>reduction in emotional distance.

Clinician A indicated that there was <sup>16</sup>no marked change in the patient's overall symptomatic behaviour. Clinician B indicated that there was <sup>17</sup>no symptomatic behaviour throughout the session and clinician C reported a <sup>18</sup>decrease in symptomatic behaviour.

***Additional clinical observations:***

Clinician A added that at times <sup>15</sup>false feedback was given by the therapist which may have impacted on the patient's symptomatic behaviour. (The clinician validated the perception of the patient that the object being identified was a puppy and not a camel). Thus what occurred in this session was not completely in line with 'reality validation' since the therapist at times did not validate 'reality' but instead the patients associations of reality. In theory this would reinforce the patient's symptomatic behaviour, perhaps leading to an increase in distanced and symptomatic behaviour. Findings of this session need to be interpreted in this light.

Clinician C added that the <sup>19</sup>distance remained large despite some <sup>20</sup>body language indications of a reduction of distance. This shows us that the patient was displaying double messages, since a large emotional distance was maintained yet there were reductions in physical proximity indicating reductions in distance. The fact that double messages occurred indicates that there was some progress in the direction of change.

***Conclusion: effectiveness of therapeutic 'reality validation'***

As discussed previously, false feedback was at times given by the therapist. This may have impacted on the effectiveness of 'reality validation' in this session, resulting in the maintenance or an increase in symptomatic behaviour since the patients perceptions were reinforced, rather than the reinforcement of 'reality'. This could ultimately reinforce symptomatic behaviour and would have profoundly affected the outcome of this session and findings should be interpreted as such.

Despite these problems in the application of 'reality validation' there is some strong evidence to suggest that shifts did occur during the process indicating a reduction of symptomatic behaviour. In the analyses there is little consensus regarding the outcome of 'reality validation' yet individual observations of the clinicians indicate changes in elements of the patients behaviour and thus although these changes are slight in degree, they are changes nonetheless. The confusion in the results is probably due to the inconsistent application of 'reality validation' leading to inconsistent findings.

What is highly significant is that it is indicated in the patients file that later on the day of 'reality validation' (during a ward round), the patient denied any persecutory which was one of the most outstanding symptoms in his behaviour. He was declared apsychotic (despite some features) on that day.

Thus, there is clear evidence to suggest that there were at least small shifts in the patient's behaviour, and had the therapist given more accurate feedback, clearer shifts would perhaps have occurred. Thus, the conclusion can be made that although 'reality validation' was inconsistently applied it had resulted in some shifts in symptomatic behaviour, and was therefore only moderately effective.

#### 4.4.1.4 Candidate 4

##### CLINICAL DESCRIPTION:

The patient had been in hospital for one day prior to 'reality validation'. On admission he presented with the following symptoms:

- Auditory hallucinations;
- Inappropriate and disorganized behaviour;
- Irritable mood;
- Blunt affect;
- Illogical thinking;
- Loosening of associations and

- Was selectively mute.

He was put on a course of Haloperidol and Lorazepam

The table below contains the analyses done by three independent clinicians after the therapeutic intervention.

ANALYSIS:

<b><u>CLINICIAN A</u></b>	<b><u>CLINICIAN B</u></b>	<b><u>CLINICIAN C</u></b>
<p>1. The <sup>2</sup><u>emotional distance remained the same</u>. The patient was <sup>1</sup><u>unreachable</u> and constantly manoeuvred to define the relationship as symmetrical.</p>	<p>1. The patient did not reduce the emotional distance. His controlling and negating manoeuvres seemed to<sup>1&amp;3</sup> <u>increase the emotional distance</u> between the patient and the therapist.</p>	<p>1. No, there is a <sup>1</sup><u>large distance between therapist and patient</u> in this session. The patient doesn't accept/disregards validations and doesn't expand on them. It should be noted that the patient was slightly more responsive in the beginning of the session; his behaviour became erratic when it was observed that the patient urinated in his hospital pants in the session. It was at this point that the patient actively attempted to take control in the relationship. This resulted in distance.</p>

<p>2. There were <sup>6</sup><u>no indications of overt hallucinations</u>.</p> <p>3. The patient communicated in an <sup>4</sup><u>illogical and unsystematic</u> way throughout.</p> <p>4. The patient <sup>5</sup><u>already exhibited high levels of confidence</u>.</p> <p>5. The patient's behaviour was <sup>8</sup><u>incongruent</u> to the context.</p> <p>6. At times the <sup>10</sup><u>patient's speech volume increased</u>. This can, however, be</p>	<p>2. Overt indications of <sup>7</sup><u>hallucinations do no diminish</u>.</p> <p>3. The patient <sup>4</sup><u>did not communicate more logically and systematically</u>.</p> <p>4. This is unclear as the patient's <sup>5</sup><u>confidence levels appeared to remain constant</u>.</p> <p>5. The <sup>9</sup><u>congruence</u> with which the patient communicated <u>did not appear to increase</u>. However, the analyst observed that during the course of the interview, the patient began to feel frustrated and negated by the therapist. This was <u>conveyed congruently</u> by the patient.</p> <p>6. The <sup>10</sup><u>patient's volume of speech did increase</u> during the course the interview.</p>	<p>2. There were <sup>6</sup><u>no indications of overt hallucinations</u>.</p> <p>3. The patient spoke in an <sup>4</sup><u>illogical fashion, jumped logical levels</u> and was incoherent in his communication.</p> <p>4. <sup>5</sup><u>No</u></p> <p>5. No the patients <sup>8</sup><u>verbal and non-verbal behaviour does not always match in the session</u>. His non-verbal situation (having urinated in his pants) did not fit the patient's verbal expressions.</p> <p>6. The patients <sup>11</sup><u>volume of speech remained large</u> throughout most of the</p>
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<p>attributed to the symmetrical definition of the relationship between the therapist and the patient and not to the “reality validation”.</p>	<p>The analyst hypothesizes that this was due to the patients increasing levels of frustration.</p>	<p>session</p>
<p>7. The patient was confident and <sup>12</sup><u>assertive from the start</u>. He constantly exhibited symmetrical manoeuvres. The confidence and assertiveness that he presents with is thus part of his interactional style and not a result of the “reality validation”.</p>	<p>7. The patient’s confidence and <sup>13</sup><u>assertiveness levels appeared to remain constant</u>.</p>	<p>7. No, there was no indication of a change in confidence. The patient was <sup>12</sup><u>very assertive</u> (controlling) in the thought. He was unwilling to follow or answer the therapist instructions or answered on another logical level.</p>
<p>8. The therapist <sup>14</sup><u>could not effectively take control in the session</u> and thus, in my opinion, “reality validation” wasn’t effective.</p>	<p>8. No.</p>	<p>8. The <sup>15</sup><u>patient’s manoeuvres for distance are very effective and ingrained</u>. He uses various manoeuvres such as talking over the therapist, selectively ignoring/listening to what is asked, jumping logical levels in order to maintain distance and be untouchable in the session.</p>

<p>9. The patient's <sup>16</sup><u>symptomatic behaviour increased</u>, especially his delusional behaviour.</p>	<p>9. It appeared as though the patient's <sup>17</sup><u>symptomatic behaviour remained the same</u>.</p>	<p>9. Based on the above observations the <sup>16</sup><u>symptomatic behaviour increased</u> in the session.</p>
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INTEGRATION:

*Answers to the standardized questions common in analysis by three clinicians:*

All three clinicians indicated a <sup>1</sup>large emotional distance between the patient and therapist. Clinician A indicated that although the patient was unreachable, this was <sup>2</sup>constant throughout, while clinician B indicated an <sup>3</sup>increase in the distance.

All three clinicians observed that the patient was <sup>4</sup>illogical and unsystematic in his communication and that there was <sup>5</sup>no change in his levels of confidence.

*Answers to the standardized questions common in analysis by two clinicians:*

<sup>6</sup>No overt indications of hallucinations were indicated by clinicians A and C, while clinician B noted <sup>7</sup>no change.

Clinicians A and C noted that the patient was <sup>8</sup>incongruent throughout, while clinician B notes some instances where the patient was <sup>9</sup>congruent.

Clinicians A and B noted an <sup>10</sup>increase in volume of speech, which was attributed by them to frustration and the symmetrical nature of the relationship (the therapist disregarded repeated false observations (symmetrical manoeuvres) and moved on to different items, both patient and therapist disregarded one another's manoeuvres – this led to frustration in both patient and therapist). In theory the symmetrical nature of the

relationship would have resulted in an increase in symptomatic behaviour, since in this process the therapist was unable to engage in the ‘validation’ of ‘reality’ which is the purpose of the intervention.

Clinician C also reported a large <sup>11</sup>volume of speech.

<sup>12</sup>High levels of assertiveness were indicated by clinicians A and C, with clinician B reporting that it <sup>13</sup>remained constant.

According to clinicians A and C, this patient’s <sup>16</sup>symptomatic behaviour increased, while clinician B indicated that the symptomatic behaviour present in the session <sup>17</sup>remained constant.

***Additional clinical observations:***

Clinician A noted that the therapist <sup>14</sup>did not effectively take control in the relationship (this was due to the unanticipated symmetrical nature of the relationship – the patient did not respond accurately to questions, manoeuvred to change the focus of the session, whereas the therapist counter-manoevred by disregarding this, resulting in an escalation of symmetrical manoeuvres and a large increase in distance). As discussed previously, the symmetrical nature of this relationship would have in theory resulted in an increase in symptomatic behaviour.

Clinician C added that the patient’s <sup>15</sup>manoeuvres for distance are effective and ingrained. This is also evident in the patient’s pre-clinical picture, which shows a severe manifestation of ‘schizophrenia’.

***Conclusion: effectiveness of therapeutic ‘reality validation’***

Since the therapist did not effectively take control and manoeuvred symmetrically which is counter to the goals of ‘reality validation’ in which the focus is on the ‘validation’, a

conclusion cannot be made regarding ‘reality validation’ but instead a conclusion can be made in light of the effect of this symmetrical form of intervention. This symmetrical intervention clearly led to an increase in symptomatic behaviour as discussed by the analysts. These results are very much in line with the theory (firstly, no validation of reality was taking place which should enhance confidence and intimacy a closer relationship – thus the inverse should be true since the therapist was actively opposing the patient, secondly, the theory shows that the patient regulates emotional distance and may increase emotional distance in threatening situations).

The conclusion can be made here that it is clear that in this session the symmetrical nature of the relationship led to greater distance in the relationship and an increase in symptomatic behaviour.

#### 4.4.1.5 Candidate 5

##### CLINICAL DESCRIPTION:

‘Reality validation’ was conducted on the day that the patient was admitted to the hospital. This patient was previously treated on an outpatient basis and had been brought to the hospital following an increase in symptomatic behaviour. He had previously been treated on a course of Clopixol, Haloperidol and Disipal and to the psychiatrists knowledge had not defaulted on treatment. The length of this course of treatment is unknown.

According to the residing psychiatrist the patient presented with the following symptoms:

- paranoid delusions (believed his family were bewitching him),
- self-isolating behaviour,
- decreased motor activity,
- poverty of speech and ideas,
- hypervigilance (suspicious of others)\
- and distressed mood.

The table below contains the analyses done by three independent clinicians after the therapeutic intervention.

ANALYSIS:

<b><u>CLINICIAN A</u></b>	<b><u>CLINICIAN B</u></b>	<b><u>CLINICIAN C</u></b>
<p>1. The <sup>9</sup><u>distance between the therapist and the patient remained the same</u>. The relationship was distanced.</p>	<p>1. <sup>10</sup><u>No emotional distance was observed</u> on the part of the patient to begin with, therefore it is not possible to state whether or not there was a decrease in emotional distance during the course of the interview.</p>	<p>1. There are points in the session where the <sup>11</sup><u>emotional distance is slightly reduced</u>. The patient changes his posture in the session from having folded arms to unfolding his arms and leaning slightly forward. He makes eye contact when asked a question by the therapist but then looks down. He accepts validations by the therapist and as the session progresses elaborates on validations.</p>
<p>2. There was <sup>1</sup><u>no indication of overt hallucinations</u>.</p>	<p>2. <sup>1</sup><u>No indications of hallucinations</u> were observed during the course the interview, therefore the analyst is unable to state</p>	<p>2. There were <sup>1</sup><u>no overt indications of hallucinations</u> during the session.</p>

<p>3. The patient <sup>2</sup><u>communicated in a logical and systematic manner.</u></p> <p>4. Initially the patient presented as unassertive and shy. His levels of <sup>5</sup><u>confidence increased</u> slightly where he stood up and reached for the Tupperware.</p> <p>5. The patient's level of <sup>12</sup><u>congruency remained the same.</u></p> <p>6. His volume of <sup>4</sup><u>speech remained the same.</u></p> <p>7. A slight <sup>7</sup><u>change</u> (increase) in assertiveness was evident, although the</p>	<p>whether or not the hallucinations diminished or disappeared.</p> <p>3. This is unclear as the analyst <sup>2</sup><u>did not observe any point during the course of the interview when the patient did not communicate logically or systematically.</u></p> <p>4. The patient's <sup>6</sup><u>confidence levels appeared to remain constant.</u></p> <p>5. This is <sup>14</sup><u>unclear.</u></p> <p>6. The patient's volume of <sup>4</sup><u>speech appeared to remain constant.</u></p> <p>7. The analyst <sup>8</sup><u>did not observe a change in the patient's level of</u></p>	<p>3. The patient does <sup>2</sup><u>communicate logically and as the session progresses makes <sup>3</sup>more systematic elaborations.</u></p> <p>4. Yes, levels of <sup>5</sup><u>confidence increased.</u> The patient appeared comfortable to get up and look at objects in an appropriate manner.</p> <p>5. The patient's <sup>13</sup><u>verbal and nonverbal behaviour matched.</u></p> <p>6. No, the patient spoke in a <sup>4</sup><u>soft manner throughout the session.</u></p> <p>7. <sup>7</sup><u>Yes</u></p>
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<p>patient was still markedly shy and withdrawn.</p>	<p><u>assertiveness.</u></p>	
<p>8. None</p>	<p>8. No</p>	<p>8. The patient seemed <sup>15</sup><u>cooperative</u> in the session.</p>
<p>9. It is difficult to communicate on the <sup>17</sup><u>patient's symptomatic behaviour as it is not clear</u> in the interview. The patient's withdrawn and distanced style however mostly remained the same.</p>	<p>9. As was stated with the previous interviews, this is unclear as the <sup>17</sup><u>patient's symptomatic behaviour was not apparent during the course of the interview.</u> As a result, the analyst would need to state that the behaviour remained the same.</p>	<p>9. The <sup>16</sup><u>emotional distance reduced slightly and the patient became more interactive.</u></p>

INTEGRATION:

*Answers to the standardized questions common in analysis by three clinicians:*

All three clinicians observed that there were <sup>1</sup>no overt indications of hallucinations throughout the session and that the patient <sup>2</sup>communicated logically and systematically.

All three clinicians observed no <sup>4</sup>change in the volume of speech.

*Answers to the standardized questions common in analysis by two clinicians:*

Both clinician A and C reported an <sup>5</sup>increase in confidence levels, with clinician B indicating <sup>6</sup>no change.

An <sup>7</sup>increase in assertiveness was reported by clinicians A and C, while clinician B indicated that there was <sup>8</sup>no change.

Clinicians A and B concluded that there was <sup>17</sup>no evidence of symptomatic behaviour throughout the session. In light of the pre-clinical description, this is highly significant.

***Answers to the standardized questions in analysis by one clinician:***

Clinician A indicated that the <sup>9</sup>emotional distance in the relationship remained constant. Clinician B indicated that there was no emotional distance to begin with, therefore also <sup>10</sup>no change, while clinician C noted a <sup>11</sup>reduction in emotional distance.

Clinician A noted that the patient's level of <sup>12</sup>congruency remained the same. Clinician C showed an <sup>13</sup>increase in congruence, while clinician B was <sup>14</sup>unclear on this point.

Clinician C observed a slight <sup>16</sup>decrease in overall symptomatic behaviour.

***Additional clinical observations:***

Clinician C added that the patient was <sup>15</sup>cooperative.

***Conclusion: effectiveness of therapeutic 'reality validation'***

The conclusion as to whether 'reality validation' was effective in this session in reducing symptomatic behaviour is based on both pre- and post-clinical descriptions as well as indications that during the short period of 'reality validation' changes in the individuals behaviour were evident.

Firstly, regarding the pre-clinical picture, the patient was displaying symptomatic behaviour such as paranoid delusions (believed his family were bewitching him), hypervigilance (suspicious of others) and distressed mood. None of these symptoms were observed during the course of 'reality validation' and it was noted by the clinicians that in general there was no symptomatic behaviour during the session. It is at least evident based on these observations that during the course of 'reality validation' the patient was somewhat symptom free.

During the session it is evident based on the analysis of the clinicians that there were shifts in the patients overall symptomatic behaviour. These changes, in particular the increase in confidence and some reduction in emotional distance, are indicative of some reduction in symptomatic behaviour. Thus, the conclusion can be made that 'reality validation' was to some extent effective in this session.

#### 4.4.1.6 Candidate 6

##### CLINICAL DESCRIPTION:

The patient had been in the hospital for two days prior to 'reality validation'. He was considered not interviewable on admission due to aggressive behaviour and was thus sedated.

According to the residing psychiatrist the patient presented with the following symptomatic behaviour:

- bizarre delusions,
- inappropriate behaviour (undressing),
- aggressive behaviour,
- psychomotor agitation
- and thought blocking.

He was also objectively seen hallucinating. He was described as having blunted affect, labile mood, illogical thinking and poor insight.

The patient was put on a course of Lorazepam and Haloperidol. According to the psychiatrist the sedation had worn off sufficiently to interview the patient.

The table below contains the analyses done by three independent clinicians after the therapeutic intervention.

ANALYSIS:

<b><u>CLINICIAN A</u></b>	<b><u>CLINICIAN B</u></b>	<b><u>CLINICIAN C</u></b>
<p>1. The <sup>2</sup><u>emotional distance decreased</u> as the interview progressed.</p> <p>2. The psychotic behaviour <sup>5</sup><u>remained the same.</u></p>	<p>1. The patient approaches the tasks intellectually and displays tangentiality. The analyst hypothesizes that the patient employs these tactics to maintain emotional distance as well as to maintain control. The analyst did <sup>3</sup><u>not observe a decrease in emotional distance</u> during the course of the interview.</p> <p>2. <sup>4</sup><u>No indications of hallucinations</u> were observed during the course the interview, therefore the</p>	<p>1. The patient used various manoeuvres to maintain distance initially such as reading labels. He also seemed to just carry on with expansive elaborations (excluding the therapist) and looked for the therapist confirmation at times. There was a slight <sup>2</sup><u>reduction in emotional distance</u> toward the end of the session.</p> <p>2. There were <sup>4</sup><u>no overt indications of hallucinations.</u></p>

<p>3. The patient at times makes <sup>1</sup><u>illogical jumps</u>. <u>This remains the same throughout the interview.</u></p> <p>4. The patient's <sup>6</sup><u>confidence levels increased.</u></p> <p>5. The patient's levels of <sup>11&amp;12</sup><u>congruency remained the same.</u></p> <p>6. The patient's <sup>8</sup><u>volume of speech</u> changed as he communicated about different topics. It is congruent to the context and the content.</p>	<p>analyst in unable to state whether or not the hallucinations diminished or disappeared.</p> <p>3. This is unclear as the analyst did not observe any point during the course of the interview when the <sup>1</sup><u>patient did not communicate logically or systematically.</u></p> <p>4. The patient's <sup>7</sup><u>confidence levels appeared to remain constant.</u></p> <p>5. This is <sup>18</sup><u>unclear.</u></p> <p>6. The patient's <sup>10</sup><u>volume of speech appeared to remain constant.</u></p>	<p>3. No, the patient communicated in a very vague and at times <sup>1</sup><u>illogical manner.</u></p> <p>4. <sup>6</sup><u>Yes, the patient smiled at times</u> and with the validation from the therapist responded promptly and enthusiastically to questions.</p> <p>5. There <sup>12</sup><u>didn't appear to be any discrepancies between verbal and non-verbal behaviour.</u></p> <p>6. <sup>8</sup><u>Yes.</u></p>
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<p>7. An <sup>9</sup><u>increase in the levels of assertiveness</u> was evident.</p> <p>8. The patient made links with what something looks like instead of naming the object that he sees. He thus communicates with associations. The <sup>14</sup><u>therapist at times validated the associations and not the real object</u> which was observed by the patient. The effectiveness of the ‘reality validation’ in this session is thus questionable.</p> <p>9. The <sup>17</sup><u>symptomatic behaviour stayed the same.</u></p>	<p>7. The analyst <sup>10</sup><u>did not observe a change</u> in the patient’s level of assertiveness.</p> <p>8. The patient displays a great deal of tangentiality and approaches the tasks presented to him intellectually. The analyst hypothesizes he may be <sup>15</sup><u>employing these tactics to create and keep emotional distance</u> as well as maintain control.</p> <p>9. Besides for the apparent tangentiality that the patient displayed, no other symptomatic behaviour was apparent. As a result, the analyst would need to state that the <sup>17</sup><u>behaviour remained the same.</u></p>	<p>7. <sup>9</sup><u>Yes</u>, with the validation from the therapist <u>responded promptly and enthusiastically</u> to questions.</p> <p>8. When he responded he would continue with irrelevant observations which <sup>15</sup><u>maintained some distance</u></p> <p>9. <sup>16</sup><u>Symptomatic behaviour decreased slightly</u> when the therapist asked questions and the patient responded to this.</p>
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## INTEGRATION:

### *Answers to the standardized questions common in analysis by three clinicians:*

All three clinicians observed that the patient was <sup>1</sup>illogical and unsystematic in his communication.

### *Answers to the standardized questions common in analysis by two clinicians:*

Clinicians A and C indicated a <sup>2</sup>decrease in emotional distance, while clinician B indicated <sup>3</sup>no change.

Clinician B and C indicated that there were <sup>4</sup>no indications of hallucinations. Clinician A noted <sup>5</sup>no changes.

An <sup>6</sup>increase in confidence was noted in the patient by clinicians A and C, with clinician B reporting <sup>7</sup>no change in the patient's level of confidence.

Both clinicians A and C indicated <sup>8</sup>fluctuations in the patient's volume of speech and an <sup>9</sup>increase in assertiveness. Clinician B observed <sup>10</sup>no changes in this regard.

With regards to the patient's level of congruency, clinicians A and C the patient was <sup>12</sup>congruent. With clinician C adding that the <sup>11</sup>level of congruency was constant. Clinician B was <sup>18</sup>unclear on this point.

Clinicians A and B indicate that there was <sup>17</sup>no decrease in the patient's overall symptomatic behaviour.

*Answers to the standardized questions in analysis by one clinician:*

Clinician C indicated a <sup>16</sup>slight decrease in overall symptomatic behaviour.

*Additional clinical observations:*

Clinician A added included a comment that the therapist <sup>14</sup>validated associations that the patient made instead of validating accurate observations, concluding that this could impact on the patient's behaviour (The patient made links with what something looks like instead of naming the object that he sees – thus the therapist was not validating accurate observations but associations which was not what the therapist had asked the patient to do). In theory this would reinforce the patient's symptomatic behaviour, perhaps leading to an increase in distanced and symptomatic behaviour. Findings of this session need to be interpreted in this light.

Clinicians B and C added that despite some changes, a <sup>15</sup>large emotional distance was maintained in the session.

*Conclusion: effectiveness of therapeutic 'reality validation'*

Once again only small changes were observed in the patient's symptomatic behaviour. This could be viewed in light of the inaccurate feedback given to the patient. As previously discussed validations of associations and not 'reality' would ultimately reinforce this distorted and distanced form of communication and ultimately lead to the maintenance or an increase in symptomatic behaviour. Thus since the 'reality validation' was inconsistently applied (at times accurately and at times inaccurate), inconsistent results should in theory occur. This is exactly what happened in this session. The analysts observed some indications of decreases in the patient's symptomatic behaviour. Whereas some symptomatic features were still very much intact.

When comparing the pre- and post-clinical pictures, there is however a clear difference since the bizarre delusions, inappropriate behaviour (undressing), hallucinations, aggressive behaviour, psychomotor agitation and thought blocking were not present during 'reality validation'. Thus based on this picture and the small shifts that occurred within the session (increase in confidence and decrease in distance), the conclusion can be made that 'reality validation' was moderately effective.

#### **4.5 DISCUSSION AND CONCLUSION**

The aim of the study was to investigate the effects of therapeutic 'reality validation' on the 'schizophrenic dance'.

- 'Reality validation' was effective with candidate 1. This conclusion was reached based on indications that there was a decrease in emotional distance and increases in logical and systematic communication, volumes of speech and assertiveness, thus indicating a reduction in symptomatic behaviour. Also, when taking into account that none of the symptomatic behaviour, as described by the residing psychiatrist, was observed, a conclusion can be drawn that 'reality validation' was an effective therapeutic tool in this session resulting in the patient abandoning symptomatic behaviour within the therapeutic context. Remarkably, it was noted by the residing psychiatrist that on the day of 'reality validation' post treatment, the psychiatrist was unable to elicit any symptomatic behaviour on questioning, including the patients unshakable delusions. It was the first time since the patient had been admitted that she appeared symptom free. The following day the symptomatic behaviour was once again observable. Thus, it appears that 'reality validation' had a profound effect on the patient on the day of the treatment, which was somewhat short-lived. This, in light of the fact that it was a treatment of a very short duration, highlights the possible effects of the same treatment for extended periods of time.

- ‘Reality validation’ was effective with candidate 2. This conclusion was reached based on observations by the analysts that there was a decrease in emotional distance and increased congruence and volume of speech, indicating a reduction in symptomatic behaviour. In addition, when taking into account that none of the pre-clinical symptomatic behaviour, as described by the residing psychiatrist, was observed, a tentative conclusion can be made that ‘reality validation’ was responsible for this change in the patient’s manifestation of his symptomatic behaviour.
  
- ‘Reality validation’ was moderately effective with candidate 3. As discussed in the previous section, false feedback was at times given by the therapist. This may have impacted on the effectiveness of ‘reality validation’ in this session, resulting in the maintenance or an increase in symptomatic behaviour since the patients associations of ‘reality’ were reinforced, rather than actual ‘reality’. This could ultimately reinforce symptomatic behaviour and would have profoundly affected the outcome of this session and findings should be interpreted as such. Despite these shortcomings, there were some indications of a reduction in emotional distance, increases in confidence and volume of speech. According to the analysts only small shifts in the patients behaviour occurred during the process of ‘reality validation’, but they were shifts nonetheless. In addition, when taking into account that no overt indications of symptomatic behaviour, as described by the residing psychiatrist, were observed, a tentative conclusion can be drawn that ‘reality validation’ was responsible for this. Based on the observed behavioural changes by the analysts the conclusion can be made that ‘reality validation’ was moderately effective in this session resulting in some decreases in symptomatic behaviour.
  
- ‘Reality validation’ was not conducted as described in the research design in the session with candidate 4. Instead the therapist was unable to effectively take control and this resulted in a symmetrical relationship. What occurred in this intervention is in line with the theory that the schizophrenic regulates emotional

distance. In this threatening environment, the patient became more symptomatic as evidenced by the analysts observations that there were increases in emotional distance and that the patient remained illogical and unsystematic in his communication throughout. This intervention which was symmetrical in nature resulted in an increase in symptomatic behaviour.

- ‘Reality validation’ was to some extent effective with candidate 5, this conclusion was drawn when taking into account some indications of a reduction in emotional distance, increases in systematic communication, increase in confidence, congruence and assertiveness. Additionally, when taking into account that no overt indications of symptomatic behaviour, as described by the residing psychiatrist, were observed, a conclusion can be made that ‘reality validation’ was effective in this session resulting in slight reductions in symptomatic behaviour.
  
- ‘Reality validation’ was moderately effective in session 6, since there were some indications of a reduction in emotional distance and an increase in confidence. It was noted that in this session the therapist validated associations made by the patient instead of validating accurate observations. In theory, this would have maintained or increased the patient’s level of symptomatic behaviour. Since this error had not occurred consistently, changes in the patient’s behaviour were still evident, but perhaps not as clear as they may have been had the error not occurred. However, of importance is the fact that no overt indications of symptomatic behaviour, as described by the residing psychiatrist, were observed. Based on this and the observations of the analysts that there was a reduction in some symptomatic behaviour, the conclusion can be made that in this session ‘reality validation’ was moderately effective

It is clear that there is evidence to support the efficacy of ‘reality validation’ in most of the sessions, and that in general, when used effectively it leads to a reduction in some if not all of the symptomatic behaviour such as decreases in emotional distance, increases in

logical and systematic behaviour, increases in confidence, assertiveness, congruence and volume of speech.

What is remarkable is that very little symptomatic behaviour was observed in at least five of the six candidates during the process of 'reality validation' even though all of the candidates were diagnosed with schizophrenia and regarded symptomatic at the time by the residing psychiatrist. That no or very little symptomatic behaviour was observed in the context of 'reality validation' is highly significant.

Also of importance is that in three of the sessions, the therapist conducted 'reality validation' inaccurately. This was immediately evident in the results. In session four, the therapist conducted 'reality validation' so ineffectively, that it resulted in a symmetrical struggle. This session resulted in a profound increase in symptomatic behaviour and supports the literature which indicates that the schizophrenic regulates emotional distance and increases symptomatic behaviour in threatening situations. The other two sessions in which 'reality validation' was applied inconsistently, resulted in more inconsistent results and smaller shifts in symptomatic behaviour. Had this not occurred perhaps clearer results would have occurred. This highlights the sensitivity of the patient to differences in approach to the schizophrenic patient.

Despite these shortcomings, 'reality validation' resulted in an observable change in the patient's symptomatic behaviour in sessions 1, 2, 3, 5 and 6. There were some clear reductions across sessions (apart from session 4) in some of the symptomatic behaviour such as a reduction in emotional distance, an increase in logical and systematic communication, an increase in confidence and assertiveness and volume of speech and in increase in congruence was observed. When taking the shortcomings into account, it is possible that if these were addressed, more conclusive results would arise, giving more evidence for the efficacy of 'reality validation'.

## **CHAPTER 5**

### **CONCLUSION**

The considerable and persistent personal and social consequences of schizophrenia are well known: the chronicity of the illness and its impact on cognition, health, functioning and quality of life leave many sufferers and their families with devastated lives (Knapp and Healey, 1997). The consequences can clearly be far reaching in individual and social terms, and they can also be enormously burdensome in economic terms when taking into consideration that there is a one in a hundred lifetime risk (Frith & Johnstone, 2003). The costs of schizophrenia fall to the individual patient, his or her family and other caregivers, the healthcare system and to the wider society. Some of these costs are directly connected to the care and treatment of schizophrenia, whilst others are more indirect, perhaps long term and often almost hidden from observation. Therefore, these wide ranging consequences need to be recognized in professional practice and empirical research (Knapp & Healey, 1997).

Psychological therapies are argued to be scarce relative to the number of schizophrenia patients who might benefit from them. It has been suggested for example, that too many clinicians are spending less time on 'seriously ill' patients and more on less serious neuroses and affective disorders (Knapp & Healey, 1997). Considering the vast numbers of individuals diagnosed with schizophrenia, the need for therapeutic assistance far outstrips available resources. Due to these shortcomings in the treatment of schizophrenia, there is a desperate need for the development of effective and practical tools that can be used in the treatment of schizophrenia and which can be imparted to those of different professions, thus reaching a greater number of individuals.

Thus, the aim of this study was to take a fresh look at the literature on schizophrenia and based on this, test a strategy or therapeutic tool that would logically follow from the literature as an effective intervention in changing the 'schizophrenic dance'.

The research focusing on interactional theories on schizophrenia explains ‘schizophrenic symptoms’ in terms of the function that they serve within a schizophrenically defined relationship. These theories postulated that the individual diagnosed with schizophrenia avoids defining his relationships with others at any expense through the mechanism of his ‘distancing’ symptomatic behaviour characteristic of the schizophrenic. The individual diagnosed with schizophrenia is experienced as unreachable by all who come into contact with him, including family and, in particular, those trying to treat him. Some descriptions of the schizophrenic, such as being detached from reality, isolated and withdrawn are only a few used to illustrate the distance created by the schizophrenic symptoms. Those attempting to communicate with schizophrenic patients and, in particular, treat the schizophrenic may experience difficulty and frustration when trying to make a connection with the patient. The schizophrenic seems to use the symptomatic behaviour for the function it serves, and that is to create distance within the relationship. Once the patient learns to make use of this symptomatic behaviour across contexts, he inadvertently learns to behave repeatedly as such and perceive his world in terms of distorted communication, thus the distortion in his perception of reality. In systemic terms, this symptomatic behaviour of the schizophrenic patient can be termed the ‘schizophrenic dance’ and has been the focus of the investigation in the current study.

The objective of this study was to investigate the effects of therapeutic ‘reality validation’ on individuals diagnosed with schizophrenia or the ‘schizophrenic dance’. This was done through evaluating the implementation of therapeutic ‘reality validation’. The therapeutic ‘reality validation’ was applied by a trained clinician with six selected candidates which were considered suitable for the study. They were selected from the psychiatric unit at Dr. George Mukhari Hospital. Each of these six sessions was video recorded and transcribed. These data were then given to three independent clinicians to analyze according to specific questions which were posed indicative of the effects of therapeutic ‘reality validation’.

The analysis of each candidate's session was presented with each of the three clinicians' analyses together in a table format. Arranging the data in this manner assisted in providing a clear picture of what occurred in each interview and allowed for a comparison of each of the clinician's analyses. The analyses were integrated, drawing out similarities, and a conclusion was reached on the effect that this intervention had on the 'schizophrenic dance'.

The analyses of therapeutic 'reality validation' showed encouraging results. Based on five of the conducted sessions, there were clear indications of behavioural changes in the individuals which were indicative of a reduction in symptomatic behaviour. Although the amount of change varied from candidate to candidate, even the small changes are indicative of progress in the direction of change. Results indicated that when 'reality validation' was conducted inaccurately or inconsistently, the results were less profound but still evident. In one of the sessions in which 'reality validation' was conducted so ineffectively (of a symmetrical nature) that in fact it should probably be renamed as another intervention, it led to an increase in symptomatic behaviour. This session was in such contrast to the goals of 'reality validation' that perhaps it can be viewed as a control session and in this case would support the findings that when conducted accurately 'reality validation' results in a reduction in symptomatic behaviour.

Therapeutic 'reality validation' as a means of approaching the schizophrenic patient deals with some of the challenges posed by the schizophrenic patient to those attempting to communicate with him or treat him. It is a small step in a long process which brings the patient somewhat closer in touch with reality and those around him. Although therapeutic 'reality validation', in the way it was employed for the purposes of the study, does not create sudden and dramatic long-term change, the immediate effects on the patient are apparent, leaving room for further exploration and improvement with this method and possible adaptations thereof.

This study was confronted with the following challenges and limitations:

- No baseline data were available;
- A control group was not used for comparisons due to difficulty in obtaining sufficient candidates;
- There are many extraneous and confounding variables that could have contributed to the observed effects, including medication of the patients, observed patient physical variables (such as one patient incontinence) and therapist error;
- The sample size was too small for findings to be generalized;

Nevertheless, this study being a preliminary exploratory study provided valuable insights that could contribute significantly to the effectiveness of those working with individuals diagnosed with schizophrenia.

Future studies in the field of psychotherapy with patients diagnosed with schizophrenia through therapeutic ‘reality validation’ could benefit from taking the following recommendations into account:

- Attempting to increase experimental variance while minimising confounding and extraneous variance;
- The use of larger sample size in order to generalize findings;
- The inclusion of a control group;
- More preparedness on the part of the therapist, paying particular attention to more accurate feedback to the patient.

Therapeutic ‘reality validation’ resulted in observable behavioural changes in at least five of the six therapeutic trials. **The conclusion can be made that therapeutic ‘reality validation’ is a potentially effective tool which in the sample studied lead to observable changes in the ‘schizophrenics’ behaviour. The results hold the promise of further progress toward changing the ‘schizophrenics’ interactional pattern and thus the ‘schizophrenic dance’.**

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**APPENDIX A**

UNIVERSITY OF LIMPOPO (Medunsa Campus) CONSENT FORM

**Statement concerning participation in a Clinical Research Study.**

Name of Study

**The effect of therapeutic “reality validation” on the ‘schizophrenic dance’: A preliminary study.**

I have been informed of the general aims and objectives of this study, in particular that it is a risk free therapeutic trial. I have not been pressurized to participate in any way.

I understand that participation in this Clinical study is completely voluntary and that I may withdraw from it at any time.

I know that this has been approved by the Research, Ethics and Publications Committee of Faculty of Medicine, University of Limpopo (Medunsa Campus)/ Dr George Mukhari Hospital. I am fully aware that the results of this study will be used for scientific purposes and may be published. I agree to this provided my privacy is guaranteed.

I hereby give consent to participate in this study.

.....

Name of participant

.....

Place

Date

Witness

**Statement by the Researcher**

I provided verbal information regarding this study.

I agree to answer any future questions concerning the study as best as I am able.

I will adhere to approved protocol.

Bonny Cameron

.....

.....

.....

Name of researcher

Signature

Date

Place

## APPENDIX B INTERVIEW 1

**Interviewer:** (Participants name)

**Participant:** Mmmm

**Interviewer:** (Participants name), if you have a look behind you over there, there's something in the middle over there

**Participant:** Change

**Interviewer:** Okay, that d, that does, there's something there that says change, exactly. That's right. It says change, I agree with you.

**Participant:** For women only

**Interviewer:** Pardon

**Participant:** For women

**Interviewer:** For women only, yes, I agree with you, that's what it says. It says for women only over there I agree with you. And over there, next to, next to those books.

**Participant:** It's a camel

**Interviewer:** That's right, that's exactly right, it is a camel, I agree with you, I also, when I look at that I see a camel. Okay, I agree with you.

**Participant:** Abhu Dhabi... Abhu...Abhu Dhabi

**Interviewer:** Abhu Dhabi, yes, that's exactly right, it says Abhu Dhabi on the on the back of the camel, it says Abhu Dhabi. I agree with you.

**Interviewer:** (picks up keys) And this, can you tell me what this is?

**Participant:** A key

**Interviewer:** Exactly, it's a key. Can you tell me a bit more about the key?

**Participant:** It opens

**Interviewer:** Exactly

**Participant:** The lock

**Interviewer:** Exactly right, when you put it in the lock it opens the lock, exactly right, I agree with you. Um and this?

**Participant:** Mineral water

**Interviewer:** That's very accurate, that's a that's mineral water, that's exactly right, mineral water

**Participant:** And this is my personal information (points to hospital tag on her arm)

**Interviewer:** Exactly, I agree with you

**Participant:** Personal and patient

**Interviewer:** So it's the patient information, personal information and patient information. Exactly you are right, exactly right. Okay that's a very accurate description that. How about this, can you tell me what this is? (picks up newspaper)

**Participant:** Paper

**Interviewer:** Exactly, it is a paper, I agree with you, I also see a paper, can you tell me more about the paper?

**Participant:** It's a newspaper; it updates people about the happenings. The headlines the headlines of what's happening in the world.

**Interviewer:** That's exactly, exactly right, so it's a very accurate description, you are right, it updates people, it tells you what's going on in the world, I agree with you. Exactly right, um, how about this?

**Participant:** It's a mirror

**Interviewer:** It's a mirror

**Participant:** Where you see yourself, look at yourself, view your features

**Interviewer:** Okay, I agree, exactly, its exactly, that's exactly what it is, it's a mirror, where you can see yourself, you can look at your features. That's exactly right, exactly, it is a mirror.

**Interviewer:** And on the bed over there?

**Participant:** It's a magazine

**Interviewer:** That's right, that's exactly it, it's a magazine, I agree with you. Can you describe it for me?

**Participant:** Longevity

**Interviewer:** It says Longevity. Yes.

**Participant:** Longevity

**Interviewer:** Yes

**Participant:** Diane Lane. (reading headlines on the cover of the magazine)

**Interviewer:** Diane Lane.

**Participant:** Slim down, tone up.

**Interviewer:** That's exactly right

**Participant:** Show off.

**Interviewer:** MMhmm, that's right

**Participant:** Easy plans to get results fast.

**Interviewer:** Exactly

**Participant:** Can vitamin C reduce your risk of diabetes?

**Interviewer:** Yes, you, that's exactly right

**Participant:** When a bad attitude is good for you

**Interviewer:** Mhmmm, it says that, I agree.

**Participant:** Friends and money, bridging the wealth gap.

**Interviewer:** Exactly, okay.

**Participant:** Exclusive, exclusive, my miracle baby was conceived from a frozen egg

**Interviewer:** Yes, that's exactly what it says, I agree with you, I've read that and I I also see that it says that. Okay um, how about this (points to stationary holder). Can you tell me what that is?

**Participant:** It's a pencil holder, pen, a holder for writing equipment, stationery.

**Interviewer:** I agree with you a hundred percent, it's a holder that you keep stationary equipment, that's exactly right, I agree with you, I also see that. Um, and how about, what are those um things on the on the fridge (points to cutlery and crockery on a small fridge), what do you see there?

**Participant:** Kitchen equipment

**Interviewer:** Kitchen equipment

**Participant:** For eating, eating and drinking

**Interviewer:** Yes

**Participant:** Washing dishes

**Interviewer:** Yes

**Participant:** Spoons

**Interviewer:** Yes, exactly, its kitchen equipment for washing, there's spoons, all sorts of things there.

**Participant:** Eating

**Interviewer:** And for eating, exactly, I agree with you. And how about what you are sitting on? Over there.

**Participant:** It's a chair

**Interviewer:** Exactly, I agree. Can you describe the chair to me?

**Participant:** It's a plastic, leather chair

**Interviewer:** uhuh

**Participant:** With steel frame.

**Interviewer:** Exactly its got a steel frame.

**Participant:** Grey painted

**Interviewer:** And its painted grey

**Participant:** Floor, floor protective covers, four

**Interviewer:** Exactly, the floor has got protective rubber on that, I see exactly the same thing, that's right, same; I see exactly the same thing.

**Participant:** No, the chair

**Interviewer:** Hey? Oh, on the chair, okay, I thought you were talking about the ground. Yes, okay.

**Participant:** Protective rubbers, protect the floor from the chairs.

**Interviewer:** Yes, okay, so there are protective rubbers that stop this floor from scratching. Okay, I agree with you, I actually, I do see that too, that's exactly right.

**Interviewer:** Okay (participants name), I think that's all then for today. Okay.

**APPENDIX C**  
**INTERVIEW 2**

**Interviewer:** Okay, (participants name), um, Id like you to just take a look over here on the bed, what do you see there?

**Participant:** It's the books

**Interviewer:** It's books, yes

**Interviewer:** That's right I agree its books. Can you describe them to me?

**Participant:** No

**Interviewer:** You can't describe them? Okay, alright

**Participant:** Longe... Longevity

**Interviewer:** Longevity, okay, that's right, I agree with you, that's what it says, I agree.  
(pause) How about this?

**Participant:** It's a Bonaqua

**Interviewer:** That's exactly right, it's a Bonaqua, okay, I agree with you. Okay, um (participants name) how about, if you look behind you, in the middle over there, can you tell me what that is? (Long pause whilst participant looks toward object twice)

(long pause)

**Participant:** It's a camel

**Interviewer:** It's a camel, that's exactly right, it is a camel, I agree with you. I also, when I look there I see a camel. I agree. Okay, and next to the camel?

**Participant:** Psychologist books

**Interviewer:** Psychologist books, that's a very accurate description, I agree. Psychologist books there, that's right, okay. Can you tell me anything about those psychologist books?

**Participant:** No, I don't have a idea about this because I didn't read. I don't know what is going on about these psychologist books.

**Interviewer:** Okay, so you haven't read inside, so you can't, I agree, you cant tell me anything about it if you haven't read it.

**Participant:** (mumbles something)

**Interviewer:** I agree you can't explain if you haven't read it. Okay, can you tell me what this is?

**Participant:** It's a car key

**Interviewer:** It's a car keys, that's right, okay, these are car keys; can you tell me anything, can you describe it to me?

**Participant:** It's got a immobiliser

**Interviewer:** There's an immobiliser, yes

**Participant:** For gate keys

**Interviewer:** For gate keys, okay, maybe its both, I agree with you, okay, it's an immobiliser

**Participant:** Immobiliser for the gate key

**Interviewer:** Okay, I agree with you

**Participant:** Or for the door or what, I don't know

**Interviewer:** So its like some sort of immobiliser, either for a door or gate, yes, okay, I agree with you, it is, it's a kind of an immobiliser. Okay.

**Interviewer:** How about this? (picks up news paper) Can you tell me what this is?

**Participant:** It's a book

**Interviewer:** It's a book, yes I agree with you, its some kind of book. Can you describe it to me?

**Participant:** Of life

**Interviewer:** A book of life (laughs) I agree with you it says life over there, okay I didn't see that, but now I see that, I agree with you it says life over there. Okay, I agree, anything else?

**Participant:** No

**Interviewer:** No, okay

**Interviewer:** Alright, how about this?

**Participant:** It's near a mirror

**Interviewer:** It's near a mirror, yes, it is, I agree with you, that's right, can you describe it to me?

**Participant:** What?

**Interviewer:** The, the mirror that, you pointed out that it's a mirror; I agree with you, can you describe it to me? Can you tell me something about it?

**Participant:** I see my face

**Interviewer:** That's right you can see your face in the mirror. Okay. (participants name) how about this, can you tell me what that is?

**Participant:** It's a chocolate

**Interviewer:** It's chocolate? Okay (pause). You see chocolate. Okay. What about this over here have a look down here? Can you tell me what this is?

**Participant:** It's a plastic bag

**Interviewer:** It's a plastic bag, okay, I agree it is a bag; it is a bag, that's right. Its definitely a bag. And on the fridge?

**Participant:** What?

**Interviewer:** Can you see what's on the fridge?

**Participant:** No I didn't open to see inside

**Interviewer:** Okay, so you can't see what's inside, no, okay

**Participant:** Unless I open it

**Interviewer:** Unless you open it, that's right, so if you open it you can see what's inside

**Participant:** Can I open it? (laughs)

**Interviewer:** You want to open it, how about..

**Participant:** If you don't mind

**Interviewer:** What's on top? Can you see what's on top there?

**Participant:** Dishes

**Interviewer:** Yes I agree, there are dishes on top there

**Participant:** Coffee dishes

**Interviewer:** Coffee dishes, yes. Can you tell me anything about them?

**Participant:** I don't know

**Interviewer:** You don't know, okay. Alright (participants name), that's all then for today. Okay.

**APPENDIX D**  
**INTERVIEW 3**

**Interviewer:** Okay, its (participants name)

**Participant:** Yes (participants name)

**Interviewer:** Okay, alright um (participants name) have a look at this thing over here?  
Can you tell me what it is?

**Participant:** A mirror (smiles)

**Interviewer:** A mirror, okay, I agree with you, okay, I agree with you, it is a mirror. Tell me what you are seeing there.

**Participant:** I see myself

**Interviewer:** You see yourself

**Participant:** I see my face. Yeah

**Interviewer:** Okay, you see yourself in the mirror

**Participant:** (Nods)

**Interviewer:** I agree with you, when you look in the mirror, you can see yourself.  
Alright, let's see, how about this? Can you tell me what this is?

**Participant:** It's a bottle of Bonaqua

**Interviewer:** It's a bottle of Bonaqua, exactly right; I agree with you, it's a bottle of Bonaqua. Can you, can you describe it to me?

**Participant:** What? The bottle?

**Interviewer:** This

**Participant:** The bottle?

**Interviewer:** The bottle of Bonaqua, ja.

**Participant:** It's a blue bottle

**Interviewer:** Okay

**Participant:** A blue bottle

**Interviewer:** It's a?

**Participant:** A blue bottle

**Interviewer:** A blue bottle, exactly, that's right, okay, anything else? No?

**Participant:** No

**Interviewer:** No? How about what you are sitting on?

**Participant:** A chair

**Interviewer:** I agree, yes, it is, it is a chair. Can you tell me about the chair?

**Participant:** It's a brown chair

**Interviewer:** It's a brown chair, that's right, anything else? No

**Interviewer:** Okay, I agree with you it's a brown chair, that's exactly right. How about this over here, can you tell me what that is?

**Participant:** It's a box of pencils, a bag of pencils

**Interviewer:** A box of pencils

**Participant:** Yeah

**Interviewer:** That's exactly right, it's a box and it's got pencils. That's exactly right, I agree with you, I see that too. Um lets see, and on the bed over there? Can you tell me what that is?

**Participant:** Magazines

**Interviewer:** Magazines, that's right

**Interviewer:** Okay, can you describe them to me?

**Participant:** The magazines?

**Interviewer:** Ja, can you describe the magazines?

**Participant:** Theres a, (stutters lady – partly inaudible) theres theres theres theres theres a lady

**Interviewer:** There's a lady, I see that too. I agree there's a lady on the front page. Anything else? No?

**Interviewer:** How about this (picks up newspaper)

**Participant:** Newspaper

**Interviewer:** That's right, it's a newspaper, I agree, can you tell me about the newspaper?

**Participant:** (stutters – partly inaudible) the we we we we hear we hear we hear different news

**Interviewer:** You hear different news, okay so when you read it, you hear different news, that's exactly right, when you read the newspaper, it tells you all the different news. Okay, that's exactly right, I agree with you. Anything else?

**Participant:** No

**Interviewer:** No, okay. How about that behind you?

**Participant:** Books

**Interviewer:** Books, ja, its books, I agree can you tell me more about them?

**Participant:** There are four

**Interviewer:** Okay, you counted them and you see there is four, I agree, I also, I am counting, one, two, three, four, I agree, that's exactly right. Anything else about the books?

**Participant:** No

**Interviewer:** No, okay, alright, and how about next to those books, there is something there next to those books, can you tell me what that is?

**Participant:** A puppy (the object is in fact a stuffed camel, however it does appear somewhat like a puppy)

**Interviewer:** A puppy, okay alright. Can you tell me anything about that puppy? I agree, it is its a puppy

**Participant:** (inaudible)

**Interviewer:** Can you tell me something about it?

**Participant:** There's, there's a label

**Interviewer:** There's a label on it, exactly, and?

**Participant:** That's all

**Interviewer:** That's all, okay, so it's a puppy with a label on it, I agree. I see that too, okay on top of the fridge, there are a few things

**Participant:** Cups

**Interviewer:** Cups (long pause) I agree with you, I see cups. Anything else there?

**Participant:** And the and the the th eh the Tupperware Tupperware

**Interviewer:** There's a Tupperware, I can see that as well. Anything inside the Tupperware?

**Participant:** Yes

**Interviewer:** What do you see there?

**Participant:** (gets up to look) Knives

**Interviewer:** Knives, okay, I agree, there are knives inside there. That's exactly right. Okay, this over here, can you tell me what that is?

**Participant:** A bag, brown bag

**Interviewer:** A brown bag, exactly. That is right, I agree, that is a brown bag. Anything else about that bag, that you can tell me?

**Participant:** No

**Interviewer:** No, okay, that's a that's an accurate description, everything you have told me is very accurate, its right, that's a mirror, those are chairs and it's a brown chair. Everything is right, okay, how about, let's see, this, can you tell me what this is?

**Participant:** It's a pen

**Interviewer:** It's a pen, exactly. Can you tell me about the pen?

**Participant:** It's a blue pen

**Interviewer:** It's a blue pen, I agree, that's exactly right. Okay (participants name) that's all for today. Okay.

**APPENDIX E**  
**INTERVIEW 4**

**Participant:** (Talks to interviewer whilst turning the camera on) ...eh, the paper, the pen and paper

**Interviewer:** Okay

**Participant:** Ja, when your camera is going to be on, I going to take so, and read, I look the camera.

**Interviewer:** Okay

**Participant:** Eh

**Interviewer:** Alright, um before we do that

**Participant:** Yea

**Interviewer:** (Participant's name), um, just have a look behind you over there

**Participant:** Where?

**Interviewer:** Over there

**Participant:** Over there? (Touches books)

**Interviewer:** Yes, can you tell me what that is?

**Participant:** It's a book

**Interviewer:** It's a book, that's right

**Participant:** Yes

**Interviewer:** It's a book, I agree with you

**Participant:** Yes

**Interviewer:** Okay I agree with you, it's a book and if you look behind you, next to, next to the book

**Participant:** (Picks up another book) Next to the book

**Interviewer:** Okay, what is that?

**Participant:** Eh, it's a book

**Interviewer:** Yes, okay, um, this is also a book, and then again if you look over there, next to the book

**Participant:** There

**Interviewer:** No, no

**Participant:** This?

**Interviewer:** Yes that one and next to the book

**Participant:** That side (picks up another book)

**Interviewer:** Okay, can you tell me what that is?

**Participant:** This, eh, its one of the family

**Interviewer:** Its one of the family

**Participant:** Ja, it's the emblem of respectful whites

**Interviewer:** Okay

**Participant:** ...as I talk with the respectful whites, I talk like you are emblem so, because you know all you have got the emblem, yes

**Interviewer:** So, so far you said that these are books hey?

**Participant:** Where is toilet, I can

**Interviewer:** You want to go to the toilet?

**Participant:** Toilet, yes

**Interviewer:** Um okay, you can go to the toilet. The security guy is over there, you can come back

**Participant:** Oh (leaves room)

**Interviewer:** Follows participant to security guard to escort participant at which point he decides not to go to the toilet)

**Interviewer & Participant:** (both enter room again)

**Interviewer:** Okay, you can take a seat

**Participant:** I can... (mumbles)

**Interviewer:** (Participant's name), what is this? (picks up keys)

**Participant:** Oh, its it's the I don't know, all everything is registered

**Interviewer:** It's registered

**Participant:** Its registered in the emblem of eh (looks at bottle of water) barcode

**Interviewer:** (points to barcode on bottle) so here you see a barcode

**Participant:** Yes

**Interviewer:** I agree with you, it is a barcode

**Participant:** Me, I support, this is a key, it's a key

**Interviewer:** Exactly right

**Participant:** Ja

**Interviewer:** I agree with you, its a key

**Participant:** Ja, it's a key

**Participant:** So me I'm not the problem, my aunt...

**Interviewer:** Okay before, before you um, make the speech for the camera, can you tell me what this is?

**Participant:** This, I think it can be (pauses thinking) a what you call, what about, what about a a sweet ma

(phone rings)

**Participant:** Sweet

**Interviewer:** Okay a sweet

**Participant:** Yes

**Interviewer:** Okay and if you have a look on the bed over there

**Participant:** Eh

**Interviewer:** Can you see anything on the bed over there?

**Participant:** Here?

**Interviewer:** Yes, what do you see, what is that over there on the bed?

**Participant:** On the bed

**Interviewer:** Ja, on the bed over there

**Participant:** Oh, you see it's your, it's your look ingram because as a barcode

**Interviewer:** (points to barcode on the bottle) I agree with you, it is a barcode

**Participant:** Yes

**Interviewer:** I agree with you

**Participant:** Yes

**Interviewer:** I also see the barcode

**Participant:** Yes

**Interviewer:** Okay, alright (participants name), um

**Participant:** Eh?

**Interviewer:** This over here (picks up newspaper) Can you tell me what that is?

**Participant:** A barcode of you

**Interviewer:** A barcode okay, alright, what else can you tell me about this

**Participant:** No, you see you .... Talk so

(Phone rings)

**Interviewer:** Yes

**Participant:** I, I, I yes do you see when I talk so I just nkobetsi, ngigobetsi, I just drain blood, eh my grandfathers farm there at Kliprivier

**Interviewer:** Okay

**Participant:** Ja, eh, the time when I see the, the skiet fly come, so uyabona, you that call.

**Interviewer:** (Participants name)

**Participant:** You've got a, you've got a pen?

**Interviewer:** I do

**Participant:** But I can draw that, look, I can draw (leans over to pick up paper), give me a chance

**Interviewer:** (Participants name)

**Participant:** Let us trust, I assist you

**Interviewer:** I am going to give it to you

**Participant:** I assist you, let bring so

**Interviewer:** Okay

**Participant:** Ja

**Interviewer:** No (tries to pick up another paper)

**Participant:** You see that thing, no I can so, I put here have in your barcode, understand, no problem, your barcode, yeah

**Interviewer:** So this is a barcode (points again to barcode)

**Participant:** Yes it's yours, it's not mine, yes it's yours

**Interviewer:** I agree with you, it is my barcode

**Participant:** Yes, it's your barcode, I've got no problems, eh you see that call eh give you ja, give you so, so

**Interviewer:** What is that you are folding?

**Participant:** So when are you, I, I, there at the farm of my, at Kliprivier I get I get, you've got a cellotape?

**Interviewer:** I don't know, what do you want to use the cellotape for?

**Participant:** Or cellotape to, to massage here

**Interviewer:** What is that?

**Participant:** You see, you know the treams, you see the tree, when you see the tree, you see maybe, you want the wood ne? You make..... that call lepaka, yes so after, you make so (shows chopping motion) then the wood is coming, uyabona so when the skiet fly move there, its ther gweee. I mean what is wrong? It's the war or what? Look I just look.

**Interviewer:** I am looking (points to books again)

**Participant:** Eh

**Interviewer:** What is that (participants name)? What is that over there?

**Participant:** Well when I look above the with that eh, eh lepaka, when I look so I I That skiet fly ca ja uyabona that skiet fly is stray uyabona, so I said so mona hawu so uyabona I said eish my heart is jump other way so I, I make sure I ja I take wood so, like so bona so understand I said so, uyabona, and after eh, the blood is out, aah now now look, now

look, I just drain that blood uyabona, when I move I go there and there, its that.... Eh it's not a problem because even now I

**Interviewer:** (Participants name)

**Participant:** Mmm

**Interviewer:** I will, I will um, we are going to talk about your speech just now for the camera; you said you wanted to for the camera here. You said this is a camera, okay um you wanted to do a speech, yes we, yes we can, that is a camera and you can do the speech okay

**Participant:** Uyabona

**Interviewer:** Um, for now just behind you those books, look next to, next to those books, there's something there in the corner, can you tell me what that is?

**Participant:** E ghukona

**Interviewer:** Over there, over there, just behind you

**Participant:** I just look next here (point to floor)

**Interviewer:** Okay, what is that there?

**Participant:** Oh there you see oh (turns to look where interviewer initially pointed)

**Interviewer:** What is that?

**Participant:** (gets of chair to look at object)

**Interviewer:** Yes

**Participant:** This?

**Interviewer:** Yes, that's it, can you tell me what that is?

**Participant:** It's a, what is this, this, its not a stamp?

**Interviewer:** There is a stamp on there (referring to the badge on item)

**Participant:** Yes, it's your barcode

**Interviewer:** Huh huh

**Participant:** Huh

**Interviewer:** It looks like a barcode, similar to this one hey?

**Participant:** Eh

**Interviewer:** Similar, it looks similar to this barcode (points to barcode on bottle) I agree with you

**Participant:** Eh, ja its just like a barcode

**Interviewer:** I agree with you it looks like a barcode too

**Participant:** Ja

**Interviewer:** There is something, it's like a stamp on there

**Participant:** Eh, ja

**Interviewer:** I agree with you

**Participant:** Yes, you start ah, that so, I've got my mum here ne, I..

**Interviewer:** Okay, before you continue

**Participant:** Ja, I, I

**Interviewer:** Can you tell me what this is?

**Participant:** Eh

**Interviewer:** Can you tell me what this is? Do you know what this is?

**Participant:** No, I deliver that speech; I talk about that your stamp

Woa

**Interviewer:** About the stamp, okay yeah lets can you tell me about the stamp

**Participant:** Eh, so when I see there, I, I see the skiet fly so, that blood is out, uyabona, I see eina, I go there ne, I get the what kind the eh eh lerabo ja that make you and after I move even now my father is die ne, no money that I can get so and I know, know maar haauwaa, I must go back home, uyabona

**Interviewer:** Okay

**Participant:** Eh

**Interviewer:** Okay (participants name), can you tell me then okay again, what is this?

**Participant:** This?

**Interviewer:** Yes can you tell me what that is?

**Participant:** No, this I think...

**Interviewer:** Can you tell me what it is?

**Participant:** It's your try commission

**Interviewer:** Okay

**Participant:** Its your...

**Interviewer:** And what about this? (picks up keys)

**Participant:** It's still your l-emblem

**Interviewer:** Okay, and what about uh, this?

**Participant:** Ah, there you jump, you jump, you jump your emblem stand

**Interviewer:** Did I jump? Okay I agree I did jump. What is this?

**Participant:** Ah, maar you are, just just just no me you you see...

BREAK IN VIDEO FOOTAGE

**Participant:** My, my decoration, my my decoration. I like to decorate, to stop to feel ne about eh eh silver

**Interviewer:** What about these/?

**Participant:** Uh

**Interviewer:** Can you tell me what those are? Over there?

**Participant:** No

**Interviewer:** Have a look over there?

**Participant:** Uh, uh no maar awughuti you look

**Interviewer:** Okay

**Participant:** Look, look I I don't I look, look, ek vra first...

**Interviewer:** Just before I look, what is that over there? (Participants name), can you tell me what that is over there?

**Participant:** Where?

**Interviewer:** Can you, can you tell me what that is? Over there

**Participant:** AAhu yes

**Interviewer:** What, what is that? Can you tell me? Can you describe it?

**Participant:** No it's a place that eh I want to relax

**Interviewer:** Okay, so it's a place you want to relax, how about this. Can you tell me what this is?

**Participant:** Yes I tell my blood is move uyabona and when I, if you've got a problem...

**Interviewer:** And what about this?

**Participant:** Yes I know, its your barcode ne, when you, you've got a problem, you don't write a letter to eh, if maybe your eh ashtray is not clean and first you all the time I come here, but even now those people that I've make sure, whether I've move.

**Interviewer:** (Participant's name), I don't mean to interrupt you, I don't mean to interrupt you, um you can continue with what you were saying. You, can you see this over here?

**Participant:** Uh oh

**Interviewer:** What, can you tell me what that is?

**Participant:** Aah, aah, maybe at home

**Interviewer:** Okay, what about this over here? Can you tell me what this is?

**Participant:** What?

**Interviewer:** This over here. Can you tell me what that is?

**Participant:** Oh, there, what is this?

**Interviewer:** Ja, can you tell me what that is?

**Participant:** This

**Interviewer:** Yes

**Participant:** Oh, it's the, it's the emblem, maybe...

**Interviewer:** Okay and what is this over here, can you tell me what this is?

**Participant:** Yes, aah I think maybe it's the way eh people they try to leave to get fresh air and those people is not it's not a problem

**Interviewer:** Okay

**Participant:** Eh, just touch

**Interviewer:** What about this, what about this, can you tell me what this is?

**Participant:** I know, I talk about that one

**Interviewer:** Okay, but now we are moving on to this one. Can you tell me what this is?

**Participant:** Yes, yes, I I tell you, I ye I see because of, because when I one the the..

**Interviewer:** Okay

**Participant:** The thing that I can look

**Interviewer:** Can you tell me what this is?

**Participant:** When, when, I want the thing that I can, I can, I can eat, its not a problem because you know we are differ people uyabona in in A up to Z and in tradition uyabona because even now maybe somebody when I just visit at your office

**Interviewer:** Charles, just now you told me this is a camera

**Participant:** Yes

**Interviewer:** Dou you agree?

**Participant:** Yes

**Interviewer:** Okay, I agree that is a camera

**Participant:** Yes

**Interviewer:** Okay

**Participant:** Yes, maar look

**Interviewer:** And just now you told me that these are keys, do you agree

**Participant:** Yes

**Interviewer:** I, I agree with you, they are keys

**Participant:** Yes but the problem, problem, problem, why maar you you challenge me?

**Interviewer:** And what did you say this was?

**Participant:** Why you, you challenge you challenge me? Because of I'm stay there you know...

**Interviewer:** Okay Charles, can you tell me what this is?

**Participant:** I want to stay...

**Interviewer:** Can you tell me what this is? Just now you told me there is a barcode here.

**Participant:** Ja

**Interviewer:** Do you agree?

**Participant:** Ja

**Interviewer:** I agree with you, there is a barcode here

**Participant:** Ja

**Interviewer:** Okay

**Participant:** Ja

**Interviewer:** And, just now you told me there's a book over there

**Participant:** There's what?

**Interviewer:** There's a book, do you agree with me?

**Participant:** A book

**Interviewer:** Yes, you told me there's a book over there, do you agree with me?

**Participant:** Yes, maar about the tradition

**Interviewer:** Okay, I agree with you, there is a book over there

**Participant:** Ja, ja, so because about the tradition. I want to stay to each and every one of my family, can not want to see me, you understand?

**Interviewer:** And what is this?

**Participant:** It's a, this one?

**Interviewer:** Yes

**Participant:** It's the place I must stay there

**Interviewer:** Okay

**Participant:** Because I don't know where, where

**Interviewer:** And what is this?

**Participant:** I I go where that blood, I going to get where because I look, I is can I because when I move so, there's a chance

**Interviewer:** (Participant's name), um, I agree, we are finished for today...

**APPENDIX F**  
**INTERVIEW 5**

**Interviewer:** (participants name)

**Participant:** Yes

**Interviewer:** I want to ask you, just have a look behind you, over there. There are a few things over there; can you tell me what they are?

**Participant:** It's a book, four books

**Interviewer:** That's right

**Participant:** A camel

**Interviewer:** That's right

**Participant:** And two files

**Interviewer:** Two files, that's exactly right, everything that you see there, I agree with you

**Participant:** And air conditioner

**Interviewer:** And the air conditioner, that's very accurate, there are four books, one camel, two files and the airconditioner, that's exactly what I see, that's very accurate. Okay, how about this over here, can you tell me what this is?

**Participant:** This is a pamphlet

**Interviewer:** It's a pamphlet, that's right, I agree, can you tell me anything about it?

**Participant:** It's a pamphlet advertising what's being sold

**Interviewer:** Exactly right, I agree with you. It's a pamphlet and it advertises what's being sold. Um, what sort of things can you see there being sold?

**Participant:** It's a laptop

**Interviewer:** Uhhuh, a laptop.

**Participant:** A T.V.

**Interviewer:** That's right

**Participant:** And a wine, whatever, I don't know

**Interviewer:** Okay, oh wine, okay I agree with you, that is some sort of wine or something like that, I agree, exactly, ok so that's all right, you got, I agree with you everything you have described is exactly right. Okay, how about this over here, can you tell me what this is?

**Participant:** It's a it's a, it's a mirror

**Interviewer:** It's a mirror, exactly, I agree it is a mirror and what can you tell me about the mirror?

**Participant:** The mirror, its something that reflects your faces or you face

**Interviewer:** Yes

**Participant:** You can put your makeup on

**Interviewer:** Exactly I agree with you, so the mirror is something that reflects your face and you can see so you can put your makeup and that sort of thing. I agree with you, that's exactly right. Um, what about this?

**Participant:** It's a keys

**Interviewer:** That's right, its keys

**Participant:** Maybe keys for a car, a house, immobiliser for car

**Interviewer:** I agree with you that's very accurate, that's exactly right, so its keys for the car, maybe a house and an immobiliser. That's a very accurate description, it's got, you've described, explained everything very well, that's exactly what it is. Okay have a look on the bed over there, there are a couple of things, can you tell me what they are?

**Participant:** Magazines

**Interviewer:** Magazines, that's right. Anything about them?

**Participant:** Magazines for reading, self entertainment

**Interviewer:** That's very, that's also, that's a very good description of, it's very accurate, it's a very clear description of what its for, because its for reading, for self entertainment. That's a very, very accurate description, because that's exactly what magazines are for. Okay, let's see, maybe one or two more things. Okay, how about this, what is that?

**Participant:** I don't know what it's called but it's a (inaudible)

**Interviewer:** Okay, so it's a thing that you contain a pens and crayons in. I agree a hundred percent. Um so it's an accurate description, you don't know what it's called but

you do know what its, what its use is. I agree, okay, then over there on the fridge, there are a couple of things. Can you describe them to me?

**Participant:** It's a coffee mug, a bowl, a Tupperware

**Interviewer:** A coffee mug, a bowl, a Tupperware

**Participant:** Yes, containers

**Interviewer:** And containers?

**Participant:** Ja and this one is a container, this one is a container, this one is a container, these two are tupperwares

**Interviewer:** That's very accurate as well, very, very, accurate description, so those are containers and those ones in the centre are Tupperware. Very, very accurate. I agree with you a hundred percent, when I look there I see the same things, I see a mug, I see a bowl, I see containers and I see Tupperware. I see exactly the same thing. Okay, um I am going to ask you one last thing, over there, in the middle. You said it was the camel. Can you tell me anything about the camel?

**Participant:** You find camels in the desert

**Interviewer:** You find camels in the?

**Participant:** Desert

**Interviewer:** In the desert, that's exactly right. I agree you find camels in the desert, a hundred percent. Okay, alright, that's all for right now, okay, I'm going to turn this of.

**APPENDIX G**  
**INTERVIEW 6**

**Interviewer:** Okay (participants name)

**Participant:** Yes

**Interviewer:** I want you to have a look just behind you, over there. Can you have a look over there? Can you tell me what you see there? Can you tell me what that is?

**Participant:** Yes

**Interviewer:** Okay, what is that?

**Participant:** I see the the camel

**Interviewer:** That's right, that's exactly right, that is a camel

**Participant:** Over the ca camel, it's a something like a bag.

**Interviewer:** Okay

**Participant:** There's a two bags

**Interviewer:** Okay so on the camel there's a back

**Participant:** It's a bag ja

**Interviewer:** A bag, okay, that's right, there's two bags

**Participant:** Two bags

**Interviewer:** I agree, I see that too

**Participant:** And that bag, it shows drawing ne?

**Interviewer:** Its got a drawing, I agree

**Participant:** A drawing, it's a dice

**Interviewer:** Okay

**Participant:** It's a dice it's a dice, dice dice dice (there are small squares on the picture)

**Interviewer:** Okay so its like little dice on the on the drawing

**Participant:** Little dice and at the corners four corners, the big dice

**Interviewer:** Okay I agree with you

**Participant:** And then there a it's a yellow line

**Interviewer:** That's very accurate; you are giving me a very good or accurate description of what it is. That's exactly right, I see that too

**I Participant:** it's a cut

**Interviewer:** Okay

**Participant:** It's a yellow cut, yellow and then white and blue

**Interviewer:** Okay

**Participant:** Inside the blue, it's a yellow, coloured by yellow and the it's a heart

**Interviewer:** Okay, so you see some yellow, um, you see a heart

**Participant:** Yes

**Interviewer:** I agree with you, I also see that. When I look there I see also..

**Participant:** And after that, it's a Jewish writing and Abhu Abhu Fhabi.

**Interviewer:** Abhu Fhabi

**Participant:** It's a label

**Interviewer:** That's a label

**Participant:** That card you see

**Interviewer:** Exactly right

**Participant:** And then, after that, I see the books

**Interviewer:** Okay

**Participant:** Number one is the books

**Interviewer:** That's right

**Participant:** The name of the books is the Change

**Interviewer:** Exactly, it says change

**Participant:** And then number two the name is its for, the name of the book is for women only.

**Interviewer:** That's right, it says For Women Only. I agree with you. That's the name of the book.

**Participant:** And the writer of this book is Shanti Feldhahn

**Interviewer:** Okay, it's Shanti

**Participant:** Number one it's a Change, the writer of, the writer of this book it's a Watzlawick

**Interviewer:** That's right

**Participant:** Weakland and Fisch

**Interviewer:** That's exactly right. It's Watzlawick, weakland and Fisch. That's very accurate because you are giving me the names and you are telling me it's the writer

**Participant:** It's a Norton, it's a Norton, you see the structure of that (the emblem on the book is a seagull with Norton written beneath) of a bird

**Interviewer:** MmmHmm

**Participant:** After that its number three, it's a book of An Introduction to Psychological Assessment

**Interviewer:** That's exactly right

**Participant:** In the South African Context

**Interviewer:** Yes

**Participant:** Oxford

**Interviewer:** Yes that's right

**Participant:** And number four, it's a Psychological testing

**Interviewer:** That's right its says Psychological testing

**Participant:** And shows Pipe or Phipe (publisher and emblem)

**Interviewer:** Yes, okay

**Participant:** Another... structure of that something like a skeleton, you see

**Interviewer:** Okay so there's like a picture

**Participant:** Picture, ja

**Interviewer:** Or a structure that looks like a skeleton

**Participant:** It's a Prentice Hall

**Interviewer:** Okay yes

**Participant:** And the on the top its Anastasi Urbina (author of book)

**Interviewer:** Yes

**Participant:** Ja

**Interviewer:** Yes that's right

**Participant:** After that....

**Interviewer:** Okay, should we look at something else?

**Participant:** You have two portfolios

**Interviewer:** Two portfolios, okay, I agree, there's two over there

**Participant:** I look here ne

**Interviewer:** This

**Participant:** This

**Interviewer:** Yes

**Participant:** Look that side (indicating direction the file is facing)

**Interviewer:** Yes

**Participant:** Another one look this side ne?

**Interviewer:** That's exactly right

**Participant:** That one

**Interviewer:** So the ones looking this way

**Participant:** That one

**Interviewer:** Yes

**Participant:** Ja that one is looks like this ne this

**Interviewer:** Uhhuh

**Participant:** On the, on the vertex

**Interviewer:** Yes so the vertex is on this side. I agree with you, that's exactly right. I agree with you. So the one is facing this way and the other one is facing the other way

**Participant:** Ja

**Interviewer:** That's exactly right

**Participant:** That one ne...

**Interviewer:** I see that too

**Participant:** The vertex the vertex is this one ne

**Interviewer:** Ja

**Participant:** Ja

**Interviewer:** That's right

**Participant:** You know this one, on this side ne, not the vertex, in this one that... The red and the bar

**Interviewer:** Yes that's right

**Participant:** On the bar we have numbers... we have a six

**Interviewer:** That's right

**Participant:** Double zero

**Interviewer:** That's right

**Participant:** Seven, one, thirty five, zero, two, one, eight, two, seven

**Interviewer:** Exactly

**Participant:** For code, fifty seven two hundred and three

**Interviewer:** That's exactly right

**Participant:** On the colour black, it's a W seven one and then it's a something like a eye

**Interviewer:** Okay that's

**Participant:** Silver eye

**Interviewer:** Okay, I agree with you, I see its silver and its round like a eye

**Participant:** And it's a whiet all over, have a scotch, you know scotch lines

**Interviewer:** You are giving me very accurate descriptions

**Participant:** Okay right and its yellow, I mean to say red line

**Interviewer:** Yes

**Participant:** One, two, three, four, five it's a five grid lines ne?

**Interviewer:** Exactly right

**Participant:** On top it's a red, on top it's a Waltons

**Interviewer:** Waltons that's right, its does say that

**Participant:** Under Waltons, it's a primline, it's a primeline

**Interviewer:** Okay

**Participant:** Walt shows you the black one and and O Walt it's a black

**Interviewer:** Okay

**Participant:** Between it's a O but it's a red one

**Interviewer:** Okay

**Participant:** Inside the O of red there's a small tick white ne?

**Interviewer:** Okay

**Participant:** And next to O, it's a NS which is black

**Interviewer:** Okay you are giving very in depth

**Participant:** So it's a Waltons

**Interviewer:** You are giving very in depth descriptions and I agree, they are very accurate

**Participant:** Under the Waltons it's a Prime, it's a black

**Interviewer:** Okay

**Participant:** They use black to show, to write the prime. After the prime it's a line which is red

**Interviewer:** I agree

**Participant:** Ne, colour ne

**Interviewer:** I agree

**Participant:** And after it's a box

**Interviewer:** There's a box around it, I see that too

**Participant:** Ja, it's a box white, after the box one, something like a cross, you se

**Interviewer:** Like a cross

**Participant:** It's a wide cross

**Interviewer:** Okay I've seen that as well, what about this?

**Participant:** It's a mirror

**Interviewer:** Exactly, it is a mirror

**Participant:** Yes

**Interviewer:** I agree, can you tell me about the mirror, like you told you've told me a lot about the books, you've told me a lot about the camel and you've told me a lot about the portfolio

**Participant:** Yes

**Interviewer:** Um, how about the mirror, you've said this is a mirror, I agree with you

**Participant:** Yes

**Interviewer:** What can you tell me about the mirror?

**Participant:** The mirror

**Interviewer:** Yes

**Participant:** The mirror is something when you wash

**Interviewer:** Ja

**Participant:** Let's talk about me

**Interviewer:** Okay

**Participant:** Iriwe I like the mirror

**Interviewer:** You like the mirror

**Participant:** Because I like myself always you see like I, I always see when I after I wash myself, I have to look the mirror, how am I you see

**Interviewer:** So when you look at the mirror, you get to see yourself, how you looking and then

**Participant:** Yes and then after that, some other people got to tell me, hey you like you, you act like a women, hey I'm not a women, you see if I'm a women its good because all women look good ne. I want.

**Interviewer:** So people who look in the mirror are acting like women

**Participant:** People says that

**Interviewer:** People say that

**Participant:** Ja

**Interviewer:** I agree people do say that

**Participant:** I agree with them

**Interviewer:** And you agree with them, okay, I agree

**Participant:** Okay yes

**Interviewer:** I agree as well, how about this one?

**Participant:** Bonaqua

**Interviewer:** Bonaqua, exactly, its says Bonaqua

**Participant:** It's a Bonaqua, under bonaqua we have a sixty it contains it contains sixty kilojoules

**Interviewer:** Mhhmm

**Participant:** Or less per hundred mils ne?

**Interviewer:** I agree that's what it says

**Participant:** Something like a, like a eye ne, look see

**Interviewer:** This

**Participant:** Ja its like a eye

**Interviewer:** It's like a eye, I agree with you

**Participant:** Between the eye it's sixty five

**Interviewer:** Okay

**Participant:** Which is kilojoules

**Interviewer:** That's right I see it too so there's like a something like a shape of an eye and then inside it says sixty five kilojoules

**Participant:** Sixty five kilojoules ja it's a sixty five

**Interviewer:** Exactly

**Participant:** And then after that I see something like a.... okay... something like a, maybe its like a ship

**Interviewer:** Okay

**Participant:** You see

**Interviewer:** Okay

**Participant:** This thing it's a g.. it's a seat

**Interviewer:** So it's in the shape of a seat

**Participant:** Ja this one

**Interviewer:** Okay

**Participant:** You decide, here it's a wheel, you see it's a big wheel

**Interviewer:** Okay so it's like a wheel, it's a circle so

**Participant:** This is a small wheel and then you see here it's a where that shape of cars or a ship. It's finished here ne, its starts here, something like, you see, but like a...

**Interviewer:** Okay, so the whole pattern makes the shape

**Participant:** Ja

**Interviewer:** Okay, I agree with you it does

**Participant:** It's like a, maybe it's a ship on the water

**Interviewer:** Okay

**Participant:** You see

**Interviewer:** It could be, you are right. I suppose it could, it looks like there's a pattern and if you look at it from a you know from a different perspective it could look like a sheep or a car

**Participant:** Ja or or it's a ship

**Interviewer:** It does, it does, its a funny, it's a different

**Participant:** Ja lets make lets say let me say a ship on the water

**Interviewer:** Okay, like a ship

**Participant:** Ja

**Interviewer:** Okay

**Participant:** Alright then how about this over here?

**Interviewer:** Where?

**Participant:** That only or what I see?

**Interviewer:** Ja, what what do you see here, what is it, can you describe it to me?

**Participant:** Okay that one it's like a dustbin

**Interviewer:** Okay

**Participant:** You put some veils, rubbish, newspaper, whatever you see is veil

**Interviewer:** Okay so it's like a container you put things in

**Participant:** Ja

**Interviewer:** Okay alright

**Participant:** After that you have a bottle

**Interviewer:** On this side

**Participant:** Ja, on that side

**Interviewer:** Okay, it is a bottle

**Participant:** It's a bottle

**Interviewer:** Yes

**Participant:** That bottle you use to you use when we make a jam

**Interviewer:** Jam, that's exactly right, that's a

**Participant:** It's a Console

**Interviewer:** Ja, it's a console, that's a very accurate description, very, that's very very very accurate

**Participant:** And it's a quality

**Interviewer:** Okay

**Participant:** It's a quality when you put some peaches to make jam, you can save until until until ne

**Interviewer:** Okay so if you make peach jam in here

**Participant:** It will last a long time

**Interviewer:** It will last for many, many years. I agree with you that's a very accurate description of that, very accurate

**Participant:** After that I see the bottle

**Interviewer:** Uhuh

**Participant:** The glass I mean to say

**Interviewer:** Yes there's a glass

**Participant:** I'm going to say next to the bo.. glass between glass and something like a bottle that contains tea

**Interviewer:** Okay

**Participant:** Sugar or it's a it's a milk ja

**Interviewer:** That's exactly right

**Participant:** Between there, it's a container of vas Vaseline

**Interviewer:** Okay

**Participant:** You see, but when I'm, I'm in this side it's like a colour of drink

**Interviewer:** Mhmm

**Participant:** And then after that you see the container of sugar

**Interviewer:** Exactly

**Participant:** Yes

**Interviewer:** So you got you, you also, you see things, you you giving me very accurate descriptions and this one they look the same but in this one

**Participant:** Ja

**Interviewer:** You see sugar and in this one you see milk

**Participant:** Ja

**Interviewer:** That's very very accurate, I agree with you

**Participant:** Yes

**Interviewer:** That's a very accurate description

**Participant:** After that I see the, something she's blue e

**Interviewer:** Mhmm

**Participant:** When it comes blue, I like it

**Interviewer:** Mhmm, you like the colour of blue

**Participant:** Its something like a something like a yoyo, you know what is a yoyo?

**Interviewer:** Its does look like a yoyo, that's right

**Participant:** Its have a rope you use to... you see

**Interviewer:** Yes

**Participant:** A yoyo

**Interviewer:** I agree with you it's a its blue and its kind of like the shape of a yoyo, it looks actually kind of like a yoyo

**Participant:** Ja

**Interviewer:** I agree with you

**Participant:** Ja after that I see the the stapler

**Interviewer:** Yes that's exactly what it is, it's a stapler

**Participant:** A stapler when I sit here its look like a its look like a snakes on the black you see

**Interviewer:** Ja

**Participant:** On the red it looks like a crocodiles

**Interviewer:** Okay so you see the colours of it, there's a black on it and there's some red on it

**Participant:** Ja

**Interviewer:** I'm going to ask you one more thing (participant's name)

**Participant:** Okay

**Interviewer:** On the fridge over there, there are a couple of things

**Participant:** Yes

**Interviewer:** What can you tell me about them or can you describe what they are, or give me a description

**Participant:** It's a it's a mug

**Interviewer:** Exactly, it's a mug

**Participant:** For tea or coffee ne

**Interviewer:** That's right, for tea or coffee

**Participant:** That neck have have a three colours

**Interviewer:** I agree I see the different colours

**Participant:** It's a white, it's a pink, it's a brown

**Interviewer:** Exactly, that's very accurate, there's three colours there

**Participant:** And and look look the handle ne

**Interviewer:** Yes

**Participant:** Its looks like a one eye (points to ear)

**Interviewer:** Like a, yes, like a ear

**Participant:** Ja or

**Interviewer:** Okay

**Participant:** It looks like a half moon

**Interviewer:** It does, it's the shape of a half moon

**Participant:** Its look like a heart, when the heart is broken you see

**Interviewer:** Yes

**Participant:** This side, after that...

**Interviewer:** I agree, I didn't see that, but now I see that too, that's very accurate

**Participant:** Oh right

**Interviewer:** I see that too

**Participant:** And then after that I see the the containers

**Interviewer:** Yes there are containers

**Participant:** That container according to me

**Interviewer:** Yes

**Participant:** I can put the sugar, inside there ne

**Interviewer:** Okay, so it can be a sugar container, yes

**Participant:** Sugar container, after that. I can take that eh plate, not a plate, dish

**Interviewer:** Yes

**Participant:** And on the dish we have a many colours

**Interviewer:** That's right

**Participant:** We have red, we have white

**Interviewer:** That's right, that's right

**Participant:** We have blue and green, the brown have orange

**Interviewer:** That's right, there's many colours on there

**Participant:** Many colours

**Interviewer:** There's red, green, blue, orange, I agree, I see that too

**Participant:** Ja on this side maybe green dish ne

**Interviewer:** Yes

**Participant:** Plastic ja

**Interviewer:** There's a green plastic dish yes

**Participant:** Ja, its n.

**Interviewer:** Okay I think we've, we've got, you've explained it all pretty well

**Participant:** Okay

**Interviewer:** You've covered everything and I agree with you, everything that you see, I agree with you

**Participant:** Okay

**Interviewer:** Okay alright we are done for today

**Participant:** Okay