

The Expression of Schizophrenia through Interpersonal Systems at the Level of Discourse Semantics

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Abstract

This study characterizes interpersonal discourse semantic systems of systemic functional linguistics in the language of speakers with schizophrenia in the social context of a conversation. Eggins and Slade (1997) note that a conversation is a critical linguistic site for the construction of interpersonal relationships and negotiation of social identity. An analysis of the interpersonal semantics of schizophrenics' conversation enables the interpretation of their dialogic structure, the quality of their interpersonal relationships, and their roles and attitudes. The atypical use of interpersonal discourse semantics may compromise the patients' ability to coordinate social interaction and form social relationships.

The hypothesis is that the social impairment and emotional disturbance of patients with schizophrenia are reflected in their failure to take part in dialogue, to negotiate the exchange of interpersonal meaning, to establish their social identity and to create social relationships. In order to test this hypothesis, the research addresses two interpersonal systems, Speech function and Appraisal. Speech functions are the primary interpersonal system of choices for the exchange of interpersonal meanings, encompassing initiating moves and responses. Speech function theory is important for studying the patients' communicative failures and disorganized speech. It explores the negative symptoms conveyed directly by language and how they may contribute to the inability to coordinate social interaction and form social relationships. Speech functions are considered as they interact with Appraisal, a system of interpersonal meanings describing evaluative uses of language. The Appraisal theory is important for exploring the patients' emotional disturbance, mood disorder and impaired occupational and social functioning. Thus, the diagnostic criteria of schizophrenia are described by interpersonal patterns of conversational structures and evaluative lexis. The importance of the methods of analysis used in this study is that they identify a wide range of the diagnostic criteria that define schizophrenia. Speech functions and instances of Appraisal are important for therapists for making a clinical diagnosis and for providing insight into the nature of schizophrenia.

Eight patients, four with schizophrenia and four with other psychiatric disorders, are studied. The patients selected were matched as closely possible according to age, verbal IQ, performance IQ and judgment of thought disorder.

The negotiation in interaction between patients and interviewer is analyzed for the kind of roles and identities established and how they establish some of the main diagnostic criteria of schizophrenia. The results of the analysis describe the main characteristics of schizophrenia in three categories; each category correlates to different social roles and interpersonal positioning of the participants. (1) The emotional and social dysfunctions are diagnosed in patients' evaluative language as expressed by sustaining speech functions (reacting and continuing moves). The patients often experience negative emotions associated with depressive symptoms which include: pessimism, guilt, lack of confidence, loss of interest and pleasure. In response, the interviewer establishes his role as an active listener, being supportive and expressing positive and empathic responding. (2) Poverty of speech, as expressed by patients with schizophrenia, reveals restriction in the amount of speech. The patients show difficulty developing the discussion both in their immediate responds to questions and in their amount of extensions. The patients prefer not to share much personal information concerning their illness and often lead exchanges to their completion. The interviewer, in response, chooses specific speech functions as initiation of open opinion questions and Rejoinders that overcome the communicative difficulties and succeed in eliciting information from patients with schizophrenia. (3) The patients' communicative failures and disorganized speech are expressed through certain atypical behaviors in discourse. Patients with schizophrenia (a) fail to express certain and coherent interpersonal positions, often providing contrastive information by continuing: extension moves, which challenge and reject an immediately prior move. (b) fail to engage with the truth value of their utterances, frequently expressing low and mid modal values and concession in sustaining moves and (c) express low precision and accuracy in language, often using rejoinder: resolving speech functions, which provide clarification. The interviewer maximizes his effort to create a coherent and fluent discussion, and assures that his speech is clear, accurate and explicit. He often extends the discussion by prolonging moves that add new information that is contributive rather than clarifying his own talk. The patients can then easily address the topic discussed and provide the relevant information.

The conclusion is that these interpretations of patients' dialogic structure, interpersonal relationships, their roles and attitudes are important for identifying the characteristic symptoms of schizophrenia. The symptoms of atypical emotional expressiveness, social dysfunction and incoherent speech, are evident at the level of interpersonal meaning and have clear social implications. Patients with schizophrenia will find it difficult to form communicative and efficient conversation and thereby establish their identity and create social relationships with others.

Research Objectives

The proposed study examines how the diagnostic criteria of schizophrenia are expressed through interpersonal discourse semantic systems within systemic functional linguistics. The atypical use of language at the level of interpersonal discourse semantics makes it difficult for patients with schizophrenia to form communicative and efficient conversation and thereby create social relationships.

The speech function system is the primary interpersonal set of choices used to describe this area of meaning potential for analyzing initiating moves and responses in casual conversation. The model of speech function will be correlated to Appraisal, a system of interpersonal meanings used to describe all evaluative uses of language.

The hypothesis is that the social impairment and emotional disturbance of patients with schizophrenia are reflected in their failure to take part in dialogue, to negotiate the exchange of interpersonal meaning, to establish their social identity and to create social relationships.

1. Introduction

1.1. Systemic Functional Linguistics

The current study is set within the systematic functional linguistic tradition. According to Halliday and Matthiessen (2004), systemic functional linguistic theory views language as a social semiotic, a resource people use for expressing meaning in context. Since language is characterized as a systematic resource, the account is couched in terms of systems: “set of options which are available for the speaker covering the meanings that can be and are typically expressed in a particular context, and the linguistic means of expressing them” (Martin, 2000: 142). Thus, the description of language is a description of choice. The choices psychiatric patients make are not always appropriate or used with typical frequencies and therefore, atypical speech occurs. Anomalies in language use are considered a diagnostic indicator of schizophrenia. The primary language impairment in schizophrenia is in the area of pragmatic performance. "Pragmatics is the study of language communication in context: the choices users of language make and the process of meaning-making in social interaction" (Van Dijk, 2011:143).

This study examines the atypical speech produced by patients with schizophrenia at the level of interpersonal discourse semantics. Namely, the study focuses on the role relations established through talk, attitudes schizophrenic patients express and how they negotiate turns to express their interpersonal positioning. The atypical use of language at the level of interpersonal discourse semantics makes it difficult for patients with schizophrenia to form communicative and efficient conversation and thereby establish their social identity and create social relationships.

1.2. Schizophrenia

1.2.1. *Clinical description*

“Schizophrenia is a complex psychiatric disorder that is frequently manifest in language and related cognitive function” (Kuperberg & Caplan, 2003: 459).

According to the DSM-IV (American Psychiatric Association, 1994), the essential features of schizophrenia are a mixture of the following characteristic signs and symptoms (both positive and negative) that have been present for a significant portion of time during a 1 month period (or for a shorter time if successfully treated):

(1) delusions, (2) hallucinations, (3) disorganized speech (e.g. frequent derailment or incoherence), (4) grossly disorganized or catatonic behavior, (5) negative symptoms, i.e., affective flattening, alogia or avolition.

The diagnostic criteria for schizophrenia also include the notions of: (a) social/ occupational dysfunction, (b) duration, (c) schizoaffective and mood disorder exclusion, (d) substance/ general medical condition exclusion, (e) relationship to a pervasive developmental disorder.

It is further stated in the DSM-IV, that language disorder is central in the diagnosis of schizophrenia. This disturbance has traditionally been termed “thought disorder”.

According to Rochester and Martin (1979), the assessment of “thought disorder” is based on inferences from the discourse of patients. They further pointed out that, because thought cannot be accessed directly, attributing thought disorder to a speaker is tautological, i.e., we infer thought disorder based on disordered speech. “Thought disorder” is schizophrenia’s most prominent symptom, therefore, a true understanding of the nature of the thought disorder through the use of atypical language might illuminate the nature of schizophrenia.

1.3. Conceptual framework

The following study describes the language of schizophrenia to detail why the language sounds atypical and why the speakers are not able to accomplish normal social goals. Thus, the linguistic approach aims to understand how language works in social context. The dysfunctions that characterize schizophrenia are available for observation and diagnosis in the community and therefore, the description of schizophrenia should be from a social perspective. According to Fine (2006), “a speaker typically contributes to an interaction by relying on the context that has been built up and agreed on. Hearers attempt to make sense of what is said in terms of this context. However, the language of schizophrenia fails to build social reality. The language is uninterpretable because it does not fit with the hearer’s sense of context” (p.199).

Among the functional linguistic theories, systemic functional linguistic was chosen as an appropriate approach to describe how the language of speakers with schizophrenia works in social context. "SFL places the function of language as central; it starts at social context, and looks at how language acts upon, and is constrained and influenced by, this social context" (isfla.org/Systemics).

1.4. The rationale of this research

In diagnosing schizophrenia, language should play the most significant part because it will clearly reflect the degree of severity of the diagnostic criteria and features of schizophrenia. The clinical description of schizophrenia includes a number of positive symptoms (delusions, hallucinations, disorganized speech and behavior) and negative symptoms (flat affect, blocking, poverty of speech and poverty of content of speech). The positive symptoms of schizophrenia reflect an excess or distortion of normal functions. According to Fine (2006), these symptoms are expressed in language that does not encode the experiential reality in typical ways. Thus, schizophrenia appears as the failure of the speakers to connect appropriately to context. Fine notes in his summary of discontinuities that schizophrenia will appear severe as a function of the number of linguistic factors that are atypical and how far the speaker departs from the expected social context. “The clinician must pay attention to both the kind of signal showing the disconnection and the distribution of the signals in terms of frequency and density. The clinician’s intuitive judgments and the lay community’s impression of bizarre behavior are quite reliable in identifying schizophrenia” (Fine, 2006: 234).

The disconnection of meaning from context suggests that the speakers do not share a social reality and find it difficult to establish a social identity. The evidence to discontinuity in schizophrenia is also in terms of negative symptoms. The negative symptoms reflect a diminution or loss of normal functions. These symptoms reflect a reduction in the usual flow of language and result with the patients’ failure to communicate with others and form social relationships. The patients’ failure to establish their identity and create interpersonal relationships reflects their social impairment and emotional disturbance.

Eggins and Slade (1997) note that, the construction of social identities and social relationships is the primary task of casual conversation. A semiotic-linguistic analysis of schizophrenics’ conversation potentially enables the interpretation of their dialogic structure, the quality of their interpersonal relationships, their roles and attitudes. Thus, a semiotic-linguistic analysis of casual conversation contributes to identifying a variety of symptoms in schizophrenia.

1.5. Hypothesis

This study examines how the diagnostic criteria of schizophrenia are expressed through interpersonal discourse semantic systems.

The hypothesis is that the social impairment and emotional disturbance of patients with schizophrenia are reflected in their failure to take part in dialogue, to negotiate the exchange of interpersonal meaning, to establish their social identity and to create social relationships.

In order to test this hypothesis, the research addresses two interpersonal systems, speech function and Appraisal. The primary interpersonal system of choices for the exchange of interpersonal meanings is that of speech functions, encompassing initiating moves and responses in casual conversation. The system of speech function will be considered as it interacts with Appraisal, a system of interpersonal meanings describing the evaluative uses of language. The research questions are presented after the theoretical background for schizophrenia and the two interpersonal systems.

2. Theoretical background

2.1. Schizophrenia: Classification through language

Schizophrenia is a severe mental disorder characterized by a variety of symptoms affecting most aspects of human cognition, emotion and behavior.

According to the DSM-IV (American Psychiatric Association, 1994), schizophrenia is estimated to affect approximately 1% of the general population with a much higher incidence being present among family members of patients with the disease. The typical age of onset is between the late teens and the mid 30s, with onset prior to adolescence rare.

The DSM-IV (American Psychiatric Association, 1994), groups the characteristic symptoms of schizophrenia into positive and negative clusters. The positive symptoms appear to reflect an excess or distortion of normal function: for example, hallucinations, delusions, disorganized speech or positive thought disorder. The negative symptoms appear to reflect a diminution or loss of normal functions: for example, affective flattening, avolition and poverty of speech. It is further stated in the DSM-IV, that language disorder is central in the diagnosis of schizophrenia. This disturbance has traditionally been termed “thought disorder”. For most clinicians, the assessment of “thought disorder” is based on inferences from the discourse of patients. Rochester and Martin (1979) explain that, "one assesses thought disorder from talk, rather than directly from thought, inferring disordered thought processes from the discourse of patients" (p.15).

Chaika (1982d) has proposed that what is frequently viewed as a schizophrenic 'thought disorder' should more precisely be regarded as a schizophrenic 'speech disorder'. Chaika and Lambe (1985) developed this argument by pointing out the inherent autonomy of the linguistic system and its arbitrary relation to the world. They conclude that there is no good evidence that disordered schizophrenic speech is a function of disordered thinking and that speech and thought should not automatically be equated. Lanin-Keterring and Harrow (1985) countered Chaika's (1982) thesis and argued that schizophrenia is a 'thought disorder'. Moreover, they assume that thought and language are identical, so that one can derive the former from the latter.

Kuperberg and Caplan (2003) note that, "to some researchers, the term 'thought disorder' refers to subjective changes experienced and reported by a patient. Observed abnormalities of spoken

or written language are referred to as speech or language disorders. Other researchers however, refer to spoken language and written language abnormalities as 'thought disorder'" (p. 444).

Thus, anomalies in language use are considered a diagnostic indicator of schizophrenia. Patients with schizophrenia often display unusual language impairments. From a linguistic point of view, these impairments include abnormalities at the level of phonology, morphology, syntax, semantics, and pragmatics (Rochester and Martin (1979), Andreason (1979) Wrobel (1990), Chaika (1990), Riberio (1994), Covington et al. (2005), Fine (2006). Pragmatics, the relationship between language and context, is the level most obviously disordered in schizophrenia. Covington, et al. (2005), note that even when their pronunciation and grammar are perfectly normal, people with schizophrenia say strange things at strange times. Meilijson, et al. (2004), add that there may be a great deal of speech, but it is not intended to convey anything or to communicate with the environment.

Andreasen (1979) outlined several clinical signs that are used to describe the communicative characteristics of schizophrenia patients, such as, illogical thinking, incoherence (incomprehensible speech), loose associations (unpredictable changes in the topic of conversation), tangentiality (irrelevant responses), derailment (vague connections between the ideas conveyed), illogicality (illogical conclusions), loss of goal, press for speech, poverty of speech (brief and concrete speech), poverty of content of speech (minimal elaboration on the topic of conversation), echolalia (patient echoes interviewer's speech) and others.

Schizophrenia then is associated with a variety of language characteristics. As Fine (2001) notes, "there is a direct relationship between psychiatric syndromes and language. Crucial aspects of psychiatric syndromes are diagnosed and characterized by the use of language"(p.137).

Another prominent diagnostic symptom of schizophrenia which is recognized through language is patients' impaired emotional expressiveness. According to Flack, et al. (1999), "disordered emotional processes, including the diminution of expressiveness, known as 'flattened affect', and discrepancies between overt expression and internal feeling, referred to as 'inappropriate affect', are considered an important characteristic of schizophrenia" (p.2). Keltner and Kring (1998) indicate that emotional expression and experience provide important information about the speaker's emotion, intentions, orientation to the relationship and the conditions of social relations. Because emotions provide such valuable social information, it is argued that emotions help to coordinate social interaction and are important to the formation and maintenance of social relationships. Keltner and Kring (1998) explain that "emotions provide structure to social interactions, guiding, evoking, and motivating the actions of

individuals in interactions in ways that enable individuals to meet their respective goals" (p.326). Not surprisingly, then, disturbances in emotional experience and expression will have important consequences for the quality of social interactions and relationships. As Kring and Salem (1999) note, "to the extent that emotional expressivity is an important component of socially appropriate interaction, it is possible that schizophrenic patients' diminished expressiveness in a social situation is largely a function of their concurrent social skills deficit" (p.159).

This review has shown that crucial clinical signs of schizophrenia are often described or even defined by the use of language. These symptoms such as disordered language and impoverishment of emotional expression are typically assessed via an interview, an inherently social context. Within the social context of a clinical interview, patients display communicative difficulties and emotional dysfunctions that disrupt their social interaction and interpersonal functioning.

The current study examines the way speakers with schizophrenia use different linguistic resources to coordinate social interaction and negotiate interpersonal meanings.

In order to describe and interpret the patients' dialogic structure, the quality of their interpersonal relationships, their roles and attitudes, both the roles of patients with schizophrenia and of the interviewer and the dynamic negotiation of relationships between the two are analyzed.

2.2. The nature of a therapeutic conversation

Conversation is said to be the essence of human interaction and human relationships. Labov and Fanshel (1977) refer to a conversation as an everyday situation in which two or more people address each other for a period of time, communicating something about themselves and their experience in the process. In fact, through conversation we establish and maintain social relationships with others, achieve a measure of co-operation and keep channels open for further relationships. Armstrong and Mortensen (2006) further extend that "a conversation embraces a variety of motivations, purposes and opportunities that reflect the variable and ever-changing contexts in which it occurs" (p.175).

The therapeutic interview, in particular, is a conversational activity of considerable importance. The purpose of the clinical interview is much more encompassing than merely classifying of symptoms. Craig (2005) explains that the therapist may utilize the therapeutic conversation to assess clients' needs and problems, identify strengths and weaknesses, suggest diagnosis, make referrals, plan treatment, form relationships and make other interventions. Hasselt and Hersen (1998) note that for an interview to be effective, the therapist must help set the tempo and tone of initial sessions and guide the interviewee through a series of intricate steps. "These steps weave together communication of empathy, validation and understanding while simultaneously extricating information pertinent to the task at hand. The purpose of the latter, information gathering, is to develop a clinical frame of reference by which to understand the symptoms presented" (p.1).

Information gathering is one of the most primary purposes of an interview. The most common method used for gathering information is questioning. The patient is asked direct questions in areas determined by the therapist. Lipkin, et al.(1995) indicate that the form of questions is a significant determinant of patients' responses. The principal distinction drawn is between so-called open and closed questions. Closed questions evoke a brief answer from the respondent. These questions are designed to elicit a word or a phrase or a yes or no response. Williams (1997) pointed out that closed questions are worded in such a way as to avoid ambiguity or the necessity for the answer to be qualified in any way. The useful alternative is the open question which does not shape or focus the response unduly. Lipkin et al. (1995) claim that the advantage and power of open questions is that: "therapists who use a higher proportion of open questions elicit more information more efficiently. This is because the patient answers in an inclusive way, giving much more than the information sought; the patient may also include

information not thought of and therefore not asked about by the clinician" (p.9). Craig (2005) concludes that it takes a skilled therapist to obtain the maximum return from the questions asked while still maintaining free-flowing communication.

Another important interviewing technique refers to the social skill of expressing empathy and support. Hasselt and Hersen (1998) define this technique as the ability to relate effectively and comfortably with people and the ability to empathize and convey such empathy through validation and understanding of others' positions. Hasselt and Hersen (1998) further add that the interviewer's ability to empathize with the client's dilemma and associative experiences increases client trust. Namely, the client experiences the therapist as an attentive listener, caring and understanding. The client realizes the therapist can help and hopes for problem resolution. Once the client trusts the interviewer, the latter is able to extract information that will assist in forming a diagnosis and formulate therapeutic plans. 'Questioning' and 'Empathy' are among the various strategies and techniques therapists use to increase the effectiveness of the clinical interview. These techniques include reflection, restating confrontation, explanation, self-disclosure, silence and others. Craig (2005) indicates that these techniques form the basis of the interview process and should be used in combination to form a dynamic interview.

In analyzing the discourse of patients with schizophrenia within a clinical interview, it is initially important to consider the different techniques and the role relations the interviewer establishes through talk with the patients for diagnostic and therapeutic purposes. The interviewer's techniques described linguistically, produce certain patients' responses and response patterns. Therefore, it is further necessary to focus on the roles patients with schizophrenia take in the interaction, the attitudes they express and how they negotiate turns to express their interpersonal positioning. A semiotic-linguistic analysis of schizophrenics' conversation explores the relationships between the interactants their roles and identity and provides insight into the diagnostic criteria of schizophrenia.

2.3. SFL: approach to analyzing casual conversation

2.3.1. Casual conversation: its function and achievement

The study examines the way speakers with schizophrenia use different linguistic resources to negotiate interpersonal meanings in interaction. The idea of analyzing the patients' language disorder in the context of interaction stems from recognizing the conversation's privileged role in the construction of social identities and interpersonal relationships. As Eggins and Slade (1997) note, "despite its sometimes aimless appearance and apparently trivial content, casual conversation, is in fact, a highly structured, functionally motivated, semantic activity. Motivated by interpersonal needs continually to establish who we are, how we relate to others, and what we think of how the world is, casual conversation is a critical linguistic site for the negotiation of important dimensions of our social identity" (p.6). The analysis of casual conversation, due to this privileged role, is a tool for insight into the nature of schizophrenia; specifically, to the patients' disordered speech, emotional and social dysfunction.

2.3.2. Systemic functional linguistics

An important influence on the approach to analyzing casual conversation is that of systemic functional linguistics (SFL), as described in 1.1. According to Eggins and Slade (1997), the systemic approach offers two major benefits for conversational analysis: first, it offers an integrated, comprehensive and systematic model of language; second, it theorizes the links between language and social life so that conversation can be approached as a way of doing social life. Such a theory enables the description of the degrees of discourse failures and the inability to construct and maintain interpersonal positioning and relationships and to coordinate social interaction.

2.3.3. Strands of meanings: ideational, interpersonal and textual

One important aspect of the systemic approach is that language is viewed as a resource for making several strands of meaning simultaneously. Eggins and Slade (1997) explain that, a casual conversation, itself an extended semantic unit or text, is modeled as the simultaneous exchange of three types of meaning. These three types of meaning, or metafunctions, can be glossed as follows: (1) Ideational meanings: meanings about the world: the propositional content. (2) Interpersonal meanings: meanings about roles and relationships, concerned with speech-function, exchange structure and expression of attitude. (3) Textual meanings:

meanings about the message, concerned with how the text is structured as a message to fit into the context. This study focuses on the interpersonal meanings; namely, role relations established through talk, attitudes schizophrenic patients express and how they negotiate turns to express their interpersonal positioning.

2.3.4. *Interpersonal Metafunction*

Eggins (2004) defines interpersonal meaning as "a strand of meaning running throughout the text that expresses the writer's role relationship with the readers or the relationship between speakers, and the writer's attitude towards the subject matters" (p.11).

This description covers both interpersonal and personal meaning. The two meanings as expressed in the language of speakers with schizophrenia are realized through two important developments at the level of interpersonal discourse semantics.

- (i) Speech function theory is a functional semantic interpretation of a dialogue. This model covers the interpersonal meaning: the speaker's role relationship with his interlocutor.
- (ii) Appraisal theory describes the evaluative uses of language. This theory covers mainly the personal meaning of the interpersonal function: the speaker's attitude to the meaning he is making. Speech function theory is important for studying the patients' communicative failures and disorganized speech in discourse. It is a tool for exploring the negative symptoms conveyed directly by language and how they may result in the patients' inability to coordinate social interaction and form social relationships appropriately. The Appraisal theory which is concerned with the language of evaluation, attitude and emotion, contributes in exploring the patients emotional disturbance, mood disorder and impaired occupational and social functioning. Thus, the diagnostic criteria of schizophrenia are found in interpersonal patterns of conversational structures and evaluative lexis.

2.3.5. *Speech function theory: The discourse structure of a casual conversation*

The following section presents Halliday's functional semantic interpretation of dialogue and Eggins and Slade's (1997) extensions of the description of casual conversational data as a set of speech functions. The major subcategories of speech function classes are presented and are then related to the diagnostic criteria of schizophrenia and to the speech choices of both patients and interviewer.

Halliday (2004) approaches interaction from a functional semantic perspective, offering both a way of describing dialogic structure explicitly and quantifiably, and a way of interpreting dialogic structure as the expression of interpersonal positioning. He suggests that dialogue is a "process of exchange" involving simultaneously two variables of exchange:

commodity (information or goods and services) and exchange role (giving or demanding). These two variables define four speech functions/types of moves interactants can make to initiate in dialogue (Appendix A, Table 1). These basic functions are central to exchanges, and are matched by a set of expected or alternative responses. Once one speaker has initiated an exchange, another speaker is very likely to respond. Thus, there is a choice between initiating and responding moves. The alternatives we face in responding can be broadly differentiated into two types: a supporting responding move, versus a confronting move, as described below in more detail (following Eggins and Slade, 1997).

Eggins and Slade (1997) present a comprehensive system of speech functions for analyzing casual conversation. Armstrong and Mortensen (2006), note that the system developed by Eggins and Slade involves a network of speech functions that are logically related to each other and presented at increasing level of delicacy. "The basic organizing concept of the system is that of choice where each stage in the system network represents a point at which a choice has to be made" (Armstrong and Mortensen, 2006:5). Speech functions are expressed as moves that are strongly related to the turn-taking organization of conversation. The following review presents the major speech function classes in terms of their meanings and purpose in casual conversation. The speech function categories are then related to the diagnostic criteria of schizophrenia.

2.3.5.1. Opening speech functions

Opening moves begin sequences of talk, or open up new exchanges. Opening moves then contrast with sustaining moves. The distinction in opening speech functions is between attending and initiating moves (Appendix A, Figure 1). Initiating moves, the relevant option, include the functions of giving and demanding, goods and services and information. There are two extensions in delicacy (Eggins and Slade 1997):

(1) Fact and opinion information are differentiated for both statements and questions. "The difference between facts and opinions is usually expressed lexically, with opinions containing either expressions of modality, or appraisal lexis" (p.193-194). Moreover, opinion exchanges tend to generate arguments, while fact exchanges often remain brief. The fact/opinion distinction is relevant for schizophrenia since emotional disturbance and mood disorder are characteristic in schizophrenia. Patients with schizophrenia often show 'blunted' or 'flat' affect, a severe reduction in emotional expressiveness. The fact/opinion difference, expressed in the interviewer's initiating moves, will be studied in relation to affective involvement. The interviewer's choices can influence the extent to which schizophrenics will freely discuss their

opinions and emotions. (2) There is a differentiation between open and closed questions. “Open questions seek to elicit completion of a proposition from the addressee, and closed questions present a complete proposition for the support or confrontation of the addressee” (Eggins and Slade 1997: 194). The interviewer's choice between open and closed questions is important for his effort to expand the discussion and elicit information about patients' opinions, attitude and behavior. Again, these kinds of questions construct relations of power and affect between the patients and interviewer. Given the social context of the conversations, the interviewer initiates talk more often and thus claims a degree of control over the interaction. The interviewer's privileged role enables him to elicit information and evidence concerning the patients' atypical emotional expressiveness and mood disorder.

2.3.5.2. Sustaining speech functions

In contrast to opening moves, sustaining moves keep negotiating the same proposition set up in an initiation. “Sustaining talk may be achieved by the speaker who has just been talking (continuing speech functions) or by other speakers taking a turn (reacting speech functions)” (Eggins & Slade, 1997: 195).

2.3.5.2.1. Continuing speech functions

A speaker continuing conversation with a continuing move has two main suboptions: to monitor or to prolong (Appendix A, Figure 2). “Monitoring involves deploying moves in which the speaker focuses on the state of the interactive situation, for example, by checking that the audience is following. Prolonging moves are those where a continuing speaker adds to their contribution by providing further information” (Eggins & Slade, 1997: 195). Prolonging moves include the expansions of elaboration, extension and enhancement.

The analysis of continuing moves will describe: (1) the way the interviewer monitors the conversation by providing further information in order to avoid possible challenges and create continuation, coherence and fluency in discourse. These are characteristics lacking in interaction with speakers with schizophrenia. (2) The negative symptom of schizophrenia, poverty of speech, is proposed to be identified in the atypical choices of continuing moves. In interaction, speakers with poverty of speech simply say less than is expected. Fine (2006) notes, that there are atypical amounts of information after a speaker initiates in interaction or responds to another speaker's contribution. When there is less talk than expected, we hear terseness, perhaps sounding as if the speaker does not want to interact or cannot interact. This symptom which characterizes the disordered language of schizophrenia reflects a reduction in the usual flow of language and impair attaining communicative goals.

2.3.5.2.2. Reacting speech functions

The patients' discourse failures are further expressed through the second group of sustaining moves, the reacting moves. According to Eggins and Slade (1997) reacting moves capture the options available when turn transfer occurs; i.e. when one speaker reacts to a move produced by a different speaker. This network captures the interactive options in conversation. The network differentiates two types of reacting moves: responses and rejoinders.

2.3.5.2.2.1. Reacting: Responding moves

Responses are reactions which move the exchange towards completion by negotiating only the proposition set up by the initiating speaker. Responses may be either supporting or confronting (Appendix A, Figure 3). Supporting responses include four main categories (developing, engaging, registering and replying), all which indicate a willingness to accept the propositions or proposals of the other speakers. Confronting responses range from disengaging to offering a confronting reply. Confronting replies indicate a dependency between the initiator and respondent, but do not imply the alignment of supporting. The analysis of responding moves will reveal:

(1) the extent to which speakers with schizophrenia negotiate the other's propositions and the degree of cooperation in their conversation with the interviewer; and (2) the interviewer's preference to choose either supporting or confronting replies. These choices indicate efforts to create an alignment between him and the patients and reduce the patients' resistance to communicate and to accept treatment. Supporting moves, as preferred responses, will have a clear effect on the degree of cooperation and coherence in conversations with patients with schizophrenia.

2.3.5.2.2.2. Reacting: Rejoinder moves

"Rejoinders, on the other hand, rather than completing the negotiation of a proposition or a proposal, tend to set underway sequences of talk that interrupt, postpone, abort or suspend the initial speech function sequence" (Eggins & Slade, 1997: 207). There are two main subclasses of rejoinders: tracking and challenging moves (Appendix A, Figure 4). Tracking moves sustain the interaction by keeping an exchange open, without implying any interpersonal confronting. However, challenging moves contribute most to the negotiation of interpersonal relationships, since they invariably lead to further talk, in which positions must be justified or modified. The interviewer's rejoinder moves reflect his degree of success in building and reaffirming of relationships and identity of patients with schizophrenia. Hence, the interviewer needs the rejoinders to keep the channels open for as long as possible; this goal becomes very

challenging when dealing with language that constantly involves dysfunctions in production, discourse failures, breakdowns and uncooperative communication.

It is important to note that there are other subcategories in the speech function network other than those mentioned above. The discourse analysis goes into more detail within the speech function network to reveal a comprehensive picture of both the interviewer's and patients language during the conversation and to describe what it reveals about the nature of schizophrenia.

Thus, a detailed functional semantic interpretation of a conversation of speakers with schizophrenia, covering interpersonal meanings, will show how the characteristic symptoms of schizophrenia signal atypicality in the interpersonal metafunction and the emotional and social impairments it implicates.

2.3.6. Speech function and Appraisal theory

To account for how people negotiate interpersonal meanings, express their attitude and construct relationships with others through talk, the speech function classes are considered both functionally (what a move of each type does in conversation) and also semantically in terms of appraisal and involvement. The analysis of both these interpersonal systems at the level of discourse semantics will provide a sensitive measure of the negotiations of interpersonal relationship in talk.

Appraisal is a system of interpersonal meaning used to describe evaluative uses of language (Appendix A, Figure 5). An earlier study (Cohen, 2007) described schizophrenics' language of evaluation attitude and emotions through the Appraisal system. It showed how speakers adopt stance to construct and maintain interpersonal positioning and relationships.

Appraisal theory divides evaluative resources into three broad semantic domains: Attitude, Engagement and Graduation (Martin, 2000). The current section describes how the three semantic domains are realized through the functional linguistic resources of speech functions. Realization rules for each class of speech function are specified separately and determine how the meanings are worded in the lexicogrammar. The interpersonal patterns of conversational structures and evaluative lexis contribute to identifying the diagnostic criteria of schizophrenia.

2.3.6.1. Attitude and Opening speech functions

Attitude includes "values by which speakers pass judgments and associate emotional/affectual responses with participants and process" (White, 2001: 1). There are three sub-systems of Attitude: Affect, Judgment and Appreciation, which model the ability to express emotional, moral and aesthetic opinions respectively (Appendix A, Tables 2, 3, 4). As mentioned (2.3.5.1), the differentiations between fact/opinion information and open/closed questions are useful since degrees of affective involvement expressed in the interviewer's initiating moves impact on the extent patients will freely discuss their attitudes. The interviewer's opening moves can influence: (1) the degree of emotional expressiveness in patients' responds, and (2) how atypical emotional and judgmental responses indicate emotional disturbance, mood disorder and social impairment.

2.3.6. 2. Engagement and sustaining speech functions

The Engagement system is a set of linguistic options that convey the degree of commitment to the opinion being presented. Engagement encompasses two main resources: Modality and Concession.

(1) Modality: Halliday (1994) describes modality as a resource which sets up a semantic space between yes and no, a cline running between positive and negative poles. He discusses five types of modality: usuality, probability, obligation, inclination and ability (Appendix A, Table 5). White (2001, 2003) pointed out that values of modality act to expand or open the space for dialogic diversity and difference. With this functionality, values of modality indicate uncertainty or lack of commitment to, or confidence in the truth value of the proposition by the speaker. Values of Engagement are examined as they are inserted in patients' sustaining moves. The patients' degree of engagement is examined within sustaining moves which include both reacting: responding speech function, by which patients react to the interviewer's move and are being interactive and continuing speech functions, by which they keep negotiating the proposition discussed and contribute to the discussion. Both move types may indicate the patients' lack of confidence and hesitance in completing the negotiation of a proposition and express it with full commitment.

(2) Concession- According to White (2002), Concession is supplied by meanings by which some prior utterance or some alternative position is invoked so as to be directly rejected, replaced or held to be unsustainable. Concession includes conjunction (but) and continuatives (still, only). White (2001) notes that "values of concession are generally contracting or closing since, while they acknowledge alternative positions within the dialogistic context, they either reject or directly challenge these" (p.9). Frequent use of concession will indicate the patients' failure to express fluent and certain propositions because of their constant decision to challenge or reject prior utterances. Within the model of speech function, this characteristic of schizophrenia can functionally be realized through: (1) sustaining: continuing moves, specifically by prolonging moves: extension, in which a move provides contrasting information in an immediately prior move (linked with conjunctions such as: and, but, except, instead) and (2) patients may also create incoherent discourse by rejecting the interviewer's proposition rather than their own move. The rejection is expressed either by supporting replies in which they expand a prior speaker's move by adding contrasting details or by offering a confronting reply. Both moves disrupt the continuity of the clause and expose the patients'

language as tentative and non-fluent. Thus, the functions of both semantic resources of Engagement are realized through speech function classes and provide evidence of the patients' disorganized speech.

2.3.6.3. Graduation and Sustaining speech functions

"Graduation is concerned with values by which speakers raise or lower the interpersonal impact or force of their utterances, and by which they soften or sharpen the focus of their semantic categorizations" (White, 2001:2). The analysis of 'Focus' values reveals the accuracy and precision of both the interviewer's and patients' propositions: (1) the interviewer's degree of coherence and accuracy in discourse is realized through sustaining: prolonging moves, by which he chooses to add information that clarifies his prior move; (2) the patients' degree of precision and accuracy is realized through rejoinder: resolving speech functions, which provide clarifications; and (3) patients' degree of coherent discourse also depends on how frequent the interviewer queries information given by the patient. The interviewer's demand for clarifications is realized through a subclass of rejoinders, tracking moves (supporting), which check, confirm, clarify or probe the content of prior moves.

This chapter has presented the semantic resources used to express interpersonal meaning in casual talk. A detailed analysis of schizophrenics' discourse through the interpersonal systems of Speech function and Appraisal enables the interpretation of their dialogic structure, the quality of their interpersonal relationships, their roles and attitudes. These interpretations together become an important device in identifying the characteristic symptoms of schizophrenia.

3. Research questions and Method of analysis

3.1. Research questions

The following research questions are addressed for the two interpersonal systems of Speech function and Appraisal. The research questions relate to the roles both patients with schizophrenia and the interviewer take for a comprehensive understanding of the interpersonal meaning.

The speech function theory:

1. How do the interviewer's initiating moves build relations of power and affect between the patient and interviewer?
2. How are the negative symptoms that characterize the disordered language of schizophrenia, identified through continuing speech functions?
3. How do the interviewer's attempts in monitoring the conversation with patients with schizophrenia create continuation and fluency?
4. How do supporting and confronting functions create cooperation in conversation with schizophrenics?
5. How are the linguistic resources used to sustain the interaction (rejoinders) enable the construction of interpersonal relationships and identity of patients with schizophrenia?

The correlation between interpersonal systems of speech function and Appraisal:

6. How do opening speech functions lead to the expression of atypical attitude and emotional disturbance?
7. How do the functional linguistic resources that sustain the interaction indicate the speakers' degree of commitment to the appraisal being expressed?
8. How do the choices of sustaining moves (continuing and rejoinders) affect the degree of precision and accuracy of the patients' language?

3.2. Method of analysis

3.2.1. *The patients*

Eight patients (4 diagnosed with schizophrenia and four non-schizophrenic controls) were selected for this study from a group of sixteen patients originally studied by Bartolucci & Fine (1987). The original study examined the frequency of cohesion weakness in psychiatric syndromes. Bartolucci & Fine (1987) conclude that cohesive weakness is a more frequent characteristic of the language of schizophrenic speakers, compared to its incidence in the conversation of psychiatric patients in different diagnostic categories, with the possible exception of manic syndromes. The patients in the original study were selected at the time of their admission to a general hospital psychiatric unit according to three criteria: 1. psychiatric diagnosis which included schizophrenia, mania, depression or early Korsakoff syndrome, 2. ability to cooperate with the study, 3. English as first language.

Eight schizophrenic and eight non-schizophrenic patients were recorded. The clinician, who was one of the investigators, carried out a recorded 10-minute conversation eliciting information about the patient without a specific predetermined topic. The interview was carried out in the clinician's office on the psychiatric unit and the subjects were familiar with both the interviewer and the environment by the time they were recorded. The interview was informal and the questions asked were generally open ended. The patients seemed to be reasonably comfortable and able to relate to the interviewer without any specific problems other than those which they were experiencing and that led to their admission. The interview was then transcribed and unintelligible segments identified.

For the purpose of this study, eight out of the sixteen transcripts were chosen and analyzed; four of patients with schizophrenia and four of the patients with other psychiatric disorders. The latter group functions as a control and includes patients with mixed diagnoses, mostly depressive disorder. The patients selected were matched as closely possible according to age, verbal IQ, performance IQ and judgment of thought disorder. Table 3.1 below summarizes the subject characteristics and language data of each patient both schizophrenia and control.

Table 3.1: Summary of subject characteristics and language data

Patient #	Diagnosis	Sex	Age	VIQ	PIQ	TD
Patient 1: Al	Schizophrenia; acute	M	21	91	96	3
Patient 2: Ja	Schizophrenia; acute	F	49	84	95	2
Patient 3: Ch	Schizophrenia; chronic	F	72	102	82	3
Patient 4: Man	Schizophrenia; acute	M	22	104	98	1
Patient 1: Ha	Major depressive Disorder	M	25	95	94	1
Patient 2: Ma	Korsakoff syndrome	F	51	84	79	0
Patient 3: Mu	Manic disorder	M	20	79	55	2
Patient 4: Fl	Major depressive Disorder	F	45	102	108	0

TD stands for rating of thought disorder. * VIQ = verbal IQ, PIQ = performance IQ.

The primary aim for analyzing the language of the four patients with schizophrenia is to describe through language the mechanism underlying schizophrenia from a social perspective, rather than to generalize to the population of schizophrenia.

This group of eight patients was studied in Cohen (2007) which examined the atypical use of evaluative language within Appraisal. The current study complements the description of the interpersonal meanings, looking at what role relations are established, what attitudes schizophrenic patients express and how they negotiate turns to express their interpersonal positioning. To describe interpersonal meaning, the study initially discusses the role relations the interviewer takes in the interaction and then turns to focus on the role relationships and interpersonal meanings of the psychiatric patients. The conversational analysis between the two is revealed through the two interpersonal discourse systems of speech function and Appraisal theory.

3.2.2. Procedure

Speech functions are expressed as moves that are closely related to the turn taking organization of conversation. The speech function analysis first codes the interactions into moves. Halliday's (2004) account of dialogue sets up speech function as a separate discourse level of analysis, expressed through grammatical patterns. These two types of patterns are carried by different linguistic units. The grammatical patterns of mood are expressed through

clauses and the discourse patterns of speech function are expressed through moves. The relationship between moves and clauses is one of expression, or, more technically, realization: moves, which are discourse units, are expressed in language through clauses, which are grammatical units.

Once the transcripts are divided into moves, the speech function system outlined by Eggins and Slade (1997) is used to code the talk exhaustively, showing the distribution of initiating and responding, giving and demanding roles. Once the speech function analysis has been carried out over the whole text, patterns can be explored from two perspectives:

- (i) synoptically, by quantifying overall choices for each speaker (patient/interviewer);
- (ii) dynamically, by tracing through the speech function choices as the conversation unfolds.

The combination of synoptic and dynamic perspectives on the speech function analysis captures both the roles patient with schizophrenia and the interviewer take in the interaction, and the dynamic negotiation of relationships between the two.

The interpersonal meaning expresses the relationship between speakers and the attitude towards the subject matter. Therefore, the account should include both interpersonal and personal meaning. Thus, the conversational structure of patients with schizophrenia includes both a functional interpretation through speech function classes and a semantic interpretation, in terms of appraisal and involvement. The analysis describes how the broad semantic domains of evaluation (Attitude, Engagement and Graduation) are realized through functional linguistic resources within the model of speech function. Realization rules for each class of speech function are specified separately and determine how the meanings are worded in the lexicogrammar.

A detailed functional semantic interpretation of the conversation of speakers with schizophrenia, from both interpersonal (speech function) and personal (Appraisal) perspectives, will show how the characteristic symptoms of schizophrenia are displayed in the interpersonal metafunction and the emotional and social impairments they implicate.

The study includes both synoptic and dynamic perspectives for analyzing the discourse of patients with schizophrenia. The results of the discourse analysis are interpreted through two approaches. The first and primary approach is linguistic, defining language as a systematic resource for expressing meaning in context. This analysis describes the choices patients with schizophrenia can make in a given setting, to negotiate their interpersonal positioning. The speech function classes are presented in the form of a network representing the points at which a choice can be made. That is, the choice point represents a contrast in function. For example, patients with schizophrenia may choose either to initiate a proposition (through an opening

move) or to continue or react to another speaker's proposition (through a sustaining move). Since patients make certain choices of meanings as opposed to others, the interpretation of the results of their linguistic choices is in terms of percentages. This linguistic approach of interpreting results as percentages explores the way patients with schizophrenia use the interpersonal systems, when some meanings are chosen rather than others. The preference for some meanings in contrast to other meanings can then be compared with patients without schizophrenia.

In some points of analysis, I considered also a more direct approach for interpreting the results as raw frequencies. The frequency of a certain choice of meaning is presented when it differs in its use from the percentages, the latter being the contrasts in the networks. In describing the raw frequencies, the choices that are used most often are more evident. Raw frequencies account for what the hearer can experience directly: the phenomenon in schizophrenics' language that are expressed more frequently and thus are most noticeable. The raw frequencies account for the psychiatric phenomenon as it is heard "on-line" rather than as part of a system. This study, however, is mainly concerned with the linguistic approach which describes the language of schizophrenia to detail why choices are not always appropriate or used with typical frequencies and therefore, atypical speech occurs. This analysis is further supported by its comparison to interviews of patients without schizophrenia (control group).

4. The interviewer's role relationships through conversation with patients with schizophrenia

This study focuses on the interpersonal meanings; namely, role relations established through talk, attitudes schizophrenic patients express and how they negotiate turns to express their interpersonal positioning. The atypical use of language at the level of interpersonal discourse semantics makes it difficult for patients with schizophrenia to form communicative and efficient conversation and thereby establish their social identity and create social relationships.

In order to describe and interpret the patients' dialogic structure, the quality of their interpersonal relationships, their roles and attitudes, it is necessary to capture in the analysis both the roles patients with schizophrenia and the interviewer take in the interaction, and the dynamic negotiation of relationships between the two. A semiotic-linguistic analysis of schizophrenics' conversation explores the relationships between the interactants their roles and identity and provides insight into the diagnostic criteria of schizophrenia.

The conversations analyzed in this study were carried out by a clinician on the psychiatric unit of a general hospital. The subjects were familiar with both the interviewer and the environment by the time they were recorded. The interview was informal and the questions asked were generally open ended. The patients seemed to be reasonably comfortable and able to relate to the interviewer without any specific problems other than those which they were experiencing and that led to their admission.

The clinical interview is the primary mechanism employed by therapists in the assessment of patients. According to Craig (2005), "it calls upon most, if not all, of the therapist's skills, diagnostic as well as therapeutic. The success of the interview rests upon a particular stance and a set of attitudes on the part of the therapists" (p.42).

This section describes what role relations the interviewer establishes through talk with the patients for diagnostic and therapeutic purposes, using different linguistic resources to negotiate interpersonal meanings.

A functional semantic interpretation of a dialogue will describe the different strategies and techniques the interviewer applies to increase the effectiveness of the clinical interview; that is, to evaluate, understand and help patients with schizophrenia establish their identity and form social relationships. Such analysis will contribute in exploring schizophrenic patients' failure to

take part in a dialogue and negotiate the exchange of interpersonal meaning and the emotional and social impairments it implicates. This analysis is further supported by its comparison to interviews of patients without schizophrenia (control group).

The three main interviewing techniques the therapist uses in his conversation with patients with schizophrenia are: 4.1 Empathy and support, 4.2 Eliciting information, 4.3 Coherence and clarification. These three techniques are described linguistically at the level of interpersonal discourse semantics and are combined to form an effective interview.

4.1 Empathy and Support

Therapists bring to the interview a set of interpersonal qualities which become an important aspect of the interview and client contact. Hasselt and Hersen (1998) note that these behaviors are commonly referred to as non-specifics of therapy: appropriate social skills, ability to relate effectively and comfortably with people and ability to emphasize and convey such empathy through validation and understanding of others' positions. The expression of such interpersonal qualities conveying empathy and support is necessary in an interview with patients with schizophrenia due to their emotional disturbance and mood disorder. In general, individuals with schizophrenia often show 'blunted' or 'flat' affect, that is, a severe reduction in emotional expressiveness.

The interviewer in this study uses various speech functions designed to express sympathy and solidarity in response to the speakers' interpersonal positioning and emotional expressiveness. The interviewer then encourages the patients to express their positioning freely and expand their emotional responses without any interference.

4.1.1 Expressing Support

4.1.1.1 Reacting speech function- supporting vs. confronting moves

The speech function network differentiates two types of reacting moves: Responds and Rejoinders. Both types capture the essentially interactive options in conversation. Yet, Responds are reactions which move the exchange towards completion, while rejoinders are reactions which in some way prolong the exchange. Responds may be rather supporting or confronting and rejoinders include either tracking or challenging moves which correspond to the supporting and confronting alternatives available in the responding move classes. The interviewer's preference to choose supporting rather than confronting replies will indicate his effort to create an alignment between him and the patients and reduce the patients' resistance to communicate and to accept treatment, as demonstrated in table 4.1

Table 4.1: Frequency of Interviewer's Reacting moves: support vs. confront for patients with schizophrenia

Interviewer	Responding moves		Rejoinding moves	
	Support	Confront	Support	Confront
1	8	1	11	0
2	86	4	64	0
3	50	0	12	0
4	41	0	15	0
Total	185	5	102	0

The interviewer's frequent use of supporting replies (both responds and rejoinders) indicate his willingness to accept the propositions or proposals of the patients, avoid confrontation, and create an alignment between him and the patients. The patient, consequently, feels reassured, understood and encouraged to make contributions to the discussion, as presented in example 1.1:

Example 4.1 Interviewer/Patient#2:

I: What did you do with the mortgage eventually, did you sign or?

S: No my husband uh the first mortgage is soon to come up and I can sign for a first mortgage

I: Hmmm hmmm [S:R:respond:support:register]

S: He borrowed money for a friend of his

I: Hmmm hmmm [S:R:respond:support:register]

S: Ah it can wait til the first mortgage arrives

I: Right I met that friend yes [S:R:respond:support:reply:acknowledge]

S: Yes they say it will be all right?

I: Yes, I think everything will be fine [S:R:respond:support:reply:affirm]

S: I'm glad I waited

I: Right [S:R:respond:support:register]

S: That way he isn't tied down to two mortgages he's just got the one mortgage

I: Right [S:R:respond:support:register]

S: we can wait for it

I: Hmmm hmmm [S:R:respond:support:register]

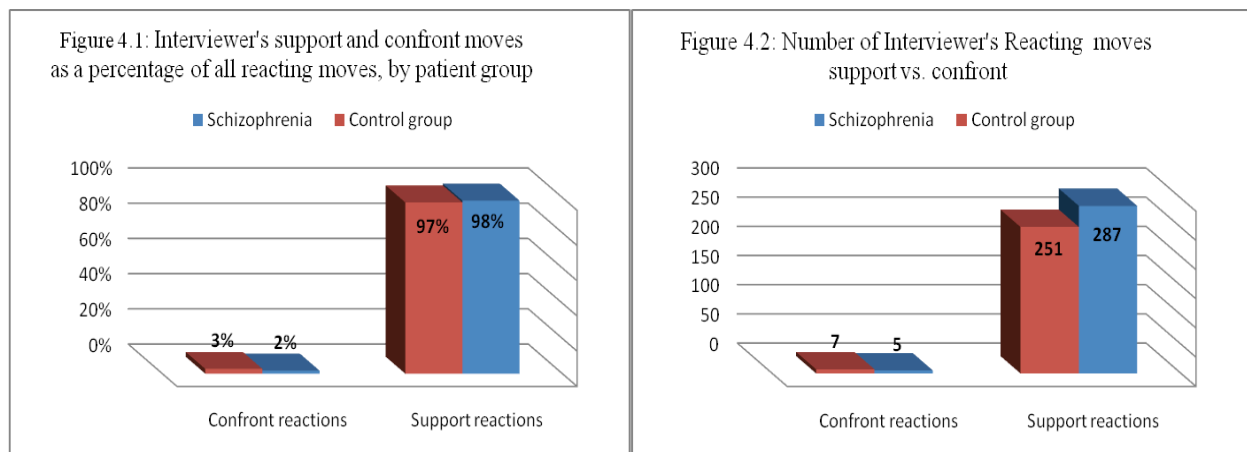
S: it's in a week or two.

Example 4.1 provides evidence for the interviewer's attempt to avoid any kind of confrontation with the patients and constantly convey support and empathy. His speech choices of registering moves provide supportive encouragement for the patient to take another turn and broaden the discussion. Other supporting moves as affirm express support and knowledge with given information.

4.1.1.1.1 Interviewer's reacting moves: support vs. confront: a comparison between patients with and without schizophrenia

For both groups of patients, the interviewer avoids any kind of confrontation and clearly prefers to express supporting replies. The interviewer similarly takes the role of a supporter with patients with and without schizophrenia (schizophrenia 98%, controls 97%) Yet, in comparing the absolute numbers (rather than percentages) of total supporting replies (Responding and Rejoining) between the two groups of patients, the interviewer is somewhat more supportive for patients with schizophrenia (287 supporting replies) than patients without (251 supporting replies). Cohen (2007) examined the emotional expressiveness of these two groups of patients and shows that patients with schizophrenia report many more negative emotions and express their severe mood disorder more often. These results require the interviewer to frequently express sympathy and be supportive in interviewing patient with schizophrenia; only then, the patients will feel encouraged to communicate and contribute to the discussion.

Figures 4.1 and 4.2 present the percentage and number of interviewer's Reacting moves for patients with and without schizophrenia. Full data for the control group is presented in Appendix B, table 6.

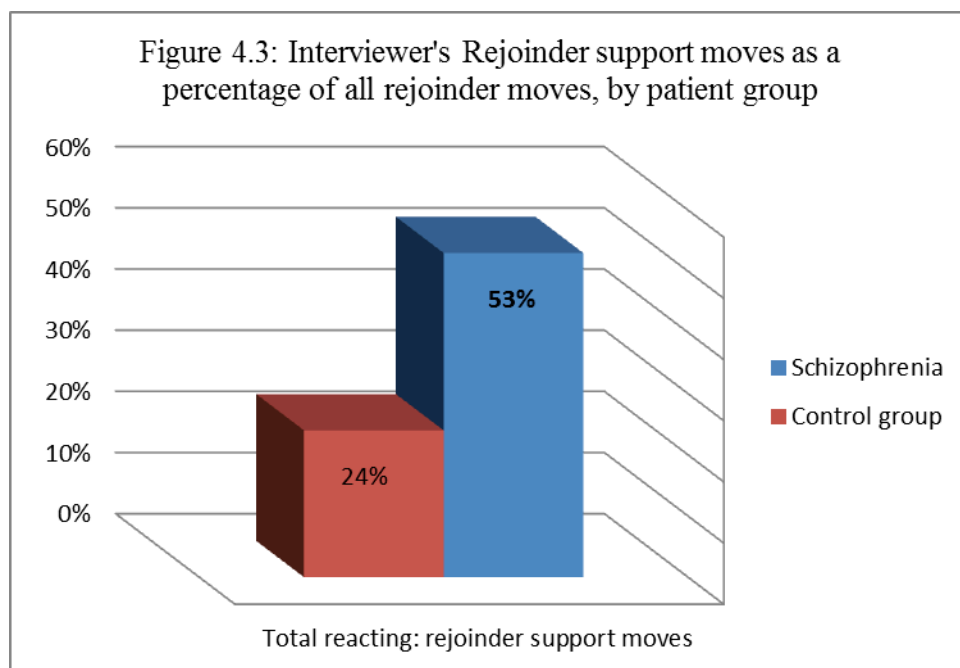


4.1.1.2 Reacting: Rejoinder moves

The frequency of rejoinder moves among the interviewer's speech choices as presented in table 4.1 relates to their potential to sustain the interaction. Eggins and Slade (1997) differentiate between two main subclasses of rejoinders: Tracking and Challenging. These two subclasses correspond to the supporting and confronting alternatives available in the responding move classes.

Among the two types of rejoinders, challenging moves contribute most to the negotiation of interpersonal relationship. Eggins and Slade (1997) explain that challenging moves directly confront the positioning implied in the addressee's move, and thus invariably lead to further talk, in which positions must be justified or modified. Despite the relative advantage of challenging moves in sustaining the interaction, the interviewer adheres to his role as a supporter and avoids any kind of confrontation with the patients (rejoinder support: 102/confront: 0). The interviewer recognizes the need to keep the exchange open for as long as possible in order to build and reaffirm the patients' social relationships and identity. However, the patients' emotional and social disturbance forces the interviewer to sustain the interaction without implying any interpersonal confrontation. The interviewer realizes that for him to create trust, understanding and cooperation with the patients, he has to avoid rejecting negotiation, express a willingness to maintain contact and imply alignment with the patients' propositions.

The interviewer similarly becomes more supportive (61) and avoids confrontation (0) in interviews with patients without schizophrenia. Yet, in interviews with schizophrenics his role of supporter becomes much more prominent and essential (Schizophrenia 53%, controls 24%). The interviewer acts more often to support and sustain the interaction with patients with schizophrenia, due to their emotional disturbance and avoidance to communicate with others. Figure 4.3 presents the percentage of rejoinder: support moves expressed by the interviewer for both groups of patients.



4.1.2 Expressing Empathy and Positivity

The interviewer in his conversation with patients with schizophrenia takes his role as a supporter a step further. The interviewer realizes that due to the patients' severe emotional disturbance and social dysfunction, it is not enough to convey support only by accepting the patients' propositions and creating an alignment, as generally accepted in clinical interviews; there is also need to emphasize his empathy and his positive attitude concerning their emotional and social situation. In linguistic terms the speech functions that express empathy and support are defined not only functionally (support/confront moves), but also semantically, in terms of appraisal. Appraisal analysis examines the attitudinal meanings of words used in a conversation. Appraisal is mainly realized lexically and generally occurs in polar pairs: positive or negative. The interviewer uses various speech functions to appraise and evaluate positively the patients' behavior, attitude and progress in illness in order to raise their self esteem and motivation.

4.1.2.1 Opening speech functions

The interviewer uses the opening move: [give: information: opinion] to express positivity. Though his main role focuses on extracting information, he conveys his opinion by expressing positive rather than negative attitudinal information about the patients' illness as in examples 4.2-4.4:

Example 4.2 Interviewer/Patient #1:

S: I mean, can I ask you if you hear voices like can't you hear people talking down the hall?

I: right now?

S: yea.

I: in this room?

I: No I don't.

S: oh

I: ah.you know if we opened the door and went out then I would probably somebody would be talking. [Open: I: give: information: opinion: positive]

Example 4.3 Interviewer/Patient #2:

I: Did you ah think that some of these messages were given to you through the newspapers?

S: I hadn't been reading much newspapers

I: I see

S: If I so many that I did know had died I'd started reading the death notices...notice so many that I did know ah I no longer will

I: yes

S: They seem more informative than their front pages at the time

I: Right (snickers)...ok well you are definitely doing better [Open: I: give: information: opinion: positive].

I: I think we are going to get rid of these voices and ah the things you see uh I think you will be alright and uh I will get the results of the tests actually we want to show you, this week maybe some faces to see or the ability to recognize them and see if that is improving too so there will be a few more things that we will ask you to do [S:C:prolong:extend].

Example 4.4 Interviewer/Patient #3:

I: do you think you are doing better now uh, or then you know what I mean,you're getting better now too. do you feel better now or you

S: I feel better now but I don't feel capable of doing work

I: yea

S: but then I felt capable of doing work

I: well I think you will feel capable of doing work pretty soon

[Open: I: give: information: opinion: positive]

All three examples aforementioned describe the interviewer's attempt to encourage the patients, who are concerned about their progress in illness and social dysfunction.

Table 4.2 summarizes the number of positive and negative opening moves of [give: information: opinion] expressed by the interviewer.

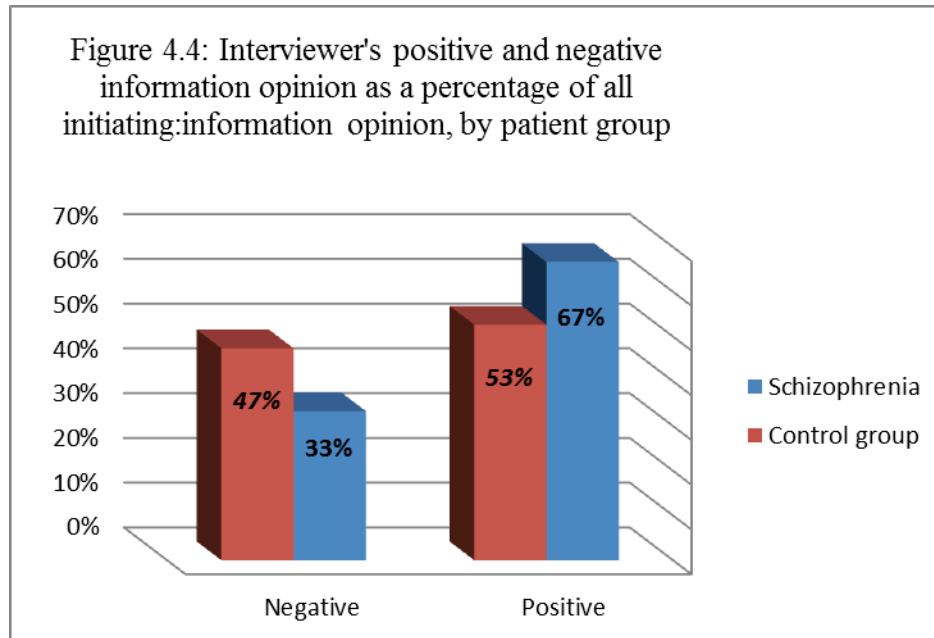
Table 4.2: Number of positive and negative information opinion expressed by the interviewer for patients with schizophrenia

Interviewer	Open:Give:information:opinion		
Patient #	Positive	Negative	Total
1	2	0	2
2	8	5	13
3	0	0	0
4	2	1	3
Total	12	6	18

4.1.2.1.1 Interviewer's expression of positive and negative information: a comparison between patients with and without schizophrenia

The interviewer's expression of positive and negative information differs between the two groups. Patients with schizophrenia often express low self esteem, lack of confidence and negative evaluations concerning their behavior and progress of illness. The interviewer, therefore, more often provides positive than negative information and raises the patients' self confidence and motivation. However, for patients without schizophrenia, the interviewer did not have an imbalance between his use of negative and positive information. He is less concerned in expressing negative information as often as positive one since patients without schizophrenia express more confidence and optimism concerning their behavior and illness (Figure 4.4).

A comparison between the two groups reveals that the interviewer provides more positive information for patients with schizophrenia and more negative information for non-schizophrenic patients (Figure 4.4). Full data for the control group is presented in Appendix B, table 7.



4.1.2.2 Continuing speech functions

One other technique in expressing positivity is through Continuing: prolonging moves. Prolonging moves are those where a continuing speaker adds to his or her own contribution by providing further information. Most of the interviewer's expansions of talk occur in his conversation with patients #2 and #4 in which he chooses to contribute to the discussion by adding further positive information rather than negative. His positive expansions are expressed either by elaborations (in which a move clarifies, restates or exemplifies an immediately prior move) or by extensions (in which a move adds to the information in an immediately prior move). The interviewer's speech choices creating continuation with positive evaluations are demonstrated in examples 4.5-4.6:

Example 4.5 Interviewer/Patient #2:

I:....What about any feelings in your body other than that strange feeling in (xxx) (xxx)

S: Just shaky

I: Just the shaking that is probably due to (clear throat) the pill to the medication in part you know, it's a side effect (clears throat) probably that's why decreased...

[S:R:respond:support:develop:enhance]. **Well things are getting better slowly...I'm sure**

that everything will be gone eventually you will feel healthy again... but it takes a little time you were sick for a long time...[S:C:prolong:extend:positive].

Example 4.6 Interviewer/Patient #4:

I: okay, we'll try to help... we'll try to help... [S:R:respond:support:develop:enhance]

I: It's been a very difficult period and. Uh you feeling bad about your relationship with your family, you feel alone. So it is a hard time [S:C:prolong:elaborate:negative]. **You're young and... you'll get it back together... I feel optimistic, maybe you don't but I think you will be all right** [S:C:prolong:extend:positive]. What are you planning to do today?

S: I don't know.

I: you have privileges, don't you? [S:R:rejoinder:support:track:probe]

I: you can go out for a walk and things like that [S:C:prolong:elaborate].

In both examples the interviewer expands his propositions with positive information. Even in a case where he elaborates negative information concerning the patient's illness (as in example 4.6) he immediately extends it further with positive evaluation. This strategy of the interviewer only emphasizes his awareness of the patients' severe emotional and social disturbance and the need to improve it by constantly conveying positivity and optimism during conversation.

4.1.2.3 Reacting: Responding moves

Table 4.1 presents the interviewer's clear preference to take a role as a supporter across all interviews with patients with schizophrenia. This preference prominently comes to an expression in Reacting: Responding moves, when the most frequent move of Responding is Support: Register (72% register moves out of total responds). Eggins and Slade (1997) define Registering moves as reactions which provide supportive encouragement for the other speaker to take another turn. In this manner, the interviewer is being attentive, understanding and conveys empathy to the patients:

Example 4.7 Interviewer/Patient #2:

I: What about your typical self if you looked at yourself in the mirror did you notice changes in you that were unusual?

S: Not in particularly a lot, thinner I thought I looked thinner and my hair needed doing.

I: Hmmm hmmm [S:R:respond:support:register]

S: I need glasses

I: Hmmm hmmm [S:R:respond:support:register]

S: I can't see very well without them

I: That happens to all of us.

Example 4.8 Interviewer/Patient #4:

I: what would that do to you when you took speed?

S: I don't know...people would say that it would speed you up

I: uh.hum [S:R:respond:support:register]

S: to me it just made me shake a lot made me nervous, made me frightened

I: uh.hum [S:R:respond:support:register]

I: did it make you suspicious of other people and that kind of thing

S: uhm... yes... mostly frightened.

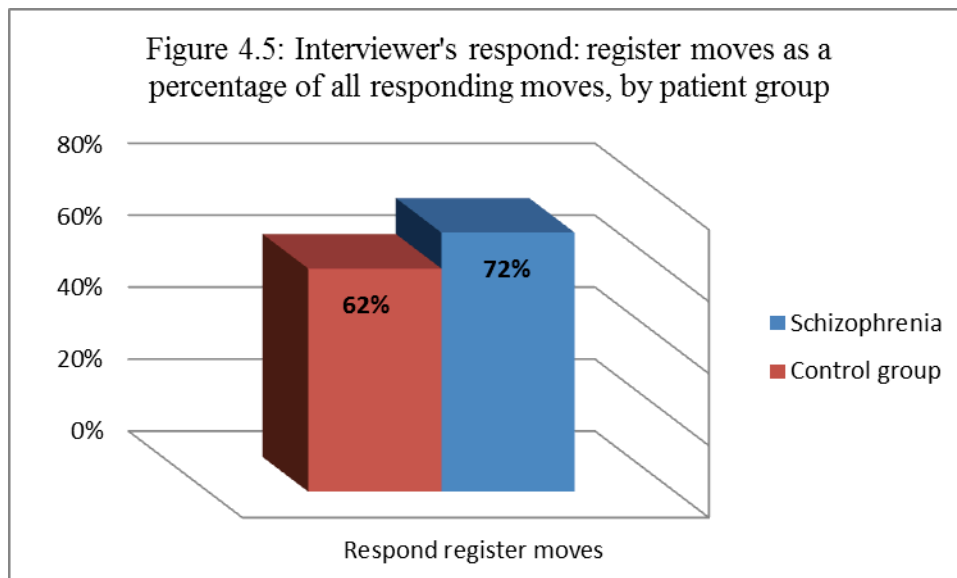
Table 4.3 presents the number of register moves expressed by the interviewer for patients with schizophrenia.

Table 4.3: Number of interviewer's register moves for patients with schizophrenia

Patient #	Total respond moves	Respond: register move
1	9	7
2	90	54
3	50	43
4	41	33
Total	190	137

4.1.2.3.1 Interviewer's register moves: a comparison between patients with and without schizophrenia

The interviewer uses slightly more register moves in interviews with patients with schizophrenia (72%) than with patients without schizophrenia (62%). In order to encourage patients with schizophrenia to express their positioning freely and cooperate during the discussion, the interviewer focuses on being attentive and empathic. Figure 4.5 presents the percentage of interviewers register moves for both groups of patients. Full data for the control group is presented in Appendix B, table 8.



4.1.2.4 Developing moves

Other supportive responds as Developing and Replying Moves function to express the interviewer's positive and optimistic attitude towards the patients.

Developing Moves indicate a very high level of acceptance of the previous speaker's proposition, as they build on it, using three types of expansions: elaborate, extend and enhance. Table 4.4 presents the number of positive and negative developing moves referring to each type of expansion.

Table 4.4: Number of interviewer's positive and negative developing moves for patients with schizophrenia

Respond: Support: Develop						
Interviewer	Elaborate		Extend		Enhance	
Patient#	Positive	Negative	Positive	Negative	Positive	Negative
1*	0	0	0	0	0	0
2	2	11	3	2	2	2
3	0	3	1	0	0	0
4	1	4	1	0	1	1
Total	3	18	5	2	3	3

Patient #1: the interviewer expresses only one support develop: elaborate move with factual information and not attitudinal.

As shown in Table 4.4, the interviewer tends to expand the patients' previous propositions with positive evaluations. An exception is seen in Elaborating moves in which the interviewer expresses more negative evaluations concerning the patients' illness. The function of elaborating move is, however, to clarify, restate or exemplify an immediately prior move. Thus, the interviewer in fact does not initiate new negative information in elaborating, but only restates previous negative propositions expressed by the patients. The role of expressing negativity turns then from the interviewer to the patients as expected:

Example 4.9 Interviewer/Patient #2:

S: Brainless I still feel brainless. [O:I:give:information:opinion:negative]

I: you still feel brainless... [S:R:respond:support:develop:elaborate] well we may do some tests to see if there is anything, umm if nothing else.

4.1.2.4.1 Interviewer's developing moves: a comparison between patients with and without schizophrenia

The interviewer similarly takes the optimistic role of a supporter with patients without schizophrenia. For all three types of developing moves, the interviewer tends to expand the patients' previous propositions with positive evaluations. It should be noted that in interviews with patients without schizophrenia the interviewer often develops information concerning factual information and not only attitudinal information as in develop: elaborating moves (see example 4.10).

Example 4.10 Interviewer/Patient #2:

I: Hmmm hmmm, have you ever thought of going to see a psychotherapist and ah discuss

S: What is that?

I: Well somebody who does counseling professionally either a psychiatrist or a psychologist or and ah who has helped people to deal with these problems before and ah who could help you

S: I'd appreciate a doctor but at the moment I can't even afford a doctor's fees. I can't

I: Well this goes without saying

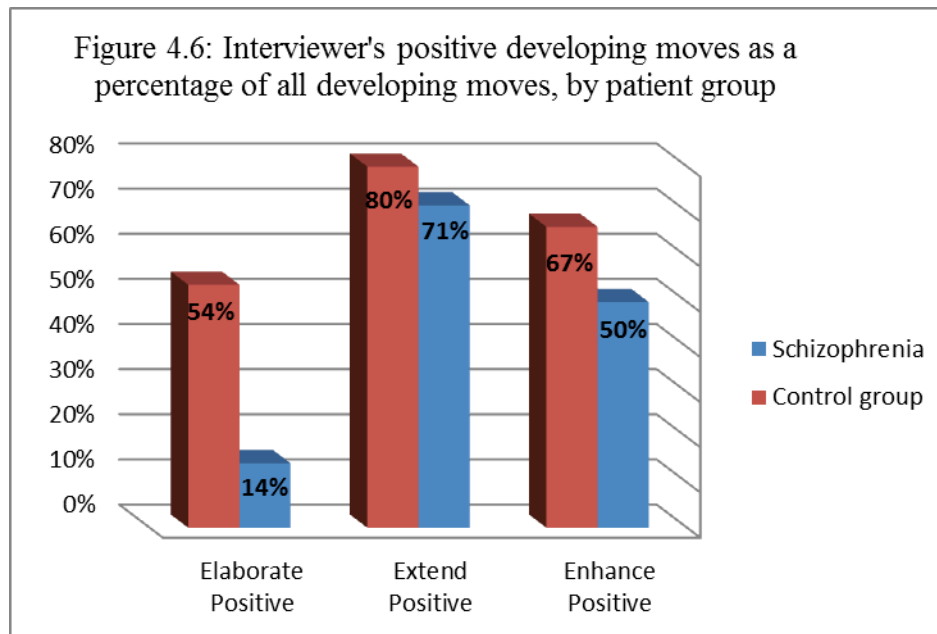
S: That's another one of my problems right now [**S:R:respond:support:develop:extend:fact**]

I: Money [**S:R:respond:support:develop:elaborate:fact**]

S: Right

Cohen (2007) showed that the emotional disturbance and mood disorder of patients without schizophrenia is less severe than schizophrenics. For speakers without schizophrenia, the interviewer considers the improved emotional expressiveness and less severe mood disorder and therefore, expands factual information, and not just the patients' emotions and experiences, as with patients with schizophrenia. Expressing mainly positive evaluations rather than facts and being optimistic is less essential in interviews with patients without schizophrenia. Furthermore, the interviewer uses developing moves in order to build on and expand the previous speaker/patient's proposition. Patients without schizophrenia express more positive evaluative language. Therefore, the developing moves of the interviewer, following the patients' proposition, involve more positive information than negative. However, patients with schizophrenia express more negativity and pessimism in their language. Accordingly, the interviewer's developing moves which expand patients' propositions include less positive information than with patients without schizophrenia (Figure 4.6). These results emphasize the negative attitude and severe emotional disturbance of patients with schizophrenia. It is

correspondingly difficult for the interviewer to frequently use positive evaluations. Figure 4.6 presents the percentage of positive and negative developing moves expressed by the interviewer for both groups of patients. Full data for the control group is presented in Appendix B, table 9.



4.1.2.5 Replying moves

Replying moves, similarly to developing moves, function to express the interviewer's positive and optimistic attitude towards the patients.

According to Eggins and Slade (1997), replies are the most negotiatory of the responding reactions, although they negotiate the proposition given by a prior speaker. Supporting replies, chosen as the preferred replies in contrast to confronts, indicate a willingness to accept the propositions of the other speaker. Most common support replies are agree and affirm. Both types of supporting replies strengthen the interviewer's role as a supporter and are a tool for the interviewer to convey his positive evaluations to the patients, as in the following example:

Example 4.11 Interviewer/Patient #3:

S: I was um wasn't very strong... and ah **I think I'm I'm on the road to recovery anyway**

[S:C:prolong:extend:positive]

I: uh.hum... okay. [S:R:respond:support:reply:agree]

Table 4.5 presents the number of interviewer positive and negative replying moves with patients with schizophrenia.

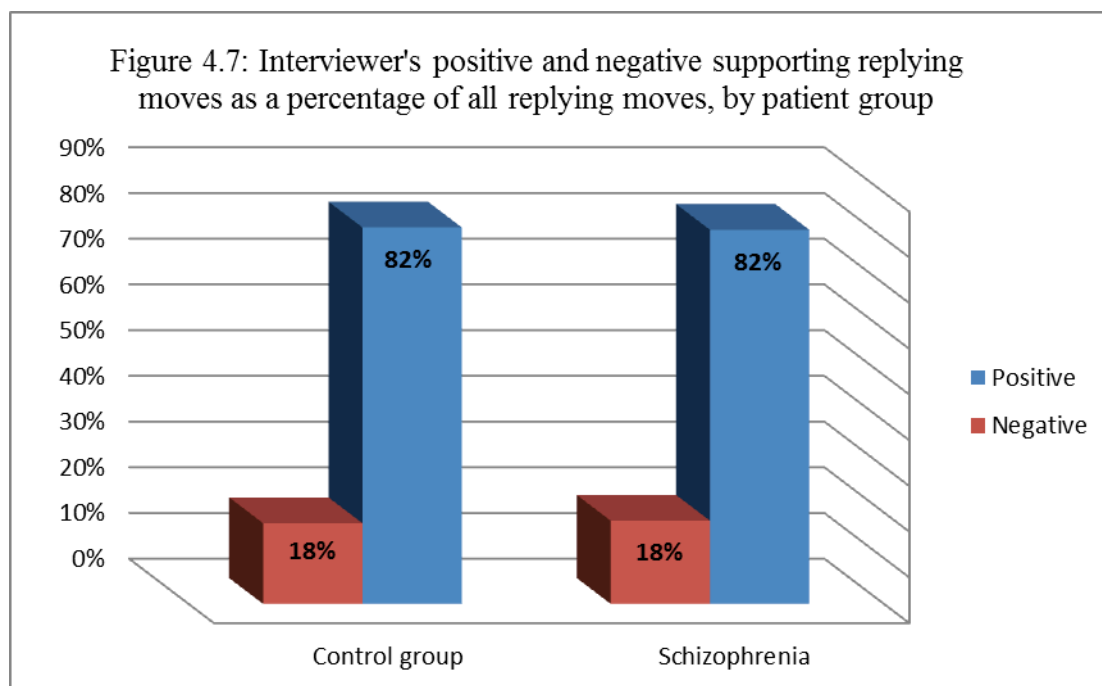
Table 4.5: Number of interviewer positive and negative replying moves with patients with schizophrenia

Replying moves				
	Agree		Affirm	
Patient#	Positive	Negative	Positive	Negative
1	0	0	0	0
2	4	1	2	0
3	2	0	1	0
4	0	1	0	0
Total	6	2	3	0

The total results of table 4.5 indicate the interviewer's clear preference to respond to the patients with replies including positive evaluations concerning their illness.

4.1.2.5.1 Interviewer's expression of replying moves: a comparison between patients with and without schizophrenia

Similar to patients with schizophrenia, the interviewer responds with replies including positive evaluations to patients without schizophrenia (Figure 4.7). For 2 control patients, however, the interviewer also replies with factual information and not only with attitudinal information. As with developing moves, expressing mainly positive evaluations is less essential and contributive as in interviews with patients with schizophrenia. For patients with schizophrenia, the interviewer focuses his entire effort in replying with attitudinal information, mainly positive. For patients' without schizophrenia, their better emotional expressiveness enables the interviewer to include factual as well as attitudinal information in his replies. Figure 4.7 presents the percentage of positive and negative replying moves expressed by the interviewer for both groups of patients. Full data for the control group is presented in Appendix B, table 10.



In return to patients with schizophrenia (4.1.2.5), one other noticeable point is concerned with the interviewer confronting responds. There are only 5 confronting responds, only in the interviews of patients #1 and #2. The discourse purpose of confronting replies is to encode non-compliance with the positioning offered. Yet, in 3/5 confronting replies, the interviewer confronts prior negative evaluations of the patients to present and emphasize his positive attitude. In this way, he succeeds in encouraging the patients concerning their behavior and progress in illness and raises their self esteem. Examples 4.12-4.13 present the interviewer's strategy in expressing positivity through confronting replies:

Example 4.12 Interviewer/Patient #1:

S: I just don't feel I've got a brain at all [Negative].

I: I think you do...a pretty bright woman [S:R:respond:confront:reply:contradict]

Example 4.13 Interviewer/Patient #1:

S: Brainless I still feel brainless [Negative].

I: you still feel brainless...well we may do some tests to see if there is anything, umm if nothing else

S: I just wondered if there were many people brainless

[O:I:demand:closed:information:opinion].

I: Nobody is brainless [S:R:respond:confront:reply:disagree].

4.1.3 Conclusion

The use of empathy and validation of the patients' emotional and other experiences is a critical tool. Hasselt and Hersen (1998) pointed out that the interviewer's ability to emphasize with patient's dilemma and other associative experiences increases patient's trust. The patient first experiences the therapist as an attentive listener and perceives the therapist as caring and concerned. The patient then realizes that the therapist has the capacity to understand; hence, he is the likely to perceive the therapist as competent and able to help. Finally, with the patient's realization that the therapist understands, he or she experiences hope for symptom/problem resolution.

The functional semantic interpretation of schizophrenic's conversation described in this section includes various linguistic resources (within the set of speech functions) which enable the interviewer to emphasize with the patients' experiences and difficulties and establish his role as a supporter.

The interviewer's critical role as supporter towards patients with schizophrenia is further emphasized when compared to patients without schizophrenia. Patients without schizophrenia show improved emotional expressiveness and their mood disorder seems less severe than patients with schizophrenia. Though the interviewer takes the role of a supporter and often expresses positive evaluations, he does not avoid expanding the discussion with factual information concerned with more technical issues.

The interviewer's role as a supporter towards patients with schizophrenia is more intense. The interviewer frequently supports the severe emotional disturbance and social impairment of patients with schizophrenia by expanding with positive evaluations rather than with just factual information.

4.2 Eliciting information

This study is based on transcriptions of recorded conversations eliciting information about the patients. Halliday and Hasan (1985) refer to a text as an interactive event, a social exchange of meanings. In order to understand the interviewer's communicative goals in eliciting information from the patients and the interpersonal meanings exchanged, it is important to interpret the context of situation of the text, the environment in which meanings are being exchanged. Halliday (1978) notes that the description of the situation type is in terms of *field*, *tenor* and *mode*: the text-generating activity, the role relationships of the participants and the rhetorical modes they are adopting. These situational variables are related respectively to the *ideational*, *interpersonal* and *textual* components of the semantic system: meaning as content, meaning as participation and meaning as texture. Halliday (1978) explains that they are related in the sense that each of the situational features typically calls forth a network of options from the corresponding semantic component; in this way, the semiotic properties of a particular situation type, its structure in terms of *field*, *tenor* and *mode*, determine the semantic configuration or *register*- the meaning potential that is characteristic of the situation type in question. The description of register, specifically the kinds of role relationships obtain among the participants (tenor), enables to interpret the patients' and interviewer's dialogic structure, the quality of their interpersonal relationships, their roles and attitudes.

This section focuses on the role relationship the interviewer takes to elicit information from the patients. The initial social goal of the interviewer in eliciting information is concerned with gathering language sample of patients with schizophrenia. However, the interviewer is aware of being the data gather, and takes the role of eliciting information a step further for achieving other communicative goals. From a diagnostic perspective the interviewer gathers information about the nature and development of the patients' problem and symptoms of illness. Hasselt and Hersen (1998) note that, the purpose of information gathering is to develop a basic coherent conceptualization, a clinical frame of reference by which to understand the symptoms presented. The interviewer is able to identify the characteristic symptoms of schizophrenia through different linguistic resources used for eliciting information concerning the illness. This information assists the clinician in making a clinical diagnostic and evaluating the patients' illness. However, the attempt to sustain the interaction and extract information is difficult and challenging in a conversation with patients with schizophrenia. The clinical description of schizophrenia includes a number of negative symptoms (flat affect, blocking, poverty of speech and poverty of content of speech) which reflect a diminution or loss of normal

functions. These symptoms reflect a reduction in the usual flow of language and resulting in the patients' failure to establish their identity, communicate with others and form social relationships. In response, the interviewer specifically chooses speech functions that overcome the communicative difficulties and succeed in extracting information from patients with schizophrenia.

The following section describes the interviewer's use of various speech functions which sustain the interaction and extract information.

4.2.1 Initiating moves: demanding information

Opening moves begin sequences of talk, or open up new exchanges. Opening: Initiating moves include the functions of giving and demanding, along with goods-and-services and information. In order to describe the linguistic resources used for gathering information, the focus is on the interviewer's choices of initiating speech function of demanding information. When the interviewer asks the patients questions to gather information, he in fact takes control over the conversation. In the context of clinical interviewing, questions are an incredibly diverse and flexible interviewer tool. As Sommers-Flanagan and Sommers-Flanagan (2003) describe, "questions can be used to stimulate client talk, to restrict it, to facilitate rapport, to show interest in your clients, to show disinterest, to gather information, to pressure clients, and to ignore the client's viewpoint (p.82)". The many types of questions require the interviewer to differentiate among them because different types of questions tend to produce different patients responses. In questioning patients with schizophrenia, the interviewer takes into consideration the patients' negative symptoms, emotional disturbance and mood disorder; and therefore seeks to differentiate among the type of questions that will most contribute in encouraging talk, sustaining the interaction and gather relevant information. In order to achieve these communicative goals, the interviewer uses fact/opinion questions and open/closed questions. Thus, these types of questions will be studied in relation to affective involvement. The interviewer's choices can impact on the extent to which schizophrenics will freely discuss their opinions and emotions.

4.2.1.1 Fact/opinion questions

According to Eggins and Slade (1997), "the difference between facts and opinions is usually expressed lexically, with opinions containing either expressions of modality, or appraisal lexis" (p.193). Thus, questions that demanded information about patients' feelings, behavior and experiences of illness were analyzed as opinion questions and not as fact questions.

"Fact and opinion initiations also tend to lead to different types of exchanges with opinion exchanges generating arguments, while fact exchanges often remain brief" (Eggins and Slade, 1997: 193-194). The interviewer takes in to consideration the characteristic symptoms of schizophrenia as severe reduction of emotional expressiveness and poverty of speech that may impair attaining communicative goals. Therefore, he creates opinion exchanges throughout conversations which encourage the patients to discuss their opinion and express their emotions.

Table 4.6 presents the number of fact and opinion questions expressed by the interviewer.

Table 4.6: Number of interviewer fact and opinion questions for patients with schizophrenia

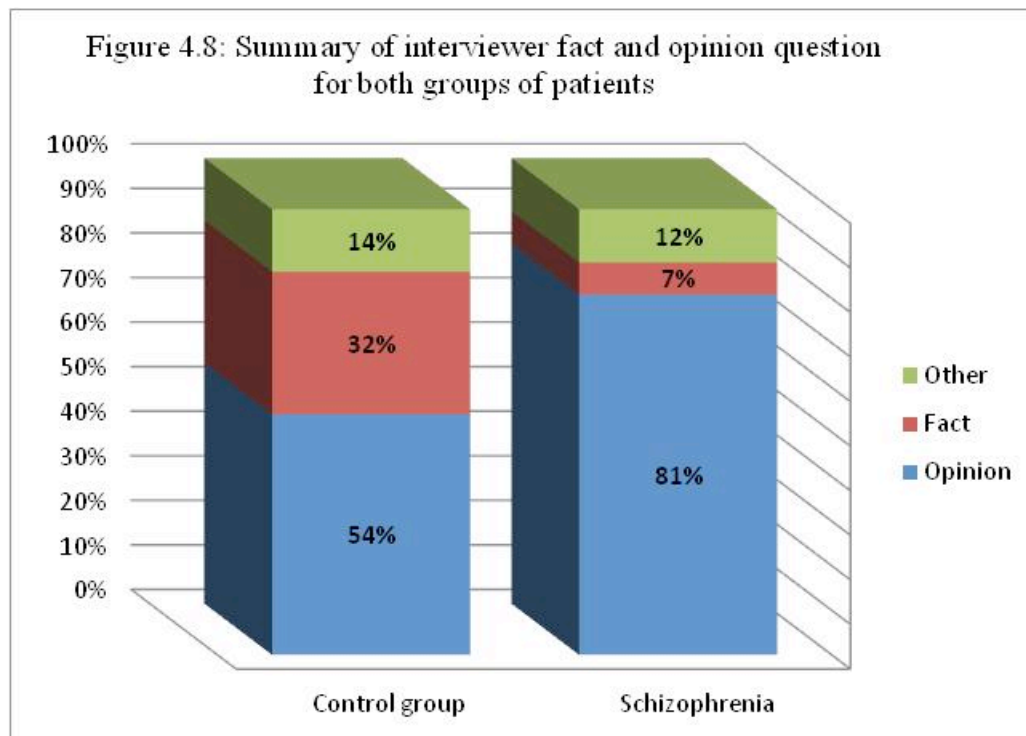
Interviewer	Open: Demand: Information		
Patient #	Total Opening Moves	Fact	Opinion
1	10	1	7
2	129	9	106
3	23	0	17
4	47	5	39
Total	209*	15	169

The 'fact' and 'opinion' numbers do not sum to the total values of opening moves since there are a few other opening moves that were not relevant for demanding information and were not included.

In initiating talk with schizophrenic patients, the interviewer's most common opening move option is demanding information concerning the patients' opinions, emotions and attitudes. The interviewer avoids demanding factual information, which often remain brief, since such exchanges hardly contribute to conversation development and in achieving communicative goals.

4.2.1.1.1 The interviewer's expression of fact and opinion questions: a comparison between patients with and without schizophrenia

For both groups of patients, the interviewer demands information concerning the patients' opinions and emotions. More important, however, is the distinct gap between fact and opinion question for patients with schizophrenia in comparison to patients without schizophrenia. The interviewer considers schizophrenics' emotional disturbance and poverty of speech and therefore almost completely avoids asking factual questions. Rather, he frequently asks opinion questions that contribute most to conversation development. For patients without schizophrenia, the interviewer prefers gathering opinion information and yet does not avoid asking factual questions during the interviews. Figure 4.8 presents the percentage of fact and opinion questions expressed by the interviewer for both groups of patients. Full data for the control group is presented in Appendix B, table 11.



4.2.1.2 Open/closed opinion questions

Once the interviewer takes the role of demanding information opinion, the distinction should be then between open/closed questions. "Open questions seek to elicit completion of a proposition from the addressee, and closed questions present a complete proposition for the support or confrontation of the addressee" (Eggins & Slade, 1997: 195). Open questions are a preferable choice in a conversation with patients with schizophrenia, since they are designed to facilitate verbal output. Closed questions restrict verbalization and lead patients towards more specific responses than open questions. In this study, when the interviewer wants to elicit information about opinions, emotions, attitude and behavior, he uses open questions, with the exception of patient 2. Patient 2 fails to connect appropriately to context relative to the other patients, which reflects a reduction in the usual flow of language. The interviewer, therefore, asks the patient more closed questions which serve as a technique for reducing or controlling how much the patient will talk and thus focus the patient and connect her to context. However, this technique with this patient is restricted, since the interviewer is aware that too many closed questions become regressive and may impair maintaining free-flowing communication. Thus, the interviewer used 61 questions closed in form addressed to patient 2. However, 23 of these questions were open in function. In other words, in order to avoid exchange completion or poverty of speech, some of the interviewer's closed questions are presented either as (1) an alternative question ("or"), which are similar in form to closed questions but similar to open questions in function, in that they ask for a specific piece of information or as (2) a closed question beginning with an open question. These two types of questions are presented in examples 4.14-4.16.

Example 4.14 Interviewer/Patient #2:

I: Do you think the glasses make a difference or is there something else that's changed?
[Alternative question]

S: No no...well I don't think it was the glasses

I: What do you think it was?

S: I am getting a bit better than I was

Example 4.15 Interviewer/Patient #2:

I: Do you ever think they are maybe symptoms of an illness that is still going on or maybe they are real people doing this to you? [Alternative question]

S: I really don't know anymore

I: Your'e not sure either way...

Example 4.16 Interviewer/Patient #2:

I: What about ah, your husband does he look familiar to you know? [Wh+ Closed question]

S: Yes...I recognize him now

S: I didn't before

Table 4.7 summarizes the number of the interviewer's open and closed opinion questions for patients with schizophrenia.

Table 4.7: Number of the interviewer's open/closed opinion questions for patients with schizophrenia

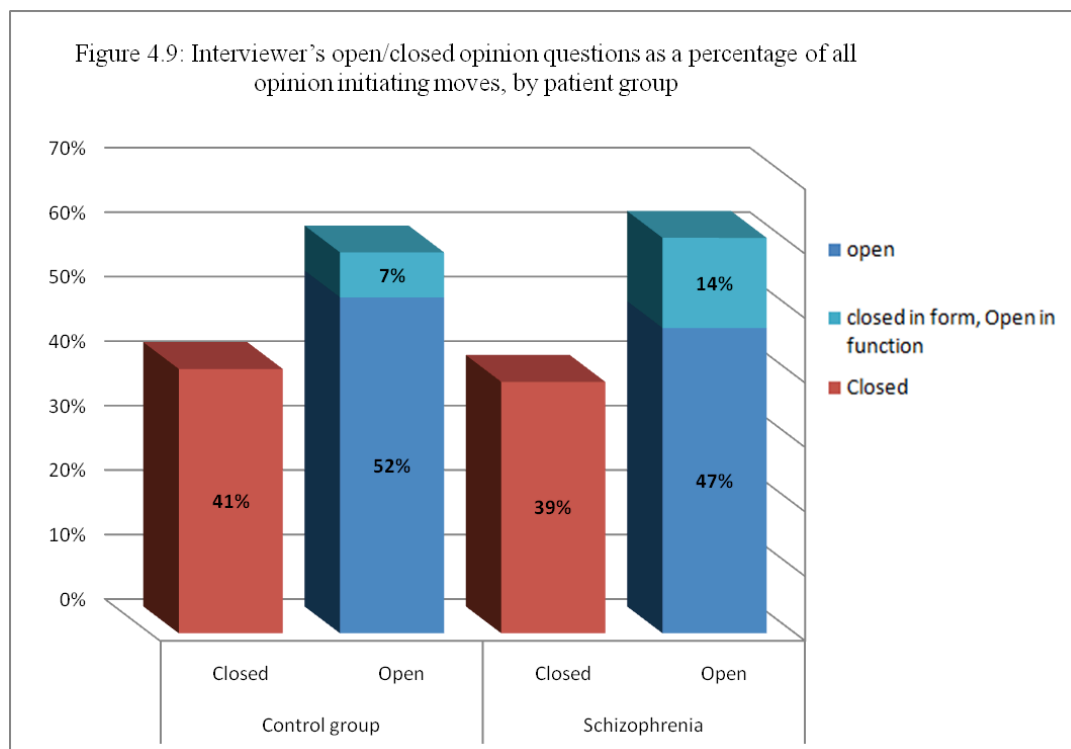
Interviewer	Open: Demand: Information: opinion			
Patient #	Total demand:opinion Moves	Open	Closed in form, open in function	Closed
			alternative question and wh+closed question	
1	7	5	0	2
2	106	45	23	38
3	17	10	0	7
4	39	20	0	19
Total	169	80	23	66

The interviewer asks open questions in order to elicit opinion information (table 4.7). The interviewer asks patient #2 38 closed questions that are explicitly closed both in their form and function, and 23 questions that are closed in form but are relatively open in their function or actually include an open question. Thus, the interviewer asks more open questions (103 open/ 66 closed) which facilitate verbal output and encourage the patients to discuss their opinions and express their emotions.

4.2.1.2.1 The interviewer's expression of open and closed question: a comparison between patients with and without schizophrenia

Similarly to patients with schizophrenia, the interviewer more often asks open than closed questions in order to elicit information concerning the patients' opinions and emotions. Further

analysis shows, however, that the two groups differ in the type of closed questions asked in their interview. The interviewer expresses about the same amount of closed questions relative to both groups but for patients with schizophrenia there are more closed questions that are relatively open in their function or that actually include an open question. The interviewer realizes that in the case of patients with schizophrenia it is necessary to frequently ask open questions, as well as to turn questions closed in form to open questions in function. This discourse technique encourages patients to develop conversation and avoid poverty of speech. However, the technique seems less essential in interviews with patients without schizophrenia and therefore, most closed question are closed both in their form and function. Figure 4.9 presents the percentage of the interviewer's open and closed opinion questions. Full data for the control group is presented in Appendix B, table 12.



4.2.2 Reacting speech function: Responding moves

Despite the central role of questions (opening moves) for interviewing, responding moves are also used as an interviewing technique which acts to extract information. The most frequent Responding move expressed by the interviewer is Support: Register (72% register moves out of total responds). Registering moves were described earlier as speech functions that convey support and empathy to the patients. Registering moves, however, do not only assist the interviewer to take the role of a supporter, but also to gather information from the patients. The interviewer considers that these reactions provide supportive encouragement for the other speaker to take another turn; and thus aims to encourage the patients to prolong the exchange and contribute to the negotiation of interpersonal positioning.

Thus, the interviewer's most frequent responding reactions are registering moves (Table 4.8, column 2). When the interviewer responds, he chooses not to introduce new material for negotiation but rather to express an expectation from the patients to continue talk. The interviewer uses registering moves in order to extract information; however, these moves do not stand on their own. In most cases, registering moves follow an interviewer's initial move of opening or rejoinder. The interviewer is aware, on the one hand, of the patients' tendency to move the exchange towards completion, and on the other hand, of the high potential of opening and rejoinder moves to sustain the interaction. Therefore, once he initiates with such moves he wishes to intensify the function of opening moves and rejoinders, and adds a register move in close proximity (Table 4.8, column 3). Example 4.17 demonstrates how together these speech functions intensify the interviewer's demand for information and further encourage the patients to prolong the exchanges.

Example 4.17 Interviewer/Patient #2:

I: So....what about the difficulty that ah..you you know that you had that...people at home didn't look familiar at all, do you still have that or is it changing at all?

[Open:demand: information:opinion]

S: ...I think it's changed... I don't see it home of course ah [Respond:support]

I: Hmmm hmmm [Respond:support:register]

S: But I still hear voices and see things. [Continue:extend]

Registering moves are added when the interviewer initiates an exchange demanding further information concerning the patients' opinions, attitude and experiences of illness. The interviewer's initiating moves are followed with a patient's immediate reacting move, mainly a

supporting one. The patients, thus, agree to negotiate and accept the interviewer's propositions and avoid confrontation (Table 4.8, column 4-5). Nonetheless, most of the patients' reacting moves (both support and confront) are 'responds' (105/137) and not 'rejoinders' (32/137). Since 'responds' are reactions that move the exchange towards completion, the interviewer chooses to frequently add registering moves after the patients' responds in order to encourage them to talk and keep the exchange open, as in example 4.18:

Example 4.18 Interviewer/Patient #3:

I: at any rate are you feeling a little better today right? [**Open:demand:information:opinion**]

S: ah yea I did feel better especially mostly in the head and this part of the body
[**Reaction:Respond:support**]

I: uh.hum [**Respond:support:register**]

S: the rest of the body's still even my stomach seems you know not quite right.

[**Continue:extend**]

Another noticeable point is the position of registering moves in the exchanges. As mentioned above, the interviewer's registering moves occur after the patient's reacting speech functions which are mainly 'responds' rather than 'rejoinders'. Yet, more than half of the registering moves (Table 4.8, column 6) are not added in the move after the patients' reactions. The interviewer often uses register moves (77/137 register moves) after prolonging moves to continue their own reactions and add further information. The interviewer recognizes those exchanges in which the patients show a degree of co-operation and broaden the discussion. The interviewer then shows supportive encouragement specifically in the exchanges in which the patients express their opinion, experiences and emotions freely. The interviewer realizes the important opportunity of those exchanges that the patients expand and decides to add a register move in order to encourage further talk and to avoid exchange completion, as demonstrated in example 4.19.

Example 4.19 Interviewer/Patient #3:

I: do you smoke grass once in a while? [**Open:demand:information:opinion**]

S: no [**Respond:confront**]

I: not even that? ...what made you stop? [**Open:demand:information:opinion**]

S: oh, when I went out to Vancouver. I had grade "8" education... and I looked at myself... and I didn't like what I seen... [**Respond:support**]

S: I didn't have any future... so I stopped doing drugs [**Continue:enhance**]

I: uh.hum [**Respond:support:register**]

S: and I went back home and I tried to go to school, to do my best [**Continue:extend**]

I: right... [**Respond:support:register**]

The detailed analysis of registering moves described above shows how the interviewer specifically locates the register moves to most contribute to obtain information and sustain the interaction. The interviewer's skillful use of registering moves and success in extracting information and sustaining the interaction is measured by whether patients with schizophrenia are encouraged to talk and prolong the exchange. The analysis reveals that registering moves, as they occur in the interviews, encourage the patients to expand the discussion and add further information concerning their illness (Table 4.8, column 7). In most cases where register move occurs, a prolonging move is then immediately added by the patients (108/137).

Skillful use of registers contributes in creating continuity and fluency along the interview and enables the interviewer to achieve the information demanded for evaluation and diagnosis.

Table 4.8 presents the interviewer's use of the register move and its implications in interaction.

Table 4.8: Number of interviewer registering moves and their implications for patients with schizophrenia

Column	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>
Patient#	Total Respond move	*Total register Moves	Register moves follow initial question/rejoinder	Register moves within patient Respond type		Register moves after patient's continuing move	Patients' Extension of talk after register moves
				Support	Confront		
1	9	7	7	6	1	6	6
2	91	54	43	40	14	18	48
3	50	43	43	37	6	31	32
4	41	33	31	25	8	22	22
Total	191	137	124	108	29	77	108

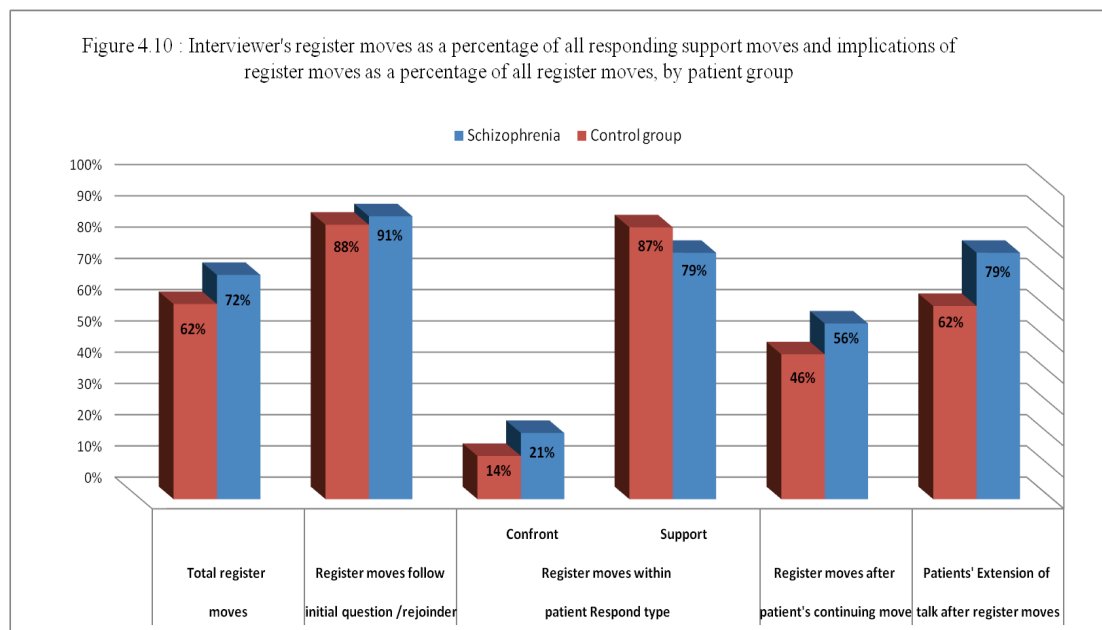
The values in columns 3-7 are derived from the values of "Total register moves" in column 2 accordingly.

4.2.2.1 The interviewer's use of the register move and its implications in interaction: a comparison between patients with and without schizophrenia

For both groups of patients, when the interviewer responds, he does not introduce new material for negotiation but rather, using registering moves, expresses an expectation that the patients continue to talk, (Figure 4.10). Yet, the interviewers' choice to elicit information is more common in interviews with schizophrenic patients. These results emphasize the poverty of speech in patients with schizophrenia and the need to constantly encourage them to talk. Furthermore, the interviewer adds a similar amount of registering moves for both groups following his initial move of opening or rejoinder. The interviewer adds a register move in close proximity to these initial moves to intensify his demand to sustain the interaction (Figure 4.10).

Further comparison shows that for both groups of patients, the interviewer's initiating moves are followed by a patient's immediate reacting move, mainly a supporting one. The patients mainly agree to negotiate and accept the interviewer's propositions. However, in comparison to patients without schizophrenia, patients with schizophrenia express more confront moves and agree less to negotiate and keep the exchange open (Figure 4.10). The two groups are further compared for the position of registering moves in exchanges. As mentioned above, the interviewer's registering moves occur after the patient's reacting speech functions, mainly supportive. Yet, for patients with schizophrenia, the interviewer often adds the registering moves after prolonging moves which continue the patient's immediate reaction. The interviewer realizes the important opportunity of those exchanges which the patients expand and adds a register move in order to encourage further talk and to avoid exchange completion. This technique for encouraging talk occurs less often with patients without schizophrenia. In their case, a prolonging move is not a necessary condition to encourage further talk (Figure 4.10). Surprisingly, registering moves encourage more the patients with schizophrenia to expand the discussion and add further information concerning their illness compared to patients without schizophrenia (Figure 4.10). The interviewer made more effort encouraging patients with schizophrenia to develop the discussion, taking into consideration their severe emotional disturbance and social impairment. These efforts were eventually successful since patients with schizophrenia expanded their talk more often than the control group.

Figure 4.10 presents the percentage of interviewer's register moves and its implications in interaction with patients with and without schizophrenia. Full data for the control group is presented in Appendix B, table 13.



4.2.3 Reacting speech function: Rejoinders

Rejoinder moves contribute most assertively to the negotiation of interpersonal relationships. Rejoinders tend to extend the exchange through queries, doubt or rejection of ideas or added information; and as responds, they can be supportive or confronting. The patients' emotional disturbance and their attempt to avoid negotiation of interpersonal positioning, require the interviewer to gain the patients' trust and encourage them to speak. Therefore, he uses only supportive rejoinders: tracking, which sustain the interaction by keeping an exchange open, without implying any interpersonal confrontation (Table 4.9, column 1). Thus, the interviewer attempts on the one hand, to take the role as a supporter and avoid confrontation, but on the other hand, to sustain the interaction and gather as much information as possible.

Tracking moves involve checking, confirming, probing or clarifying information. The interviewer realizes that in order to maximize his effort of extracting information he should clarify or probe the content of prior moves rather than check or confirm (Table 4.9, column 2). Check and confirm seek for verification or for information that has been misheard. Thus, they demand very specific prior information that is not new (Example 4.20). Clarify and probe, however, seek for additional information and offer further details for confirmation. They can contribute more in broadening the discussion and extract information that will assist in constructing the patients' identity and relationships (Example 4.21).

Example 4.20 Interviewer/Patient #4:

I: what do they tell you, why don't they want you back?

S: I'm frightening to live with

I: they what? [Rejoinder:support:track:check]

S: frightened to live with me

I: what are they frightened of?

S: my behavior.

Example 4.21 Interviewer/Patient #4:

I: do you remember, uh the kind of thing that happened that made you go to the hospital at the

S: yes

I: what was it? [Rejoinder:support:track:clarify]

S: I ... took a bus ride to Michigan... and wanted to visit Michigan State University

I: uh.hum

S: I was involved in politics and things... I was watching your public in politics

I: uh.hum

S: and there was a political change between Carter and Ford

I: yea

S: and Ford went to Michigan University

I: uh.hum

S: I just wanted to go there and see what the University was like

I: I see

S: and ... uhm on the way there... I started... I don't know how to explain it, maybe I was hallucinating.

Eggins and Slade (1997) note that Tracking moves call for further talk from the prior speaker- they thus get responded to. Most of the patients' responds to rejoinders are supporting, specifically, resolving responses (Table 4.9, column 3-4). The patients agree to co-operate with the interviewer in a way that they provide the clarification demanded and resolve misunderstandings.

Despite the patients' agreement to support negotiation, their co- operation is constrained to some extent. Patients with schizophrenia provide supportive responds to rejoinders, however, they do not tend to expand their talk further than the initial response (Table 4.9, column 5). The interviewer uses rejoinders as linguistic resources which are most effective in sustaining the interaction; and yet, he fails to keep an exchange open for long.

Since patients with schizophrenia do not develop the discussion and negotiate in detail the information proposed, it is difficult for the interviewer to achieve his communicative goals of eliciting information about the patients' problems and symptoms of illness and determining the quality of their interpersonal relationships. Table 4.9 summarizes the interviewer's use of rejoinder moves and its implications in interaction with patients with schizophrenia.

Table 4.9: Number of rejoinders expressed by the interviewer and its implications in interaction with patients with schizophrenia

Column#	1	2	3	4	5
Patient#	Total Rejoinder (support) moves	Probing+ Clarifying moves	Patients' Respond type to rejoinder moves		Patients' extension of talk after rejoinders
			Support	Confront	
1	11	6	5	5	5
2	64	47	57	7	6
3	12	8	11	1	6
4	15	11	11	4	6
Total	102	72	84	17	23

The values in columns 2-5 are derived from the values of "Total rejoinders" in column 1 accordingly.

4.2.3.1 The interviewer's use of rejoinder moves and its implications in interaction: a comparison between patients with and without schizophrenia

The interviewer mainly uses supportive rejoinders: tracking preferable to elicit information from both groups of patients. Thus, he sustains the interaction by keeping an exchange open without interpersonal confrontation. Despite this similarity, the interviewer uses rejoinders: tracking moves more frequently in interviews with patients with schizophrenia. The patients' poverty of speech and lack of communication requires the interviewer to frequently express rejoinders to sustain the interaction and elicit information. Further comparison between the groups of the interviewer's specific choice of rejoinders emphasizes his increased effort to elicit information from patients with schizophrenia.

The interviewer's attempt to clarify or probe the content of prior moves rather than check or confirm is more common for patients with schizophrenia than for controls (Figure 4.11).

Besides encouraging patients with schizophrenia to talk, it is important to use those rejoinders that will contribute most to broadening the discussion and eliciting information. This difference between the groups is even more distinct when considering the total numbers of clarify and probe moves (Figure 4.12: schizophrenia 72, controls 39). In percentages, the difference between the groups is less distinct since probe and clarify moves are calculated from different totals of rejoinders for each group (Figure 4.11).

Further analysis shows that both groups of patients are mainly supportive in their responds to rejoinders. Patients without schizophrenia, however, show more support in their responds and less confrontation relative to patients with schizophrenia (Figure 4.11).

The two groups of patients also differ in how they expand their response to the interviewer's rejoinder moves. Out of all responds to rejoinder moves, patients with schizophrenia expand less their initial responses (22%) than patients without schizophrenia (33%) (Figure 4.11). In considering the absolute numbers of extensions rather than percentages, we find similarity between the groups (Figure 4.12). The groups differ in the amount of extensions when these numbers are considered as percentage out of total rejoinders for each group (Figure 4.11). Despite the interviewer's increased attempts to elicit information from patients with schizophrenia, he does not keep exchanges open for long. There is consistent evidence that patients with schizophrenia do not sustain an interaction and develop it.

Figures 4.11 and 4.12 present the rate and number of interviewer's rejoinder moves and accompanying moves of patients with and without schizophrenia. Full data for the control group is presented in Appendix B, table 14.

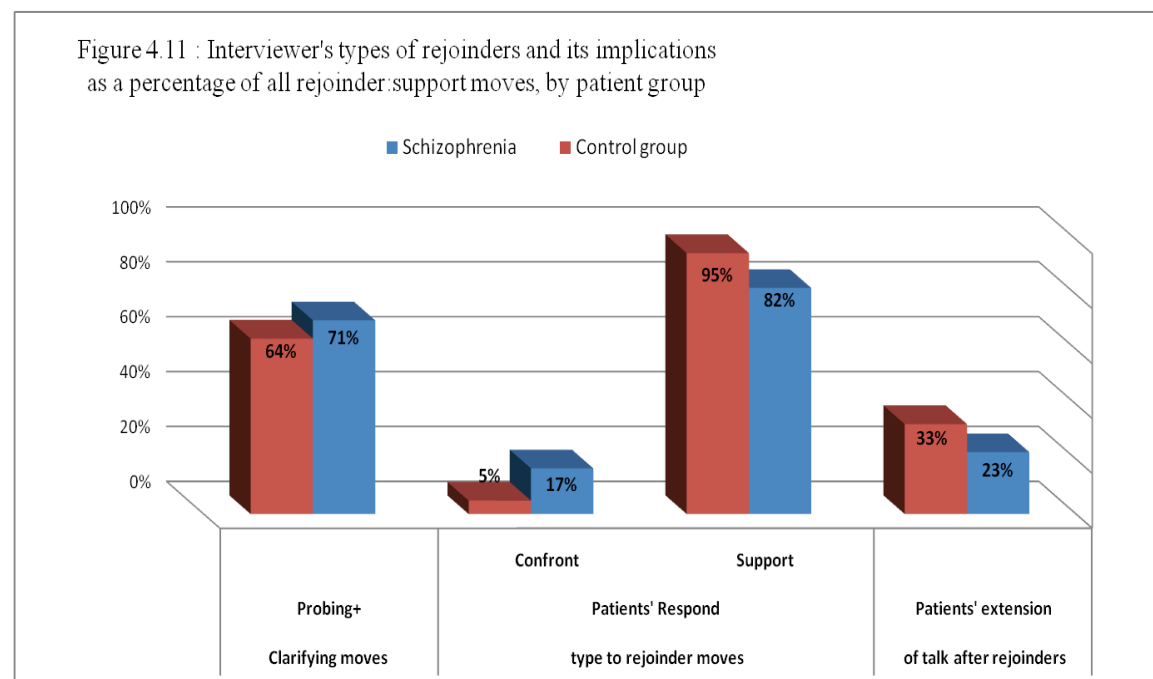
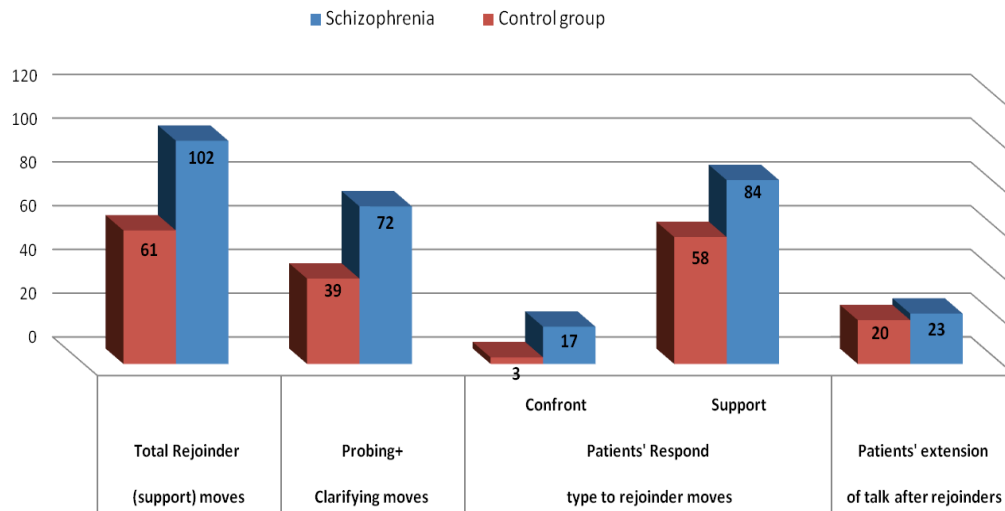


Figure 4.12 : Interviewer's number of rejoinders and its implications in interaction, by patient group



4.2.4 Conclusion

Eliciting information is perhaps the most difficult role for the interviewer due to the symptoms of poverty of speech, poverty of content of speech and flat affect.

The interviewer then uses specific speech functions that are most effective to overcome the communicative difficulties and to extract information from patients with schizophrenia.

The most common speech functions for eliciting information are initiating moves, specifically open questions that demand opinion information. This type of question encourages patients to develop the discussion and express their opinions and emotions freely. The interviewer uses other moves as reacting speech functions (responds and rejoinder) as part of his comprehensive effort to sustain the interaction and elicit information.

A comparison between the two groups of patients shows that the interviewer is more concerned in eliciting information from patients with schizophrenia. The interviewer uses both moves of initiating and reacting more often for patients with schizophrenia than patients without schizophrenia. The interviewer's increased effort to elicit information from patients with schizophrenia provides strong evidence for the patients' communicative failures and incoherent language. Skillful use of specific speech functions facilitates the interviewer's effort to elicit information from patients with schizophrenia, information that will contribute in identifying the patient's emotional and social impairment.

4.3 Coherence and Clarification

Disorganized speech is a central symptom in schizophrenia. The patients' incoherent verbal production is often senseless and incomprehensible. Fine (2006) points out that when the speech of an individual with schizophrenia is difficult to follow in context it is called disorganized speech. "The clinical understanding of disorganized speech is as either derailment which is taken to be an across clause phenomenon or incoherence which is taken to be a disturbance within a clause" (American Psychiatric Association, 1994). Both kinds of disorganized speech characterize talk that is uninterpretable in context. As Fine (2006) states, the speech is incomprehensible because there are no meaningful or logical connections between words, phrases or clauses.

Since language of schizophrenia is incoherent and not connected typically to the context, it is difficult for the interviewer to comprehend the patients' interpersonal positioning and to achieve a well formed communicative discourse. The interviewer, in response, adapts two strategies through the use of speech functions, which enable him to facilitate communicative failures and create a coherent and fluent discourse.

4.3.1 Providing clarifications: Prolonging moves

Discourse coherence depends much on how clear the interviewer is. The interviewer follows the turn-taking rules, clearly introduces the discourse topics and requests information, asks accurate and comprehensible questions, is clear in his intentions and avoids misunderstandings during conversation.

The interviewer in this study is constantly being clear and coherent as evident in his use of prolonging speech functions. Prolonging moves are those in which a speaker provides further information. Prolonging moves include three types of expansion: elaboration, extension and enhancement. In cases where the interviewer expands his talk he frequently uses extensions, adding new information which is not concerned in clarifying prior moves but rather continuing and developing prior information. Less common are elaborations and enhancement which according to Eggins & Slade (1997) act to clarify, restate, exemplify or modify an immediately prior move. The interviewer's speech is clear, accurate and explicit, and therefore he does not often express elaborations or enhancement to clarify his own talk. The patients, consequently, can easily address the topics discussed and provide the relevant information, without

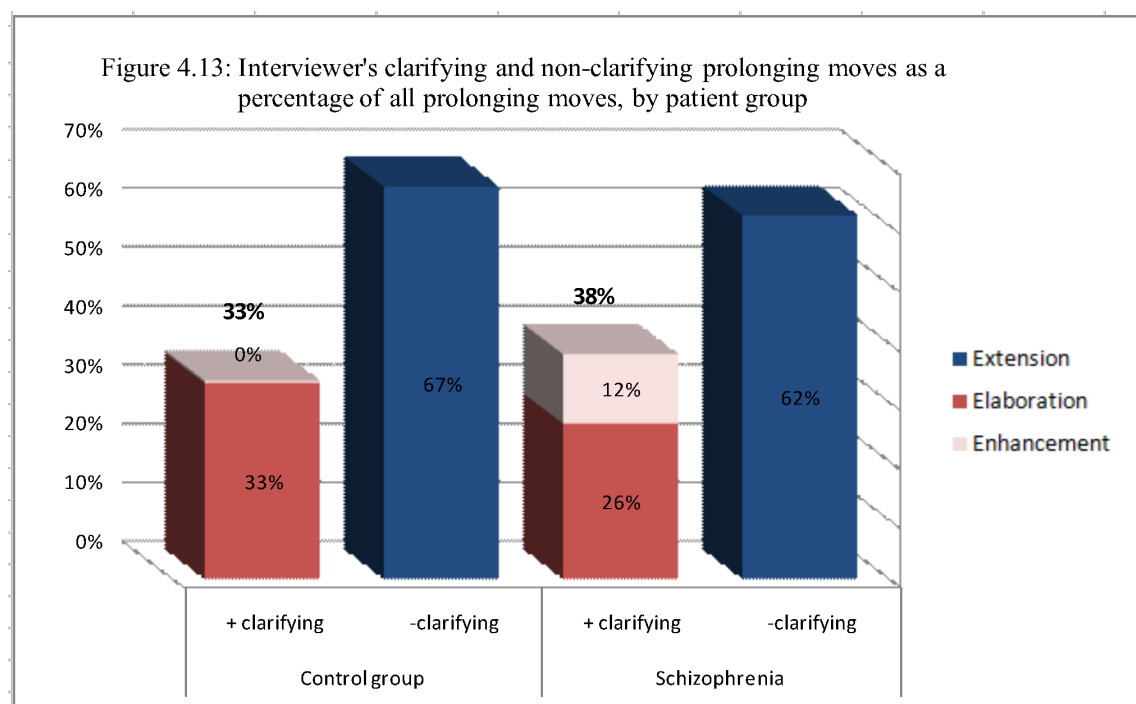
misunderstandings. The interviewer's role of being clear and coherent is presented in table 4.10.

Table 4.10: Number of clarifying prolonging moves the interviewer expresses compared to non-clarifying moves for patients with schizophrenia

Interviewer	Prolonging	-clarifying	+ clarifying	
Patient #	Moves	Extension	Elaboration	Enhancement
1	2	0	1	1
2	22	16	4	2
3	2	0	2	0
4	8	5	2	1
Total	34	21	9	4

4.3.1.1 The interviewer's expression of prolonging moves (clarifying vs. non-clarifying): a comparison between patients with and without schizophrenia

The interviewer is clear and coherent in the interviews with patients with and without schizophrenia. In general, the interviewer expresses fewer prolonging moves with patients without schizophrenia. However, for both groups of patients, the interviewer expands his talk mostly with extension moves, which add new information that continues and develops prior information rather than clarifying it. The interviewer's role of being clear and coherent is presented in Figure 4.13. Full data for the control group is presented in Appendix B, table 15.



4.3.2 Demanding clarifications: Rejoinder moves

The degree of incoherence in schizophrenics' discourse requires the interviewer to demand clarifications from the patients rather than providing clarifications in order to assist in creating an interpretable, coherent and fluent conversation. Schizophrenia appears as the failure of the speakers to connect appropriately to the context. Fine (2006) notes that the disconnection with the context is in terms of meanings, wordings and interpersonal factors. Speakers with schizophrenia who lack connection in any of these ways fail to build social reality, which makes it difficult for the interviewer to accurately interpret the patients. The interviewer then, uses 'rejoinder' speech functions that contribute most in sustaining the interaction in order to query the information discussed. The interviewer uses specifically a subclass of rejoinders, tracking moves (supporting), which check, confirm, clarify or probe the content of prior moves. These moves are necessary for understanding the patients' disordered and uninterpretable language. Constant demands for clarifications enables the interviewer to make sense of what is said in context, to receive more accurate information and create a coherent and fluent discourse. The interviewer's demands for clarification through rejoinder moves are presented in table 4.11.

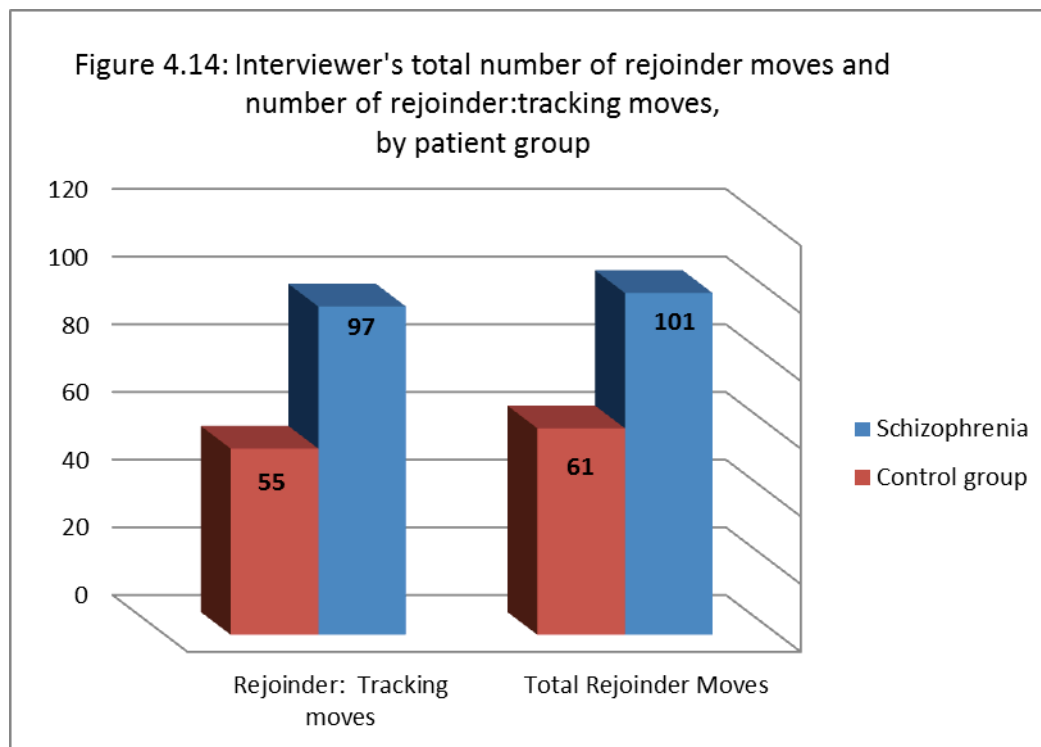
Once the patients provide the clarification, it may not only contribute to more coherent discourse, but also to their own understanding of the information they are providing concerning their illness, feelings and behavior. It may help them in defining the interpersonal meanings they are expressing and assist in self-evaluation and awareness of illness.

Table 4.11: Number of rejoinder moves the interviewer expresses in order to demand clarification from patients with schizophrenia

Interviewer	Rejoinder	Rejoinder:				
Patient #	Moves	Tracking moves	Check	Confirm	Clarify	Probe
1	10	10	3	1	3	3
2	64	63	4	12	21	26
3	12	10	2	0	5	3
4	15	14	2	1	6	5
Total	102	97	11	14	35	37

4.3.2.1 The interviewer's expression of rejoinder moves: a comparison between patients with and without schizophrenia

The comparison in demands for clarifications between the two groups of patients provides strong evidence of the incoherence in schizophrenics' discourse. The interviewer more frequently uses rejoinder moves for patients with schizophrenia than for patients without schizophrenia. These results emphasize the disordered and uninterpretable language of schizophrenics and the necessity to constantly query the information presented by the patients and demand clarifications. The interviewer less often uses rejoinder moves for patients without schizophrenia, implying that their language is more coherent, interpretable and connected to context. The interviewer is less concerned with demanding clarifications and overcoming misunderstanding and therefore, is able to conduct more fluent and coherent interviews. The interviewer's demands for clarification through rejoinder moves from patients with and without schizophrenia are presented in Figure 4.14. Full data for the control group is presented in Appendix B, table 16.



4.3.3 Conclusion

The interviewer maximizes his effort to create a coherent and fluent discussion, and assures that clarification is provided both from his side and from the patients.

Once the interviewer develops the discussion, he is mainly concerned with adding new information that is contributive rather than clarifying his own talk. The interviewer attempts to avoid misunderstandings and to be clear and fluent, but more challenging and important is inducing clarifications and coherence from the patients. Patients with schizophrenia fail to produce accurate and interpretable information, therefore, the interviewer frequently expresses rejoinder: tracking moves that contribute most in sustaining the interaction in order to query the information discussed. The frequent use of both prolonging and rejoinder moves for clarification emphasizes the degree of severity of patients' disordered and incoherent language, in comparison to patients without schizophrenia.

5. The expression of schizophrenia through an analysis of the patients' dialogic structure.

As presented in chapter 4, part of describing and interpreting the patients' dialogic structure and the quality of their interpersonal relationship is an analysis of the role relations the interviewer establishes. The interviewer uses various linguistic resources to increase the effectiveness of the clinical interview. The interviewer explores schizophrenic patients' failure to take part in a dialogue and negotiate the exchange of interpersonal meaning and the emotional and social impairments it implicates.

In order to understand the diagnostic categories that define schizophrenia it is necessary to focus on the roles patients with schizophrenia take in the interaction, the attitudes they express and how they negotiate turns to express their interpersonal positioning. A functional linguistic analysis of speech functions is used to explore the main characteristics of schizophrenia. The model of Speech function is important for studying the patients' communicative failures and disorganized speech in discourse. The speech function model is correlated with Appraisal theory which is concerned with the language of evaluation, attitude and emotion and contributes in exploring the patients' emotional disturbance, mood disorder and impaired occupational and social functioning. Thus, the diagnostic criteria of schizophrenia are detailed through interpersonal patterns of conversational structures and evaluative lexis. The functional linguistic analysis is further supported by its comparison to interviews of patients without schizophrenia (control group).

This section describes the characteristics of schizophrenia in three categories: 5.1. Emotional and social deficit, 5.2. The negative symptoms of poverty of speech and poverty of content of speech, 5.3. Disorganized thought and speech.

5.1 Emotional and social deficit

One of the most prominent symptoms of schizophrenia is the patients' emotional disturbance and mood disorder, which are partly responsible for the patient's inability to coordinate social interaction and form social relationships appropriately. Patients with schizophrenia often show 'blunted' or 'flat' affect. This symptom refers to a severe reduction in emotional expressiveness. Castellano-Hoyt, et al., (2003) explain that a person with schizophrenia may not show the signs of normal emotion, perhaps may speak in a monotonous voice, have diminished facial expressions and appear extremely apathetic. The person may withdraw socially, avoiding contact with others; and when forced to interact, he or she may have nothing to say, reflecting 'impoverished thought'.

The emotional disturbance in schizophrenia is associated with depressive symptoms. As Heiden, et al., (2005) note, "Depressive symptoms are among the earliest and most frequent signs of schizophrenia onset. The symptoms may be depressive mood, loss of pleasure, loss of interests, loss of self confidence, feelings of guilt, suicidal thoughts/suicide attempt" (p.1).

The emotional and social dysfunctions are diagnosed through an analysis of speech functions that include semantic information expressing the patients' evaluative language. The analysis reveals how speakers adopt and indicate positive or negative attitudes and how they negotiate these attitudinal positionings with an actual or potential dialogic partner.

The interviewer most frequently uses the initiating move [demand:open:opinion:information] in order to gather information concerning the patients' illness. The interviewer's initiating move produces certain patients' responses and response patterns which provide evidence to their emotional disturbance and mood disorder.

In examining the language of evaluation, attitude and emotion of the patients mentioned in this study, Cohen (2007) notes that the characteristic symptoms of schizophrenia involve a range of cognitive, emotional and social dysfunction. Disordered perception of reality, disorganized thought and speech, mood disorder, emotional disturbance and impaired occupational and social functioning are all symptoms associated with feelings of fear, confusion, anxiety, depressive mood, loss of pleasure, loss of self confidence, feelings of guilt and decreased motivation. Cohen (2007) concludes that these kinds of emotions are expressed frequently in the interviews of all four patients in this study.

5.1.1 Evaluative language through responding speech functions expressed by patients with schizophrenia

The patients' negative evaluative language is expressed frequently through responding speech functions. When the interviewer elicits information about the patients' emotions and experiences of illness, he does so by the speech choices of opening and rejoinder moves that demand opinion/information. Both types of speech functions contribute most to the maintenance and open-endedness of the talk. The patients, in respond, reveal their depressive mood, emotional disturbance and social dysfunction. Most of their responds include information/opinion that expresses negative emotions, attitude and behavior, rather than positive emotions, as demonstrated in examples 5.1-5.4:

Example 5.1 Interviewer/Patient #1:

I: Can you hear a voice of people talking now. right now? [Question:opinion]

S: yea. I think so. [Respond: negative]

Example 5.2 Interviewer/Patient #2:

I: What's still bothering you? [Question:opinion]

S: I still hear voices [Respond: negative]

I: You do?

S: See things [Negative]

I: What kind of things?

S: (xxx) (xxx) kind of things...(xxx) (xxx) the white shoes. [Negative]

Example 5.3 Interviewer/Patient #3:

I: and how do you know that she is doing these things? [Question:opinion]

S: Well I know when I when I ah, when I'm walking around and all that that's different, you know, it isn't ah ---- all the time seems to be inside of me [Respond: negative]

I: but how do you know. I mean you are walking around and uh what happens that makes you

S: well I I know what --- is like you see and uh. I'm uh, and without having I feel that I have missed something has been lost taken away from me, and replaced by. [Negative]

I: is it a feeling in your body that you ha-get?

S: no. right no-now it's in the stomach. [Negative]

Example 5.4 Interviewer/Patient #4:

I: what would that do to you when you took speed? [**Question:opinion**]

S: I don't know... people would say that it would speed you up [**Respond: negative**]

I: uh.hum

S: to me it just made me shake a lot, made me nervous, made me frightened [**Negative**]

I: uh.hum... did it make you suspicious of other people and that kind of thing

S: uhm...yes... mostly frightened. [**Negative**]

Table 5.1 summarizes the patients' number of positive and negative responds to the interviewer's opinion (open and closed) questions and rejoinders:

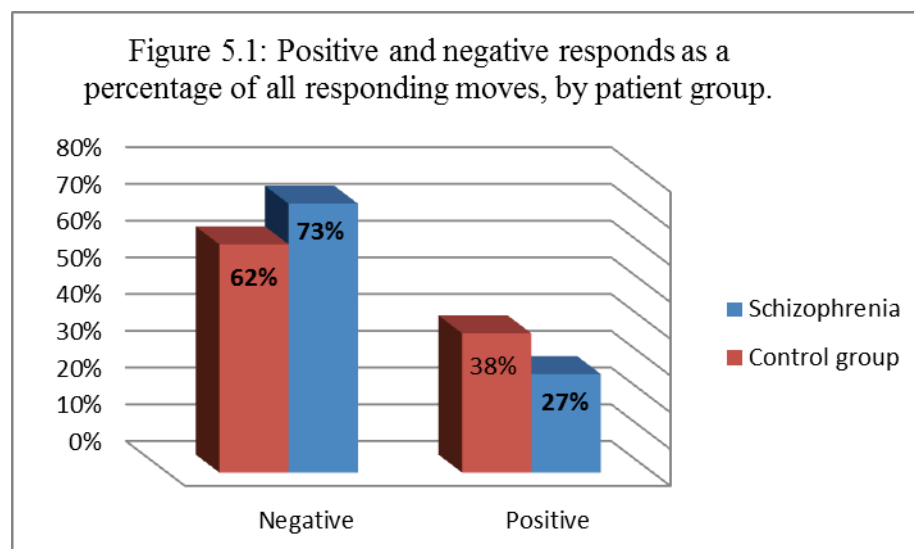
Table 5.1: Number of positive and negative responds expressed by patients with schizophrenia

Interviewer	Interviewer's Demand:information: opinion/rejoinders	Patients' responding moves	
Patient #		Negative	Positive
1	13	12	1
2	117	85	32
3	20	14	6
4	40	28	12
Total	190	139	51

5.1.1.1 Expression of evaluative language through responding moves: a comparison between patients with and without schizophrenia

The interviewer elicits information about schizophrenics' emotions and experiences of illness more frequently than with patients without schizophrenia. Patients with schizophrenia express in respond atypical use of evaluative language. Their atypical attitude and emotional expressiveness is distinct when compared to patients without schizophrenia. Patients with schizophrenia report less positive evaluations and more negative and unpleasant emotions, compared to patients without schizophrenia. They express their depressive mood and emotional disturbance more frequently than patients without schizophrenia.

Figure 5.1 presents the percentage of positive and negative responds to the interviewer's opinion questions and rejoinders, as expressed by both groups of patients. Full data for the control group is presented in Appendix B, table 17.



When the absolute numbers of positive and negative responds (rather than percentages) are compared, the negative emotional expressiveness of patients with schizophrenia (139) is even more distinct from patients without schizophrenia (77). The percentages of negative responds are more similar for the groups since they are then calculated out of different total numbers of responds. The interviewer more frequently asks patients with schizophrenia than controls opinion questions in order to elicit as much information concerning their attitudes and emotions. The patients, in respond, reply with more of negative evaluations. Both the percentage of negative responds and the absolute frequency need to be taken into account. The nature of the interaction with the speakers with schizophrenia is that there are more questions asked of them. The co-occurrence of frequent questions and a somewhat higher percentage of negative responds leads to a compounding of the impression of negativity in the interaction of speakers with schizophrenia.

5.1.2 Evaluative language through continuing speech functions expressed by patients with schizophrenia

The patients' negative evaluative language and attitude is also expressed through their continuing speech functions. In most cases where the patients provide further information to their initial responds and continue to negotiate their interpersonal positioning, they tend to add negative evaluations concerning their illness rather than positive evaluations. The patients' pattern of expressing negative evaluative language is consistent for all three types of continuing moves (Elaboration, Extension and Enhancement) and is demonstrated in examples 5.5-5.8:

Example 5.5 Interviewer/Patient #1:

I: so you think you've really changed (cleared throat) radically some time ago that you changed? [**Question:opinion**]

S: changed? Not radically. Slowly. [**S:R:respond:confront:reply:contradict**]

S: but.ah....ahm.....I haven't really uh seen the process it's been kind of mixed up you know [**S:continue:prolong:extend:negative**]

Example 5.6 Interviewer/Patient #2:

I: what were you seeing about his (the voice) hair that was different? [**Question:opinion**]

S: Well he was just so different that his head was a cancer (xxx)...if he (xxx) he can eat here at all all kinds of nasty stuff. [**S:R:respond:support:reply:answer**]

I: I see [**S:R:respond:support:register**]

S: He's a devil [**S:continue:append:extend:negative**]

Example 5.7 Interviewer/Patient #3:

I: why would she (voice) do that? [**Question:opinion**]

S: I don't know [**S:R:respond:confront:reply:withhold**]

S: I guess that's just in her to destroy people steal-steals from them

[**S:continue:prolong:elaborate:negative**]

I: uh.hum [**S:R:respond:support:register**]

S: she's taken all mo-mostly all my insides out [**S:continue:append:elaborate:negative**]

Example 5.8 Interviewer/Patient #4:

I: what would that do to you when you took speed? [Question:opinion]

S: I don't know... [S:R:respond:confront:reply:withhold]

S: people would say that it would speed you up [S:continue:prolong:elaborate:negative]

I: uh.hum [S:R:respond:support:register]

S: to me it just made me shake a lot, made me nervous, made me frightened

[S:continue:append:extend:negative]

Table 5.2 summarizes patients' with schizophrenia number of positive and negative continuing moves added to their initial responds.

Table 5.2: Number of positive and negative continuing moves expressed by patients with schizophrenia

Patient #	Elaborations		Extensions		Enhancement		Total Negative/Positive Continuing moves	
	Pos	Neg	Pos	Neg	Pos	Neg	Positive	Negative
1	5	12	6	10	3	5	14	27
2	10	16	7	32	1	1	18	49
3	4	20	26	41	3	8	33	69
4	3	7	17	17	4	2	24	26
Total	22	55	56	100	11	16	89	171

Table 5.2 shows clear evidence that patients with schizophrenia prefer to develop and continue the negotiation of their interpersonal positioning in expressing negative evaluations and attitudes concerning their illness, experiences, emotions and social function. The evidence is further strengthened by closer examination of the positive elaborating moves. The patients express in total 22 positive elaborations, however, in 11/22 elaborations, the patients chose to lower the degree of the positivity expressed. They chose to do so by adding modality, a resource by which the current proposition is represented as just one of a range of possible propositions. With this functionality, values of modality indicate uncertainty or lack of commitment, or confidence in the truth-value by the speaker. Patients with schizophrenia, who frequently insert modal values in their positive elaborations, reveal their lack of commitment to the truth-value of their evaluations, lower the degree of positivity expressed, and in fact

emphasize their emotional deficit. Examples 5.9-5.10 demonstrate how patient 1 lowers the degree of positivity of the elaborations expressed within a respond:

Example 5.9 Patient #1:

I: you mean inside your own head you talk to yourself or you really talk to yourself loud?

[S:R:rejoinder:support:track:probe].

S: ah-h yes I talk to myself not loud [S:R:rejoinder:support:response:resolve].

S: I don't know if people can hear me or not... I think it's me the whole time (laugh)

[S:C:prolong:elaborate:negative].

S: **I don't know [modality:low] I just think[modality]** it's me **I think [modality]** I'm I'm slowly getting out of of being alone and and and not seeing people

[S:continue:elaborate:positive].

Example 5.10 Patient #1:

S: **I don't know [modality:low]** I have a funny feeling that ah things are going pretty good

[S:continue:elaborate:positive]

S: **I think [modality: mid]** tonight I.I.like I said I have to get into something

[S:continue:elaborate:positive]

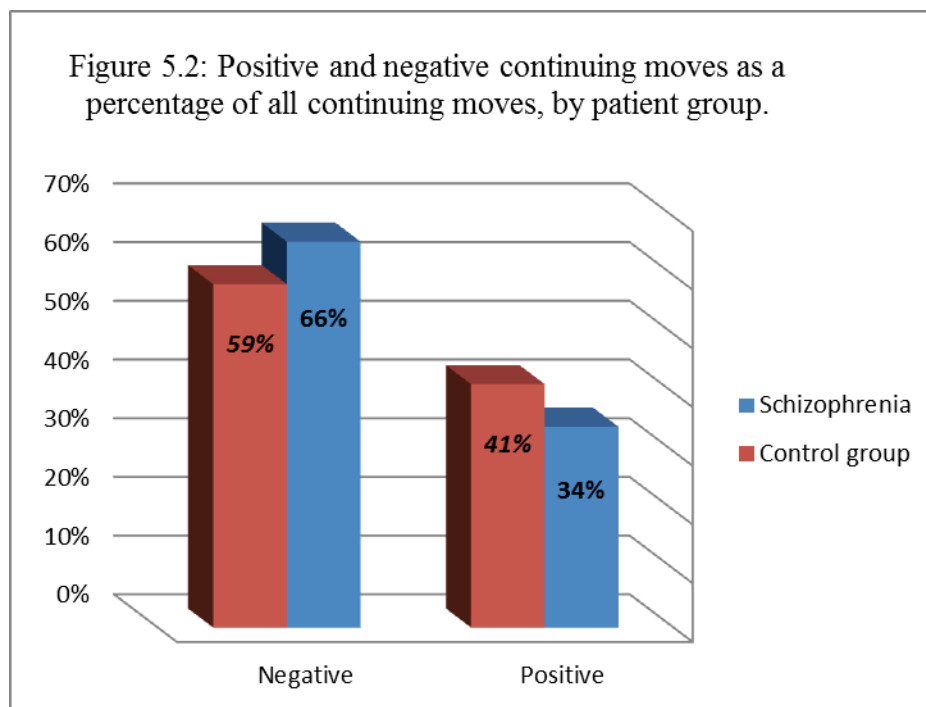
S: I should've put my head into it instead of giving something away

5.1.2.1 Expression of evaluative language through continuing speech functions: a comparison between patients with and without schizophrenia

Both groups of patients extend more frequently their interpersonal positioning by adding negative evaluations concerning their illness rather than positive evaluations. Yet, there are two main differences between the groups. First, patients with schizophrenia report more negative evaluations and less positive evaluations than patients without schizophrenia. Second, is the distinct gap between positive and negative evaluations for patients with schizophrenia (positive 34%/negative 66%) in comparison to patients without schizophrenia (positive 42%/negative 58%). The analysis within and between the groups of patients shows that patients with schizophrenia have clear preference to extend their initial propositions with further values of negative attitude and evaluations rather than positive. These findings are evidence to patients' with schizophrenia atypical use of attitudinal language which often expresses emotions revealing depressive mood, loss of pleasure, loss of self confidence and decreased motivation, consequent with social dysfunction. The patients' severe emotional

deficit, mood disorder and social dysfunction are clearly evident in comparison to other psychiatric patients.

Figure 5.2 presents the percentage of positive and negative continuing moves for patients with and without schizophrenia. Full data for the control group is presented in Appendix B, table 18.



In comparing the absolute numbers (rather than percentage) of positive and negative continuing moves between the groups, the difference in negative attitudinal language is greater (schizophrenia 171, controls 79). The speakers with schizophrenia seem to expand with more positive evaluations (89) than speakers without schizophrenia (56). However, when these numbers of positive evaluations are considered as percentages out of total continuing moves for each group, the impression is that patients with schizophrenia expressed positivity less often (schizophrenia 41%, controls 34%).

5.1.3 Evaluative language through rejoinder speech functions expressed by patients with schizophrenia

The last kind of speech functions used to express the patients' emotional deficit is rejoinders. In general, patients with schizophrenia avoid using rejoinders since rejoinders act to sustain the interaction by keeping the exchange open. The rejoinders function contradicts with the patients' roles of moving the exchange towards completion. Yet, in cases where the patients use rejoinders, they mainly use the speech function of rejoinder: resolve which acts to provide clarification. The patients are frequently asked to clarify their emotions, behavior and social function and when they do so, they usually confirm or provide clarification to negative rather than positive information and evaluations, as presented in examples 5.11-5.12:

Example 5.11 Interviewer/Patient #1:

I: You mean inside your own head you talk to yourself or you really talk to yourself loud? [S:R:rejoinder:support:track:probe].

S: ah-h yes I talk to myself not loud [S:R:rejoinder:support:response:resolve:negative].

S: I don't know if people can hear me or not... I think it's me the whole time (laugh)

[S:C:prolong:elaborate:negative].

Example 5.12 Interviewer/Patient #4:

I: you have privileges, don't you? [S:R:rejoinder:support:track:probe].

I: you can go out for a walk and things like that [S:C:prolong:elaborate].

S: I don't want to walk outside [S:R:respond:confront:reply:contradict].

I: you don't... why not? [S:R:rejoinder:support:track:clarify]

S: I don't have any money [S:R:rejoinder:support:response:resolve:negative].

S: I haven't anywhere to go, I haven't any friends... I haven't any interests out there... just a lot of people doing their job everyday and I haven't got a job to do

[S:C:prolong:elaborate:negative].

Table 5.3 presents patients' with schizophrenia number of positive and negative rejoinder: resolve moves to the interviewer's demand of clarification.

Table 5.3: Number of positive and negative rejoinder: resolve moves expressed by patients with schizophrenia

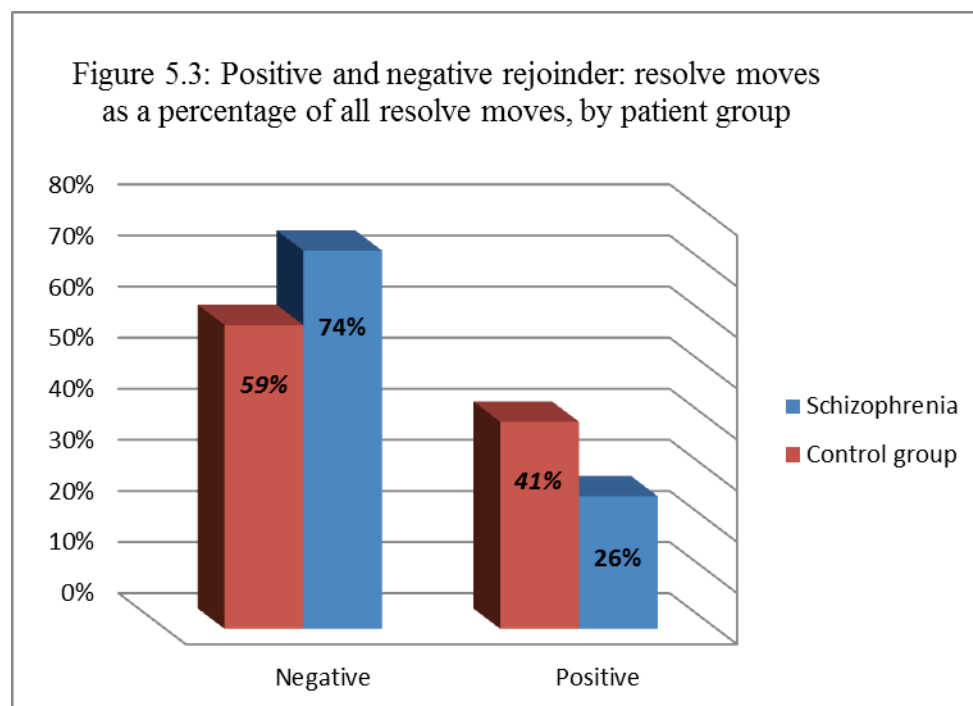
Patient #	Total rejoinder: resolve	Patients' rejoinder: resolve moves	
		Negative	Positive
1	4	4	0
2	54	39	15
3	8	6	2
4	11	8	3
Total	77	57	20

5.1.3.1 The expression of evaluative language through rejoinder speech functions: a comparison between patients with and without schizophrenia

Similarly to patients with schizophrenia, patients without schizophrenia express most frequently rejoinder moves, the speech function which acts to provide clarification. However, patients without schizophrenia are demanded less often to clarify their emotions, behavior and social function and thus express less resolve moves than schizophrenic.

A comparison between the two groups shows that out of total resolve moves, patient with schizophrenia provide clarifications to more negative information and less positive than the controls (Negative: schizophrenia 75% , controls 59% / Positive: schizophrenia 25%,controls 41%). Patients with schizophrenia further show a distinct gap between the positive and negative information they confirm or clarify. These findings present patients without schizophrenia as more optimistic and positive concerning their illness and in contrast emphasize the negative attitude and emotional deficit of patients with schizophrenia.

Figure 5.3 presents the percent of positive and negative rejoinder: resolve moves expressed by patients with and without schizophrenia. Full data for the control group is presented in Appendix B, table 19.



5.1.4 Conclusion

Speakers with schizophrenia express their attitudinal language most frequently through sustaining speech functions (reacting and continuing moves). The patients' response pattern to the interviewer's demand of opinion information indicates primarily negative values of attitude and evaluations. The patients experience strong emotions of misery, pessimism, guilt, lack of confidence and disappointment about their progress and disturbances of perception. They often criticize and condemn their own behavior, actions and beliefs. The negative attitudinal language is also expressed through rejoinder: resolve speech function. In comparison to other psychiatric patients, schizophrenic patients express more frequently values of negative attitude and evaluations, both in the responds and in their extensions of the discussion. The patients also show diminished use of positive attitudinal propositions and thus, provide evidence to their depressive mood and emotional impairment.

5.2 Negative Symptoms: poverty of speech and poverty of content of speech

The negative symptoms of poverty of speech and poverty of content of speech are conveyed directly by language. Poverty of speech includes restriction in the amount of spontaneous speech, so that replies to questions tend to be brief and unelaborated. In poverty of content of speech, replies may be long enough so that speech is adequate in amount, but it conveys little information. Fine (2006) notes that "speakers with poverty of speech fail to build up semantic information as the utterance, or interaction, continues" (p.230). In such case, language tends to be vague and inadequate including incomprehensible replies. The following linguistic analysis describes the speech functions that express the negative symptoms of schizophrenia. The analysis shows a reduction in the usual flow of language, resulting in the patients' failure to build social reality, communicate with others and form social relationships appropriately.

5.2.1 Negative symptoms expressed through Responding/ Rejoinder moves by patients with schizophrenia

The interviewer most frequently uses the speech functions of initiating moves (opinion questions) in order to encourage speakers with schizophrenia to broaden the discussion, avoid poverty of speech and to delay as much possible exchange completion. The analysis of the patients' responds to the interviewer's of the 169 opinion questions asked of the patients with schizophrenia, in 125 cases there are supporting reactions indicating a willingness to accept the propositions or proposals of the interviewer. The patients, in some sense, give the impression that they agree to the negotiation and create a co-operative conversation. However, further analysis of the patients' replies and their development shows that the initial positive impression is quite misleading. Eggins and Slade (1997) differentiate two types of reacting moves: 'responds' and 'rejoinders'. All of the patients' reactions to the interviewer's opinion questions are considered 'responds', which move the exchange towards completion. Despite the fact that most responses are supportive, they complete the negotiation of the proposition, rather than prolong the exchange.

5.2.1.1 Extension of responding moves expressed by patients with schizophrenia

One way to measure the amount of information given by the patients and their agreement to continue the discussion is to examine how often they tend to extend their responses. In total, the patients provide 255 responds to the interviewer's initiations or rejoinders. Most responds

are supporting, indicating a degree of agreement to negotiate the propositions. However, the sense of co-operation does not prolong and most reactions end with the immediate respond with no further expansion. The patients avoid interaction, provide brief responds and provide less information than expected. The responds that are further extended, in most cases, occur as a respond to an initial question: opinion or rejoinder move of the interviewer, in which he demands information concerning the patients' illness, emotions and behavior. The interviewer's main focus is to expand the discussion for understanding the patients' interpersonal relationships and situation of illness. Therefore, questions that demanded information about patient's feelings, behavior and experiences of illness were analyzed as opinion questions and not as fact questions. The patients do not expand their responses to questions demanding factual information. The interviewer, who recognizes the lack of information given, continues to demand further information or clarification to keep the exchange open and create fluency of talk. Poverty of speech as conveyed by language of speakers with schizophrenia is demonstrated in examples 5.13- 5.14:

Example 5.13 Interviewer/Patient #1:

I: do you hear things in the background voices noises or

[O:I:demand:closed:information:opinion]

S: sure I can hear them but [S:R:respond:support:reply:affirm]

I: hear what? [S:R:rejoinder:support:track:check]

S: I hear voices [S:R:rejoinder:support:response:resolve]

Example 5.14 Interviewer/Patient #4:

I: what do they tell you, why don't they want you back?

[O:I:demand:open:information:opinion]

S: I'm frightening to live with [S:R:respond:support:reply:answer]

I: they what? [S:R:rejoinder:support:track:check]

S: frightened to live with me [S:R:rejoinder:support:response:resolve]

I: what are they frightened of? [O:I:demand:open:information:opinion]

S: my behavior [S:R:respond:support:reply:answer]

Examples 5.13-5.14 show how speakers with schizophrenia provide brief, concrete and unelaborated answers even when they are demanded to give opinion information. The interviewer does not receive responses that are informative and contributing enough to achieve his communicative goals. The interviewer therefore continues to ask for further clarification

and information. It is only the interviewer's effort that makes it possible to create a coherent, interpretable and fluent discourse. Table 5.4 summarizes the number of responds that are extended by speakers with schizophrenia.

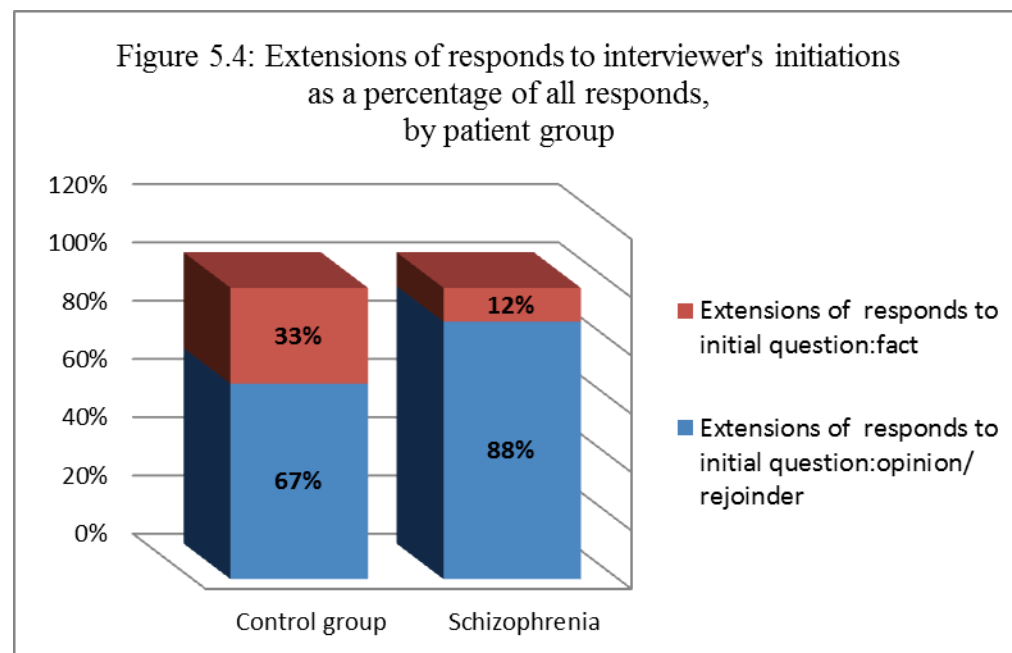
Table 5.4: Number of responds extended in interaction by speakers with schizophrenia

Patient #	Number of patients' responds	Number extensions of responds	Extensions of responds to initial question:opinion/rejoinder	Extensions of responds to initial question:fact
1	17	7	6	1
2	156	38	31	7
3	30	12	12	0
4	52	12	12	0
Total	255	69	61	8

5.2.1.1.1 Extensions of responds: a comparison between patients with and without schizophrenia

Both groups of patients share about the same amount of responds to interviewer's initiations and rejoinders. The two groups also showed similar degree of agreement to negotiate their interpersonal positioning and develop their responds (patients with schizophrenia 27%, controls 33%). The groups of patients choose often to move the exchange towards completion and avoid further interaction rather than extend the discussion. Those responds which patients with schizophrenia agree to extend mainly follow an initial question: opinion or rejoinder move of the interviewer, in which he demands information concerning the patients' illness, emotions and behavior. The patients hardly expand responses to questions demanding factual information. Patient without schizophrenia realize the importance in extending responses concerning their emotions and experiences of illness, and yet do not avoid extending also responses to initial factual questions. The gap between their extensions to initial opinion and fact questions is less distinct (opinion 67%, fact 33%) than for patients with schizophrenia (opinion 88%, fact 12%). These findings demonstrate for patients' with schizophrenia the poverty of speech and lack of confidence to extend exchanges that are concerned with other information than their illness. Figure 5.4 presents the percentage of responds that are

extended by speakers with and without schizophrenia. Full data for the control group is presented in Appendix B, table 20.



5.2.2 Negative symptoms expressed through Continuing moves by patients with schizophrenia

Continuing moves enable the speaker to add further information to his/her initiating statement. As Eggins & Slade (1997) note, "the continuing move subclasses capture the options open to a speaker who retains the turn at the end of a move and who produces a move which is heard as related to an immediately prior move produced by the same speaker" (p.195).

The analysis of continuing moves provides evidence to the amount of information extended by patients with schizophrenia, the kind of information extended and the way it's presented in discourse.

As mentioned in section 5.2.1.1 above, only 69 of 255 responds of the patients are extended. However, these extensions of responds are frequently developed by several continuing moves which sustain the interaction. In all, there are 260 continuing moves in all four interviews.

Eggins and Slade (1997) present three types of continuing moves: elaboration, extension and enhancement. The analysis of the three kinds of expansion shows that the speakers with schizophrenia most often use extending moves which add to the information in an immediately prior move. That is, when the patients co-operate and sustain the interaction they often chose the kind of expansion that contributes most in revealing new information about their illness, emotions and behavior. Speakers with schizophrenia express less elaborating moves in which a move clarifies, restate or exemplifies an immediately prior move. The patients' choice to add further information that is new rather than restating or clarifying indicates a degree of success in building text.

Yet, a further differentiation between the two types of continuing moves prolong/append queries the patients' agreement for interaction and negotiation. According to Eggins and Slade (1997), prolonging moves add to the information in an immediately prior move. Appending moves, on the other hand, occur when a speaker makes one move, loses the floor, but then as soon as they regain the floor and take another turn they produce a move which represents a logical expansion of their immediately prior move. More than 40% of the patients' continuing moves are appending ones. That is, patients often expand their respond only after they are interrupted by the interviewer and encouraged to elaborate their replies. The fact that the interviewer frequently interrupts to encourage further talk (by a "register" move) implies poverty of speech and that schizophrenic patients do not show high level of agreement to

provide information and sustain the interaction. Examples 5.15, 5.16 and 5.17 demonstrate the use of appending moves indicating difficulty in fluent interaction.

Example 5.15 Interviewer/Patient #2:

I: What about your typical self if you looked at yourself in the mirror did you notice changes in you that were unusual? [O:I:demand:closed:information:opinion]

S: Not in particularly a lot. [S:R:respond:confront:reply:disagree]

S: thinner myself I thought I looked thinner and my hair needed doing [S:C:prolong:extend]

I: Hmmmhmmm [S:R:respond:support:register]

S: I need glasses [S:C:append:extend]

I: Hmmm hmmm [S:R:respond:support:register]

S: I can't see very well without them [S:C:append:enhance]

I: That happens to all of us [S:R:respond:support:reply:agree]

Example 5.16 Interviewer/Patient #3:

I: In what way do you feel better? [S:R:rejoinder:support:track:clarify]

S: in my strength [S:R:rejoinder:support:response:resolve]

I: uh.hum [S:R:respond:support:register]

S: I was um... wasn't very strong... [S:C:append:extend]

S: and ah . I think I'm I'm on the road to recovery anyway [S:C:prolong:extend]

Example 5.17 Interviewer/Patient #4:

I: what kind of experience have you had when you were on LSD?

[O:I:demand:open:information:opinion]

S: hallucination [S:R:respond:support:reply:answer]

I: tell me about it, what kind you know people have different kinds of experiences

[O:I:demand:open:information:opinion]

S: uh... usually there would be music playing [S:R:respond:support:reply:answer]

I: uh.hum [S:R:respond:support:register]

S: and there would just be hallucinations all over [S:C:append:extend]

S: and... you would just sort of enjoy the music and.. sorta be awed by the hallucinations

[S:C:prolong:extend].

In examples 5.15, 5.16 and 5.17 the patients are asked a question concerning their experiences of illness and emotions and provide a brief response without much information. The sense of poverty of speech requires the interviewer to interrupt and encourage further talk

in order to avoid exchange completion. Only then, the patients expand their talk and provide further information concerning their illness. Table 5.5 summarizes the number of continuing moves (prolong/append) expressed by speakers with schizophrenia.

Table 5.5: Number of continuing moves (prolong/append) expressed by speakers with schizophrenia

Patient#	Elaborations		Extensions		Enhancement		Total continuing moves: prolong/append	
	Prolong	Append	Prolong	Append	Prolong	Append	Prolong	Append
1	16	1	13	3	7	1	36	5
2	10	16	9	30	0	2	19	48
3	14	10	49	18	8	3	71	31
4	6	4	20	14	2	4	28	22
Total	46	31	91	65	17	10	154	106

5.2.2.1 Expansion of talk through continuing moves: a comparison between patients with and without schizophrenia

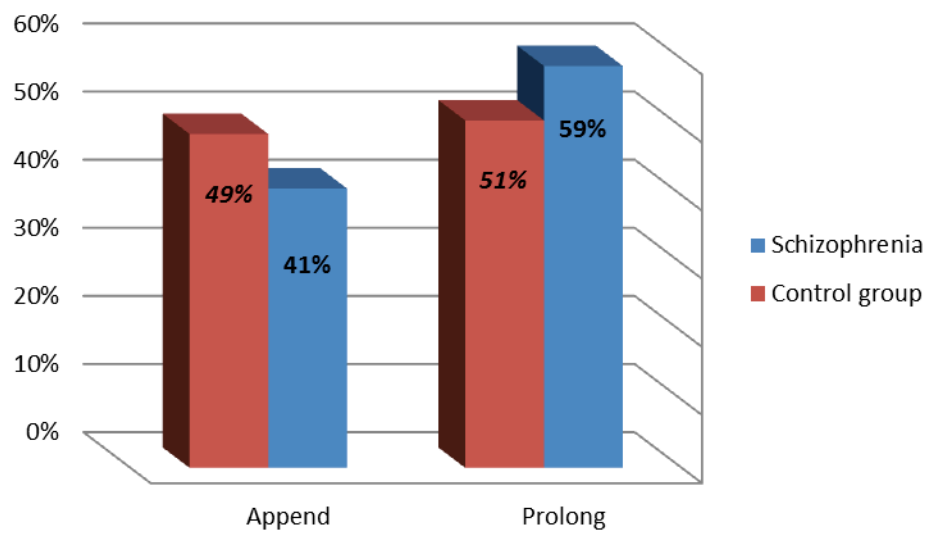
The two groups of patients differ in the amount of information they add to prolong the discussion. Despite the degree of severity of schizophrenics' poverty of speech, they expand and develop the discussion to greater extent (260 continue moves) than patients without schizophrenia (154 continue moves). The success of patients with schizophrenia to continue and develop interpersonal positioning largely depends on the interviewer's effort in eliciting information. The interviewer increases his efforts to elicit information about the illness of patients with schizophrenia through various speech functions. This discourse technique proves to be worthwhile since it encourages patients to develop conversation and avoid poverty of speech. The interviewer need not work hard to elicit information from patients without schizophrenia, assuming they are more talkative and cooperative. The patients, who are less encouraged to talk, respond with fewer extensions than patients with schizophrenia. In

addition, as mentioned in section 5.2.1.1.1, patients without schizophrenia often extend responds to initial factual questions. Fact initiations lead to exchanges that often remain brief and do not contribute to conversation development. Patients without schizophrenia consequently are less encouraged to continue and sustain the interaction.

The two groups of patients further differ in their choice between the two types of continuing moves prolong/append. The choice to extend responds to initial fact or opinion questions affects the amount of appending versus prolonging moves. Patients without schizophrenia express more appending moves than patients with schizophrenia relative to all the continuing moves. Since patients without schizophrenia often extend respond to initial fact questions, it is more difficult for them to develop the discussion. Therefore, in almost half of the cases, their responds are expanded only after they are interrupted by the interviewer and encouraged to elaborate their replies.

Despite the relative advantage in the amount of extensions of talk, there is evidence to poverty of speech. Precisely because of the fact that the interviewer maximizes his effort to elicit information and because they mainly extended responds to initial opinion questions, it was expected that they would continue the discussion to greater extent without hesitation. Patients with schizophrenia had all the conditions and encouragement to sustain the interaction and still, more than 40% of the patients' continuing moves are appending ones. Since the interviewer often encourages further talk, the apparently large amount information provided in continuing moves is not inconsistent with the poverty of speech for these speakers with schizophrenia. Rather they, unlike the speakers without schizophrenia have been greatly encouraged to add information. Figures 5.5 presents the percentage of continuing moves (prolong/append) expressed by speakers with and without schizophrenia. Full data for the control group is presented in Appendix B, table 21.

Figure 5.5: Prolong and append moves as a percentage of all continuing moves, by patient group



5.2.3 Negative symptoms expressed through Rejoinder moves by patients with schizophrenia

Rejoinder moves are less common in the language of speakers with schizophrenia due to their potential to sustain the interaction. Poverty of speech is seen in the patients' avoidance to keep exchanges open and negotiate interpersonal relationships. In cases where speakers with schizophrenia use rejoinder moves, fully 92% of them are rejoinder: resolve, a supportive response that provides clarification to the prior move. The patients are not 'active' in a way that they interrupt, postpone or challenge the initial speech function sequences; rather, they just provide clarification when they are asked to do so. Furthermore, the patients almost never expand their resolve responses; they provide the clarification demanded and do not add further information to it, as demonstrated in example 5.18.

Example 5.18 Interviewer/Patient #4:

I: did it (drugs) make you suspicious of other people and that kind of thing

[O:I:demand:closed:information:opinion]

S: uhm... yes ... mostly frightened [S:R:respond:support:reply:affirm]

I: so you stopped taking it? [S:R:rejoinder:support:track:probe]

S: yes [S:R:rejoinder:support:response:resolve]

I: were you doing it by mouth or were you, uh [O:I:demand:open:information:opinion]

S: injection [S:R:respond:support:reply:answer]

Rejoinder moves enable to keep the exchange open and lead to further talk; a function that is most important for building and reaffirming relationships and identity. Speakers with schizophrenia do not realize its potential and fail to build up semantic information that will assist them to establish their social identity and create interpersonal relationships. Table 5.6 summarizes the number of rejoinder moves and their extensions as expressed by speakers with schizophrenia.

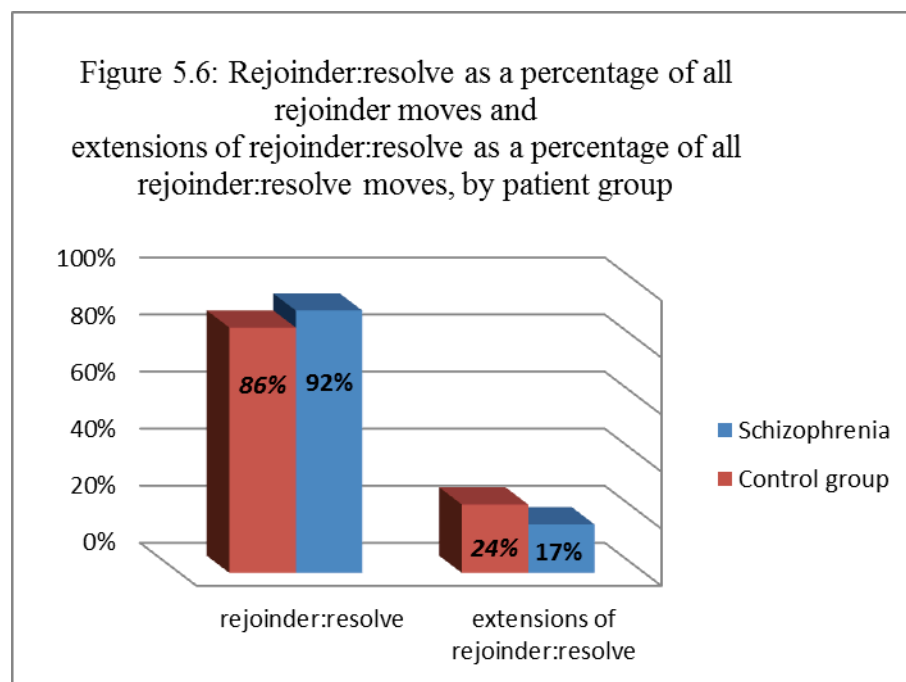
Table 5.6: Number of rejoinder moves and their extensions expressed by patients with schizophrenia

Patient #	Number of rejoinder Moves	Number of rejoinder: resolve	Number of extensions of rejoinder: resolve
1	4	4	2
2	56	54	2
3	11	8	4
4	13	11	5
Total	84	77	13

5.2.3.1 Expansion of talk through rejoinder moves: a comparison between patients with and without schizophrenia

Rejoinder moves are less common reactions in the language of both groups of patients due to their potential to sustain the interaction. The most common rejoinder moves expressed by both groups of patients is rejoinder: resolve move (Schizophrenics 92%, controls 86%), a supportive response that provides clarification to the prior move. The two groups mostly provide the clarifications demanded, showing lack of cooperation to develop the discussion and ability to communicate appropriately with others. In addition, both patients with schizophrenia and controls do not often extend rejoinder: resolve moves (schizophrenics 17%, controls 24%). The patients show a reduction in the usual flow of language and fail to build up semantic information that will assist them to create interpersonal relationships.

Figure 5.6 presents the percentage of rejoinder moves and their extensions as expressed by patients with and without schizophrenia. Full data for the control group is presented in Appendix B, table 22.



5.2.4 Conclusion

Poverty of speech in language of patients with schizophrenia is expressed through various sustaining speech functions. The patients show restriction in the amount of speech and difficulty developing the discussion both in their immediate responds to questions and in their amount of extensions. The patients prefer to express speech functions which lead to exchange completion and which do not require them to negotiate interpersonal positioning. The only case patients with schizophrenia show an advantage compared to non schizophrenic patients is in the amount of extensions of talk. However, even then, considering the support, encouragement and guidance of the interviewer, it would be expected for them to show less restriction in speech than they have preformed. The patients' difficulty sustaining and continuing the conversation despite the interviewer's support only emphasizes the severity of the negative symptoms. The poverty of speech expressed in the language of patients with schizophrenia creates discontinuity with the context and the patients fail to build up semantic information as the conversation continues. Consequently, the patients fail to communicate with others and create interpersonal relationships appropriately.

5.3 Disorganized thought and speech

“Schizophrenia is a complex psychiatric disorder that is frequently manifest in language and related cognitive function” (Kuperberg & Caplan, 2003: 459). Language disorder is central in the diagnosis of schizophrenia; this disturbance is heterogeneous and has traditionally been termed “thought disorder”. Rochester and Martin (1979) noted that for most clinicians, the assessment of “thought disorder” is based on inferences from the discourse of patients. They further pointed out that, because thought cannot be accessed directly, attributing thought disorder to a speaker is tautological, i.e., we infer thought disorder based on disordered speech. The language of patients with schizophrenia is considered disorganized and uninterpretable when it does not fit with the hearer's sense of context. According to the DSM-IV (American Psychiatric Association, 1994), the clinical understanding of disorganized speech is as either derailment which is taken to be an across clause phenomenon or incoherence which is taken to be a disturbance within a clause. Both kinds of disorganized speech characterize talk that is uninterpretable in context. As Fine (2006) states, the speech is incomprehensible because there are no meaningful or logical connections between words, phrases or clauses

The theory of speech functions, a functional semantic interpretation of a dialogue, covers the interpersonal meaning: the speaker relation to his listener and describes how language works in social context; therefore the theory is important for studying the patients' communicative failures and disorganized speech in discourse. Thus, the following analysis shows evidence for their failure to take part in dialogue, to negotiate the exchange of interpersonal meaning and to create social relationship. The analysis reveals that patients fail to express certain and coherent interpersonal positions, often providing contrastive information (5.3.1), engagement with the truth value of their utterances (5.3.2) , and low precision and accuracy in language (5.3.3).

5.3.1 Certain and coherent discourse

The analysis describes the degree in which patients with schizophrenia are engaged and committed to their utterances and what it reveals about the nature of schizophrenia. One of the ways patients with schizophrenia express their degree of commitment to the truth value of their proposition is with sustaining: continuing moves, specifically by continuing: extension moves, in which a move provides contrasting information to an immediately prior move (linked with conjunctions such as: and, but, except, instead). Patients with schizophrenia often decide to challenge or reject their own prior utterances; as a result, they fail to express fluent, certain and coherent propositions concerning their illness, behavior and actions. Patients with schizophrenia may negotiate and continue the discussion; however, in more than 50% of the cases they add contrastive information. Thus, they reveal their lack of confidence and commitment to the truth value of their utterances. Consequently, the listener (a clinician) feels confused and cannot follow what the patient is saying or to make sense of what is said. Examples 5.19-5.22 demonstrate how patients with schizophrenia challenge or reject prior utterances, and not completing the social interaction with others.

Example 5.19 Interviewer/Patient #1:

I: do you hear things in the background voices noises or

[O:I:demand:closed:information:opinion]

S: sure I can hear them **but** [S:R:respond:support:reply:affirm]

I: hear what? [S:R:rejoinder:support:track:check]

S: I hear voices like well I can hear people talking

[S:R:rejoinder:support:response:resolve]

I: yea [S:R:respond:support:register]

S: **but** I'm not you know I'm not saying that their talking about me or anything like that

[S:C:append:extend:contrast]

Example 5.20 Interviewer/Patient #2:

I: so....what about the difficulty that ah...you know that you had that...people at home didn't look familiar at all, do you still have that or is it changing at all?

[O:I:demand:closed:information:opinion]

S: **I think it's changed..** [S:R:respond:support:reply:answer]

S: **I don't see it home of course ah** [S:C:prolong:elaborate]

I: Hmmm hmmm [S:R:respond:support:register]

S: **but I still hear voices and see things** [S:C:append:extend:contrast]

Example 5.21 Interviewer/Patient #3:

I: have you seen her lately? [O:I:demand:closed:information:opinion]

S: **yes I had** [S:R:respond:support:reply:affirm]

S: **we-well no I haven't seen her for a long time** [S:C:prolong:extend:contrast]

S: **but I saw somebody that's supposed to be ---- and Lo is not the right ---- at all. -- is uh all together different** [S:C:prolong:extend:contrast]

Example 5.22 Interviewer/Patient #4:

I: do you think you are doing better now uh or then you know what I mean, you're getting better now too, do you feel better now or you? [O:I:demand:open:information:opinion]

S: **I feel better now** [S:R:respond:support:reply:answer]

S: **but I don't feel capable of doing work** [S:C:prolong:extend:contrast]

Examples 5.19-5.22 are evidence of the patients' incoherent and uncertain discourse. The patients convey interpersonal positioning, however, they decline to commit to the truth value of their propositions. The speakers constantly counter expectations that they have created for the hearer and restrain their own evaluations. By this pattern, speakers with schizophrenia reveal their uncertainty, hesitation and lack of confidence. The language presented by the patients is incoherent and uncertain, which directly affects their ability to communicate fluently and appropriately with others and coordinate social interaction. Table 5.7 summarizes the number of schizophrenics' continuing: extension moves providing contrasting information.

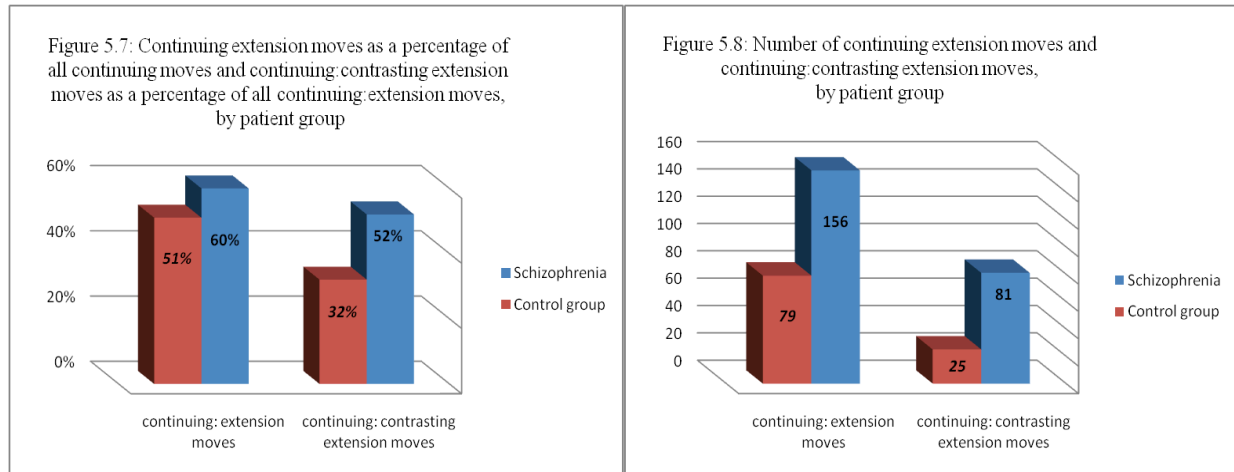
Table 5.7: Number of continuing: extension moves providing contrasting information by speakers with schizophrenia

Patient #	Total continuing: extension moves	Total continuing: contrasting extension moves
1	16	12
2	39	14
3	67	40
4	34	15
Total	156	81

5.3.1.1 Coherent discourse: a comparison between patients with and without schizophrenia

Section 5.2 of this chapter examined the patients' degree of agreement to extend their responses and develop the discussion. The analysis shows that due to interviewer's intensive effort to elicit information from patients with schizophrenia, they eventually develop the discussion to greater extent (260 continue moves) than patients without schizophrenia (154 continue moves).

Despite the advantage in extension of talk, patients' with schizophrenia show a severe reduction in their ability to express certain and coherent discourse in comparison to non schizophrenic patients. Patients with schizophrenia may negotiate and continue the discussion; however, in 52% of the cases they add contrastive information. They fail to express fluent, certain and coherent propositions concerning their illness, behavior and actions. Patients without schizophrenia, in contrast, add only in 32% of the extensions contrastive information and show higher degree of confidence and commitment to the truth value of their utterances. Figure 5.7 and 5.8 present the percentage and numbers of continuing: extension moves providing contrasting information by speakers with and without schizophrenia. Full data for the control group is presented in Appendix B, table 23.



In comparing the numbers of continuing: contrasting extension moves between the two groups (Figure 5.8), patients with schizophrenia (81) appear even more hesitant and uncertain in expanding the discussion compared to patients without schizophrenia (25).

5.3.2 *Engagement to the truth value of utterances*

Once patients with schizophrenia sustain interaction and negotiate interpersonal positioning, it is important to examine their engagement to the truth value of the utterances. For the purpose of the analysis, the system of speech function will be considered as it interacts with Appraisal. That is, the semantic resource of appraisal theory: Engagement is realized through sustaining moves within the model of speech function. The Engagement system is a set of linguistic options that convey the degree of commitment to the position being presented. Engagement encompasses two main resources: Modality and Concession. White (2001) pointed out that, values of modality act to expand or open the space for dialogic diversity. Modality, as for most values of Appraisal, is scaled for intensity, in the sense that is located somewhere on a cline between high and low degrees. White (2001) notes that “values of concession are generally contracting or closing since, while they acknowledge alternative positions within the dialogistic context, they either reject or directly challenge these” (p.9). Concession includes conjunction (but) and continuatives (still, only, just). With this functionality, atypical use of values of Engagement will show why patients with schizophrenia fail to produce coherent and fluent discourse and show the difficulty in coordinating social interaction and forming social relationships. The patients' degree of engagement is examined within sustaining moves which include both reacting: responding speech function, by which patients react to the interviewer's move and are being interactive and continuing speech functions, by which they keep negotiating the proposition discussed and contribute to the discussion.

Patients' with schizophrenia consistently do not express modal values in sustaining moves associated with assertions to which they are strongly committed. The patients' frequently use of low and mid modality revealing their low degree of commitment to the propositions being expressed. Similar to Modality, the patients frequently express concession which reflects their lack of confidence and constant need to reject their prior utterances. The values of Engagement are presented in examples 5.23-5.25:

Example 5.23 Interviewer/Patient #1:

I: yes...so you were telling me you were feeling well and then. What happened?

[O:I:demand:open:information:opinion]

S: well, ah... I don't know [Modality] [S:R:respond:confront]

S: I was sitting there doing my art and I just [Concession] started losing things I just [Concession] started ah feeling empty I just [Concession] started kind of...

[S:C:prolong:elaborate]

S: I guess [Modality] I was giving too much of myself away [S:C:prolong:elaborate]

S: uh... probably [Modality] because I guess [Modality] I was hearing things

[S:C:prolong:enhance]

Example 5.24 Interviewer/Patient #2:

I: So....what about the difficulty that ah... you know that you had that... people at home didn't look familiar at all do you still have that or is it changing at all?

[O:I:demand:closed:information:opinion]

S: I think [Modality] it's changed, I don't see it home of course ah

[S:R:respond:support:reply:answer]

I: Hmmm hmmm [S:R:respond:support:register]

S: But [Concession] I still hear voices and see things [S:C:append:extend]

Example 5.25 Interviewer/Patient #4:

I: do you think you are doing better now uh or then you know what I mean you're getting better now too, do you feel better now or you? [O:I:demand:close:information:opinion]

S: I feel better now [S:R:respond:support:reply:answer]

S: but [Concession] I don't feel capable of doing work [S:C:prolong:extend]

I: yea [S:R:respond:support:register]

S: but [Concession] then I felt capable of doing work [S:C:append:extend]

I: well I think you will feel capable of doing work pretty soon [O:I:give:information:opinion].

The sense of uncertainty and lack of commitment occurs most when the patients report on their illness, motivation, social relationships and emotions. They seem incapable of reporting accurate and fluent evaluations concerning their behavior, decisions, improvement in situation, and their desires for the future.

The patients' lack of commitment and engagement to utterances occurs more frequently within continuing speech function rather than in responding moves. That is, when patients initially respond to the interviewer's move, they express propositions that are relatively more certain and coherent; however, once they continue the discussion and add further information they become less certain and committed to the truth value of their utterances. As patients develop the conversation, they do not express fluent and certain propositions and insert values

of engagement more often. Table 5.8 presents schizophrenics' number of values of Engagement (modality and concession) for both classes of sustaining speech function: responding and continuing moves.

Table 5.8: Number of values of Engagement expressed through sustaining speech functions by speakers with schizophrenia

Patient	Total Responding Moves	Modality and concession in <u>responding</u> moves	Total Continuing Moves	Modality and concession in <u>continuing</u> moves
1	17	12	41	34
2	156	43	67	21
3	30	3	102	46
4	52	8	50	21
Total	255	66	260	122

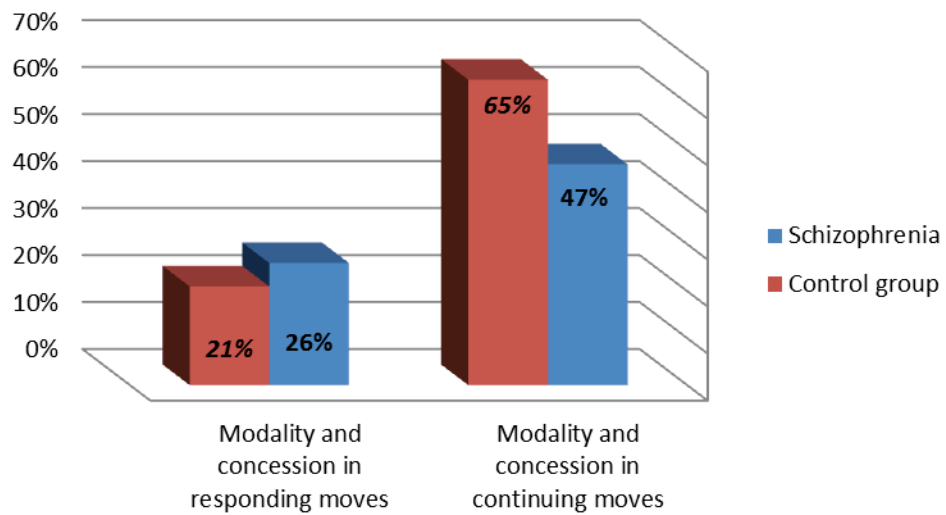
The two resources of Engagement provide similar evidence of the patients' disorganized speech. Patients with schizophrenia decline to commit to the truth-value of their evaluations and often present their language as tentative and uncertain. Discourse with others cannot be fluent and comprehensible if the patients frequently respond, challenge or reject their own prior positions. The frequent use of both Modality and Concession disrupts the continuity of the propositional information and the fluency of conversation. Consequently, the communication with others becomes difficult since the hearer may fail to interpret the interpersonal positioning and sequence of propositions. Thus, the atypical use of Modality and Concession contributes to the patients' inability to construct and maintain interpersonal positioning and relationships and to coordinate social interaction.

5.3.2.1 Engagement to the truth value of utterances: a comparison between patients with and without schizophrenia

Both groups of patients share similar amount of responds to interviewer's questions. The two groups further show low ability to engage to the truth value of their responds (schizophrenics 21%, controls 26%). The patients do not seem confident, accurate and certain in their immediate responds however, different results occur between the groups for continuing moves. When patients without schizophrenia extend the discussion and add further information they become even less certain and committed to the value of their utterances (65%) than patients with schizophrenia (47%). These findings again, may be affected by the interviewer's techniques. During his interviews with patients with schizophrenia, the interviewer becomes more supportive and expresses more empathy and positivity; he further increases his effort to elicit information and directs the conversation to specific topics. The interviewer's guidance and support contribute to raising the patients' confidence during discussion, which may lead them to speak with greater certainty and commitment to the truth value of their utterances. It should be noted, that despite the interviewer's effort to increase the effectiveness of the clinical interview, patients with schizophrenia insert values of engagement frequently (47%) especially mid and low values. The patients agree to sustain the conversation but often fail to express certain and coherent propositions.

Figure 5.9 presents the percentage of Engagement (modality and concession) for both classes of sustaining speech function: responding and continuing moves for speakers with and without schizophrenia. Full data for the control group is presented in Appendix B, table 24.

Figure 5.9: Continuing and responding moves with engagement (modality and concession) as a percentage of all continuing and responding moves, by patient group



5.3.3 Precision and accuracy in language

The patients' disordered language is further examined by an analysis of the degree of precision and accuracy in language. The patients' difficulty in expressing accurate and precise positions is evident mostly in their use of sustaining: rejoinder moves. Rejoinder tracking moves call directly for further talk from the prior speaker. The responses may be supporting as when a tracking request is resolved, that is, when patients provide the clarification requested or agree with information given. The patients' frequent use of rejoinder: resolving speech functions, which provide clarification, indicates the low degree of precision and accuracy of the patients' propositions. The fact that 90% of the patients' rejoinder moves are resolving shows that they are very often demanded to provide clarification during the interview; their language is often not clear or accurate and could involve many misunderstandings with the interviewer.

Examples 5.26-5.28 demonstrate patients' low degree of precision and accuracy that require tracking by the interviewer and resolution by the patient. For both examples 5.26-5.28, the interviewer's questions were concerned with the patients' feelings, experiences of illness etc' and were therefore analyzed as 'opinion', since the context showed that the interviewer was really looking for more information that was not only factual. The interviewer consistently develops those opinion questions.

Example 5.26 Interviewer/Patient #1:

I: do you hear things in the background voices noises or

[I:demand:closed:information:opinion]

S: sure I can hear them but [R:respond:support:reply:affirm]

I: hear what? [R:rejoinder:support:track:check]

S: I hear voices [R:rejoinder:support:response:resolve]

Example 5.27 Interviewer/Patient #2:

I: Do you still believe that your family died and? [O:I:demand:closed:information:opinion]

S: No [S:R:respond:confront:reply:disagree]

I: That thought is gone? [S:R:rejoinder:support:track:probe]

S: Yes [S:R:rejoinder:support:response:resolve]

I: What's still bothering you? [O:I:demand:open:information:opinion]

S: I still hear voices [S:R:respond:support:reply:answer]

I: You do? [S:R:rejoinder:support:track:confirm]

S: See things [S:R:rejoinder:support:response:resolve]
I: What kind of things? [S:R:rejoinder:support:track:clarify]
S: kind of things... the white shoes [S:R:rejoinder:support:response:resolve]
I: come on tell me, I'm curious to know [O:I:demand:open:information:opinion]
S: It's only white shoes... [S:R:respond:support:reply:answer]

Example 5.28 Interviewer/Patient #3:

I: well I just wanted to ask you how you felt. Do you remember talking with me a few days ago? [O:I:demand:open:information:opinion]
S: well, I must admit I feel uh somewhat better [S:R:respond:support:reply:answer]
I: uh hum [S:R:respond:support:register]
I: in what way do you feel better? [S:R:rejoinder:support:track:clarify]
S: in my strength [S:R:rejoinder:support:response:resolve]
I: uh.hum [S:R:respond:support:register]
S: I was um wasn't very strong... [S:C:append:extend]
S: and ah I think I'm on the road to recovery anyway. [S:C:prolong:extend]

Examples 5.26-5.28 indicate that when patients with schizophrenia are asked about their experiences of illness, feelings or behavior, they often provide brief and restricted responses including information that is not precise. As a result, the interviewer constantly uses tracking moves for further information and clarifications. Table 5.9 presents the number of rejoinder: resolving moves patients with schizophrenia use to provide clarifications required by the interviewer.

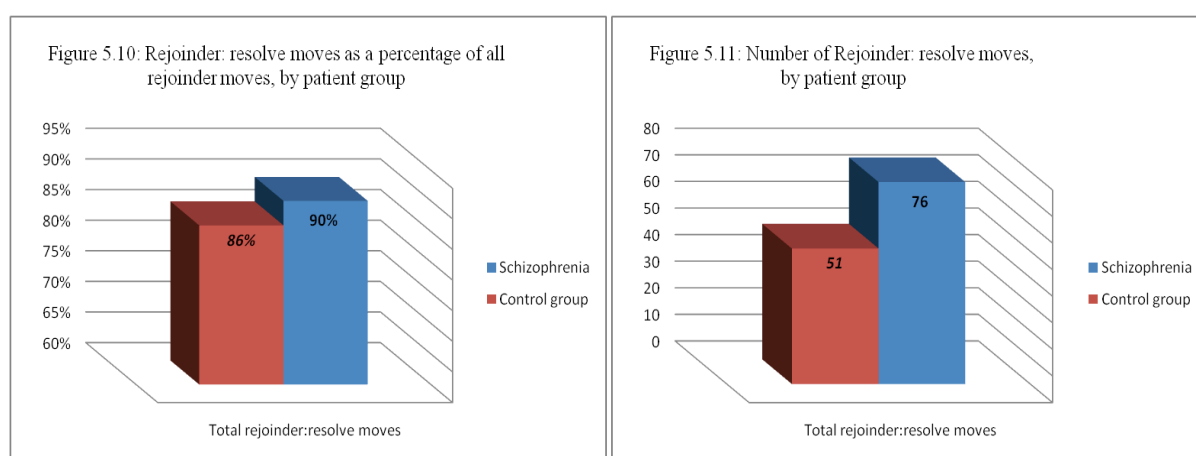
Table 5.9: Number of rejoinder: resolving moves expressed by speakers with schizophrenia

Patient	Total rejoinder moves	Total rejoinder: resolve moves
1	4	3
2	56	54
3	11	8
4	13	11
Total	84	76

5.3.3.1 Precision and accuracy in the language: a comparison between patients with and without schizophrenia

The two groups of patients express most often resolving moves out of total rejoinders. Thus, instead of keeping the exchange open and sustain the interaction, they prefer to provide only clarifications requested by the interviewer. The fact that 90% of the patients' rejoinder moves are resolving shows that they are very often demanded to provide clarification during the interview. Clearly, the language of patients with schizophrenia involves many misunderstandings and breakdowns in discourse and therefore the patients' main focus in developing the conversation is to provide clarification and raise the degree of accuracy and precision of their propositions, as requested from the interviewer. Patients with schizophrenia similarly most often express rejoinder: resolve moves (86%), evidence for the low degree of precision and accuracy in the language of patients with schizophrenia.

Figure 5.10 and 5.11 presents the number and percentage of rejoinder: resolving moves patients with and without schizophrenia use to provide clarifications required by the interviewer. Full data for the control group is presented in Appendix B, table 25.



When considering the numbers of rejoinder: resolving moves (Figure 5.11), rather than percentage of these moves, essentially the rate, the groups are quite different from each other. Patients with schizophrenia express resolving moves more frequently than patients without schizophrenia. The high frequency of resolving moves is evidence of the patients' difficulty in expressing accurate and precise propositions and the frequent demand for clarification by the interviewer. These differences across groups are less distinct when considering the rates rather than the absolute numbers (Figure 5.10) of rejoinder moves for the two groups.

5.3.4 Conclusion

The analysis describes why patients with schizophrenia fail to produce coherent and fluent discourse and show the difficulty in coordinating social interaction and forming social relationships. The patients' communicative failures and disorganized speech are expressed through certain atypical behaviors in discourse. Patients with schizophrenia (a) fail to express certain and coherent interpersonal positions, often providing contrastive information by continuing: extension moves, which challenge and reject an immediately prior move. (b) fail to engage with the truth value of their utterances, frequently expressing low and mid modal values and concession in sustaining moves. Atypical use of values of Engagement reflects the patients' lack of confidence and low degree of commitment to the propositions being expressed. and (c) express low precision and accuracy in language, that require tracking by the interviewer and resolution by the patient. The patients provide the clarifications demanded using rejoinder: resolving speech functions.

The patients' communicative failures and disorganized speech results in their failure to take part in dialogue and form an efficient conversation and social relationships.

6. General discussion and conclusions

This study examines how the diagnostic criteria of schizophrenia are expressed through interpersonal discourse semantic systems within systemic functional linguistics.

The study focuses on the role relations established through talk, attitudes schizophrenic patients express and how they negotiate turns to express their interpersonal positioning. The atypical use of language at the level of interpersonal discourse semantics makes it difficult for patients with schizophrenia to form communicative and efficient conversation and thereby create social relationships.

A detailed analysis of schizophrenics' discourse through the interpersonal systems of Speech function and Appraisal enables the interpretation of their dialogic structure, the quality of their interpersonal relationships, their roles and attitudes (6.1). These interpretations together become an important device in identifying the characteristic symptoms of schizophrenia (6.2).

6.1 Interpersonal metafunction and discourse semantic systems within SFL: their importance and contribution in studying the language of schizophrenia

The linguistic approach of this study aims to understand how the language of patients with schizophrenia works in the social context of a conversation. Eggins and Slade (1997) note that a conversation is a critical linguistic site for the construction of interpersonal relationships and negotiation of important dimensions of our social identity.

Systemic functional linguistics defines language as a systematic resource for expressing meaning in context; therefore, the organizing principle is system (rather than structure). Since language is viewed as semiotic potential, the description of language is a description of choice. SFL places the function of language as central; it starts at social context, and looks at how language acts upon, and is constrained and influenced by, this social context.

Taverniers (2011) notes that one of the most central theoretical aspects of systemic function linguistics (SFL) is its view of language as a *stratified* semiotic system i.e. a system consisting of multiple strata, linked through the semiotic relationship of realization. Four such strata are linked through the semiotic relationship of realization: context is seen as realized in semantics; semantics in lexicogrammar; and lexicogrammar in phonology or graphology.

This study focuses on the semantic stratum that captures an aspect of the meaning of the text and its realization by the lexicogrammar.

At the stratum of semantics, language is viewed as a resource for making several strands of meaning simultaneously. The three meanings or *metafunctions*: ideational, interpersonal and textual, contribute in parallel to the overall meaning of the text in context. According to Taverniers (2011), "the idea of 'metafunctional diversity' is a hypothesis about the organization of language on two levels: (1) on a macro level, it is a hypothesis about the way in which language, as a semiotic system, plays a role in human life in general; (2) on a more specific, linguistic level, it is a hypothesis about the way in which linguistic structure is organized" (p.1004).

These three types of metafunctions, can be glossed as follows: (1) Ideational meanings: meanings about the world: the propositional content. (2) Interpersonal meanings: meanings about roles and relationships, concerned with speech-function, exchange structure and expression of attitude. (3) Textual meanings: meanings about the message, concerned with how the text is structured as a message to fit into the context.

The current study shows how the characteristic symptoms of schizophrenia signal atypicality in the interpersonal metafunction, however, studies have also shown that the ideational and textual meanings malfunction in schizophrenia. The atypicality of the two latter metafunctions in the language of patients with schizophrenia is outlined as follows as opposed to the interpersonal metafunction.

According to Butt, et al. (2000), the textual metafunction uses language to organize our experiential, logical and interpersonal meanings into a coherent and, in the case of written and spoken language, linear whole. As Halliday (2004) explains, the textual metafunction includes meanings that enable the building of sequences of discourse, organizing the discursive flow and creating cohesion and continuity as it moves along. Halliday and Hasan (1976) identify five general categories of cohesion that create coherence in a text: reference, ellipsis, substitution, lexical cohesion, and conjunction. Rochester and Martin (1979) and Chaika (1990), have shown that, inappropriate reference chains make language sound psychotic with less than the normal attachment to reality. Bartolucci and Fine (1987) similarly suggest that "cohesive weakness is a linguistic problem found in schizophrenics. These speakers seem to have a specific difficulty in appropriately signaling the continuity of meanings to their hearers. Language, from the point of view of communication, should be clear and understandable. It is precisely this socially appropriate use of language that is not demonstrated by the schizophrenic subjects" (p. 73). Speakers with schizophrenia show atypical use of the different cohesive devices in language; i.e. talk is uninterpretable in context since there are fewer meaningful or logical connections between words or phrases. This atypicality in textual meaning is evidence of the disordered language of patients with schizophrenia.

The ideational metafunction uses language to represent human experience, in terms of objects, events and circumstances. Halliday (2004) distinguishes the two components of experiential and logical within the ideational metafunction. The experiential organizes our experience and understanding of the world, looking at the grammar of the clause as representation. The logical, however, looks at the grammar between clauses in clause complexes, expressing conjunctive, logical, and causal meanings. The ideational metafunction, in contrast to the textual metafunction represents experience in language; yet, both meanings are used to describe the characteristic symptom of disorganized speech in schizophrenia. According to DSM-IV (American Psychiatric Association, 1994), the clinical understanding of disorganized speech is either derailment (disturbance across clause), also known as loosening of association, or incoherence (disturbance within a clause), known as "word salad". Much of

the discussion of derailment and incoherence dwells on the ideational metafunction.

Derailment, for example, is described in Fine (2006) as inconsistency and unusual transitions in how the external world is encoded in language.

Beside disorganized speech, the symptoms of delusions and hallucinations also signal atypicality in the ideational metafunction of language. "These symptoms are expressed in language that does not encode the experiential reality in typical ways" (Fine, 2006: 205). Fine (2006) notes that delusions, for example, are expressed in language when one or more kind of information do not match with external reality as the rest of the community understands it (*'While I was a baby, I bought three houses and built up my business'*).

The two kinds of metafunctions, textual and ideational, can be then used to describe the disorganized and incoherent speech associated with patients with schizophrenia.

In contrast to the textual and ideational metafunctions, this study focuses on the interpersonal metafunction and its unique contribution and importance in describing atypicalities in the language schizophrenia. The language of speakers with schizophrenia fails to build social reality since it does not fit with the hearer's sense of context. Taverniers (2011) indicates that, "the interpersonal metafunction refers to speaker related aspects of language; it is concerned with the enactment of roles (social as well as speech roles) which are taken up by speaker and hearer in a linguistic interaction" (p.8). The interpersonal metafunction provides the resources for enacting social roles and relations as meaning in a text. To describe the language of schizophrenia in the social context of interaction, interpersonal meaning should be given the priority to understand the structuring in conversation.

Egins and Slade (1997), explain that the primary task of a conversation is the negotiation of social identity and social relations and thus, a conversation is 'driven' by interpersonal, rather than ideational or textual meaning. The interpersonal metafunction, by its definition, covers a wide range of meanings, each describing different impairments and characteristics of schizophrenia. As mentioned in Martin (1992), at the level of interpersonal metafunction, the speaker is using language as a means of his own intrusion into the speech event: the expression of his comments, his attitudes and evaluations, and also of the relationship that he sets up between himself and the listener. Martin (1992) indicates that this description includes in fact, both *personal* meaning, the speaker attitude to the meaning he is making, and *interpersonal* meaning, the speaker's relation to his listener.

Unlike ideational and textual metafunctions, the interpersonal meaning not only describes meanings expressed in context as attitudes, but also reflects the speech roles of speakers. In characterizing schizophrenia, it is crucial to describe the speech roles of both interviewer and

patient and the negotiation between the two. The interpersonal meanings expressed by the speaker do not stand by their own; they are part of an interaction and may even be affected by the speech choices of the listener.

According to Eggins and Slade (1997), the social identities of participants in a conversation are represented by four main types of linguistic patterns. These patterns, which operate within different linguistic units, are: (i) grammatical, (ii) discourse, (iii) semantics and (iv) generic patterns. The level of interpersonal discourse semantics is the focus of this study for describing the atypical speech produced by patients with schizophrenia. Namely, the study focuses on schizophrenics' dialogic structure, the quality of their interpersonal relationships, their roles and attitudes.

6.1.1 Interpersonal discourse semantic systems: Speech function and Appraisal theory

As mentioned above, the interpersonal metafunction includes both interpersonal and personal meaning. The two meanings as expressed in the language of speakers with schizophrenia are realized through two important components at the level of interpersonal discourse semantics: (i) Speech function theory and (ii) Appraisal theory.

(i) Speech function theory is a functional semantic interpretation of dialogue. According to Eggins and Slade (1997), the theory examines the overtly interactive discourse patterns of conversation: how people chose to act on each other through their choice of speech functions, such as, 'demanding', 'challenging', 'contradicting' or 'supporting'. Fine (2001) notes that these kinds of speech function reflect the social roles of speakers in specific contexts and are negotiable as a conversation develops. Fine (2001) adds that "speech functions are important for a speaker to function in the recurring socially defined settings of a society. It is these speech functions that encode the goals of a speaker in interaction and express what each individual wants and will give to another" (p.152). The speech function theory, then, becomes an important linguistic tool for describing the way patients with schizophrenia fail to take part in dialogue, to negotiate the exchange of interpersonal meaning, to establish their social identity and to create social relationships. The functional linguistic analysis explores schizophrenics' language behavior in discourse and provides evidence to patients' communicative failures, disordered speech and negative symptoms conveyed directly by language.

(ii) Appraisal theory describes the evaluative uses of language, focusing mainly on the personal meaning of the interpersonal function. The linguistic resources of appraisal express the attitudinal meanings in talk. These attitudinal meanings are expressed at the semantic level largely through lexical selections. This study is concerned with the types of evaluative and attitudinal lexis which patients with schizophrenia and the therapist use, and the directness with which they speak to each other. A semantic linguistic analysis of schizophrenics' language of evaluation, attitude and emotion, contributes in exploring the patients emotional disturbance and mood disorder, and how it may result in impaired occupational and social functioning. Thus, the diagnostic criteria of schizophrenia are found in interpersonal patterns of conversational structures and evaluative lexis.

6.1.2 Speech function and Appraisal theory: methodological importance in therapeutic conversation

In therapeutic terms, the interviewer can use the two interpersonal discourse systems to identify the characteristic symptoms of schizophrenia. The speech function theory provides a comprehensive picture of a conversation in terms of options available to speakers with schizophrenia and their interviewer. The interviewer sets certain communicative goals which are combined to form an effective interview. In order to achieve his communicative goals in therapy, the interviewer realizes that the kinds of speech functions must be chosen carefully. The interviewer's choice of moves produces certain patients' responses and response patterns which provide evidence of the diagnostic criteria of schizophrenia. Both patients and interviewer choose specific speech functions and take specific social roles in interaction to negotiate their interpersonal positioning and achieve their communicative goals. Fine (2001) notes however, that if the speech function system is not used appropriately, the speaker will be at risk for being misinterpreted in terms of the purposes or goals of the interaction. As evident in this study, patients with schizophrenia fail to take part in dialogue and negotiate the exchange of interpersonal meanings; thereby they find it difficult to establish their social identity and create social relationships appropriately.

Appraisal theory deepens our understanding of the language of speakers with schizophrenia, as well. The semantic system provides a set of options by which interactants can express their attitudinal meanings and negotiate their social relationships. The expression of attitude in interaction is an important device for constructing and signaling degrees of solidarity and intimacy in relationships (Eggins and Slade, 1997). In a therapeutic conversation, the interviewer uses Appraisal to express support, positivity and solidarity and to create comfortable interactions with the patients. Simultaneously, the interviewer examines the kinds of attitudes that are negotiated by the patients, the strength of the feelings involved and the evaluative lexis they use. In analyzing the language of evaluation, attitude and emotion, the interviewer can identify important diagnostic criteria of schizophrenia as patients' emotional disturbance and mood disorder.

Both interpersonal discourse semantic systems provide a set of options for negotiating their interpersonal positioning. The importance of the methods of analysis used in this study is that they identify a wide range of the diagnostic categories that define schizophrenia. Speech functions and instances of Appraisal are important for therapists as they can be used both as

linguistic tools for making a clinical diagnosis and provide insight into the nature of schizophrenia.

6.1.3 Further research through grammatical patterns at the interpersonal metafunction

The current study describes the atypical language behavior of patients with schizophrenia at the level of interpersonal discourse semantics. However, the level of lexicogrammar could also be studied. Halliday's (2004) account of dialogue sets up speech function as a separate discourse level of analysis, expressed through grammatical patterns. These two types of patterns are carried by different linguistic units. The grammatical patterns of mood are expressed through clauses and the discourse patterns of speech function are expressed through moves. The relationship between moves and clauses is one of expression, or, more technically, realization: moves, which are discourse units, are expressed in language through clauses, which are grammatical units.

Eggins and Slade (1997) suggest that there are two ways of looking at dialogue: from the point of view of grammar (the constituent mood structures of conversational clauses) and from the point of view of discourse (the types of moves made in an interactive context). The first tells us primarily about the linguistic rights and privileges of social roles in the culture. That is, "the analysis of mood choices in a conversation can reveal tensions between equality and difference, as interactants enact and construct relations of power through talk" (Eggins and Slade, 1997: 67). The second tells us primarily how, while enacting those social roles, participants are constantly negotiating relationships of solidarity and intimacy. That is, "discourse patterns as confrontation and support, expressed through conversational structure enable interactants to explore and adjust their alignment and intimacy with each other" (Eggins and Slade, 1997: 169).

The two linguistic patterns of discourse and grammar, can together contribute to our understanding how patients with schizophrenia and the interviewer enact their interpersonal positioning in a conversation, and therefore how power relations are negotiated through talk. Furthermore, the linguistic patterns of discourse (speech function) and semantics (Appraisal) examined in this study, are patterns which operate *between speakers*. That is, the focus is primarily on the interpersonal positioning negotiated between the interactants in conversation. The semantic patterns explore how attitudinal and expressive meanings are encoded in conversation; and the discourse patterns explore how people chose to act on each other through their choice of speech function.

The lexicogrammar creates structure in clauses. Eggins and Slade (1997) note that, it may

seem that the grammatical patterns are dealing with monologic issues. However, they explain that even in the analysis of a conversation there is importance in describing what goes on in individual speaker turns. "Interactive conversation is constructed through the individual contributions of each speaker. Through their grammatical choices interactants take up roles in the conversation, thus positioning themselves and other interactants, such that their individual choices are fundamental in making dialogue possible" (Eggins and Slade, 1997: 71).

The linguistic patterns of interpersonal meaning: grammatical, discourse and semantic, operate within different linguistic units and at different levels. Yet, in approaching the conversation of patients with schizophrenia at the three interpersonal linguistic levels, it is possible to create a clearer and more comprehensive picture of patients' and interviewer's language behavior and its reflection of their social roles and identities. As Eggins and Slade (1997) suggest, "the interaction of grammatical, semantic and discourse patterns creates meanings which can only be fully appreciated when we are able to analyze linguistic choices at all three levels" (p.71).

6.2. Identification of the characteristic symptoms of schizophrenia through a functional- semantic linguistic analysis of patient-interviewer conversation

This study provides a detailed functional semantic interpretation of the conversation of speakers with schizophrenia, from both interpersonal (speech function) and personal (Appraisal) perspectives. The conversational analysis of patients with schizophrenia is conducted within a clinical interview and therefore, it is important to consider the notion of this social context. Sommers-Flanagan and Sommers-Flanagan (2002) note that two interacting participants affect each other's style of communication resulting in specific patterns of interaction.

Therefore, in describing patients' dialogic structure in the context of a clinical interview, it is important to consider both the roles patients with schizophrenia and the interviewer take in the interaction, and the dynamic negotiation of relationships between the two. Such analysis enables the interpretation of the dialogic structure of the participants, the quality of their interpersonal relationships, their roles and attitudes. These interpretations show how the characteristic symptoms of schizophrenia are displayed in the interpersonal metafunction.

Thus, this section presents the negotiation in interaction between patients and interviewer, the kind of roles and identities established, and how they are used to explore some of the main diagnostic criteria of schizophrenia. The following discussion describes the characteristics of schizophrenia in three categories: emotional and social deficits (6.2.1), the negative symptoms of poverty of speech and poverty of content of speech (6.2.2), and disorganized thought and speech (6.2.3). The different social roles and interpersonal positioning of the participants are correlated with each of the diagnostic criteria.

6.2.1 Emotional and social deficit

One of the most prominent symptoms of schizophrenia is the patients' emotional disturbance and mood disorder, which are partly responsible for the patient's inability to coordinate social interaction and form social relationships appropriately. The emotional and social dysfunctions are diagnosed in patients' evaluative language as expressed by speech functions. Speakers with schizophrenia express their emotions and attitudinal language most frequently through sustaining speech functions (reacting and continuing moves), by which they chose to keep negotiating the exchange. The evaluative language expressed by patients with schizophrenia involves primarily negative values of attitude. The patients experience strong emotions of misery, fear, unhappiness and disappointment about their progress and disturbances of perception. Their atypical emotional expressiveness is associated with depressive symptoms which include: pessimism, guilt, lack of confidence, loss of interest or pleasure, and disturbance in sleep, appetite and energy level. The patients often criticize and condemn their own behavior, actions, beliefs and question their normality. They judge themselves as undependable, irresponsible and incapable of working, having friends or interests. The patients' mood disorder and emotional and social deficits are further stand out when compared to patients without schizophrenia.

In interviewing patients with schizophrenia the therapist must consider patients' emotional disturbance and the social deficit it implicates. The patients' emotional and mood disorder requires the interviewer to develop a strong and positive therapeutic relationship with the patient. Before even applying any assessment or clinical intervention, the interviewer has to establish his role as an active listener, being supportive and expressing positive and empathic responding. These kinds of role relations are expressed through various speech functions designed to express sympathy and solidarity in response to the speakers' interpersonal positioning and emotional expressiveness. Reacting moves (both responds and rejoinders) are the most common speech functions by which the interviewer conveys support and empathy. His frequent use of supporting reactions indicate his willingness to accept the propositions or proposals of the patients, avoid confrontation, and create an alignment between him and the patients. Furthermore, within supporting respond moves, the interviewer most often expresses support through register moves. Registering moves provide supportive encouragement for the other speaker to take another turn. In this manner, the interviewer is being attentive,

understanding and conveys empathy to the patients. The patients, consequently, feel reassured, understood and encouraged to make contributions to the discussion.

In his attempt to create a positive relationship with patients with schizophrenia, the interviewer takes the role of a supporter a step further and becomes more 'activist' for therapeutic and treatment purposes. The interviewer realizes that due to the patients' severe emotional disturbance and social dysfunction, it is not enough to convey support only by accepting the patients' proposition; there is also need to emphasize his empathy and his positive attitude concerning their emotional and social situation. The interviewer uses various speech functions to appraise and evaluate positively the patients' behavior, attitude and progress in illness in order to raise their self esteem and motivation. The interviewer regards his role of conveying support and empathy for the patients as important. Further, he expresses positivity and optimism concerning the patients' illness in order to improve the patients' self esteem and motivation. The interviewer's roles as a supporter, being empathic and optimistic, contribute to assessing and treating the patients' emotional and social dysfunction.

6.2.2 The negative symptom of poverty of speech

The negative symptom of poverty of speech is the lessening of speech fluency and productivity, characterized by brief and empty replies to questions. Patients with schizophrenia suffering from poverty of speech find it considerably difficult to hold a fluent conversation, resulting in failure to communicate with others and failure to form social relationships appropriately.

Poverty of speech as expressed by patients with schizophrenia, challenges the interviewer's ability to elicit relevant information from the patients for therapeutic purposes. Patients with schizophrenia, however, show restriction in the amount of speech; they prefer not to share much personal information concerning their illness and often lead exchanges to their completion. In response, the interviewer specifically chooses speech functions that overcome the communicative difficulties and succeed in extracting information from patients with schizophrenia. This role of eliciting information about the patients' problems and symptoms of illness becomes central in diagnosing schizophrenia. The interviewer most frequently uses the speech functions of initiating moves (opinion questions) and rejoinders in order to encourage speakers with schizophrenia to broaden the discussion and exchange their interpersonal positioning. In most cases, patients with schizophrenia provide supporting responds to interviewer's opinion questions and indicate agreement to negotiate their positioning. However, responding moves, though supporting, complete the negotiation of the proposition, rather than prolong the exchange. The sense of exchange completion and lack of co-operation continues and most reactions to interviewer's questions end with the immediate respond with no further expansion (only 27% of total responds are extended).

Beside questions (initiating moves), the interviewer attempts to elicit information from patients through other speech functions. Rejoinder moves, for example, contribute most assertively to the negotiation of interpersonal relationships. Rejoinders tend to extend the exchange through queries, doubt or rejection of ideas or added information. It is suggested that the interviewer considers the patients' emotional disturbance and therefore uses only supportive rejoinders: tracking, which sustain the interaction by keeping an exchange open, without implying any interpersonal confrontation. Rejoinders, as initiating moves, are most effective in sustaining the interaction; and yet, as in the case of questions, patients with schizophrenia provide supportive responds to rejoinders but do not tend to expand their talk further than the initial response (only 22% of rejoinders have a following extension).

The interviewer further uses the register move to elicit information from patients. Register moves provide supportive encouragement for the other speaker to take another turn and therefore are expressed most frequently to encourage conversation development (72% register moves out of all respond moves). Registering moves, unlike initiations and rejoinders, successfully encourage the patients to expand the discussion and add further information concerning their illness. In most cases (79%) where a register move occurs, a prolonging move is then immediately added by the patients. Thus, the interviewer skillfully uses register moves to reduce poverty of speech, and to create continuity and fluency and to gather information helpful for evaluation and diagnosis.

As mentioned, only 27% of patients' responds to interviewer's questions and rejoinders are further extended as an immediate response. These extensions of responds are frequently developed by several continuing moves. In all, there are 260 continuing moves in the four interviews. Despite the large number of extensions of talk, there is evidence for poverty of speech. The patients find it difficult to provide further personal information and develop the discussion fluently; therefore, more than 40% of the patients' continuing moves are appending ones. That is, patients often expand their respond only after they are interrupted by the interviewer, mostly by a "register" move, and encouraged to elaborate on their replies. The interviewer encourages the then immediately added by the patients. Thus, the interviewer skillfully uses register moves to reduce poverty of speech, to create continuity and fluency and yet, the patients do not provide information and expand the interaction independently and fluently.

The interviewer establishes his role of eliciting information through various speech functions that contribute to encouraging patients with schizophrenia to expand their interpersonal positioning and share relevant information concerning their illness. Two important generalizations can be concluded concerning the negotiation between the interactants within the attempt to elicit information.

(1) Patients with schizophrenia react with a variety of degrees of co-operation and poverty of speech to the interviewer's moves that elicit information. Patients with schizophrenia show more poverty of speech when the interviewer elicits information through initiating moves (opinion questions) and rejoinders moves. Initiations and rejoinders contribute most assertively to the negotiation of interpersonal relationships. Both moves include explicit questions that ask for direct information about the patient's emotions, behavior and experiences of illness. The interviewer does not create the opportunity for the patient to question the need to provide the

relevant information. Example 6.1 demonstrates the interviewer's use of explicit opinion questions to elicit information from the patient.

Example 6.1 Interviewer/Patient #2:

I: Do you think the glasses make a difference or is there something else that's changed?

[O:I:demand:closed:information:opinion]

S: No no...well I don't think it was the glasses [S:R:respond:confront:reply:disagree]

I: What do you think it was? [O:I:demand:open:information:opinion]

S: I am getting a bit better than I was [S:R:respond:support:reply:answer]

These types of questions or rejoinders are concerned directly with sensitive and emotive issues. The patients, in respond, are concerned about the intimacy involved and become hesitant and unconfident in sharing their personal positioning. They express their concern in exposing their emotions by showing disagreement to negotiate their interpersonal positioning and create exchange closure. Register moves are also used to sustain the interaction, however by only providing supportive encouragement for the speaker to take another turn. Since register moves do not encourage talk through direct question about the illness, patients with schizophrenia feel less exposed and are more confident in prolonging the exchange and contributing to the negotiation of interpersonal positioning. Patients' extension of talk occurs more frequently after register moves compared to after initiations or rejoinders. Clinically for patients with schizophrenia, it is important to consider their emotional disturbance and chose the appropriate speech functions to elicit the relevant information for therapy.

(2) Patients with schizophrenia often agree to sustain the interaction and extend their responds only after the interviewer encourages them to do so. Despite the interviewer's intensive effort to encourage patients to speak, the patients show little co- operation and more than 40% of their responds are extended only after intervention. The poverty of speech of patients with schizophrenia and their lack of co- operation to sustain interaction requires the interviewer to constantly be supportive and encouraging during conversation in order to get information. Furthermore, it is important that the therapist chose those speech functions that will elicit information about the patients' illness and are less affected by patients' emotional disturbance. Information gathering, if done skillfully, can develop a clinical frame of reference for diagnosing the main criteria of schizophrenia.

6.2.3 Disorganized thought and speech

Abnormalities in language are central to psychosis, particularly the schizophrenia syndrome. "The language of patients with schizophrenia is uninterpretable because it does not fit with the hearer's sense of context (Fine, 2006:199). The current study examines how schizophrenics' language works in social context and reveals the patients' communicative failures and disorganized speech. The functional semantic analysis shows evidence for patients' failure to take part in dialogue, to negotiate the exchange of interpersonal meaning and to create social relationships. The patients' communicative failures and disorganized speech are expressed through certain atypical behaviors in discourse. Patients with schizophrenia (1) fail to express certain and coherent interpersonal positions, often providing contrastive information, (2) fail to engage with the truth value of their utterances and (3) express low precision and accuracy in language.

Patients with schizophrenia may agree to negotiate and continue the discussion; however, in more than 50% of the cases, they add contrastive information. The patients decline to commit to the truth value of their propositions and constantly counter expectations that they have created for the hearer and restrain their own evaluations. Speakers with schizophrenia thus express their interpersonal positioning with a sense of uncertainty, hesitation and lack of confidence. Moreover, the frequent use of the engagement resources of modality and concession disrupts the continuity of the clause and exposes the patients' language as tentative and uncertain. The patients neither express strong commitment to interpersonal positioning nor provide accurate information concerning their behavior, emotions and experiences of illness. Finally, the use of rejoinder: resolve moves, which provide clarification shows the patients' difficulty in expressing accurate and precise positions. The fact that 90% of the patients' rejoinder moves are resolving shows that they are very often demanded to provide clarification during the interview; their language is often not clear or accurate and could lead to many misunderstandings with the interviewer.

These atypical language behaviors are evidence of discourse failures in schizophrenia. Patients with schizophrenia who express tentative and inaccurate language are unable to complete the social interaction with others. Communication with others becomes very difficult since the hearer may fail to interpret the patients' real intentions in their positioning and follow their speech in context. The patients fail to construct and maintain interpersonal positioning and coordinate social interaction appropriately. The interviewer, in response to patients' incoherent

speech, maximizes his effort to create a coherent and fluent discussion, and assures that clarification is provided both by him and by the patients. The interviewer's speech is clear, accurate and explicit, so patients can easily address the topics discussed and provide the relevant information, without misunderstandings. Furthermore, the interviewer constantly queries the information presented by the patients and demand clarifications. In order to understand the patients' disordered language, the interviewer has to overcome the misunderstandings and make sense of what is said in context. Only then he can receive accurate information and create a coherent and fluent discourse

The functional semantic analysis reveals that the emotional and social disturbance and the disorganized speech of patients with schizophrenia are reflected in their failure to take part in dialogue, to negotiate the exchange of interpersonal meaning and create social relationships. These interpretations are important for identifying the diagnostic criteria of schizophrenia. The conclusions of this study were drawn from the findings of the group of patients with schizophrenia. Though the conclusions were drawn from groups of patients (both schizophrenia and controls), the primary aim was to describe through language the mechanism underlying schizophrenia from a social perspective, rather than to generalize to the population of schizophrenia. Moreover, it is important to recognize that there are many individual differences. Since this study, however, aimed to examine the language of patients with schizophrenia in social context, it was useful to consider the patients as a group. From a social perspective, this study could not rely on only one person's characteristics. It has to consider external factors that are similar across patients, such as the social situation of a therapeutic interview. Only then, it is possible to draw conclusion about the language that characterizes schizophrenia.

The study characterizes interpersonal discourse semantic systems of systemic functional linguistics in the language of speakers with schizophrenia in the social context of a conversation. The discourse analysis of the conversational structure of patients with schizophrenia includes both a functional interpretation through speech function classes and a semantic interpretation, in terms of appraisal and involvement. In analyzing patients discourse within the social context of a therapeutic interview, it was necessary to consider the roles patients with schizophrenia and the interviewer take in interaction and the dynamic negotiation of relationships between the two.

A detailed analysis of schizophrenics' discourse through the interpersonal systems enables a comprehensive interpretation of their dialogic structure, the quality of their interpersonal relationships, their roles and attitudes. These interpretations together become an important

device in identifying the characteristic symptoms of schizophrenia. The symptoms of atypical emotional expressiveness, social dysfunction and incoherent speech, are evident at the level of interpersonal meaning and have clear social implications. Patients with schizophrenia will find it difficult to form communicative and efficient conversation and thereby establish their identity and create social relationships with others.

The main contribution of this study to diagnostic classification of schizophrenia is that, the interpersonal discourse systems of Speech function of Appraisal can be used to provide a specific profile of the patients' degree of severity of their emotional and social dysfunctions and incoherent speech. The analysis of patients' language at the level of interpersonal meaning is intended to deepen the understanding of the language of speakers with schizophrenia, assist clinicians to establish efficient language behaviors for therapeutic discourse and to plan treatment goals for patients.

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Appendix A

Table 1: Speech role and commodities in interaction

(Halliday, 1994: 69)

Speech role	Commodity exchanged	
	Information	Goods-and-Services
Giving	statement	offer
Demanding	question	command

Table 2: Realis AFFECT

(Martin, 2000: 151)

UN/HAPPINESS	SURGE (of behaviour)	DISPOSITION
unhappiness: misery [mood: 'in me']	<i>whimper</i> <i>cry</i> <i>wail</i>	<i>down</i> <i>sad</i> <i>miserable</i> <i>low</i> <i>median</i> <i>high</i>
unhappiness: antipathy [directed feeling: 'at you']	<i>rubbish</i> <i>abuse</i> <i>revile</i>	<i>dislike</i> <i>hate</i> <i>abhor</i>
happiness: cheer	<i>chuckle</i> <i>laugh</i> <i>rejoice</i>	<i>cheerful</i> <i>huyant</i> <i>jubilant</i>
happiness: affection	<i>shake hands</i> <i>hug</i> <i>cuddle</i>	<i>fond</i> <i>loving</i> <i>adoring</i>

IN/SECURITY	SURGE (of behaviour)	DISPOSITION
insecurity: disquiet	<i>restless</i> <i>twitching</i> <i>shaking</i>	<i>uneasy</i> <i>anxious</i> <i>freaked out</i>
insecurity: surprise	<i>start</i> <i>cry out</i> <i>faint</i>	<i>taken aback</i> <i>surprised</i> <i>astounded</i>
security: confidence	<i>declare</i> <i>assert</i> <i>proclaim</i>	<i>confident</i> <i>assured</i> <i>boastful</i>
security: trust	<i>delegate</i> <i>commit</i> <i>entrust</i>	<i>comfortable with</i> <i>confident in/about</i> <i>trusting</i>

DIS/SATISFACTION	SURGE (of behaviour)	DISPOSITION
dissatisfaction: ennui	<i>fidget</i> <i>yawn</i> <i>tune out</i>	<i>bored</i> <i>fed up</i> <i>exasperated</i>
dissatisfaction: displeasure	<i>censure</i> <i>scold</i> <i>castigate</i>	<i>cross</i> <i>angry</i> <i>furious</i>
satisfaction: interest	<i>attentive</i> <i>busy</i> <i>flat out</i>	<i>curious</i> <i>absorbed</i> <i>engrossed</i>
satisfaction: admiration	<i>pat on the back</i> <i>compliment</i> <i>reward</i>	<i>satisfied</i> <i>impressed</i> <i>proud</i>

Table 3: A framework for analyzing JUDGEMENT in English

(Martin, 2000: 157)

SOCIAL ESTEEM 'venial'	positive [admire]	negative [criticize]
normality: fate 'is s/he special?'	<i>lucky, fortunate, charmed... normal, average, everyday... in, fashionable, avant garde...</i>	<i>unfortunate, pitiful, tragic... odd, peculiar, eccentric... dated, dagggy, retrograde...</i>
capacity 'is s/he capable?'	<i>powerful, vigorous, robust... insightful, clever, gifted... balanced, together, sane...</i>	<i>mild, weak, wimpy... slow, stupid, thick... flaky, neurotic, insane...</i>
tenacity: resolve 'is s/he dependable?'	<i>plucky, brave, heroic... reliable, dependable... tireless, persevering, resolute...</i>	<i>rash, cowardly, despondent... unreliable, undependable... weak, distracted, dissolute...</i>
SOCIAL SANCTION 'mortal'	positive [praise]	negative [condemn]
veracity: truth 'is s/he honest?'	<i>truthful, honest, credible... real, authentic, genuine... frank, direct...</i>	<i>dishonest, deceitful... glitzy, bogus, fake... deceptive, manipulative...</i>
propriety: ethics 'is s/he beyond reproach?'	<i>good, moral, ethical... law abiding, fair, just... sensitive, kind, caring...</i>	<i>bad, immoral, evil... corrupt, unfair, unjust... insensitive, mean, cruel...</i>

Table 4: A framework for analyzing APPRECIATION in English

(Martin, 2000: 160)

linguistics	positive	negative
reaction: impact 'did it grab me?'	<i>arresting, captivating, involving, engaging, absorbing, imposing, stunning, striking, compelling, interesting... fascinating, exciting, moving... remarkable, notable, sensational... lively, dramatic, intense...</i>	<i>dull, boring, tedious, staid... dry, ascetic, uninviting... unremarkable, pedestrian... flat, predictable, monotonous...</i>
reaction: quality 'did I like it?'	<i>lovely, beautiful, splendid... appealing, enchanting, pleasing, delightful, attractive, welcome...</i>	<i>plain, ugly... repulsive, off-putting, revolting, irritating, weird...</i>
composition: balance 'did it hang together?'	<i>balanced, harmonious, unified, symmetrical, proportional...</i>	<i>unbalanced, discordant, unfinished, incomplete...</i>
composition: complexity 'was it hard to follow?'	<i>simple, elegant... intricate, rich, detailed, precise...</i>	<i>ornamental, over-complicated, extravagant, puzzling... monolithic, simplistic...</i>
valuation 'was it worthwhile?'	<i>challenging, significant, deep, profound, provocative, daring... experimental, innovative, original, unique, fruitful, illuminating... enduring, lasting...</i>	<i>shallow, insignificant, unsatisfying, sentimental... conservative, reactionary, generic... unmemorable, forgettable...</i>

Table 5: Metaphorical realizations of modality
(Halliday, 2004)

Kind of MODALITY	congruent realizations			metaphorical realizations	
	Finite	Adjunct (mood)	Predicator	mental clause	attributive clause
	implicitly subjective	implicitly objective	implicitly objective	explicitly subjective	explicitly objective
probability	can/could, may/might, will/would, should, ought to, must	possibly, probably, certainly ...		[cognitive:] I guess, I think, I know	it is possible... it is probable... it is certain...
usuality		sometimes, usually, always ...		–	It is unusual (for him to leave)
obligation		necessarily ...	be allowed to, be supposed to, be obliged to	[affective:] I'm willing for... I expect... I want... (him to leave)	it is permitted it is expected it is necessary (... for him to leave)
readiness: inclination		willingly, eagerly ...	be willing to, be keen to, be determined to	[verbal group complex:] I'd like to leave I want to leave	it'd be lovely to leave
readiness: ability	can/could		be able to	–	it is possible for him to leave

Figure 1: Opening speech functions in casual conversation
(Eggins and Slade, 1997: 193)

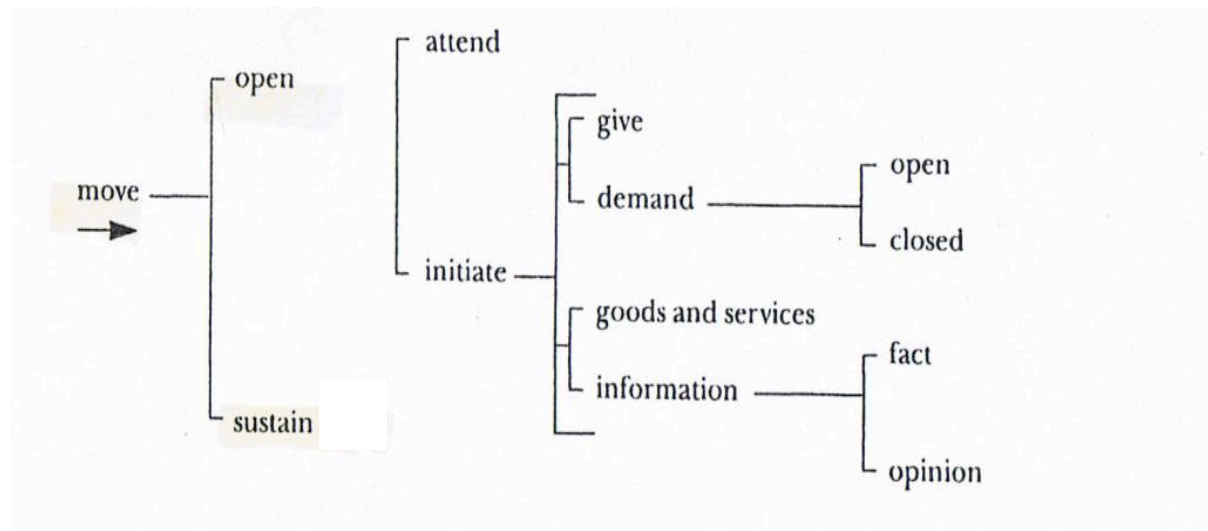


Figure 2: Sustaining: continuing speech functions in casual conversation
(Eggins and Slade, 1997: 195)

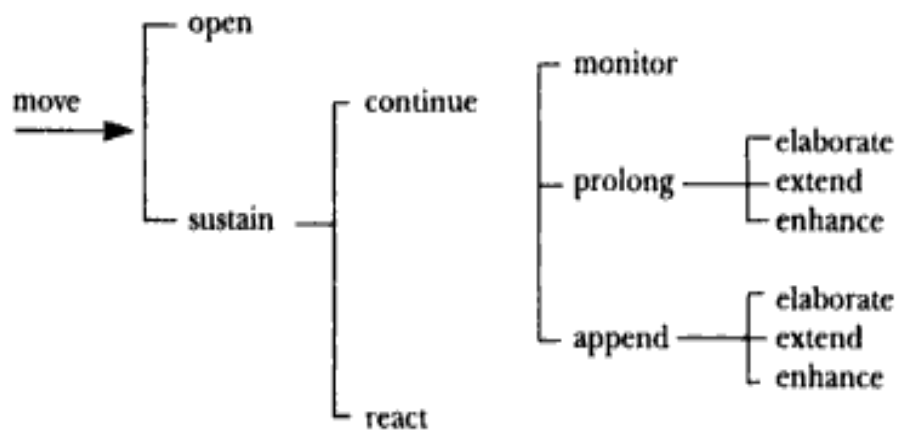


Figure 3: Sustaining: responding speech functions in casual conversation
(Eggins and Slade, 1997: 202)

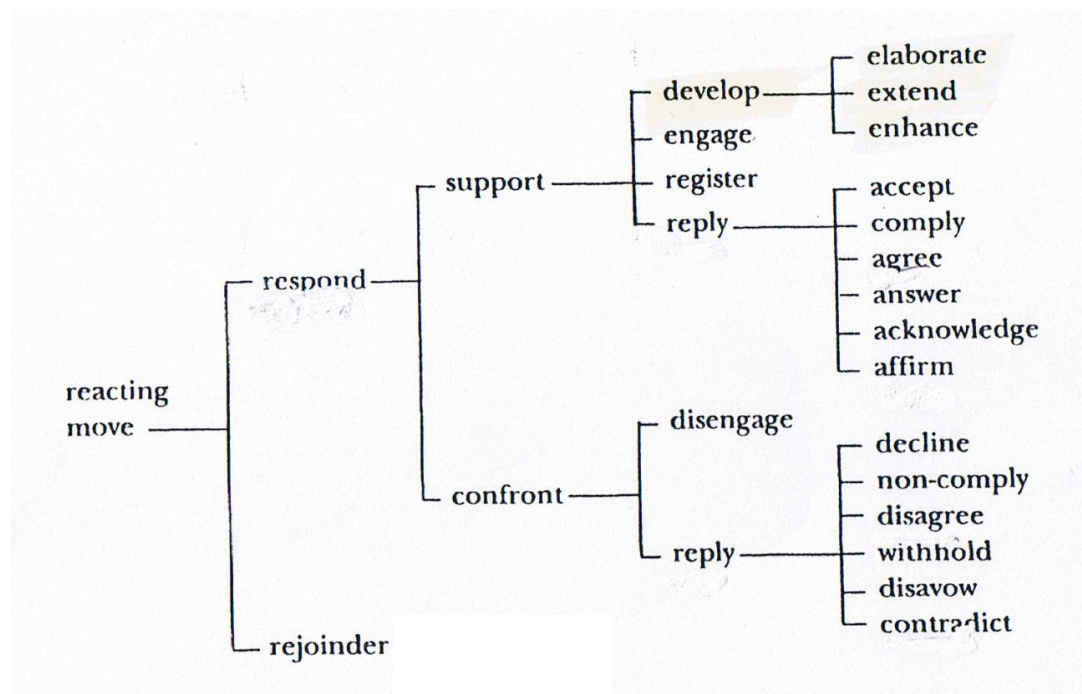


Figure 4: Sustaining: rejoinder speech functions in casual conversation
(Eggins and Slade, 1997: 209)

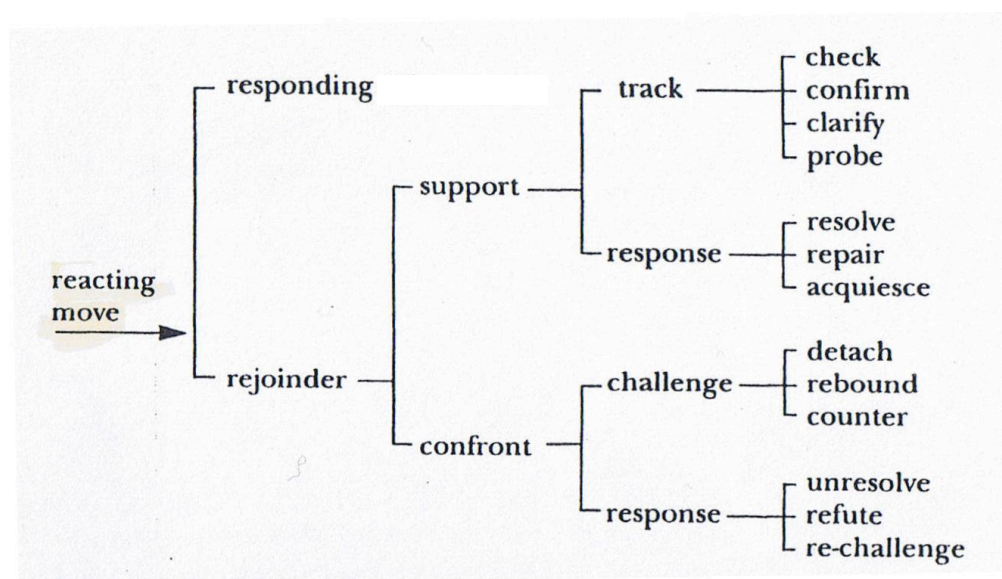
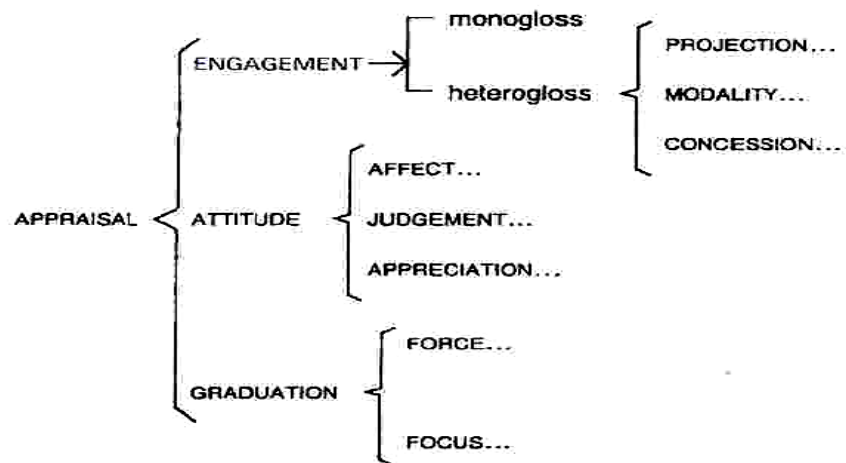


Figure 5: Appraisal systems: an overview

(Martin and Rose, 2007: 54)



Appendix B

Full Data for the control group (Chapter 4)

Table 6: Frequency of Interviewer's Reacting moves: support vs. confront for patients without schizophrenia

Interviewer	Responding moves		Rejoinding moves	
	Support	Confront	Support	Confront
1	42	2	10	0
2	66	1	19	0
3	38	2	13	0
4	44	2	19	0
Total	190	7	61	0

Table 7: Number of positive and negative information opinion expressed by the interviewer with patients without schizophrenia

Interviewer	Open:Give:information:opinion		
	Positive	Negative	Total
1	3	1	4
2	1	1	2
3	2	2	4
4	4	5	9
Total	10	9	19

Table 8: Number of interviewer's Register moves for patients without schizophrenia

Patient#	Total Respond move	Total Register Moves
1	44	20
2	68	46
3	40	25
4	45	32
Total	197	123

Table 9: Number of interviewer positive and negative developing moves with patients without schizophrenia

Respond: Support: Develop						
Interviewer	*Elaborate		Extend		Enhance	
Patient#	Positive	Negative	Positive	Negative	Positive	Negative
1	1	2	5	1	2	0
2	3	1	1	0	0	0
3	2	1	0	0	0	1
4	1	2	2	1	0	0
Total	7	6	8	2	2	1

12 Elaborating developing moves were not included in this table since they included factual and not attitudinal information.

Table 10: Number of interviewer positive and negative replying moves for patients without schizophrenia

Replying moves				
	Agree		Affirm	
Patient#	Positive	Negative	Positive	Negative
1*	3	0	0	0
2*	4	2	0	0
3	3	1	0	0
4	3	0	1	0
Total	13	3	1	0

For patients 1 and 2, 5 reply moves were not included since they had factual information and not attitudinal information.

Table 11: Number of interviewer fact and opinion questions with patients without schizophrenia:

Interviewer	Open: Demand: Information		
Patient #	Total Opening Moves	Fact	Opinion
1	31	9	18
2	50	26	19
3	47	14	28
4	51	8	31
Total	179	57	96

The 'fact' and 'opinion' numbers do not sum to the total values of opening moves since there are a few other opening moves that were not relevant for demanding information and were not included.

Table 12: Number of the interviewer's open/closed opinion questions with patients without schizophrenia

Interviewer	Open: Demand: Information: opinion			
Patient #	Total demand:opinion Moves	Open	Closed in form, open in function	Closed
			alternative question and wh+closed question	
1	18	9	3	6
2	19	9	0	10
3	28	12	2	14
4	31	20	2	9
Total	96	50	7	39

Table 13: Number of interviewer registering moves and their implications for patients without schizophrenia

Column#	1	2	3	4	5	6	7
Patient#	Total Respond move	*Total register Moves	Register moves follow initial question/rejoinder	Register moves within patient Respond type		Register moves after patient's continuing move	Patients' Extension of talk after register moves
				Support	Confront		
1	44	20	14	20	0	12	13
2	68	46	38	34	12	24	30
3	40	25	23	22	43	10	14
4	45	32	33	31	1	11	19
Total	197	123	108	107	17	57	76

The values in columns 3-7 are derived from the values of "Total register moves" in column 2 accordingly.

Table 14: Number of rejoinders expressed by the interviewer and its implications in interaction with patients without schizophrenia

Column#	1	2	3	4	5
Patient#	Total Rejoinder (support) moves	Probing+ Clarifying moves	Patients' Respond type to rejoinder moves		Patients' extension of talk after rejoinders
			Support	Confront	
1	10	8	10	0	4
2	19	10	17	2	6
3	13	10	12	1	4
4	19	11	19	0	6
Total	61	39	58	3	20

The values in columns 2-5 are derived from the values of "Total rejoinders" in column 1 accordingly.

Table 15: Number of clarifying prolonging moves the interviewer expresses compared to non-clarifying moves for patients without schizophrenia

Interviewer	Prolonging Moves	-clarifying	+ clarifying	
Patient #		Extension	Elaboration	Enhancement
1	4	4	0	0
2	4	2	2	0
3	3	1	2	0
4	1	1	0	0
Total	12	8	4	0

Table 16: Number of rejoinder moves the interviewer expresses in order to demand clarification from the patients without schizophrenia

Interviewer	Rejoinder Moves	Rejoinder: Tracking moves	Check	Confirm	Clarify	Probe
Patient #						
1	10	9	0	1	3	5
2	19	18	2	6	4	6
3	13	11	0	1	6	4
4	19	17	2	4	9	2
Total	61	55	4	12	22	17

Full Data for the control group (Chapter 5)

Table 17: Number of positive and negative responds expressed by patients without schizophrenia

Interviewer	Interviewer's Demand:information: opinion/rejoinders:opinion	Patients' responding moves	
Patient #		Negative	Positive
1	19	12	7
2	29	15	14
3	37	25	12
4	39	25	14
Total	124	77	47

21 rejoinder moves were not included in this table since they demanded factual and not attitudinal information

Table 18: Number of positive and negative continuing moves expressed by patients without schizophrenia

Patient #	Elaborations		Extensions		Enhancement		Total Negative/Positive Continuing moves	
	Pos	Neg	Pos	Neg	Pos	Neg	Positive	Negative
1	3	12	10	13	2	0	15	25
2	6	8	13	5	3	1	22	14
3	2	13	3	15	1	0	6	28
4	6	6	6	6	1	0	13	12
Total	17	39	32	39	7	1	56	79

19 continuing moves of controls are not included in this table since they include factual information

Table 19: Number of positive and negative rejoinder: resolve moves expressed by patients without schizophrenia

Patient #	Total rejoinder resolve	Patients' rejoinder: resolve moves	
		Negative	Positive
1	6	4	2
2	8	5	3
s3	8	6	2
4	15	7	8
Total	37	22	15

14 rejoinder: resolve moves are not included since they provide clarification to factual info.

Table 20: Number of responds extended in interaction by speakers without schizophrenia

Patient #	Number of patients' responds	Number extensions of responds	Extensions of responds to initial question:opinion / rejoinder	Extensions of responds to initial question:fact
1	50	15	7	8
2	69	25	15	10
3	56	21	18	3
4	74	21	15	6
Total	249	82	55	27

Table 21: Number of continuing moves (prolong/append) expressed by speakers without schizophrenia

Patient	Elaborations		Extensions		Enhancement		Total continuing moves prolong/append	
	Prolong	Append	Prolong	Append	Prolong	Append	Prolong	Append
1	12	7	19	4	1	1	32	12
2	8	8	6	18	0	4	14	30
3	10	8	13	6	0	1	23	15
4	4	10	5	8	0	1	9	19
Total	34	33	43	36	1	7	78	76

Table 22: Number of rejoinder moves and their extensions expressed by patients without schizophrenia

Patient #	Number of rejoinder Moves	Number of rejoinder: resolve	Number of extensions of rejoinder: resolve
1	10	9	3
2	15	14	1
3	15	11	3
4	19	17	5
Total	59	51	12

Table 23: Number of continuing: extension moves providing contrasting information by speakers without schizophrenia:

Patient #	Total continuing: extension moves	Total continuing: contrasting extension moves
1	23	7
2	24	9
3	19	7
4	13	2
Total	79	25

Table 24: Number of values of Engagement expressed through sustaining speech functions by speakers without schizophrenia:

Patient	Total Responding Moves	Modality and concession in <u>responding</u> moves	Total Continuing Moves	Modality and concession in <u>continuing</u> moves
1	50	7	44	39
2	69	19	44	20
3	56	18	38	26
4	74	9	28	15
Total	249	53	154	100

Table 25: Number of rejoinder: resolving moves expressed by speakers without schizophrenia:

Patient	Total rejoinder moves	Total rejoinder: resolve moves
1	10	9
2	15	14
3	15	11
4	19	17

Total	59	51
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Appendix C

Transcriptions of patients with schizophrenia

I = Interviewer

S= Subject

Patient 1 (A1)

- I. what's the origin of your name?
- S. ----- . I think it's English
- I. is it English? uh.huh
- S. I'm not sure
- I. it's not very common is it?
- S. ah-h. no it's common in Vancouver and . and in ah western parts of Canada and the States but it isn't common in this area
- I. on the western . huh
- S. usually Italian . there's a lot of restaurants . and ah . things like that
- I. Huh
- S. Hotels
- I. yea... so you were telling me you you were feeling well and then . what happened?
- S. well. ah.. I don't know I was sitting there doing my art .and I just started . losing things I just started ah feeling empty . I just started kind of ... I guess I was giving too much of myself away .. uh ... probably because . I guess I was hearing things (xxx xxx)
- I. when you say losing things uh
- S. I I th- I th- I think I have to keep control.. of of myself .. uh concentrate more on what I am doing but ah . . I don't know. Ah
- I. what does it feel like?
- S. yea . what does it feel like when you
- I. yea that you. about what you describe as . you were losing things
- S. ah. I used to. give a lot away of myself
- I. uh.hum
- S. losing. no I wasn't losing . I used to give a lot of away of myself . but . then . I knew what I was giving away and I knew I would get it back .. you know
- I. what were you giving away?
- S. ah..... I really don't know..... I really don't know (laugh) . ah .. I guess I put myself somewhere and .. and .. I guess I want t if I am doing something like when I was doing that art . I really didn't feel that I was . ah . into it . I really felt anxious

- to do something more of a challenging driving and ah . more ah . more ah .
movement I guess physical something physical
- I. uh.hum
- S. and ah .. so I guess I had to give something away so I could get into ah . what I was
doing there . ah .. so I could get into the art ... but I guess I really shouldn't of . I
just should of put my mind in . in that ah . I should have put. I should have got in
that state of mind you know
- I. uh.hum
- S. Um
- I. and you were hearing things? even now I noticed do you . do you hear things in the
background voices noises or
- S. sure I can hear them but
- I. hear what?
- S. I hear voices like. well I can hear people talking
- I. Yea
- S. but I'm not you know I'm not saying that talking about me or anything like that
- I. can you hear a voice of people talking now . right now?
- S. yea . I think so
- I. saying what?
- S. oh I don't know what they are talking about but I hear ah I hear a
- I. conversation?
- S. yea well not a conversation really I hear voices that's all . I mean. can I ask you if
you hear voices like can't you hear people talking down the hall and
- I. right now?
- S. Yea
- I. in this room? no I don't
- S. Oh
- I. ah . you know if we opened the door and went out then I would probably
somebody would be talking but (cleared throat) do you hear voices at times when
nobody's around? right?
- S. uh.hum
- I. have you had this experience frequently or . has it been fairly vivid or

- S. ah-h. no. I think I know what it is . I think ah .. I've been alone too much. and ah I talk t-to ah.. myself I guess . I shouldn't talk to myself
- I. (cleared throat) you mean inside your own head you talk to yourself or . you really talk to yourself. Loud
- S. ah-h yea I talk to myself not loud . I don't know if people can hear me or not I think it's me the whole time (laugh) . I don't know I just think it's me I think I'm . I'm I'm slowly getting out of of of . being alone and and and not seeing people . ah . because I used to be with . people all the time I used to talk in front of audiences and be in front of audiences and people used to be around me and you know . like I was like I was their idol or something like this and all of a sudden I just you know just kind a couldn't take it and . decided to go on my own and and . that didn't work . so I kind of . went into ah . hibernation hermit type thing but it re-really wasn't you know I really didn't go all out and . and ah .. put myself in a room for three months . by myself you know like I went out and saw people but I . I I I . I ah when I did go out and see people ah they s- they it appeared to them that I was a little. spaced out . . so I did it made me upset . I don't know I I I have a funny feeling that ah things are going pretty good I think. tonight I . I . like I said I have to . get into something I should've put my head into it instead of . giving something away
- I. uh.hum
- S. I might of went back ... uh. I might have ... lost what I was trying to think about and I went hack just on recent things like since I've been here. I haven't gone back too far I think
- I. uh.hum you know
- I. so you think you've really changed (cleared throat) radically some time ago that you changed?
- S. changed? . not irratically. slowly . but . ah ... ahm I haven't really uh seen the process it's . been kind of mixed up you know it's

Patient 2 (Ja)

- I. So.... what about the difficulty that ah .. you you know that you had that . . people at home didn't look familiar at all do you still have that or is it changing at all?
- S. .. I think it's changed.. I I don't see it home of course ah
- I. Hmmm hmmm
- S. But I still hear voices and see things
- I. You still have that problem. what what do the voices say?
- S. I really don't know.. I was going to be permanent here today
- I. Hmnm hmmm... and you have these voices at home too?
- S. Yes
- I. Uh do you remember what they were saying then?
- S. The government ah was going to take the house and ah
- I. Hmnm hmmm... go ahead
- S. We weren't going to have anything
- I. Hmmm hmmm
- S. Mostly all scary stuff
- I. Yes .. could you come a little closer so that . the mike will pick you up you speak very softly ... so that's why you were so concerned when you first came in about . real estate and the mortgage
- S. Yes
- I. Because you felt it was a way... a trick to make you give up. your ownership I guess
- S. Well my husband wanted a second morgage and I didn't know whether it was a nightmare or . for real
- I. Yes
- S. I thought he had an accident and died.. just the last couple of visits I recognized him anyway
- I. You did... but . before that he looked totally unfamiliar to you?
- S. Yes
- I. Did he look . in any way .. when you were not well and . . you didn't recognize

- him did he look . ummm ... similar to your husband . but not quite . like him or did he look totally different?
- S. He seemed like a relative of my husband
- I. Hmmm hmmm so there was a similarity?
- S. Yes
- I. But he didn't come across as being . really him?
- S. No
- I. And what . how did you know it wasn't really him?
- S.well he was tall looking
- I. Hmmm hmmm .
- S. And dark hair and glasses on ... as though his head changed not a head of his own and and there was a different head on . there was one with you could see through the head and the eyes would twirl around and around that way
- I. Really
- S. And ah . (xxx) (xxx) (xxx) they just turned . all different blue colors — and just like a (xxx) (xxx) (xxx)
- I. A a different what (xxx)?
- S. Eyes
- I. Would you use the word I didn't uh catch (xxx)
- S. (xxx) it's like ah .. cylinder
- I. Yes
- S. From music
- I. Oh I see .. so you noticed that his eyes were changing color?
- S. Yes
- I. (clears throat) ... and uh you smoke don't you?
- S. Yes
- I. And uh ... you also mentioned something in the past about his hair... not being the same
- S. Yes
- I. It changed color too?
- S. Uh I was told he's ah Zeller's management. well I don't know Zellers at all (laughs)
- I. . Zeller's management. well those were the voices telling you

- S. Yes
- I. But in terms of his physical appearance. you noticed ah. that his hair and head wasn't quite . the same every day?
- S. That's right. yes
- I. How did it change?
- S. Oh it just as though it was by electric ... there was too much electric around ... I know it heard it was done by electric and got hydrophobia well I don't know what that is either
- I. Hmmm hmmm ... and that's what you were hearing?
- S. Yes
- I. What about what you were seeing you see the voices were explaining to you how it was done right?
- S. Yes
- I. And what were you seeing about his hair that was different?
- S. Well he was just so different that his head was a cancer (xxx) (xxx) ... if he (xxx) he can eat here at all . all kinds of nasty stuff
- I. I see
- S. He's a devil.
- I. Hmmm hmmm ... what about theah the actual colour of his hair did you notice it it changing?
- S. Yes it could go to instant grey
- I. Hmmm hmmm
- S. As well as instant ah black
- I. Hmmm hmmm .
- S. Always kind of skimpy... one where it's shaved to. like a close cut shave ... at times
- I. What about his other features his nose his eyes his ears
- S. Oh well. they seem to go all fat and thin
- I. Hmmm hmmm
- S. So on
- I. What about his body?
- S. That too seemed to grow. be very tall and then medium
- I. Hmmm hmmm

S. How legged looking.

I. Hmmm hmmm ... so there were very noticeable changes to you?

S. Yes they were to me anyway

I. Yes.. and then you heard these voices that were telling you things about him ... which were frightening?

S. Yes

I. What about his voice you made a comment to the effect that you found his accent being alien to you?

S. Well yes I do remember he had ah an accent out no foreign tongue .. right now it seems more foreign. still notice that his accent is more foreign than — accents.

I. You you feel his accent was more foreign than you'd remembered it?

S. Yes

I. And different also from what you remember?

S. Yes

I. Did you have actual trouble in understanding what he was saying?

S. Yes

I. Did you have the same problem with other people who did not have. a foreign accent as well like ah?

S. Not in particular. I don't see many people

I. Hmmm hmmm .. that's right. What about the children at home?

S. There is just the one

I. There's only one .. it's a girl isn't it?

S. That's right yes

I. Uh (clears throat) has she come to visit you?

S. Yes

I. Does she look more familiar to you?

S. She does right now than before yes

I. Hmmm hmmm .. what were the problems with her .. that you had in recognizing her?

S. Well... looking through the window trying to scare me and

I. I see was this (xxx)

S. Leaving

I. Hmmm

S. Needles on the buffets and stuff

I. And you thought she was placing them there to frighten you?

S. Yes

I. Did the voices tell you that or you thought so?

S. Yes

I. The voices did... well what about her physical appearance did that look different to you?

S. Yes (that changed as well

I. How how did that change?

S. Just like ., a painted mask all the time

I. As if she didn't look real?

S. Yes

I. Did you feel that her colors had changed to like your husband?

S. Yes

I. The eyes

S. Yes

I. The same thing (xxx) (xxx)

S. Yes

I. Ummm what about other people that were familiar to you I mean people you knew?

S. I don't know

I. You haven't you haven't seen really anyone for awhile eh?

S. No

I. What about your typical self if you looked at yourself in the mirror did you notice changes in you that were unusual?

S. Not in particularly a lot. thinner myself I thought I looked thinner and my hair needed doing

I. Hmmm hmmm

S. I need glasses

I. Hmmm hmmm

S. I can't see very well without them

I. That happens to all of us

S. (laughs)

- I. In due time. but you didn't find that your own face was as unfamiliar as. the face of your husband?
- S. Not like that no
- I. There were no such changes. changes in the color of the eyes
- S. No no look at mine sometimes and they don't change like that
- I. Yes ... what about objects in the environment ah you know like tables chairs your furniture did they change in any way?
- S. No they just got older that's all
- I. So the changes were mostly with ah. your relatives and there physical appearance
- S. Yes
- I. Was changing.... ummm
- S. And trees plants
- I. Oh yes
- S. I see a bird on one of those like a blue parrot
- I. Hmmm hmmm
- S. And then... really I see hands but it's parrots.. I mean I don't know if he's on the inside or the outside the darkest one
- I. And you tended to see changes in plants or things in trees?
- S. Yea I've seen things
- I. What about what you were hearing on radio and television I I had the impression that at times you felt that uh they were talking to you or about you?
- S. But not so much as the residue
- I. Tell me about that residue do you ah
- S. Like it can come into people's faces and
- I. Hmmm hmmm
- S. Like see through skin and people can walk into them and play boo
- I. Was that an impression you had or again were the voices telling you that?
- S. The voices... were telling me that
- I. They were telling you that television had the influence. on people .. did you ever experience it yourself?
- S. No
- I. No... ummm

- S. And then I had the feeling that somebody wants to take my and I don't know why
I... I think my heads damaged
- I. Do you think so?
- S. Yes
- I. Why?
- S. I just don't feel I've got a brain at all
- I. I think you do.. a pretty bright woman
- S. Well it's gone somewhere (laughs)
- I. Well you haven't been well that is true
- S. (clears throat) I see
- I. But that doesn't mean that you... don't have a brain
- S. It just feels rattly I'm sure it will rattle it I shake it
- I. You think so?
- S. Yes
- I. What about these things you told me you saw things like metal floating through
the air or going through
- S. Well I still see the as though these strings of metal tied up much like a lot of
empty windows all hanging around
- I. And you actually see them?
- S. Yes
- I. But.
- S. Often often not... they're some in that corner there or twisted wire
- I. Hmmm hmmm .
- S. About finger size thickness like twisted coat hangers ... they seem to be swaying
through things
- I. Yes
- S. Then it just swings
- I. Do you know whether it's real or not now?
- S. I don't know
- I. But if you tried to touch it
- S. It's like seeing another world
- I. Hmmm hmmm
- S. At the same time

- I. Yes
- S. And if I go south it's dinosaurs
- I. That's what you expect you haven't been south you know
- S. No I haven't been south at all
- I. Hmmm hmmm .. but you're told if you go south
- S. Dinosaurs
- I. It will be dinosaurs
- S. Look out the window and see great big .. I don't know whether they're painted stones or ... or great huge people
- I. Hmmm hmmm
- S. Only half of them and there hands waving wanting to grab hold of .. others
- I. I think they are all terrifying experiences
- S. Still are yes
- I. They still are ... and most of the things you saw had to do with metals informal metal window frames
- S. Yes
- I. Twisted
- S. All broken like a broken city
- I. Hmmm hmmm .. I see.. were you in ah in
- S. Dressed up insects
- I. Dressed up insects
- S. Yes
- I. Can you describe one
- S. Well . almost like a dressed up ant ... skinny legs and with black stockings all wearing black wools mostly black wools
- I. Hmmm hmmm ... what happened to these ah things you see do they disappear suddenly
- S. Yes they did (xxx) through the wall
- I. And they disappear?
- S. Yes
- I. Have you ever felt them on your body or touched them?
- S. Not particularly
- I. (clears throat)

- S. Only my hands used to get hit . and it hurts
- I. Hmmm hmmm. so you
- S. It's in my head
- I. So you thought there may be a relationship between the effect on your head and some of the things you were seeing?
- S. It (xxx) being knocked off
- I. Yes
- S. I'm not (xxx) (xxx) (upset) it hurts sometimes
- I. Yes ... did you have any other funny feelings in your body at any time?
- S. Other than being nervous about it all
- I. Hmmm hmmm what about smells ... did you ever have you know (xxx)
- S. I never sewer odours
- I. Hmmm hmmm.. sewer what?
- S. Sewer odours
- I. You did smell .. sewer kind of odours?
- S. Sewer odours yes
- I. With no reasons all of a sudden you would ... do you still have that?
- S. Off and on but not as much
- I. Hmmm hmmm ... what about .. funny tastes in your mouth have you ever experienced that?
- S. Only with a bit of garlic
- I. Hmmm hmmm
- S. And I haven't had garlic
- I. Hmmm hmmm.
- S. But that was only once or twice
- I. Hmmm hmmm and the sewer odours were more common than that
- S. Yes
- I. They came more often
- S. At the time yes
- I. Hmmm hmmm ... now independently of the changes you saw in your husband's eyes have you noticed if ah .. the ah ... colors of things at times change . for you?
- S. Not particularly I wasn't looking
- I. You didn't notice anything like that?

S. Bright lights sometimes seem to go by ... especially with my eyes closed

I. Hmmm hmmm

S. See ... shiny objects like from nails heads . to a . ball size

I. Hmmm hmmm

S. Somebody cried to put a ball in my head

I. Hmmm hmmm

S. A brass one I don't know why a brass one

I. You were told that by your voices again hmmm . I see . are they less now the voices .. less frequent?

S. Not in particular I the pills helped ... to reduced that

I. And you don't seem to be upset by them as much

S. Well I feel safer right now being among more people

I. Right

S. Higher up

I. That's good .. what did you do with the mortgage eventually did you sign or?

S. No my husband uh the first mortgage is soon to come up . and I can sign for a first mortgage

I. Hmmm hmmm

S. He borrowed money from a friend of his

I. Hmmm hmmm

S. Ah it can wait til the first mortgage . arrives

I. Right I met that friend. yes

S. Yes they say it will be all right?

I. Yes I think everything will be fine

S. I'm glad I waited

I. Right

S. That way he isn't tied down to two mortgages he's just got the one mortgage

I. Right.

S. we can wait for it

I. Hmmm hmmm

S. It's in a week or two

I. Yes your husband and his friend will take care of things it looks all right. I also tried to make sure that ah his friend was on the level if you know what I mean

- and he is. he is not trying to make a profit out of it ... ummm what about after coming here and meeting people and then seeing them every day . did you notice if they changed toff
- S. Oh yes it's not as (xxx). I mean one right now has a rash and it's very noticeable (laughs)
- I. What about the kind of changes you had noticed in your husband did you notice them in some of the people who work here once they became familiar to you?
- S. Oh I don't know... I wasn't really looking
- I. Hmmm hmmm
- S. I can't see without my glasses to tell you the truth
- I. So that's another problem to?
- S. Yes
- I. What happened to your glasses did you (xxx)?
- S. They broke right in the centre and uh they were twenty years old anyway
- I. When ah when did you break them?
- S. About fifteen twenty years old... oh... about (eight years ago)
- I. And you haven't replaced them?
- S. No
- I. Hmmm. well we could replace them you could go to an optician here or ophthalmologist
- S. I see
- I. I'll leave word to make an appointment for you
- S. Thank you.. I'd appreciate that I don't know which way to turn about that
- I. Right. but you recognize me when I walk in the hall do you?
- S. Yes
- I. Have I changed?
- S. (xxxx)
- I. Huh
- S. No
- I. I haven't?
- S. No
- I. I was just curious to know . you have the same .. ah impression of other people besides your husband

- S. Hmmm hmmm
- I. Now tell me about this
- S. I think my husband had been drinking too much perhaps
- I. Hmmm hmmm
- S. This is maybe why he looks different sometimes
- I. Oh . oh .. ummm what about that as you called today a nightmare or some other thing where you had the impression that everybody was dead in a car crash
- S. Yes that's true
- I. How when how did that happen?
- S. Seems part of that broken city looks
- I. Hmmm hmmm and how did you learn about it . about this car crash?
- S. Well I'm not so sure again (laughs) I don't know whether it was voices or somebody else told me I remember ah ... trying to get in touch with my lawyers
- I. Hmmm hmmm
- S. And heard they were dead and .. I really don't know
- I. Did you ah . think that some of these messages were given to you through the newspapers?
- S. I hadn't been reading much newspapers
- I. I see
- S. If I so many that I did know had died I'd started reading the death notices ... notice so many that I did know ah I no longer will
- I. Yes
- S. They seem more informative than their front pages at the time
- I. Right (snickers) ... ok well you are definitely doing better I think we are going to get rid of these voices and uh the things you see uh I think you will be all right and uh I will get the results of the tests actually we want to show you . this week maybe some faces to see or the ability to recognize them and see if that is improving too so there will be a few more things that we will ask you to do
- S. I think I had that test this morning
- I. Oh did you this morning?
- S. Yes
- I. Ok I didn't know it had been done already ... and I'll discuss it with you. umm.

- but I can tell you now that to prevent it from happening chances are that you'll have to take a pill or two a day even when you're well
- S. Yes I know
- I. Ummm but we'll make plans for you when the time is right uh I'm quite sure we are going to be able to clear this whole nightmare of yours ... do you want to ask me anything?
- S. I just wondered if you had the results yet from the uh
- I. Yea .. I will have them this week and I'll talk to you
- S. Brainless I still feel brainless
- I. You still feel brainless ... well we may do some tests to see if there is anything. ummm if nothing else
- S. I just wondered if there were many people brainless
- I. Nobody is brainless
- S. Yes
- I. No. . but we will do .. we will talk about it after we get the results and we will see if we want to make some more do some more tests
- S. I had two.
- I. I'm thinking of an X-Ray test
- S. Oh I see... I think I had that done when I first came in
- I. Yea but this is another one
- S. Oh I see
- I. And uh but I will discuss it with you beforehand and we will talk about the results and the second part of the test
- S. Yea ok
- I. Anything else?
- S. No
- I. Well you're doing well and uh you'll get even better

Patient 3 (Ch)

- I. good morning
- S. good morning
- I. how are you to-day?
- S. well I slept in this morning and uh . my legs feel a little weak . I don't know why but
- I. well I see (cleared throat) you're having some yogurt
- S. this yogurt
- I. I have no-o
- S. homo milk . homo milk
- I. oh I see .. would you like to have it?
- S. uh.hum
- I. go ahead
- S. not right now I can wait
- I. not right now you can wait .. well I just wanted to ask you how you felt . do you remember talking with me a few days ago?
- S. well. i must admit I feel . uh somewhat better
- I. uh.hum . in what way do you
- S. oh-h-h
- I. better?
- S. in my strength
- I. uh.hum
- S. I was um . wasn't very strong .. and ah . I think I'm I'm on the road to recovery anyway
- I. uh.hum .. okay . I asked you last time if I could put this conversation we were going to have on a tape just to look at the way . conversation goes
- S. uh.hum
- I. as a way of .. measuring change
- S. uh.hum
- I. is that okay?
- S. Yes
- I. Okay

- S. try it (laughter)
- I. tell me you said that you get better . let me . hold this thing closer . um . that you feel better as far as your strength is concerned . uh . how do you notice that . how do you notice that?
- S. well I feel mu-much better I . I I don't feel as if my body is leaving me
- I. and you have that feeling before?
- S. yes . I was uh . I felt as if I was wasting away
- I. I see . that's what you mean by . your body leaving you
- S. Yea
- I. just . your body was washing away
- S. that's right . do you mind if I put this on the
- I. no sure I'll do it for you . here
- S. thank you . it's full of milk (laughter)
- I. right . I'll be careful ... uhm ... and your appetite has been pretty good?
- S. yes . uh.hum . I eat my breakfast and mo-most of the meals
- I. uh.hum
- S. we-well I usually clean the tray up all the time
- I. and how is your sleep now?
- S. I slept well last night .. and uh I usually sleep good
- I. any dreams?
- S. no I can't say there's any dreams . uh . it's a case I I go to sleep and then I wake up in the morning
- I. uh.hum
- S. but I was up through the, night last night . but uh . I had to go to the washroom
- I. uh.hum
- S. chat's about all ... I'm not bothered in my sleep with not sleeping
- I. uh.hum .. what about this ... uh ... problem that you've been describing to us of um . your children complaining to you from . somewhere. have you heard their voices anymore?
- S. they are . I still heard them this morning they're upstairs and . I'm able to go and see my sons now . the one of them just had a very bad operation .. and uh . because he's recuperating . he didn't tell me about the other boy . the older . youngest son . that mommy can come up and see us now because we're

recuperating

I. Hum

S. and ah .. but I have ah . she's my sister but her name is across the street and . she's up there sitting with my boys and I don't like her to be there because . she doesn't uh treat them properly . she's really after the penis and that and . destroying of their first instead uh . uh their body like those (xxx xxx xxx) and uh that one she lives at ----- but I'm at ----- just across the road

I. uh.hum

S. they're very filthy people

I. why would she do that?

S. I don't know I guess that's just in her to . to destroy people steal-steals from them

I. uh.hum

S. she's taken all mo-mostly all my insides out

I. of your insides out?

S. yes she has . alot of things that I have to have to getting along you know I have to get working around with . and um . she um . she puts them inside of her her body . and exchanges them . but like for her own stuff she puts in my body

I. Hum

S. and that I uh . I disapprove of . she's really ah . she's really aggravating me as if . with . with that she can ma-make believe that she is what she really isn't

I. hum . I see . and how do you know that she is doing these things?

S. Well I know when I when I ah . when I'm walking around and all that that's different . you know . it isn't ah . ----- all the time seems to be inside of me

I. but how do you know . I mean you are walking around and uh what happens that makes you

S. well I I know what ----- is like you see and uh . I'm uh . and without having I feel that I have missed something something has been lost taken away from me . and replaced by

I. is it a feeling in your body that you ha-get?

S. no . right . no-now it's in the stomach

I. uh.hum

- S. and uh . she's uh . she's one of these I don't know what type . she she likes to play with her bum . tickle her own bum and that . and that's how she steals I was I was uh dreaming about that this morning . early this morning . I wasn't awake yet but
- I. uh.hum
- S. it's a ... she's real-really a nuisance
- I. have you seen her lately?
- S. y-yes I had . we-well no I haven't seen her for a long time . but I saw somebody that's supposed to be ----- and Sara is not . not the right ----- at all . ----- --- is uh all together different . the other girl is very nice and uh she's the polite and she's um . more classical than what ----- would ever be able to . because ----- body is that of a of a . of a devil she's a devil . and um . ----- just said that is the devil's name that's why there aren't so many Nose... in the city . but um ... um . the man that uh was taking care of her . he um . he's a I think it is or . and uh . he's had an awful time . (xxx xxx) ----- and . there she set fire to the the hotel that she wanted . not quite a hotel it's a restaurant . it was out of the way and it was ah . she thought tney'd make good like with the travellers going by and stopping for a meal
- I. uh.hum
- S. but that's the way she wanted it and she got it that way and . therefore . it turned out to be more of a beveridge room so ah . no she's uh she's really it it gets me all worked up I just hate her at all oh I just hate her . I don't like her at all
- I. uh.hum
- S. she's supposed to be a sister but she is no sister
- I. your sister?
- S. she s supposed to be but she isn't even the ma- the woman her mother .
- I. uh.hum
- S. she's the real ----- . . she did kidnap me from the Buckingham Palace when I was quite young . but wh-how I can remember is a mystery to me because I do remember it to recall its on my mind all the time
- I. uh.hum
- S. I'd been kidnapped but she was . she used to give me the strapping when ah instead of ah ----- when was doing anything wrong . the whip always came at

up to on to me . she always whipped me

I. she what?

S. she always whipped me . she used the strap you know the a belt and licked gave me a whipping with it . and I hadn't done anything even when I come in from the uh uh door like . from ah school she'd uh be there . sitting right in the hall . with a box of chocolates . not always but occasion once uh she did that .and uh she had ----- and ----- . on the floor they're eating chocolates and she'd start yelling at me . well she said what are you looking at . I said well yo- ----- and them are sitting there I said what an what's going on . and ah . she said well if you had come in earlier she said you'd of had a chocolate but we have no more chocolates left for you

I. Hum

S. so it was always a thing out of something like that . with something nice and something good well . you should come in earlier . but she used to try and send a note to the teacher . and uh . I forget the name of this teacher but uh . she uh . say um . out at the she wanted her to keep me in after school because people were coming in to see me and they only wanted to come to kidnap me

I. uh.hum

S. to take me away with them .. well that was all right but should never of kept my people away from seeing me

I. Right

S. and a lot of them were . real-really just helpless because they do want me back

I. uh.hum

S. but uh . my husband and I ----- is ah . my name is really ----- but

I. uh.hum

S. I haven't rechanged it . so ah . see ah . we'll be going up to the Buckingham Palace one of these days . very soon because he was he was going down the stairs also and then I was pushed down the stairs

I. Yes

- S. and the Buckingham Palace was uh you know they have . a long ways to go up to the next room . and there's uh quite a long ah stretch and um . there is we had ah . three four about five about five si- five or six children . so ah . but they were toddlers they weren't toddlers they were a little past beyond that toddling mark . and that . they um . they were pushed down the stairs and uh . they rolled down the stairs is at quite a hut . a long uh staircase . and the little children they just uh went right through the floor they disappeared . my husband fell down he disappeared too . but they landed in Utica New York . that's where they uh landed . and so we're still uh at we're till trying to pick up with all our children that we've had since those days
- I. Right
- S. so um . they're so unhappy (xxx xxx) there's nothing nice in the world for them or us how they even urgent ni- nothing nice really . but ----- was kidnapped he was overpowered by that ----- she's overpowered she was . very mean and nasty with him
- I. uh.hum
- S. so he's had spent a a turn with her . but uh . in the winter time she used to want him to come over and ah ----- so he had to get up and go out in his bare feet and then pajamas he didn't have time to change or anything . and ah . but he's breaking away from her now and he's coming back to me
- I. uh.hum
- S. and he is the father of my boys
- I. these are the ones who are upstairs?
- S. yea t- yea two upstairs
- I. uh.hum . but you have more?
- S. there are more of them yea there are quite a few of them
- I. do you ever hear their voices?
- S. Pardon
- I. do you ever hear the voices of the other ones?
- S. no the other ones you see we'd have to find them first we could tell by their uh . the way they're . they're built . and um . they're built the same as the others but however . it means that you know we have to ha- make sure that they're ours
- I. uh.hum . how can you tell? how will

- S. Well
- I. you be able to tell?
- S. well for instance last night I was dreaming .. that wife was uh sick and he was taking care of the children . and the children saw me and they started yelling . they're whooping it up because they're ha- they saw their they saw their real mother . and I wouldn't doubt that they weren't our real ones because Mr. ----- - was down with his wife . down to the Buckingham Palace and that was ages ago
- I. uh.hum
- S. and ah . the little children were with us . we were picking them up again .. and uh . they ah there was a little fellow there was a fellow ----- is the girl by right
- I. (cleared throat)
- S. and um . she starts jumping and laughing and she's come running right over to me . and Justin . well he's a little bit older . he came to me but then he went back again he saw his
- I. uh.hum
- S. there . and uh Mr. ----- . I was holding ----- in my arms she was only a baby then . and um . Mr. ----- came by . and ah he was on his way to to the Parliament Building
- I. hm-m
- S. and he took the two little children with him . because we were travelling . and we were on foot . so he took them up there and that's how it is they're ours but I don't like to . say anything to anybody about it because they'll wonder why how is it that ----- gave birth to them . well the way it was . he just uh had them put inside of -----and they're really not hers they're not of hi-her sperm or his sperm or anything like that . the little children do know . they're very very intelligent little children . we had to practically drag them away he was taking them up to see his wife . ----- by the way had her head cut off ----- wife had her head rut off , and Joan of Arc is the one that did it because
- I. who told you that?
- S. well the I was watching television and uh . that's what ah came on the on the .. there must have been the viewer . and that they ah . that's how I happened to see . and I knew that it was ----- . and uh that ----- really . but uh I'm not Mrs.

----- because they can't they degraded the name

- I. uh.hum
- S. so however the um however the little children would start balking they didn't want to leave . they knew these children know their minds . and ah that's why they . the child wants the mother the real mother they wait until they do get their real mother mother
- I. I see . at any rate are you feeling a little better today right?
- S. ah yea I did feel better especially mostly in the head and this part of the body
- I. uh.hum
- S. the rest of the body's still even my stomach seems you know . not quite right
- I. But
- S. the murmur in it
- I. a murmur
- S. uh.hum
- I. uh.hum . but it feels better it feels more like yours you mean . nobody's taken it away from you?
- S. wha-what the (xxx)
- I. the stomach
- S. oh the stomach . no nobody seems to take that away
- I. uh.hum . what parts of your body did this woman take away from you you uh you you were telling me earlier?
- S. well you mean?
- I. uh.hum
- S. well the lower part of the body .. I don't know how to explain the sperms and everything like that
- I. I see
- S. that's how she brought herself up but she's going to come down again ah
- I. Yes
- S. she's "62" but she's going right down . she has to because is gonna keep at her until he he gets every bit of m-me out of her again and
- I. uh.hum
- S. she can have her own self

- I. I see .. okay . well thank you for coming and talking with me
- S. you're welcome

Patient 4 (Man)

- S. yes
- I. yea what do they tell you . why don't they want you back?
- S. I'm frightening to live with
- I. they what?
- S. frightened to live with me
- I. what are they frightened of?
- S. my behaviour
- I. what kind of things have you done that they would be frightened of?
- S. oh . before I went back to school . like I had grade “8” education . and I was sort of a hippy .. then I went back to school
- I. uh.hum
- S. and got my grade “12” .. and half my “13” .. and ... I thought I was doing really well . but ... my parents didn't think I was .. I don't know what to say
- I. umm?
- S. I don't know what to say
- I. so you dropped out of school for awhile
- S. yes
- I. when you were what?
- S. “16”
- I. “16” how long were you out of school?
- S. a year
- I. about a year ... what did you do?
- S. hitch-hiked across Canada
- I. tell me about it
- S. I hitch-hiked across to Vancouver
- I. uh.hum
- S. I stayed with some friends from Vancouver . and I found work in a factory ... then I took a train home . and when I got home then I went back to school ... and stayed in school for two years
- I. uh.hum

S. I got my grade "12" ... (xxx xxx) (had Grade "8")

I. so you did . what .. "4" years in "2"

S. I had grade "9" twice . but it was I failed twice

I. uh.hum

S. and then I went to school and they changed it to a credit system

I. uh.hum

S. so they gave me my grade "9" . so I started from grade "10"

I. I see

S. so I got the two years in two years

I. how did you like it out on the west coast?

S. I didn't have much chance to visit anything . I was just working

I. you didn't have much money?

S. no

I. you were in Vancouver proper?

S. uh . boundary . right on the boundary of Vancouver and (xxx)

I. uh.humyou told us that you were doing drugs at the time. right?

S. yes

I. what kind of drugs?

S. marijuana . hashish . LSD

I. how many trips have you had . would you say?

S. uh ... I couldn't count them

I. what kind of experience have you had when you were on LSD?

S. hallucination

I. tell me about it . what kind . you know people have different kinds of experiences

S. uh .. usually there would be music playing

I. uh.hum

S. and . there would just be hallucinations all over . and ... you would just sort of enjoy the music and .. sorta be awed by the hallucinations

I. uh.hum ... were they actual scenes that you were seeing

S. no . they . you couldn't explain them . they were there . but you couldn't . you couldn't explain them . um by the time they were gone they were forgotten . and the mood would always change

- I. uh.hum ... was your mood mostly pleasant. or . you had periods when you felt real frightened . or low . on a trip?
- S. uhm . just once I was frightened ... went home and hid in bed if I knew where I was it would be okay
- I. otherwise it was mostly pleasant . it was okay
- S. yes
- I. have you had any flashbacks .. you know
- S. nothing I know
- I. never had any of that .. have you ever done speed . amphetamines?
- S. yes.1
- I. how long ago?
- S. when I was . before I was seventeen
- I. what would that do to you . when you took speed?
- S. I don't know .. people would say that it would speed you up
- I. uh.hum
- S. to me it just made me shake alot . made me nervous . made me frightened
- I. uh.hum . . . did it make you suspicious of other people and that kind of thing
- S. uhm .. yes ... mostly frightened
- I. so you stopped taking it?
- S. yes (xxx xxx xxx) (I didn't like it)
- I. were you doing it by mouth or were you . uh
- S. injection
- I. you were mainline
- S. yes (xxx xxx)
- I. is that the word . still? but you haven't been doing drugs lately . have you?
- S. not since I was seventeen
- I. do you smoke grass once in a while?
- S. no
- I. not even that? what made you stop?
- S. oh . when I went out to Vancouver . I hade grade "8" education and I looked at myself ... and I didn't like what I seen .. I didn't have any future .. so I stopped doing drugs
- I. uh.hum

S. and I went back home and I tried to go to school . to do my best

I. right ... were you going to school before caning to the hospital?

S. no

I. no . you had quit in the middle of the

S. “76”

I. oh I see you quit two years ago

S. yes

I. what have you been doing since then?

S. I joined the malitia . well first after I quit . I was in the Henderson for depression . or for whatever it Was .. and then . I joined the malitia .. April till about September

I. uh.hum

S. “77” and in “78” I bought a bible .. and was reading the bible . this year . and this year I haven't been doing anything

I. do you remember . uh . the kind of thing that happened that made you go to the hospital at the

S. yes

I. what was it?

S. I ... took a bus ride to Michigan .. and wanted to visit Michigan State University

I. uh.hum

S. I was involved in politics and things .. I was watching your public in politics

I. uh.hun

S. and there was a political change . between Carter and Ford

I. yea

S. and Ford went to Michigan University

I. uh.hum

S. I just wanted to go there and see what the University was like

I. I see

S. and ... uhm . on the way there .. I started .. I don't know how to explain it . maybe I was hallucinating

I. well what was the experience like?

S. all these things kept coming at me .. on the bus . it was late at night anduh Ioh yea .. I was looking for something .. I couldn't find anything and then

- . I got stopped at the border
- I. uh.hum
- S. and I had to stay in Windsor for a day
- I. uh.hum
- S. I had a fit there
- I. what kind of a fit?
- S. I was jumping then I went back to Hamilton and then .. the fit caught up with me in Hamilton
- I. uh.hum
- S. then I went to the ----- . I thought I was dying . so they brought me to the General
- I. what did they do there?
- S. just filled me with . uh . medication
- I. did you feel better?
- S. yes
- I. do you think you are doing better now . uh . or then . you know what I mean . you're getting better now too . do you feel better now or you
- S. I feel better now but I don't feel capable of doing work
- I. yea
- S. but then I felt capable of doing work
- I. well I think you will feel capable of doing work pretty soon . you know . we have to take a little time ... ah ... what do you think the main problem is' now . is your concentration still bad?
- S. it's my ambition . or something
- I. you don't have any ambition?
- S. I don't know what it is it's like a barrier
- I. uh.hum
- S. I'm sort of (xxx xxx xxx xxx) (between me and further) education
- I. uh.hum .. is that your main ambition to have .. more education?
- S. more education and a good job
- I. what's your ideal . you know . if you had exactly what you wanted? .. what kind of job would you like?
- S. If I had exactly what I wanted? . University education .. a job . um maybe in

chemistry

I. uh.hum

S. a chemist or something

I. you like sciences?

S. just chemistry

I. just chemistry ... did you have a good teacher that turned you on to it?

S. uh.hum

I. where were you doing your high school ... you know .. grade "12" . where were you going to school?

S. St. -----

I. is it is a good school?

S. yes

I. did you have good grades in chemistry?

S. yes

I. now you were telling me you weren't feeling well yesterday. what . what was the problem?

S. I was stiff

I. stiffness bothering you .. today you are feeling a little better?

S. I'm a bit stiff now . I still feel better

I. . you feel better eh ... well we'll try to avoid that if we can .. and . uh I'll speak with . uh . the doctor and the rest of the team today . we'll see if we can come up with something that wouldn't make you feel stiff ... is that the main problem would you say now . the stiffness?

S. yes .. right now . my main problem?

I. uh.hum

S. stiffness and courage .. and interest

I. uh.hum

S. I need an interest and I need some courage

I. okay . we'll try to help . we'll try to help it's been a very difficult period and. uh . you feeling bad about your relationship with your family . you feel alone . so it is a hard time .you're young and ... you'll get it back together ... I feel optimistic . maybe you don't . but I think you will be all right what are you planning to do today?

- S. I don't know
- I. you have privileges . don't you? . you can go out for a walk and things like that
- S. I don't want to walk outside
- I. you don't . why not?
- S. I don't have any money . I haven't anywhere to go . I haven't any friends... I haven't any interests out there .. just alot of people doing their . their job . every day. and I haven't got a job to do
- I. I think I understand the way you feel... well. pretty soon . we'll get you a job . I'm sure . we'll get you some sense of direction and. work to do... are you going back to see people at the Agency
- S. yes
- I. they're good . did you like them?
- S. um . I wasn't really enthused
- I. uh.hum .. they will Help you .. they also have to take their time you know they have to get to know you and. try to, do things that are helpful... we will help . we will try to do our best and make sure that you get a job and . a little money. and your own place . so we'll stick it out with you. okay
- S. yes
- I. all right

Appendix D

Transcriptions of patients without schizophrenia

I = Interviewer

S= Subject

Patient 1 (Ha)

- I. So how are you feeling?
- S. Good .
- I. Pretty good
- S. I went for a long walk today
- I. What does it feel like to be .. outside?
- S. Interesting . you know very interesting
- I. It's a nice change from ah .. being cooped up in here?
- S. Yes (clears throat)
- I. Do you find that uh . the stimulation of being with people and outside makes you feel more alive or is it ah . a little confusing at times?
- S. At times it's a little confusing when people are .. talking and you know they're talking about you
- I. So you think that's still going on or at least you have that strong feeling?
- S. Yes I have that strong feeling
- I. Why would people be . so interested in you?
- S. I don' t know
- I. What do you think they may be saying?
- S. About my appearance mainly
- I. What . do they make derogatory remarks or?
- S. Yes
- I. What would that be?
- S. Ah .. you know some people try to hide their .. acne
- I. Oh I see (xxxx)
- S. You know .. and you know . things like that you know wearing brown shoes with black pants
- I. You have black now (laughs)
- S. Yes .. I changed them (laughs)
- I. So you hear these remarks .. or you think that people are making remarks or do you hear them?
- S. I hear them

- I. From the people around or?
- S. Yea
- I. Is ah people are talking and you can catch
- S. Hmmm hmmm
- I. So it must be distressing more than interesting?
- S. It's a little distressing but it ahm it will work out start taking care of myself and ... cut my hair and stuff like that
- I. I see .. actually your physical appearance is quite good you look much better than you did you know you were kind of . tense and ... tired when you first came
- S. Well I'm afraid to say something to somebody that might hurt their feelings .. that's what I'm . you know like I may open my .. I have a defense mechanism .. that doesn't seem to drop when I want to be at ease .. it's just there at all times
- I. I see
- S. Someone may say to me you know when I was in the sanatorium I took a .. took a course .. right off the bat sanatorium means crazy .. and I take it the wrong way and . a few other things
- I. So we are talking about you and your present condition and that kind of thing
- S. Right
- I. Is there any way you are .. all the time would you say I mean that's worse now and . other things are going on but would you say that by and large . you always were a rather self conscious person?
- S. Yes I am
- I. Do you know where it comes from .. ummm do you think that as a child you had experiences that made you ah . become self conscious and kind of ashamed of some things about yourself?
- S. Hmmm .. it could be
- I. What kind of ummm life have you had with your parents ah . what kind of (xxxxx)?
- S. It was excellent up until .. my dad died .. and then ah ... the . guidance that I was . taught and everything else . just seemed to disappear from my life
- I. I see
- S. Well I've had to struggle along the best way I can you know trying to figure things out ... I go to other people for guidance . I've been living other peoples lives well I can't

do that . I have to live my own life . I have to be responsible for myself and my family
.. and for my name

I. Yea how long ago did your father die?

S. Seven years

I. Seven years ago

S. Seven . or eight years I'm not sure

I. So you were . seventeen

S. Seventeen Eighteen somewhere in that area

I. And uh .. what did he die of?

S. Cancer

I. Cancer

S. That's why I'm very afraid that there may be cancer in the family I've had or my
father's had it my mother's had it I'm the oldest . it's a possibility I might have it I
don't know if it's a hereditary disease or not

I. Well ... (clears throat) ... not all forms of cancer run in families some tend to do so .
what kind of cancer did your father have?

S. Stomach

I. Of the stomach and your mother had cancer?

S. Of the breast

I. Of the breast ... she had surgery?

S. Yes

I. And she's still alive?

S. Yes

I. So how long

S. But I didn't put

I. Yea

S. When my father died I didn't put much faith in doctors . after that . I figured well
that's .. ok terrific you couldn't save my Dad nice guys . nice bunch of guys .. if .
someone had a come to me and to and you know if I had a maybe sat down and talked
to Osbaldeston

I. Hmmm hmmm

- S. He might have been able to explain it to me but at that time I was a little bit . upset . and still . I'm still not upset anymore .. but ah . I have to accept the fact that he's dead he died . he . had no choi- well he had a choice they tried to save him .. they tried everything possible . I thought he was a big experiment ... that's what I thought they said we'll take this out and try this ... well that's ah no way to play with a human body .. you know we'll take this out and put that in and put this out and pull that out no .. no .. if he's going to die let him die peacefully
- I. Right ... many people feel that way .. that a
- S. He suffered a long agonizing death
- I. How long was he alive after?
- S. Two years
- I. For two years after they
- S. Yes
- I. Discovered that
- S. Yes
- I. So it must have been awfully difficult for everybody
- S. .. It was yes .. on me . I just tried to block it right out of my mind completely .. I tried to carry on . you know .. when I went back to school after my father's funeral the guys . I told the people I was around I says don't treat me any different . I says try to be . yourselves I says just try to forget it . but myself I knew back myself con er my consciousness that he was always there .. you know and ever since then I've been looking for somebody to . give me that guidance that I needed . over the last couple of years .. and ah .. I just haven't found it
- I. Whom did you look at for that . guidance?
- S. I looked at my bosses I looked at .. people that I could talk to you know people that seemed friendly .. you know ... for a little bit of guidance well .. at the time it didn't work out too well . you know . I'd take their advice and . sometimes it would backfire . you know so . I started to think well Christ why take their advice start using your own advice
- I. Might as well make your own mistakes
- S. That's right
- I. Do you have other brothers ah?
- S. No I don't I'm the only . sisters

- I. (xxxx) you're the only child (xxxx)?
- S. I have three sisters
- I. Hmmm hmmm .I
- S. Sara, Liz and Lisa
- I. And they
- S. Sara Lisa An and Liz
- I. (xxxxx)They're younger than you are?
- S. Yes they are . one is in University the other one is in high school in ----- . the other one is in public school
- I. Hmmm how long after your father's death did your mother have a carcinoma of the breast
- S. (Clears throat) . it was a year later ... it shook me all to .completely . to pieces I didn't know whether or not she was going to live or die . too . I just fell completely apart then .. tried to keep myself together I'm you know . just talking about it I start shaking
- I. Yes ... you were very frightened?
- S. Yes it is
- I. How does she feel
- S. .. She took it very calmly and very mildly now what .. what is this all about anyway (laughs)?
- I. Nothing its just ah ... I told you we ah .. you know I I .. asked you all those questions and .. and had a few tests and I gave you an opinion and I also like to look at language and the way it changes when people .. get better and ah . we talk differently when we're distressed or upset and uh .. and when we're
- S. I've had a lot of problems with ummm .. girlfriends to . . I can't seem to handle a girl . I don't know how ... I looked at I . can't go to my friends and say what am I doing wrong because they can't tell me because they don't know her .. and myself I don't know what I'm doing wrong .. you know it's .. completely confused me
- I. Hmmm hmmm
- S. I figure you know .. I'm ah half decent looking guy I've got .. some respectable looking clothing . I haven't got the greatest . things in life but I'm . I'm alive anyway
- I. That's right
- S. You know .

- I. What kind of problems do you experience?
- S. ... Ahh when I walk up to them I'm very very shy .. extremely shy .. I can't ah get into a conversation with a woman about sex or anything else .. I can't ... it's . not in me .. you know . and it makes me very very bashful .. she mentions something like that I just completely cave right in and just oh yea right ok talk to you later . and leave
- I. Hmmm ummm who was shy in your family your father or .. was your father a shy kind of a man or is your mother shy?
- S. My mother's fairly shy
- I. Hmmm hmmm
- S. And my father he was right in the middle I guess you'd really say he'd you know meet people and take them for what they were ... he had a saying what was it if they don't like it they don't have to use it ... (xxxxxxx) you know .. that's when we were redoing the bathroom he said if they don't like it they don't have to use it well if you keep going through life all that way you're going to not have too many friends
- I. Right .. well I don't know
- S. What I've done is I've change my attitude to other peoples' attitudes I tell them what they want to hear .. but now my attitude is changing again I don't know what I'm doing .. I'm just right in the middle of the stream and I just don't know whether to go right or to go left or . walk up the stream or .. drowned
- I. Hmmm hmmm .. have you ever thought of going to see a . psychotherapist and ah . discuss
- S. What is that?
- I. Well somebody who does counseling .. professionally either a psychiatrist or .. a psychologist or .. and ah .. who has helped people to deal with these problems before . and ah who could help you
- S. I'd appreciate a doctor but at the moment I can't . can't even . afford a a doctor's fees . I can't
- I. Well this goes without saying
- S. That's another one of my problems right now
- I. Money
- S. Right
- I. But this kind of
- S. The root of all evil

- I. But this kind of service this kind of service incidentally would be ah paid for by OHIP if you went to an MD you see .. but anyway we can talk about that some other time
- S. Well if you want to discuss it now it's fine talking about .. this
- I. It's only a suggestion . and ah . it's something you should pursue if you so decide ... weeks from now when you . you know when you're home when you're out of the hospital and if you want to start looking at some other things that bother you . in life . we could .. suggest a few names
- S. I would appreciate it doctor I really would
- I. Ok ... because I really think that someone could be of great help to you at this time in your life . and
- S. I need a lot of guidance I know that .. you know . but I just .. every time I talk to somebody he tells me what he did when he was .. this age and . I'm just so thoroughly confused and upset and you know I just .. I admit it I had a complete nervous breakdown
- I. Yes
- S. I just didn't know to turn left or turn right or go up straight or go backwards .. I'm cutting out the alcohol it was a crutch that I was leaning on very heavily .. cut that out and I fell completely apart and I . I admit it .. I fell completely apart .. I'm not much of a . person to be able to pull myself together look at life logically and . say ok this is what I got to do I gotta stop cryin and start doin something about it -
- I. Well I wouldn't say that you're not much of a person . it's just that you had ah . personal problems . and it makes you very much of a person because most people do (laugh) . at sometimes or another in their lives
- S. Hmmm hmmm
- I. And . you , should be proud of uh .. having been able to . quit drinking and uh . you know
- S. I'm proud of that I'm proud of the fact I got out of dope to
- I. Right
- S. I was mixed up with dope .. and I uh . I just said this . this is wrong this . is completely wrong so I said that's it .. cut it out all together said no more
- I. ' So if you were able to do that you'll be able to do more for yourself
- S. Hmmm hmmm

- I. With some .. counseling
- S. Well I would appreciate the counseling
- I. Sure .. just checking (xxxx) ok look I will ah . as I told you when you're ready to go home we'll talk about it and we'll give you the names of a few people . whom we know a -few professionals . the easiest thing to do is if you don't have any money is to go to a ah . psychiatrist and charge OHIP for the service . so they could check on the drugs you're taking and also ah .. help you to establish
- S. Am I a hyperactive person doctor . where I can't slow down?
- I. Mmmm no I I don't think so
- S. Like today I did a lot ah .. running around and paying bills and everything else . it made me feel good .. but uh there are some other things I have to get paid to .. you know I got phone and hydro and a few others coming up and I'm looking forward to getting back to work so I can get these bills taken care of
- I. I realize that .. well . ummm
- S. I'm on my own now I'm . I can't rely on anybody else I have to rely on myself
- I. Ok maybe we would help you see if they could postpone the billing by a ah . month or two . at times they can do that
- S. No I don't want that done .. I have to meet these bills
- I. What would you do then?
- S. What would I do I would have to work . overtime or double shifts or
- I. Later but right now the you know I still believe you shouldn't work for . a little while
- S. Well doctor I'm a willing worker I want to work I want to work at something I'm good at .. I'm not good at anything really . I'm just a jack of all trades really
- I. Well you have a job now that has some potential you don't want to spoil that
- S. Well I don't want to spoil it and I don't want to . ruin it completely and ruin myself
- I. Sure .. no what I'm talking about is ah . money wise ah . you may have to borrow a few hundred dollars I suppose and pay the bills if you're concerned about that
- S. I am concerned . I do not like to borrow money
- I. Nobody does but but sometimes you have to
- S. No yes . I may have to borrow .. but umm .. it will be paid back I may not be able to pay it back all at once
- I. Well that's what I mean if you

Patient 2 (Ma)

- S. That's a maid for you
- I. That's right that's right
- S. Very vice
- I. Hmmm hmmm .. yep . it's a gift
- S. Yes . it sure is
- I. Do you remember under what circumstances you came to hospital?
- S. Yea
- I. Tell me about it
- S. .. Well it Just happened that I . tripped and fell on the front concrete
- I. Hmmm hmmm
- S. That was it and then I came in . I I came in with my son in the house ... but uh .. I just tripped on a little part of the concrete that's up like that
- I. Right .
- S. And uh . twas easy to do so
- I. And uh you hurt .. yourself . where?
- S. Just bumped my head
- I. You just bumped your head?
- S. Yes ..
- I. And ah . how long ago was this . more or less?
- S. That's about three weeks oh I've been in here longer than that would be the week previous
- I. Right
- S. Yes
- I. Why do you think they're keeping you now?
- S. I don't know I'm hoping they're wrong . but do they think there is something else wrong with me?
- I. Well I don't think so . ummm they just wanted to make sure that there was nothing .. wrong with your . head after the fall I guess
- S. ummm I've got a hard rock here
- I. Hmmm (laugh) . then you have not experienced any difficulty . have you?

S. No

I. Have you had any headaches?

S. No .. in fact I find it very boring

I. Right

S. You know if you're not sick

I. That's right

S. Right now I've got my lower .. dentures out

I. Right

S. I have to take them in to be fixed

I. Right . but you do very well I I hardly noticed that there is any difference

S. Yea but I have to tell you

I. All right . fine

S. But ah outside of getting bored . to death I . I'm fine

I. You are eh?

S. I .. I feel I'm wasting time

I. Hmmm hmmm

S. Because I do a lot of sewing and knitting and .. house-cleaning and . cooking and .. I feel it's time gone you know

I. Yes

S. Although maybe not physically

I. Yea .. you were talking about some kids who were shouting there . or making noise

S. Yea

I. Who are they?

S. I don't know . really . I know my little granddaughter is there so I ... she's about seven but I I didn't hear her .. she'd be with her daddy you know

I. And they're visiting you said

S. They're visiting a teenage boy ... and it . happens that this teenage boy is a neighbour of mine

I. Hmmm

S. And Bill used to know him

I. I see . what's his name

S. ... Ummm ... ah let me see Sarvosky I think

I. Hmmm hmmm

S. They're Polish

I. I see and he's a patient here?

S. Yes

I. And your son . is visiting with your granddaughter?

S. ... Yea .. He's he's with her

I. I see

S. He's with Tina

I. Does he come to visit often

S. No ... just more or less obligation

I. Is today the first time he's visiting here?

S. Yes

I. What does your doctor tell you?

S. ... He was just giving me check-ups on .. you know

I. I mean your doctor here on the floor

S. I haven't seen him only once .. who Dr. M-----?

I. No I mean doctor . I uh the psychiatrist . Doctor

S. Oh he hasn't told me much at all

I. He has not .

S. I was talking to him this morning

I. Hmmm hmmm .. what's his name?

S. Doctor .. heavens .. it slipped my mind now .. I'd know it if I heard

I. Dr. Molnar?

S. Yes .. yes

I. Hmmm hmmm

I. What has he told you?

S. Oh he told me I should eat more . and enjoy my food

I. Hmmm hmmm why did he say that?

S. He said because I'm not eating enough

I. Hmmm hmmm he thinks that's the problem uh

S. Well that's what he told me that I shouldn't be doing

I. Hmmm hmmm.....have you lost weight?

S. I guess I have . ummm but it's hard to say exactly because I go up and down like anything you know

- I. You do?
- S. Oh yea I do . I fluctuate . a lot .. it depends on the season you know . I'll start gaining weight now that spring is coming
- I. Right
- S. Where I like it the other way
- I. What is the month do you remember?
- S. February
- I. Right do you remember the year?
- S. "79"
- I. That's right ... would you remember the date?
- S. Ummm no I'm not sure of the date . really
- I. Right how's your memory been lately?
- S. Fair . you know I mean I don't expect it to be . perfect but it's fair
- I. You haven't noticed any serious difficulty?
- S. No
- I. Have you?
- S. No
- I. What about my name do you remember it?
- S. .. I did remember it and I forgot it . uh . Dr. -----.
- I. That's pretty close B----. that's all
- S. B-----
- I. Yea that's very good
- S. Yea ok
- I. Actually that's very good ... tell me what do you remember now of your of the time when you came in . you fell and hurt . your head . you tripped on the cement
- S. Cement . I didn't come in right away
- I. Oh you didn't come in right away ?
- S. No . twasn't for two or three days
- I. You were what were you doing you were home?
- S. Yes . hmmm hmmm
- I. Ok .. and then why did you come in after that?
- S. Oh to have a talk with MrS. Taylor and tell her that I was coming in for a check-up
- I. Mrs. Taylor . who is she?

S. She's my boss

I. Uh huh ... you told her you were coming in for a check-up

S. Yes

I. What made you feel you needed a check-up?

S. Cause I wasn't set I like to have a check-up if I fall or something

I. So after two or three days you decided that you would want to come in and have a check-up?

S. Well it bothered me .. mentally and I thought I'd better have it checked

I. It bothered you that you had fallen and you hadn't been checked

S. That's right

I. Hmmm hmmm all right .. and ah .. then how did you get checked where did you got to get this check-up?

S. I went to ah Bill took me .. I went to the hospital and then Bill got doctor my doctor to come in

I. Dr. ----?

S. Gee my mouth is dry

I. Is it would you like some water?

S. I think I would please

I. Yea I'll get it for you I have a faucet here... I need a cup

S. Just get a little glass doctor

I. Yes I'll get something just a second I'll be right back are you on any medication?

S. No not right now

I. Hmmm hmmm (clears throat)

S. Thank you doctor

I. Sure .. so you were telling me (clears throat) you were telling me ... where were we?

S. Where the doctor checked me

I. Right .. and ummm tell me did your doctor check you?

S. That's about it that's about it and and then from there .. I left it to Bob

I. And did did the did the doctor put you in the hospital right a way

S. No we went in ourselves

I. Oh he checked you here

- S. There's not too much I can tell you after that doctor
- I. I see and you've been in hospital since?
- S. That's right
- I. What does the doctor tell you then uhhh?
- S. I forget what he told me I'm sorry
- I. You forgot?
- S. That's right
- I. But he told you a reason why you should be in hospital
- S. Yes but I've forgotten all right
- I. Yes . it annoys you when I ask you questions that (xxxxxx)
- S. Well you're going through a bunch of questions that uh could be answered by answering one question
- I. Right what would that question be?
- S. Well that I don't know but until I heard it .. but this is a little annoying because uh .. I can see you being interested of course every doctor is
- I. Right
- S. But uh there are so many questions you can put to a person that they get a little tired of it
- I. (xxxx)
- S. Especially if they're on edge you know .. I mean right now I feel that I've gone through it right up to here . with doctors
- I. Hmmm hmmm
- S. Now I'm getting very anxious to get out . and get home
- I. Yes
- S. It's getting on my nerves
- I. That's the main thing you want to do?
- S. Yes
- I. To go home .. well why do you think that your doctor is keeping you here I don't know personally he may have some good reason
- S. Well there .. I would say they're making sure that every things fine
- I. Yes
- S. They're all good doctors
- I. Right

S. And I'm sure I'm sure that's what it is

I. Hmmm

S. ... Is that a piece of glass there .. or am I

I. On on the floor yes yes it's a piece of plastic for

S. Yes I was wondering

I. To protect the carpet

S. So

I. Ahh

S. Oh sure everybody's interested

I. You were telling me that MrS. Taylor is you're your boss you work you work here then?

S. Yep

I. Yes

S. I'm a pharmacy technician

I. Right . how long have you been there?

S. Thirteen years

I. Oh .. do you enjoy your work?

S. Yes very much .. very much

I. You would like to go back to work too?

S. Oh yes yes I would

I. Hmmm hmmm

S. I miss it

I. I'm sure

S. Because we're very very busy

I. Hmmm hmmm .. she must miss you too I guess

S. Well providing I'm doing a good job I guess she would

I. Sure ... has she come up to see you?

S. N- no I saw her over in the other ---- hospital .. like . I have a lot of people come in and see me and I guess she feels that it's better if she's not

I. Right

S. Of course that's her business you know

I. Sure

S. I I think she's using her . judgment there

I. Hmmm hmmm .

S. I have too many people come in to see me

I. Yes .. who's coming to see you uh?

S. Oh all kinds of friends I have . naturally

I. Right right .. are they all interested in your health eh?

S. Well I imagine so

I. Well let's see I've asked you a lot of questions what would you like to ask me

S. There's nothing I think you've covered everything

I. Right .. oh one thing I wanted to ask you have you had any umm medical illness before .. being here

S. No

I. You've never been in hospital be before

S. Oh I've been in hospital sure

I. What were you in hospital for?

S. For ah ah high blood pressure

I. Hmmm hmmm

S. And uh . for tension headaches ... nothing serious really

I. Right .. (xxx)

S. I've I've umm had a hysterectomy and a few D&C's

I. Hmmm hmmm

S. Two or three

I. I see

S. Nothing really

I. But nothing major

S. Nothing alarming no

I. How was your blood pressure when ah (xxxx)

S. It was high it was high there a while ago about a year and a half ago but it's .. it depends if I don't get myself too excited or upset I'm all right

I. Hmmm hmmm

S. But if I get myself overwrought well .. it can go up a little bit

I. Right

S. But ordinarily it's been pretty good

I. Right.....how has it been here in hospital has it gone down I don't have your chart

with me

- S. ... Well it depends some days its up and some days it's down
- I. It's down yes that's the way it usually goes
- S. Yea that's right
- I. Were you taking any medication for your blood pressure
- S. Not recently .. just water tablets and I haven't taken them for a few weeks
- I. Hmmm hmmm
- S. Because I didn't wanta .. be taking something without the doctor knowing
- I. Right
- S. You know
- I. Right
- S. So I haven't been taking anything at all
- I. Right .. ok .. all right thank you very much
- S. You're very welcome
- I. For coming in
- S. You've got a very nice office here. I should add to this Stuff
- I. Thank you
- S. I have some.. some trays I think I have "152"
- I. Really
- S. From all over the world
- I. Oh you collect them eh
- S. Yea .. but I've got some duplicates
- I. Do you .. oh well .. if you want to donate one
- S. I'll pick a couple of ummm . straw ones for you
- I. Oh that's very nice of you
- S. Yea that's fine
- I. Thank you
- S. Ok thank you doctor

Patient 3 (Mu)

- I. Ok why don't you pull your chair over next to this. and then sit back
- S. Yea .. all right
- I. So you were telling me you feel bad. because. you hear voices
- S. Y- yes
- I. Tell me about it uh
- S. It started back it started back before. time .was even invented
- I. Hmmm hmmm
- S. . Yea
- I. I don't follow how how does that go?
- S. ... It's just that I'm a dago
- I. So am I
- S. Are you really?
- I. Hmmm hmmm don't you know my name B----
- S. Yea yes yes I know ... but I can't I can't (xxxxxx) .. see
- I. Hmmm hmmm
- S. I really stink I know I do
- I. Really you feel that bad about yourself .. why?
- S. (xxxxx) .. me
- I. Hmmm
- S. (xxx) (xxx) I hope I don't die that's the thing
- I. Why are you concerned about dying?
- S. No I'm not concerned about dying I feel like I I I thought I was getting better
- I. You were
- S. I know and (xxxx) what happened?
- I. Well maybe the medication is not working as well so we have ah added another medication
- S. Ok
- I. Ok
- S. All right ok

I. You will not die

S. Ok . all right

I. Tell me about the voices you hear ummm what do they ummmm .. talk about?

S. .. Talk about people

I. Hmmm hmmm

S. And the way they live

I. Do you hear them now?

S. Yes I hear em now

I. What are they saying right now?

S. R- right now they're saying .. they're saying nothing right now cause they

I. Hmmm hmmm

S. Nothing . that's the way I wish it was

I. Yes

S. Cause I don't want to hear nothing anymore

I. Yes what do they ah usually say . about people?

S. (speaks Italian) (clears throat) (xxxxx) (xxxx) xxxxx) (xxxxxx)

I. Things are good and . right

S. Yea good and right ... year

I. What about this business that ummm . you seem to be attracted to women and you uh keep unzipping your pants can you control that?

S. Yes I can control it ... this is the last time I'll do it

I. I'm not scolding you

S. Ok all right ok

I. I'm just asking how does it come about?

S. It comes about .. pretty easy

I. Hmmm

S. Pretty easy yea ... year

I. More easily than usual uh

S. Yea more easier than usual

I. So that you feel . like uh . making love all the time

S. Yes yes ... yes

I. That's a little bit of a problem

S. Oh I see

I. So what do you think?

S. I think it is to ... I think it's a problem

I. Hmmm hmmm

S. I apologize really ... the way my behavior is . in this hospital

I. That's ok you're not well now

S. Yea ok

I. We're just a little concerned uh about the women on the ward but uh we're not putting you down you're just not well

S. All right

I. What about your sleep?

S. I sleep I sleep . I sleep good

I. Hmmm hmmm

S. At nights sometimes I I h- h- hear voices in the night

I. Do you?

S. Yes

I. Are these voices new or ... like have you been hearing voices only recently?

S. .. Some are new and some are are . occasion are occasionally different

I. Hmmm hmmm

S. Yea

I. Do you feel like you're full of energy?

S. Yes I'm full of energy .. yes

I. And you get . big ideas all the time

S. Yea I get big ideas all the time oh boy .. do I get big ideas

I. Tell me about them ____ what kinds of ideas?

S. I get ideas like the buses should have slicks on the back of them

I. Hmmm hmmm

S. That was my favourite .. secret

I. Hmmm hmmm

S. And the other one was . that the world should be all together and not and not not not e- e- e- equal . equally important you know not just say . you know what I mean

I. What else?

S. Yea what else uh I see things uh that I'm not supposed to see

I. Such as what?

S. Sometimes I see stars and sometimes I don't

I. Just like uh stars in front of your eyes

S. Yes yes

I. What ideas do you get about yourself do you feel that you're a very special person at times?

S. Yes I do at times .. yes

I. Hmmm what kind of person?

S. A real nice . boy .. a real nice boy who never knew the meaning of sex

I. I see .. and you think you're misbehaving now and you feel bad about it?

S. Yes I do

I. You're not a bad person

S. Yea I know that's what you say yea ... others say no .. others say . I'm bad but I'm not bad . I'm good

I. I believe you

S. Yea ok

I. How old are you now?

S. I'm "21".1

I. Were you working before comint to hospital?

S. Y- y- ya- y- y- yes I was

I. What were you doing?

S. Dan clothes I was a suit maker

I. Hmmm hmmm

S. .. Yea

I. Where is Dan clothes where is it located?

S. It's located on . "156" Avenue Street

I. Hmmm hmmm

S. Jefferson street

I. Were you making good money there?

S. Yea I was making so and so

I. So and so eh

S. Yea

I. What would you like to do?

S. I would like to get back to work I would like to get back to work and just .
and after I get back to work I I think I would be all right . cause I'm supposed to
be leaving this hospital .. and I know one place where they'll hire me

I. Where?

S. Slater Steel maybe I mean there's a possibility chance

I. To do what?

S. To . assemble steel

I. Hmmm hmmm

S. Put steel together

I. Hmmm hmmm .

S. Yea

I. I see

S. Yea

I. Tell me more about what's wrong with you what . makes you feel bad

S. Well see it goes like this I- I- I .. I just I just wasn't feeling myself . that's
all .. I wasn't feeling myself

I. Hmmm hmmm

S. A- a- and I still a- a- aint I should be I should be well

I. Yea but unfortunately people get sick once in awhile

S. Yes I know . right .. but not as bad as me right?

I. Oh you are not any worse than most other people and you will get better

S. Yea ok

I. Do you feel very restless it's difficult for you to . sit still

S. Yes it is

I. Hmmm hmmm

S. It is

I. Do you smoke?

S. Yes I do

I. Let's have a cigarette

S. Ok all right ok

I. I think I have a couple here here they are do your family come in to see
you?

S. Yes they did ... they did uh . they did doctor

I. Who do you think these voices are? what's your interpretation?

S. My interpretation . these voices are nice people

I. Hmmm hmmm

S. And then they're ah and then again they can be just a little ... just a little crooked but ah I I know who they are

I. Who are they?

S. They're they're different people . (xxxxx) (xxxxxx) .. all different feelings though .. yea

I. Do you know these people do you know there names

S. Yes I do

I. Who are they?

S. soap yea

I. Soap you say?

S. Yep soap

I. What does that mean?

S. (laughs)no I'm I'm just joking around

I. What are they saying right now?

S. (laughs) they are saying how much of an egghead I am

I. (snickers)

S. So you're a plate head (laughs) ... see what I mean

I. Yes

S. I got the whole world on my shoulders

I. Really how do they how do you think they ummm . talk to you . how do you think they do that?

S. Uh ... I don't know how they do that I don't know how they do that gotta be some some kind of miracle worker or something like that ... it's gotta be something like that yea

I. Yea.....what are you counting now?

S. I'm counting my fingers they're just a little bit hot perspiry

I. Yea how is your appetite are you eating well?

S. That's a different thing (sighs) .. uh I'm I'm I'm not eating I'm not eating . well no no . I'm not

I. How come?

S. Because I'm afraid to touch my food

I. Oh

S. In here

I. Why?

S. Cuse .. some things that people say . to me . aint right it it isn't right you know

I. What kind of things?

S. Uh what kind of things ... uh .. s- sorta things like .. you know rock enamel and all that ... goes

I. Ghosts?

S. Ghosts yea ghosts . do you know anything about ghosts?

I. No

S. No I don't either

I. Whose saying these things?

S. .. Uh .. Adam Calvin

I. Hmmm

S. Yea

I. And where do you hear Adam Calvin?

S. . In my voices

I. So Adam Calvin is one of your voices

S. Yea he's my idol

I. Your idol aye

S. Yea

I. And what does he tell you?

S. He tells me when to do it and when not to do it

I. To do what? to do what?

S. To do to sing

I. Hmmm

S. Yea . (singing) I want to be elected you to me together now young and strong . we're going to be elected

I. Hmmm hmmm ... I see .. here there's an ashtray (xxxxxx)

S. Ok all right ok this is not an ashtray

I. No the other one

S. Oh ok

I. Pretty big
S. Yea I know that's right
I. (clears throat) Do you want to ask me anything?
S. Yes .. will I still live?
I. Yes
S. Ok all right ok
I. You will get well
S. Yea
I. Having a rough time now
S. Right I am
I. But you will get better
S. Yes I know
I. Are your family is your family concerned ah?
S. My family is concerned yes they are they're deeply concerned
I. Hmmm ok well we'll have to see how the other medication helps you and I
will check again with you tomorrow
S. all right ok
I. Oke doke
S. Ok

Patient 3 (Mu)

2nd Interview

- I. I just wanted to ask you . how are you doing?
- S. Ah well . f- from the last time I was sitting here . point of view I would say I I I was I I I feeling a way better . than before now I can talk to you and I can see you . not scat up in the middle . and ah I've been feeling m- m- m- more better like in ways . like in ah . my hands and my body I I I can feel things now and f- f- f- f- feel all right like . yea I feel ok
- I. You were saying you were seeing me split in half then ah
- S. Yes split up the middle like I couldn't see you right I could see . I could s- s- in my version ah m- m- my eyesight wasn't v- very very good so I- I could I could only see s- s- some part of it . it was split up in the middle sorta like I was i- in three dimensional
- I. Hmmm was I split this way or . or you could see just the top or the bottom of me
- S. Well the top and the bottom yea I can see but sometimes things got blurry
- I. Hmmm hmmm
- S. Yea and then just went away . it was s-straight
- I. I see
- S. Yea
- I. And you say that you were feeling better . in your hands and body?
- S. Yea
- I. Wh-what kind of feelings would hou have then
- S. Oh well before I didn't have no feeling at all like I didn't have no ah get up and go
- I. hmmm hmmm .
- S. L- l- let say I haven't got that yet but it will be coming soon
- I. Hmmm hmmm
- S. The get up and go that I had before like excited . and I was excitable
- I. I see
- S. And stuff like that
- I. And you were hearing voices too that?
- S. Yea I was hearing voices but not anymore not much longer . I haven't heard no voices yet a- anymore

- I. Good
- S. No .. they're gone
- I. What kind of voices were they?
- S. They were voices like ah . they were voices like ah . a man saying oh I think that cat's got it . or I think ah . I think ah . h- he's doing the old sabatuchi on us and stuff like that it was all corn- ball and corn
- I. What?
- S. Corn all . and and it was something dirty things too and . I didn't like . and things like that of that nature . voices just kept on comin
- I. They've been gone nor for
- S. They've been gone now for awhile now . yea
- I. That's good
- S. Yea . they haven't come back ... now that I feel good . I feel good inside they're not like they're not even close . yea that's when I was feeling really bad
- I. Hmmm hmmm
- S. I could hear voices
- I. Hmmm hmmm
- S. And the voices were telling me to do some things . t- to do in the right and some things to do in the wrong
- I. Hmmm hmmm
- S. Yea
- I. How do your parents find you?
- S. Oh they find me ah all right they find me doing ok
- I. Hmmm hmmm
- S. They just can't wait till I get home
- I. I see
- S. Yea .. they th- they think I'm all right now but they think . you know . they hope it's not long enough now . that ah . have to come home
- I. Right
- S. Yea
- I. Ummm .1
- S. They're talkin about the pills too
- I. Hmmm hmmm

- S. And the factor of the pills I- I- I'm glad h-how much they cut it ou they cut it down . yea because yea it was gettin to be enough there . yea (laughs)
- I. It was a lot wasn't it?
- S. Yea
- I. We're we're going to cut them down further you know
- S. Ok right .. yea .. I believe you
- I. How's your appetite?
- S. My appetites good it's too good I think yea I gotta I'm goin on a diet now . kietitian put me on a diet
- I. Yea
- S. Yea
- I. Yea the pills make you gain a little weight but ah
- S. Yea
- I. You'll be able to lose it you're young
- S. Right . yea . I've bee feelin good though myself I've been feelin really great yea it's comin off it's comin on good yea I don't feel stoned anymore or nothin like that . when I sleep I sleep good at nights . ah .. I wake up sometimes but then when I wake up my mouth feels dry but that's naural I guess . and that goes away
- I. Hmmm hmmm
- S. And then it feels natural . yea yea
- I. Ummm what are you going to do when you go home?
- S. Ahhh
- I. There's an ashtray here
- S. Yea ok all right ah I was thinkin of goin ah . back to work like ah I know this one place where my father used to work . and i- it's hiring sometimes . and they said they were waiting for me . to see if they had an opening . out for me that's in Slater Steel
- I. I see what kind of a job would you be doing?
- S. Ah working with steel .. assembling the steel together
- I. (clears throat)
- S. Assembling the s- steel parts together ow working with boxes on the assembly line as the boxes came down I would put a clamp on it or somethin like that or put stampin on it . and well do with a whole bunch of parcels and boxes too

I. I see

S. Yea . yea

I. You mean steel all ready ah . not hot steel or anything?

S. No not hot steel no

I. Just ah steel parts

S. Just steel parts yea . to put together

I. Your father used to work there

S. Yea he used to work there but he doesn't work there anymore

I. Has he retired

S. He's got a good name yea he's retired . he's got a good name in there to

I. Hmmm hmmm I see

S. Yea

I. What does your brother do is he working these days?

S. No my brother is going to Marvin College . he just signed in for ah an art program
.. he's goin to be takin an art program up there

I. What's an art program?

S. A Art program sorta like ah art abstract and what he does at home he paints . and
he's going to

I. Oh art

S. Yea

I. So he's a student

S. Yea right

I. Uh huh so he's a painter he likes ah

S. Yea

I. Art

S. He likes painting yea .. likes art . I like better working . (laughs) outside
(xxxxxxx)

I. Hmmm hmmm

S. Yea

I. How did you fart how I'm sorry far did you go in school?

S. Grade eleven

I. Went to grade eleven

S. Grade eleven yea .

- I. Why did you quit?
- S. I didn't quit w- w- w- I quit because a- a- a- ah I didn't I wasn't doin so hot really .. I couldn't go with the books . the books wasn't with me . so I I didn't go all the way . I was good in every subject except math . math pulled me down a little
- I. Hmmm hmmm
- S. So I decided I don't know I . was sorta s- s- s- sorta like slacking off so I didn't take the . program anymore . so I decided to quit
- I. And
- S. And that's when they needed me in the Dan clothes .. workin in there . which was pretty good .. yea
- I. Why do you want to change from ah that job to ah working with the ah steel thing?
- S. What when I was working at Dan clothes?
- I. Yea why do you why do you want to change?
- S. Oh because I I I think like the suit the suit company and the suit factory was taking too too long like ta ta know if you wanted to become a tailor . i- it was goin to become too long the the program and the program wasn't worthwhile taking because . I already have . taken the program . and it wasn't it wasn't worth it . so I quit that . and I went into . this . what my Dad was telling me . he says if you like it you go into Simon Steel but you better work . yea work every day .. I said to him I promise I would .. put a good name in there
- I. Right
- S. Yea
- I. He's concerned about keeping the good reputation of
- S. Yea
- I. The family?
- S. Yea that's right .. yea
- I. Where is this outfit ah?
- S. W- w- w- the Dan clothes?
- I. No the ah steel company
- S. The steel company is out here on Main St. West ... Main Street West yea . it's ah you can't miss it . it's out there in front
- I. Where do you live?
- S. I live at "15" Hill near ---- near near Medical Centre

- I. Oh I see
- S. Around there
- I. I see (xxxxxx)
- S. Yea
- I. So is your dad happy to see you getting better?
- S. Yea he is . oh yea
- I. He was very concerned when he talked with me
- S. Yea . right . yea he was happy . he's he's really happy to see an improvement in me and stuff like that .. he says ah .. he he can't wait to see . like me get better end . get on the way on the road . to leaving and stuff like that yea
- I. Good how do you sleep at night?
- S. I sleep good . I sleep good at nights yea I I wanted to tell you about that I sleep really comfortable . and when I get to sleep I'm out like a light now . not like before I use to sleep and it took me awhile to get to sleep
- I. Yea
- S. Turn around and toss it and yea . fight with the covers (alughs) . yea
- I. Do you still feel that you have ah . you were saying .. that you didn't have get up and go kind of thing?
- S. Get up and go energy yea . it's starting to come up now like in a way like ah before I was sorta just my mother saw me in a way where I just sat put . and I wasn't saying much and I wasn't doing much . I was probably waiting for the pills to go into effect and stuff like that . but no I I I I now I talk more a little . and I feel more vibrant and more . active like goin and I can't (xxxxx) (xxxxx) (xxxxx) I get better each time I go .. e- e- every time like before I used to be the energetic one let's do this let's do that well I think that (xxxxx) has missed
- I. Hmmm hmmm
- S. And just wen went down more and gradually and then I I feel more comfortable this way than it has but I'll still . be the energetic one again
- I. You still will be (xxxxx) change
- S. Yea . Anna Mary said one of the coworkers said before who do you think is going to be the first one movin out of your house and I said of course me because I always come up with the snappy stupid idea . (laughs) yea .. movin in that would be nice

- I. Yea
- S. Into an apartment or somethin
- I. Yea
- S. Yea .. later on though
- I. Is your brother living with ah your parents?
- S. He's still living with my parents yea
- I. He's older isn't he?
- S. Yea he's older he's "25" .. yea
- I. Well if you make enough money ah you can have your own place
- S. Yea that's what my Dad was sayin . my Dad was sayin it just takes a lot of money
- I. Yes (xxxxxx)
- S. It just takes the money to save up and . good sense of ability .nd
- I. There is only the two of you right?
- S. Yea there's only two of us right .. yea
- I. Have you ever visited Italy?
- S. Yea we went to Italy
- I. When was that?
- S. That was just this year after I got back from a trip I was feeling bad to even let me tell you doctor i- in Italy too that's when it a- all started it started right before the trip .. I started hearing the voices right before the trip and goin into the trip I I was hearing voices down there in Italy and I was (snickers) it was funny though . i- i- i- i- it had you going like I was a traffic cop or something like that you know . and . it was weird but ah that that that was ah down there in Italy and the voices started gettin stronger . and they kept on getting stronger but I didn't feel no pain or nothin like that . just kept on going and like that . but the trip was nice . and ah but I was feeling bad down there to because we we well we went into one doctor his name was Dr. Nino or something like that he was a good guy he checked us up he didn't find nothin wrong with us
- I. Yea
- S. But ah he said like ah . somethin energetic or somethin like that is missing or somethin like that he just p- prescribed the pills . so I just started taken these pills and this ah . syrup down there
- I. Right

- S. And that wasn't doin so hot though . so then I didn't ah . ah I sorta like quit down there . I I kept on taken them yea as prescribed
- I. Yea
- S. Yea . boy was I filling up li- like all split in the middle
- I. It was a feeling you had about your body?
- S. Yea my body all split up in the middle . I couldn't like . my shirt would be over here . and then my eyes like I'd be thinkin over here (laughs) it would be all loose you know what I mean and I I was feelin all mixed up and everythin . all worried . yea .. I remember that
- I. Well I'm glad you're doing so much better
- S. Yea right
- I. What are you going to do now just go home right away
- S. Well I wouldn't mind it
- I. Yea you can go if you want to sure
- S. What I can go home now?
- I. No . I mean
- S. No I know that yea go home yea
- I. For what is it your supposed to go for the evening right?
- S. Yea the evening yea but I I can't sleep over
- I. Not tonight
- S. No not tonight . just Sunday night
- I. Right
- S. Yea
- I. Ok I hope you have a nice weekend
- S. Yea right ok all right
- I. Thanks for coming in
- S. Ok all right ok ok
- I. Bye bye
- S. Ok bye bye

Patient 4 (FI)

- I. Ummm In parts of the depression it slows you down and in part the medication... so tell me how do you feel in general you know . you're not as depressed as before?
- S. No in fact I didn't realize I was depressed at the time not really I mean when I think of myself as being depressed I think of crying a lot and . probably worrying about everything you know
- I. Yea . so now that you're coming out you can see that you were depressed?
- S. I must have been yes
- I. Yes
- S. To do a thing like that you have to be very depressed I would imagine
- I. Yea
- S. Even though you don't cry
- I. Right . right ... what about the feeling that you were describing to me last time this feeling that ah . people picked on your husband and on
- S. Children
- I. Your son you know and how bad you feel about it and so forth and so on . do you think that is more common when you're depressed do you feel that way?
- S. No no
- I. That's there all the time?
- S. Yes
- I. Well looking back at your experience. how would you say you were feeling .. up to ah .. up to a week or two weeks ago?
- S. The week before .. I remember I started crying at work .. ah I thought that maybe I was depressed then .. that was just ah maybe a couple of weeks before
- I. Yes
- S. And uh . I felt that ... I blame myself for . their being hurt by other people
- I. Yea
- S. And so .. ummm
- I. Who again your husband and son?
- S. That's right even my daughter sometimes but mostly my son now its that they're

- starting to pick on my husband
- I. Hmmm hmmm
- S. The nasty jokes you know
- I. Yes
- S. Truth truthful nasty jokes
- I. Hmmm hmmm so you started crying at work
- S. Yes
- I. What kind of work do you do?
- S. I'm in receiving at a retail store
- I. I see .. so you started at work crying because you had thoughts that were sad or
- S. Yes hmmm hmmm
- I. About these matters though
- S. Yes about the matters
- I. What else . tell me . try to remember
- S. Ummm this isn't a very good day to really interview me because I haven't had much sleep for two nights you know
- I. Maybe that makes it good
- S. (laugh)
- I. Less inhibited
- S. Less inhibited
- I. If you're tired
- S. I don't know I'm not tired and relaxed I'm tired and up tight it's an awful difference
- I. Hmmm hmmm
- S. I don't know what else to say
- I. You were talking about crying
- S. Hmmm hmmm
- I. What about sleep?
- S. I wasn't sleeping that good either
- I. How was that . uh
- S. The only time I'd sleep well was when I took my . ah. Trifoloperazine and Amitriptyline
- I. Hmmm hmmm
- S. Then I'd sleep good that night and maybe the following night and then if I went

without it a few days then I'd be. sort of awake at night

I. Again

S. It would take me a while . I'd fall off eventually but

I. How long would it take you?

S. Oh it seemed like an hour or so

I. Hmmm hmmm ummm ... what about dreams

S. Oh I've had some terrible dreams ... two of them just lately I can only remember one now ... where I'd ah .. battered my son to death batter his head in and it was in pieces and I woke up screaming with a piece of his skull and hair in my hand .. that's the worst dream I ever had

I. You never had that .. dream before

S. I never had that dream before no

I. And .. do you remember the circumstances in the dream?

S. In the dream no that just seems to be all around that . that particular incident . and someone said to me uh . you'll have to pick up the pieces or something you can't leave them laying around or something like that

I. Hmmm .. horrible

S. Horrible is right

I. Ummm . was it here or was it in Wales?

S. No it was here this was just . a few weeks ago

I. I mean in the dream

S. Oh in the dream . no it wasn't in any specific place there was no ah . no room or no just the incident itself

I. (xxxx) so it was not a familiar environment?

S. No

I. And you're son was he very young or

S. In the dream? ... I can't remember that I think he was older .. I don't think he was young

I. As old as now or

S. Could be but I can't remember exactly you know

I. When you were battering him were you using something?

S. I don't remember that either .. it's like as though it was a thought went through my head but I can't see myself doing it in a dream

- I. You woke up suddenly with this horrible feeling?
- S. Hmmm hmmm I was crying I cried out . you know
- I. What did you do then?
- S. I 'got up .. because ah . I couldn't go back to sleep
- I. (xxx) what time was it?
- S. Ummm I'm not sure I think it was somewhere around four o'clock
- I. Hmmm hmmm .. did you go back to sleep that night?
- S. No
- I. No
- S. No I stayed up
- I. Did you tell your husband or anybody?
- S. Hmmm hmmm ... I did
- I. So you were crying . and you were not sleeping well . you had trouble falling asleep and you had nightmares?
- S. Hmmm hmmm
- I. Do you remember any other bad dream?
- S. I think I had one other but now I can't remember what it was about and they were kind of close together too I think
- I. Do you remember whether it was about hurting somebody or not?
- S. No it wasn't the same kind of a dream no
- I. Ah ... what about your appetite what happened to that while you were feeling so sad
- S. Ummm .. well I have been on a diet for about "8" months and ah of course I don't eat as much but I'd say I had a healthy appetite
- I. Nothing changed
- S. No I don't think so
- I. Did you feel that if you had a drink it would make you feel better at times. did it help at all?
- S. Yes I find a drink does relax me ... if I don't drink too much then the next day its I'm all right if I overdo it then I always feel worse the next day
- I. Yea
- S. It's not exactly a hangover but it's edginess
- I. Yea
- S. You know

- I. Yea at times it affects you that way. now if you had . a few drinks ah . more than you wanted to what mood would you get into?
- S. Oh I'm always in a happy mood
- I. Happy
- S. Hmmm hmmm I never get angry or.. no
- I. Even during this period of the last month or so that you were not feeling well if you had two or three drinks what would happen?
- S. I was happy
- I. It would lift you actually
- S. It lifts me hmmm hmmm
- I. I see were you going through periods when you were concerned about your physical health you felt that you were going to be sick or you were sick or you would die or anything like that?
- S. No
- I. You didn't.....what does your husband do when you when you become like that when you feel bad?
- S. Well I don't re- they night notice it but I I don't tell anybody about it and I sort of keep it to myself
- I. Hmmm hmmm
- S. I mean why upset everybody else just because I'm upset you know.. and I don't think I'm a hysterical woman I can keep pretty calm even under the circumstances
- I. Do you notice any change in their attitude did they become more tolerant or. did they try to be kind or do they become irritable with you?
- S. Oh no the're just the same
- I. Just the same?
- S. Hnunnm hmmm
- I. I never asked you do you know anybody in your own family that went through periods of depression?
- S. Like on my mother and father's side do you mean?
- I. Yes
- S. ... No I have a brother that's paranoid schizophrenic but I don't know what he experiences
- I. They told you he has this problem?

- S. Yes hmmm hmmm
- I. What does he behave like?
- S. Oh he's got a terrible vile personality
- I. How would you describe it?
- S. Uh .. well he doesn't he doesn't seem to feel any gratitude if anyone does anything for him in fact i- it's as though we owed it to him
- I. Hmmm hmmm
- S. And uh when we were visiting one time he had his feet up on the coffee table . I mean he's in his thirties .. you know .. he's very immature ... I can't think of anything else because I don't want him I never have him at my home he upsets me
- I. You haven't had much to do with him?
- S. No not really no
- I. Has he been in hospital?
- S. He has been yes from time to time
- I. Where here?
- S. Ahh ... I think he's been up to the HPH .. he might have been here to I'm not sure
- I. What's his name?
- S. Even Gold
- I. That's your maiden name?
- S. Hmmm hmmm
- I. Where is he now?
- S. I have no idea
- I. Is he a wanderer?
- S. He moves a lot.. he never stays in one place very often and he doesn't have a. steady income ... he plays the guitar and he gets the odd night out playing somewhere I guess .. nothing steady .. and he's always borrowing money off my father
- I. Is your father a soft touch?
- S. He has been but ah . my younger sister particularly she's told him to stop he's got a lot ah with him in his position and I don't suppose he'll ever learn how to look after himself
- I. Yes
- S. I think it's just a matter of time when he gets so he'll probably end up steady in one of the hospitals you know

I. Yes it would be unfortunate

S. Hmmm hmmm

I. Ok let's see (xxxxx) forgot right now it'll come to me

S. It usually comes to you when you don't try to think of it (laugh)

I. (laugh) that's right that's the way it usually is ... ok well what about you do you have any questions for me?

S. Oh I was going to ask if I could have a bottle of beer or two with what I'm taking now?

I. Ummm

S. It's stellazine isn't it? ... I remembered I tried it before and uh but it's a different pill so I don't know

I. Yes

S. And I was ah really up tight ohhh didn't go down good at all I couldn't even finish the beer

I. Yes (laugh)

S. So this is the same thing this pink one I'm taking is the same thing is it?

I. Uh

S. Or does it have different

I. I don't know

S. Properties in it

I. I'll have to check ummm

S. Some days I'd just like a beer

I. Yea. I think we'll put you back on the amitriptyline and the stellazine but ah

S. I have some of them at home should I sue what I've got the blue and the yellow?

I. I don't remember what they look like

S. Well what I'm taking now is pink

I. At times it's the same stuff

S. Oh it's just a different. color?

I. Yea

S. I thought maybe there were different properties in it or some

I. Yea there are different amounts and then the pill comes in a different color and so on and so on you're pretty much on the same medication by and large I would say that ummm you can have a beer. I wouldn't go beyond that uh simply because at times the

combination is

S. Yea just so- sort of satisfy my taste

I. (xxx) I don't think it would be much of a problem but I will check your medication tomorrow so we will.. let you know for sure

S. Ok

I. Are they treating you well here?

S. Oh yes the staff is wonderful .. even the patients are pretty good it's just the odd one that gets you up tight you know .. I guess that part can't be helped eh

I. That's right (laugh) ok ... fine that's all I wanted to do

S. Ok

I. And uh thank you

