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Self construction in schizophrenia: A discourse analysis

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Objectives. Lysaker and Lysaker (*Theory and Psychology*, *12*(2), 207–220, 2002) employ a dialogical theory of self in their writings on self disruption in schizophrenia. It is argued here that this theory could be enriched by incorporating a discursive and social constructionist model of self. Harré's model enables researchers to use subject positions to identify self construction in people with a diagnosis of schizophrenia that the dialogical model, using analysis of narrative, does not as easily recognize.

Methods. The paper presents a discourse analysis of self construction in eight participants with a diagnosis of schizophrenia. Transcripts from semi-structured interviews are analysed, wherein focus falls on how participants construct self in talk through the use of subject positioning.

Results. The findings indicate that Harré's theory of self and the implied method of discourse analysis enables more subtle and nuanced constructions of self to be identified than those highlighted by Lysaker and Lysaker (*Theory and Psychology*, *12*(2), 207–220, 2002). The analysis of subject positions revealed that participants constructed self in the form of Harré's (*The singular self: An introduction to the psychology of personhood*, 1998, London: Sage) self1, self2, and self3. The findings suggest that there may be constructions of self used by people diagnosed with schizophrenia that are not recognized by the current research methods focusing on narrative. The paper argues for the recognition of these constructions and by implication a model of self that takes into account different levels of visibility of self construction in talk.

Lysaker and colleagues' work (Lysaker & Buck, 2006; Lysaker, Lancaster, & Lysaker, 2003; Lysaker & Lysaker, 2001, 2002, 2004, 2005; Lysaker, Lysaker, & Lysaker, 2001; Lysaker, Wickett, Campbell, & Buck, 2003; Lysaker, Wickett, Wilke, & Lysaker, 2003) is based on a dialogical approach to self (Bakhtin, 1981; Hermans, 2001, 2003). The dialogical model of self describes the self as having no central core but instead multiple self voices that are in dialogue with each other. These self voices are described as characters that talk to each

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other and negotiate their relationships to each other to produce a coherent overarching self story consisting of multiple self voices. For example, a professional woman becomes a mother and wife or 'homemaker' when she leaves the office for home. In changing from one self to another type, her multiple self voices renegotiate their hierarchy and positions and create a coherent self story consistent with the role of mother and wife. Lysaker and colleagues use the dialogical model which highlights the possibility of recovery of self in schizophrenia. They theorize that self disruption occurs where there is poor narrative structure and lack of dialogue between self voices. The implication is that one can scaffold and support a viable sense of self through narrative and dialogical therapeutic work (Lysaker & Buck, 2006).

The research presented here will use Harré's methodology to explore how self is constructed by people diagnosed with schizophrenia. While the dialogical model of self used by Lysaker and colleagues highlights techniques for recovering self and identifying self narratives, it does not describe a systematic method for identifying *subject positions* in the talk of people diagnosed with schizophrenia. The Subject positions are similar to the traditional social psychological concept of role, yet like the dialogical self voices they highlight the dynamism and multiplicity of self. In contrast to dialogical self voices, subject positions draw not just on dialogue between self voices but also on cultural discourses and common discursive constructs of what it means to be positioned or take up a certain role. They suggest that discourses shape the boundaries of possibility for how a person can construct or create a particular self. For example, traditional discourses of motherhood, e.g. lacking sexual desire, selfless, nurturing, offer, and sometimes push women into certain subject positions rather than others, e.g. sexy, selfish, cold. Methods that allow us to study *both* self-narratives and subject positions are helpful because the two exist in discourse; the self is both dialogical and socially constructed. Subject positions are available in cultural practices and as such construct us as characters in a narrative even when our internal dialogical ability is limited. They are among the building-blocks for narrative and can therefore point us to narrative potential when formal structure seems thin or absent. Subject positions give us a way of making sense of ourselves, our actions and experiences (Wetherell, 2001). Narrative thickens these subject positions and develops them along a time line with a theme and plot and often includes other characters. Dialogical self voices and subject positions are different but related discursive tools used to construct a self in language. By examining subject positions, the research aims to show that people diagnosed with schizophrenia continue to construct self even at times when narrative structure and self voices appears damaged or absent. The research proposes that the analysis of subject positions can enrich and compliment a dialogical analysis of self. Using both levels of analysis could contribute to richer and more detailed descriptions of self processes in those diagnosed with schizophrenia.

Dialogical versus discursive model of self

Dialogical (Hermans, 2001) and discursive models of self agree that the self is jointly constructed in talk between people. However, the discursive model acknowledges the constituting force of cultural discourses while the dialogical model of self does not. Instead, it focuses on how dialogical relations participate in the construction of the self. Lysaker and colleagues, like Hermans, do not examine how discourses position the self. It is argued here that we need to look at both dialogical relations and subject positions. The following is an example of what looking at subject positions and the discourses that support them can contribute to a dialogical analysis of self.

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A woman (married with three children) is out shopping with a friend and she sees a pair of expensive shoes. In trying to decide whether to buy them, she engages with inner and external voices in a dialogue. She may talk to her friend (external position) who is single with no financial responsibilities and the friend may encourage her to make the purchase. She may engage with imaginary external voices – for example, her mother, who would advise her to 'buy a less expensive pair of shoes. Be sensible, you really don't need them'. She may also engage with internal voices such as self as mother and wife, 'I shouldn't spend that much money; we need the money for school books and the family holiday'. She could also engage with her internal voice of fashionable woman who appreciates beautiful things and say, 'yes, they are expensive, but very beautiful and I will get to wear them with lots of my outfits'. The above example of dialogue follows Hermans' theory of dialogical activity. Dialogue occurs between internal and external self voices and often multiple positions.

Within each individual voice, however, there are a host of other subject positions (Davies & Harré, 1999) made available by the particular discourses used (e.g. feminist discourses, discourses of motherhood, normative discourses of how a wife should behave). Discourses provide subject positions and these positions constrain and constitute how a person can be (Willig, 2000). So in our above example, the woman might be restricted to drawing on a normative discourse of what is expected of a wife and a mother. It becomes almost impossible for her to think, 'No, I work hard and I earn my salary and I should not feel guilty about treating myself instead of a family member, being a martyr is not a good thing, I will buy the shoes'. The types of discourses that are available to us and the discourses used by others about us restrict and shape how we construct the self (Burr, 1995). The self is not limitless in how it is constructed. Its possibilities for being are limited by the discourses available to us. It follows from this that to examine the self, we must be able to examine the subject positions that discourses provide (Burr, 1995). This contrasts with Hermans' method which examines only intra-psychic self positions and interpersonal relationships and how these interact in dialogue.

In order to analyse subject positions in the construction of self in those diagnosed with schizophrenia, it is necessary to use discourse analysis (Davies & Harrré, 1999; Parker, 1992) in conjunction with a discursive model of self (Harré, 1998). Subject positions such as 'self as sick', or 'self as helpless', for example, may be promoted by medical discourses that are predominant either in the person's talk, or in talk about them by others, and cannot be accounted for simply through Hermans' dialogical lens.

Lysaker and colleagues' approach differs from Harré's. Instead of using discourse analysis to examine how self is constructed as a discursive object, they use content analysis to examine the narrative structure of their participants (Lysaker & Lysaker, 2001, 2004; Lysaker *et al.*, 2003, 2001). They do not examine the influence of subject positions in the construction of the self. This limits their analysis and what can be said about the role subject positions play in self construction.

The importance of embodiment

An account of how the experience of having a self within one's skin or body would also improve Hermans' dialogical theory of self as used by Lysaker and colleagues. Dialogical theories tend not to deal with the self as experienced as within a body or embodiment. For Harré, embodiment is central to understanding the experience of the self. Harré names the embodied experience of self, self1 and has two further descriptions of self,

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self2, and self3 (Harré, 1998). He puts forward what he terms a 'standard model' of self, in terms of which the person is considered a multitude of selves held within the constant of the experience of inhabiting one's body. Self1 refers to a single embodied being with a unique point of view flowing from one's spatial and temporal location (Harré, 1998). Self2 refers to a person's talents, skills, abilities, and beliefs at a particular time. This self also positions persons in moral space as carriers of certain qualities. Self3 refers to one's awareness of the opinions and beliefs that other people have about one's self (Harré, 1998).

The use of embodiment in his model allows him to argue that self1 can be constituted from the experience of embodiment alone and does not need social interaction to be constructed as would be required for self2 and self3. Theoretically, it follows that self1 should remain intact despite disruptions in dialogical ability. Lysaker and colleagues approaches do not allow for this possibility, as they assume the self to be relational and therefore requiring dialogue for its successful construction. However, Harré takes a different view pointing to the body as a tool of reference for the self in its construction.

For Hermans, problems of the self occur because of disruptions to internal positions. To address these problems, the client needs the cooperation of a therapist or others in constructing new internal positions. This idea rests on the assumption that the constitution of the self needs to be done in cooperation with another person (real or imagined) and cannot be done alone. However, Harré's model puts forward the idea that some aspects of the self require cooperation for their constitution but that other aspects (specifically self1 and sometimes self2) do not need such cooperation. Rather, they can occur in isolation, based on the experience of existing within a body and the use of pronouns such as 'I' or 'me' to point to the self as a singular entity within a fixed, constant body. By having just one self, the dialogical self, Hermans's model cannot account for peoples' ability to constitute the self solely by referring to the body as a solid and fixed vessel for the self. His theory may not allow for subtleties in self presentation such as instances of a preserved self1 to be evidenced. This may lead to an overlooking of self1 and the mistaken conclusion that there is no evidence of self. In contrast, Harré's model allows for more nuanced analysis of self positions.

Method

Eight participants (five men and three women) with a diagnosis of either undifferentiated schizophrenia or paranoid schizophrenia (DSM IV; American Psychiatric Association, 1994) were used in this study. All were compliant with antipsychotic medication at the time of interview and ages ranged from 22 to 60 years. The participants were recruited through liaison with the community mental health nurse (CMHN) at a community-based day service for people with mental health problems and participated voluntarily. The participants came from a variety of backgrounds; all were currently unemployed although some of the younger participants hoped to go back to employment in the future. Their past occupations were various: one participant had a variety of low income jobs (Ben); two were students at institutes of technology (Jack and Mark); two were university educated to Masters level and worked in professions (Julia and Megan); one was a manager (Gary); and two had been office clerks (Hannah and Sam). All participants were single, although Megan had been married and a number of others had serious relationships prior to the onset of the schizophrenia. All participants were living alone and independently in basic accommodation (mostly bed-sits/studio apartments) and

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were reliant on social welfare/disability benefits. In preparing the manuscript, all participants' names and identifying information was removed and replaced with fictional details.

The time necessary to transcribe and analyse interviews was weighed against the requirement of variety and depth in the participants. It was decided in consultation with the CMHN who knew the participants well, that 8 would be a large enough number to achieve this balance. A small number was deemed sufficient because emphasis would be placed on a detailed analysis of a limited sample rather than aiming for a representative and generalized sample. In addition, the researcher was conscious that people diagnosed with schizophrenia are an over studied group, and did not want to unnecessarily include a large number of people in the study.

The interview was semi-structured. The participants were initially asked, 'Tell me a bit about yourself' and then allowed to direct the interview talk without interruption. Prompt questions were used if necessary to generate talk. Examples of prompt questions include: How is your life different than it was when you were younger? How do you see yourself in the future? How would other people describe you? Do you agree with their descriptions? Tell me about the things you enjoy doing or the things you are good at; Tell me about your day or your week, what do you do to keep busy? Interviews were recorded using a medium-sized tape-recorder placed in clear view between the participant and interviewer. Recordings were then transcribed using an abbreviated version of the Jefferson method outlined in Potter and Wetherell (1987). Transcripts were analysed using discourse analysis following the methods of Harré (1997, 1998) and Parker (1992). Focus fell on participants' constructions of self in talk through the use of discursive devices and subject positioning.

Analysis

All eight participants demonstrated subject positions in their talk. This finding indicates that all participants were able to discursively construct a self, pointing to the presence of subject positions in the talk of those diagnosed with schizophrenia that can be identified either instead of or alongside self narratives.

Self1

All participants constructed a self1, the embodied and singular self, in their talk. This was achieved and demonstrated through the use of first person pronouns such as I, me, mine, and my. These pronouns index the body's spatial and temporal location; for example, see extract 1 below (bold added).

Extract 1

Mark: **I** live on Pavilion Road that's near Kloof Street by the bus station . . . **I** am living in a flat **I** am . . . **my** brother is living right beside **me**.

Mark indexes his spatial location as a unique embodied and continuous being by using 'I' and 'me'. Using 'my' indexes his brother's relationship to him, and himself as a continuous being in relation to his brother. Similar uses of personal pronouns were evident in the talk of all participants.

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Extract 2

Interviewer: Hannah, I don't know you at all so will you tell me a little bit about yourself?
Hannah: Well **I** was living in Scotland in 1986, **I** was working as a secretary in Scotland, **I** started hearing noises and voices and **I** didn't know what was wrong with **me**, but **I** was drinking a lot at the time and **I** thought **it** was the drink.
Interviewer: Okay yeah.
Hannah: So **I** stopped drinking but **it** continued.
Interviewer: It continued?
Hannah: Yeah so eventually **my** landlady was very nice, it was an Irish landlady **I** had and she came to **my** GP with **me** and **he** sent **me** to the hospital. **They** were asking **me** questions in the hospital **I** couldn't remember what **they** were asking **me**.

Above we see Hannah using personal pronouns to indicate her self as an individual separate from others. The use of 'they', 'it', and 'he' also show an awareness of self-other boundaries and differentiation. This evidences awareness of her self as a separate entity from both her auditory hallucinations ('it'), her GP ('he'), and the medics in the hospital ('they'). The use of 'my' as in 'my landlady' and 'my GP' indicates an awareness of the possessive nature of a singular self. Self has a relationship to things or people that is one of possession or association with but not immersion in. She has a GP and a landlady but she has not become the GP or the landlady – her self is related to but separate from them. Also her sentence, 'I didn't know what was wrong with me' indicates a complex sense of self as both knower and known. This example illustrates the usefulness of highlighting reference to self and other in talk as a way of discovering the person's sense of self.

Self2

Six of the eight participants demonstrated the construction of a self2. Self2 necessitates that the speaker can (1) discursively construct self as having skills and qualities; (2) construct self as having a position in the moral and/or physical space; and (3) construct self as having opinions and beliefs (Harré, 1998). Below, in extract 3, we see Megan demonstrate these abilities.

Extract 3

Megan: I suffered, I was unlucky with my mental health, I had to give up consulting, couldn't handle the pressure and I imagined they were talking about me and I gave up and then I got married.
Interviewer: What was that like?
Megan: Terrible a frightful marriage. My husband went off with another woman and I neglected my children. I had some, a girl and boy and I neglected them eventually, they were always watching me Sean (CMHN). I think Kirkwood (psychiatric hospital) would have been more compassionate, I think Kirkwood would have been better.
CMHN: You weren't at Kirkwood at the time?
Megan: No I wasn't I was in Hillside. I was there for nine months as I told you, soul of kindness towards me, soul of kindness. They were the, not such a bad place as you think it might be, nice admission unit. They wanted to keep me when my father died because I'd no job, lost my children, in court they were taken off me and I got no access, they went to Italy. I used to visit them in the home and I got

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friendly with the matron and she always wanted me to have them cause I bent over backwards to be a good mother. I put them into care because the house was repossessed, should have hung on to them maybe but I was very ill at the time, mentally ill, mentally ill.

Megan constructs herself as someone who 'bent over backwards to be a good mother' describing herself as having the quality of 'good mother' despite not always being able to look after her children. By explaining the reason, she decided to put her children into care, 'I put them into care because the house was repossessed', she positions herself as a responsible mother who made the only responsible decision in her circumstances. She constructs herself as morally good despite being someone who 'neglected' her children. She gives us evidence that other people thought she was a good mother, 'I used to visit them in the home and I got friendly with the matron and she always wanted me to have them because I bent over backwards to be a good mother'. Mental illness and poverty are indicated as responsible for her bad mother behaviour, 'I put them into care because the house was repossessed, should have hung on to them maybe but I was very ill at the time, mentally ill, mentally ill'. This maintains her position of morally good. Finally, we see Megan as a self with beliefs and opinions. She clearly has the belief that she should have tried to keep her children with her, 'should have hung on to them'. In addition, she is of the opinion that another psychiatric hospital would have been more accommodating to her and helped her keep her children, 'I think Kirkwood would have been more compassionate, I think Kirkwood would have been better'.

Extract 4 below demonstrated Julia's ability to construct self2.

Extract 4

Interviewer: Okay and how did your women's studies course go?
Julia: I was sort of disappointed with it to be honest with you, if I could do it all again it would be social studies most definitely. I'd love to do it, it would be social studies, it would be, I used to love reading any subjects and I just love reading up on it and I went through a period of hating myself, absolutely hating myself.
Interviewer: Really?
Julia: I have two sisters who emm, are very conscious of their figures you know how to dress and how to envious and it never interested me you know so.
Interviewer: So you had two sisters who wanted to be pretty and wear make-up?
Julia: Well I'm not going to give up on them they have a qualification, but it was always this thing of their horrible flat stomachs and if you saw those women in the newspapers in 60's Ireland, I mean you never wanted to be like one of them, one of these horrible flat stomach nothings.

Above, we see Julia's construction of self as having skills/abilities in reading and an interest in education. She positions herself as morally superior to her sisters whom she sees as shallow and overly interested in their appearance. She connects having a flat stomach with being a 'nothing', and in so doing, places people who are overly concerned with their bodies as somehow inferior to those who have other interests. In this piece, she also sets out her opinion that women are more than their bodies arguing that having a qualification might be enough to save a woman from being

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insignificant. In this, she asserts her belief that women should strive to be more than a body and to use their minds as well.

Two participants, Jack and Ben did not demonstrate self2 construction; reasons for this will be considered in the discussion.

Self3

Seven participants discursively constructed self3 (how others see one's self) in their talk. Below in extract 5, Sam gives a brief account of how his brother sees him and a very detailed account of how people see someone with mental illness in general. In this way, he demonstrates an awareness of how he is seen by others.

Extract 5

CMHN: What about contact with your family?

Sam: Patchy enough. You see they are all scattered you know. Ken is in Donegal, Larry drove me into St. Catherine's (psychiatric hospital) there, he's in Westville Drive. Larry is a married man with a wife and two grown children, he's things to do, it's not good for me to phone him up out of the blue and get him to come up here just to cart me up to the hospital. He'd be justified to say 'why can't you go up off your own steam?' But in fact the last time I was too bad to do that, if I tried anything could have happened.

CMHN: Do you think your family have a good understanding of your illness?

Sam: Tell you the truth it depends on which member of the family you are talking to. I don't think people as a whole are really that au fait with dealing with mental illness. The media give it a terrible image, you have Frankenstein movies on one hand and axe murderers on the other. A history of psychiatric debility is very frequently quoted as the reason why a certain crime was committed and this is thrown in as an extenuating factor and the effect is it's bad in the public mind I think. No ordinary person who's never dealt with mental illness if they were to find out 'look that guy is a bit cracked' they wouldn't like it you know, they'd probably drop you.

Sam indicates an awareness of how his brother sees him. He feels that his brother might consider him lazy if he asked for his help in getting to hospital. He is also aware that his brother is busy now that he is married with children and might consider Sam an inconvenience. He also shows an understanding that people have different views of him, stating, for example, that each of his siblings has a different understanding of schizophrenia. In his description of how the media portrays people with mental illness and the effects of such a characterization, Sam show an ability to imagine how the general public see him and others with mental health problems, 'Frankenstein movies on one hand and axe murderers on the other'. He says 'they wouldn't like it you know' and predicts that 'they'd probably drop you'.

Megan also shows an awareness of how others see her, particularly her as someone with a mental health problem, in extract 6 below.

Extract 6

Megan: my next door neighbour knows and always regards me as more nervous than mad, more nervous 'you're just a bit nervous', not mad.

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Megan describes how her neighbour sees her, 'more nervous than mad'. This ability to recognize the characteristics other people see in her indicates that Megan is aware of and can demonstrate self3.

Gary in extract 7 below shows that he has knowledge of how the interviewer sees him. He believes this is as a fat person.

Extract 7

Interviewer:	So your Mam had you in the club. And were your brother's into sport as well?
Gary:	Yeah my brothers played tennis and soccer, my twin brother played soccer, he was in the motor trade final a few years ago in Undertown Park, he was in the final, he likes soccer too.
Interviewer:	He must be fairly fit then.
Gary:	Well he was he's like me now you know (points to his tummy) after putting on weight. We're not playing games anymore.

The construction of self3 was observed in seven of the eight participants. One participant, Jack, did not demonstrate self3 in his talk. Possible reasons for this will be discussed below.

Discussion

The above findings indicate that all participants demonstrated subject positions in talk that often had poor narrative quality. By using Harré's model of self, the analysis revealed subject positions that are not easily evident in Lysaker and colleagues' focus on dialogical ability and narrative. Even when narrative abilities are diminished, aspects of the self can be identified by using an analysis focused on a different level of discursive construction of the self.

There was variation in the level of subject positions demonstrated by participants. All participants discursively constructed self1. However, two participants, Jack and Ben, did not demonstrate construction of self2 in their talk. In addition, Jack did not discursively construct self3. There is a theoretical reason why self2 and self3 may be more difficult to construct than self1. According to Harré (1998), self1 is based on our experience of embodiment and does not rely on other people for its constitution. Self2 and self3 rely on relationships with and feedback from others (Harré, 1998). Theoretically then, self2 and self3 are socially constructed aspects of self. Perhaps socially produced aspects of the self are more difficult to construct than the non-social aspects. Indeed, Jack, the participant who could not construct self2 or self3 was very socially isolated. He lived alone since the death of his mother 2 years ago and had little contact with other people, only rarely leaving the house. In cases of people diagnosed with schizophrenia, there may be vulnerability to subject positions that require joint construction. If this is the case, it would be expected that aspects of self requiring joint construction with others (self2 and self3) will be more diminished than aspects of self that can be achieved in social isolation (self1). This is in keeping with Lysaker and colleagues dialogical theory of self. It is expected that more research using Harré's tripartite model of the self would reveal similar patterns. Research exploring the influence of others on self construction abilities may also be valuable. The finding highlights the interconnectedness of the dialogical and discursive models of self, both appear to influence the construction of self in those diagnosed with schizophrenia.

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Limitations and reflexive discussion

Only one interview was completed with each participant. Numerous interviews over time would have produced richer data and would have revealed more variation in the participants' self presentation. More interviews would have given an indication of how self construction skills and deficits might alter or be managed over time. The authenticity of the interviews may have been compromised by the fact that the interviewer and participants had no previous relationship, which meant that rapport building was a feature of the interview. However, having the interviews in participants' homes as much as possible (two participants were interviewed in an interview room in a Psychiatric Day Hospital) reduced the focus on mental illness and helped to make the participants feel more comfortable.

During the interview process, I was conscious of my position as a Clinical Psychologist and how this may have influenced participants' reactions to me. This power imbalance can never be totally overcome (Guilfoyle, 2003) so it has been necessary for me to pay attention to it in my reading of the transcripts. In order to reduce the power imbalance, my approach was relaxed and informal and I focused on the person's life in general rather than just their diagnosis. However, it was clear that I was positioned as a mental health professional. Most participants continued to bring the conversation back to their diagnosis of schizophrenia, perhaps based on the reasonable assumption that it was the topic of interest for me based on my position.

The current study used a non-random sample of just eight participants. No generalizations can be made on the basis of the study and all conclusions made are tentative and based on a small purposive sample. The research is a qualitative piece that describes the self construction of eight specific people with a diagnosis of schizophrenia; it does not aim to make predictions or delineate distributions in a population of people diagnosed with schizophrenia.

The role of the researcher in this study must be acknowledged and it is important to point out that other interpretations of the data are always possible. Throughout the analysis, the researcher acknowledged her biases and tried to reflect on her analysis asking constantly, 'why am I reading the text in this way?' The analysis ensured validity by adhering to the principles of reflexivity (Nightingale & Cromby, 1999), and coherence, new problems and fruitfulness as described by Potter and Wetherell (1987). Investigator triangulation, the reading of the analysis by an independent researcher familiar with discourse analysis (Denzin, 1989), was also used to ensure validity of the analysis. Triangulation helped keep the findings grounded in the data, helped ensure that the method was applied correctly, and the researcher's biases were minimized. However, any analysis will always be limited in its neutrality (Willig, 2001).

The research is limited by its focus on discourse; it does not examine what is outside of discourse. Specifically, discourse analysis does not study the extra-discursive features of space, gestures, clothing, and makeup or facial expression (Durrheim, 2005). Non-discursive material factors are increasingly being highlighted as important in the analysis of the constitution of meaning and subjectivities. One means of addressing this limitation might be the complementary use of alternative methods such as observational methods (Banister, Burman, Parker, Taylor, & Tindall, 1994), which could permit examination of such non-discursive factors in self construction.

In conclusion, this study aims to show that using more fine-grained methods of analysis such as Harré's can help us learn more about self construction in those diagnosed with schizophrenia. It also shows that self is both dialogical and discursive and argues for the use of theories and methods of analysis that allows both to be

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included. These results highlight the need for detailed analysis of the talk of people with a diagnosis of schizophrenia. The problem seems to lie between a diminished presentation of self and the listener's ability to respond to and accommodate to this. Other peoples' inability to see remaining aspects of self contributes to this diminishment of self. However, the compromised self presentation itself functions to obstruct the unskilled other in recognizing a meaningful self, thus increasing the distance between the person diagnosed with schizophrenia and (undiagnosed) other. If clinicians become more aware of the need to relate differently and to listen to different levels of talk in those diagnosed with schizophrenia, they can share this with clients and families. Acknowledging the difficulties in relating between people with a diagnosis of schizophrenia and those around them may act as a counterbalance to the dominant deficit focused story of loss of self in schizophrenia often conveyed to clients and family members. Therapeutically, recognition of subject positions could be used as a starting-point or springboard for encouraging self-construction in line with Lysaker and colleagues' approach. The person with a diagnosis of schizophrenia according to the findings of this study would be expected to enter the therapy room with subject positions that can be built on, even when narrative structure is missing.

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