The Dialogical Self in Psychotherapy for Persons With Schizophrenia: A Case Study

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Schizophrenia often involves a profound experience of one's identity as diminished, which complicates adaptation to the demands of daily life. Within a backdrop of dialogical self-theory, we provide a report of an individual psychotherapy over the course of 4 years that assisted a patient suffering from schizophrenia to move from a state in which few aspects of self were available for internal or external conversation to one in which there was greater accessibility of multiple aspects of self, leading to richer dialogues, improved function, and a better quality of life. It is suggested a primary intervention of the therapist was continuously to offer the client a view of himself that invited him to experience himself in a plausible manner shared with and listened to by another. © 2006 Wiley Periodicals, Inc. J Clin Psychol: In Session 63: 129–139, 2007.

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It is widely thought that schizophrenia spectrum disorders involve a profound alteration in persons' experience of themselves as beings in the world. Bleuler (1911/1950, p. 143), nearly 100 years ago, wrote: "Everything may seem different; one's own person as well as the external world . . . in a completely unclear manner so that the patient hardly knows how to orient himself either inwardly or outwardly. . . . The person loses his boundaries in time and space." From psychoanalytic (Searles, 1965), existential (Laing, 1978), phe-

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nomenological (Minkowski (1927/1987), and rehabilitation (Roe & Ben-Yishai, 1999) vantage points, this perspective has been echoed many times. Importantly, the key issue that has emerged is that schizophrenia involves not so much the experience of the self as having changed into something else, of the self as existentially challenged, or as becoming less than one's fellow beings. Instead it is that the person who has schizophrenia feels that his or her self, his or her sense of identity, is fundamentally and significantly lessened relative to how he or she had experienced himself or herself in the past. With a decreasing sense of self, adaptation to the requirements of daily life becomes increasingly difficult and psychosocial function rapidly erodes (Horowitz, 2006). In contrast to dementia, part of the anguish here is that the self remains fully capable of observing its diminishment and inabilities to cope (Lysaker, Wicket, Wilke, & Lysaker, 2003).

While self-disruption in schizophrenia can easily be offered as a focus of psychotherapy, one factor that has retarded such a focus is the absence of a widely accepted theory that could explain how such self-diminishment is possible. Specifically, for the loss of sense of self to be a meaningful focus of psychotherapy, a conceptual framework is needed that addresses the following: (1) what is the self that has been diminished, (2) how was the self diminished in schizophrenia, and (3) what could psychotherapy offer?

Certainly there have been attempts to address these questions. In the 1950s some psychoanalytic views asserted, for instance, that the central aspect of the self, the ego or I, survives because it is able to repress instinctual drives and keep them out of awareness. When that process failed, it was argued, instinctual urges flooded consciousness and the self collapsed (Searles, 1965). Phenomenological theorists have offered views of self-disruption as stemming from a state of fundamental disharmony or a lack of attunement with the world (e.g., Minkowski, 1927/1987). Although intriguing, neither theory explains how this process happens at a particular point in time. For instance, how does it happen one day when it had not happened a day earlier? Therefore, what is it that is in need of repair?

Dialogical Self-Therapy

More recently, a dialogical conception of the self has emerged that may answer these questions and help us move toward a systematic understanding of how and why psychotherapy could be helpful for persons who have schizophrenia. A broad multidisciplinary literature involving the humanities and the sciences has suggested that the self is dialogical—the result of ongoing conversations both within the individual and between individuals and others (e.g., Bakhtin, 1929/1985; Hermans, 1996a, 1996b; Nietzsche, 1886/1966). Different aspects of the self interanimate or give significance to one another through their interaction or dialogue. The self thus is seen as composed of multiple aspects or self-positions, which exist independently and cannot be reduced to a whole. These self-positions may oppose, help, or ignore one another and are structurally bound to particular contexts and persons (e.g., self as failed son to parent, successful worker, or colleague). The dialogical self is not merely conversations within one's own mind but reflects complex and intersubjective ongoing exchanges in the world.

The exchange among self-positions, and thereby personal identity, is made possible because of a hierarchy among self-positions, which periodically shifts, putting new self-positions in a dominant or organizing position and previously dominant self-positions in the background (Hermans, 1996a). If this hierarchy were to fail to shift or even cohere, possibly as a result of the biological and social processes in schizophrenia, the sense of self might be experienced as collapsed by a person who simultaneously retains the ability

to observe this process (Lysaker & Lysaker, 2002). Here it would not be that the self had been destroyed in some part, but that the self could be mistaken as partially destroyed as certain positions became unavailable.

One manifestation speculated to proceed from such a collapse is a monological self. In this condition, without an organizing flexible and shifting hierarchy, all internal and external conversation may become organized by a singular, rigid self-position and many previously available positions would be left out of the conversation. Conversations in this state would be stereotypical and produced by a limited number of self-positions (e.g., self-as-god, self-as-poisoned, self-as-soccer-fanatic) that dominate all exchanges within and between persons. Of note within these exchanges, self-positions are theoretically unlikely to be associated with other individuals. For instance, self-as-god might be linked to a voice that confirms the client is a god, but that self-position would not likely be linked with another person, as others in general are not likely to say things relevant to self-as-god. It is not that conversation with others is replaced by conversation with hallucinations as exchanges with hallucinations, are not conceptually dialogical. An exchange with a hallucination would be unidirectional and not bidirectional and thus likely to interrupt and colonize self-experience, only heightening the degree of the monologue.

This possibility is consistent with case studies suggesting radical changes in self-experience during the onset of psychosis may be linked to the loss of internal conversation (Lysaker & Lysaker, 2001) as well as with quantitative studies suggesting that greater neurocognitive impairment in schizophrenia may be accompanied by greater narrative impoverishment (Lysaker, Wickett, & Davis, 2005). It is also consistent with emerging views asserting that head injury may disrupt quality of life by limiting the injured person's ability to move among various aspects of self-definition (Heller, Levin, Mukerjee, & Reis, 2006).

Dialogical self-theory also points to several ways in which psychotherapy could be uniquely useful (Hermans & Dimaggio, 2004). Psychotherapy provides clients with a dialogue with another person, which could reignite conversations that had previously ceased between self-positions, leading to the regrowth of sense of a richer self. When a therapist listens, a client may find an audience to which aspects of self long silent may begin to speak. When a therapist offers his or her thoughts, clients may find that aspects of themselves previously silent become empowered to enter the conversation again. The dialogue of psychotherapy could thus provide a space where previously inaccessible aspects of self could emerge and conversations involving increasingly diverse aspects of persons could be recovered. If the discourse of psychotherapy allows the client to know someone who knows him or her, the client might be able to use the other's knowledge to frame aspects of self, or self-positions, previously inaccessible and to use them to create hierarchies that allow for the return of dialogical exchange.

In what follows we provide a case study that includes a conceptualization of the disturbances of schizophrenia from a dialogical framework, and then illustrates the therapeutic techniques that might address these hypothesized deficits. In this case, client characteristics have been systematically disguised to protect confidentiality.

Case Illustration

Presenting Problem/Client Description

Grieg was an unemployed divorced male in his 50s who had multiple sources of social disadvantage, living on a disability pension. Prodromal symptoms began in late adolescence and recognizable symptoms of psychosis in early adulthood. The course of his

schizophrenia was associated with more than 15 inpatient hospitalizations, several suicide attempts, many lost jobs, and alienation from family and friends. He had no substance abuse or legal problems. At the time therapy began, Grieg had significant levels of positive symptoms, including a variety of auditory hallucinations and tenaciously held delusions. These included experiences in which Grieg heard celebrities praise his masculinity on television and beliefs that he performed supernatural feats for which others would hunt him down and publicly humiliate and possibly kill him. He also expressed significant levels of anxiety and noted feeling sad and worried most of the day nearly every day. He tended to spend little time with others and expressed little interest in their thoughts or feelings. Neurocognitive testing revealed grave impairments in verbal memory and in his capacity to think flexibly about abstract matters.

Grieg lived in a supported apartment in a neighboring community. In Grieg's previous marriage and two other romantic relationships he fathered three adult children: two daughters and one son. All were married and had children of their own. Grieg generally visited his oldest daughter or son once per week. Grieg had a younger brother in another state with whom he was in periodic contact by phone. He sporadically dated a woman considerably older than him who lived nearby.

Grieg's father had psychosis and alcoholism and his mother had an eating disorder. His parents were divorced during his adolescence and neither remarried. At the beginning of psychotherapy both had been deceased for over a decade. In his youth Grieg had been an average student, completed high school before joining the military, and held the dream of being a carpenter as his father was.

Beyond the symptoms elicited in a structured interview, Grieg seemed to possess a sense of having a self that had largely disappeared. He offered no comment or suggestion that he considered it possible that he could affect the world in any consensually valid manner, though he acknowledged that he had in the past. There was no indication that he was aware that there were others who noticed or afforded him a sense of social worth. Events happened around him and to him. He observed those events without any awareness that he might make sense of them in a manner that he might communicate to another.

Case Formulation

Diagnostically, Grieg's clinical presentation met full criteria for schizophrenia, undifferentiated type. He exhibited neither signs of personality disorder nor had any major medical concerns.

Dialogically, Grieg appeared as someone who had previously dreamed of being a carpenter and previously had been a husband and father. He did not appear to see himself as existing in any meaningful way in consensually valid landscape. Unlike persons with dementia, he knew where he lived; he knew the year, month, and day of the week; and he knew details about local news and of the events of his life history. Nevertheless, somehow he was no longer an actor in the present day of that history and had lost the ability to cope effectively and navigate his way through his life.

We suggest that there was once a rich series of dialogical exchanges both within Grieg and between Grieg and others, which resulted in a stable sense of self. However, these had fallen away by the time he entered psychotherapy and had been replaced with a series of monologues. Previously internal and external conversations that had probably involved self-positions such as "self-as-son-who-disappointed-the-mother," "self-as-lover-of-wife," "self-as-unappreciated-worker," "self-as-grateful-father," "self-as-loved-by-brother," or "self-as-future-carpenter" had been replaced by a relatively small number of

self-positions that were not tethered to recognizable others. Grieg appeared as essentially a "self-as-persecuted-by-unknown-persons" and "self-as-beloved-through-the-television."

Furthermore, the other in these exchanges, in addition to being poorly defined, was expected and even restricted to offering one form of exchange. One group was expected to offer persecution and another adoration. All personal events and affects were framed in terms of his impending humiliation or admiration from cultural icons as broadcast on television. These monologues, which purported to explain Grieg's life, provided no sense of internal depth or opportunity for Grieg to be connected to others. Questions pertaining to concrete current events in his life such as "How do you feel about . . . ?," "What do think about . . . ?," or "What did you do about . . . ?" were responded to with virtually identical accounts of his impending capture without recognition that he was repeating himself. There was no distinction between the distinct mental spaces needed for fantasy and for reality.

On the basis of dialogical self-theory, we conceptualized that Greig had lost access to previous self-positions after the erosion of a flexible hierarchy, which had previously supported internal conversation. In other words, disruptions in the logical flow of thought linked with the underlying biological process of schizophrenia may have reduced the capacities necessary for that fluidly shifting hierarchy, which, in turn, increasingly reduced the possibility for varied self-positions to enter internal and external conversations. With the cascade of loss and dysfunction, particularly after Grieg's divorce, previous self-positions lost their social ties and either became inaccessible or were condensed into highly symbolized, implausible singular self-positions. With fewer persons to speak with, greater losses to make sense of, and fewer cognitive resources it was easier and easier to understand the world in terms of persecution by nameless forces or admiration by celebrities through the television. In addition, with decrements in the dialogical self it may have become more difficult to ward off or reframe psychotic experiences, which may have also in turn further eroded dialogical capacity, resulting in a vicious circle in which self disturbance and psychopathology supported one another.

Course of Treatment

Treatment began when Grieg requested individual psychotherapy after receiving 5 years of medication management by a clinical nurse specialist. The psychotherapy was voluntary and provided under routine conditions in an outpatient clinic. Grieg was prescribed moderate doses of both a mood-stabilizing agent and a traditional antipsychotic medication, both of which did not vary in dosage over the course of the psychotherapy.

Psychotherapy sessions were weekly, and at the client's request, lasted 45 minutes and have been ongoing for 4 years. The client attended more than 90% of scheduled weekly appointments. The psychotherapist was a clinical psychologist (PL) who had over 20 years of experience working with persons who had severe mental disorders.

Psychotherapy was integrative in orientation with interventions derived from cognitive, psychodynamic, humanistic, and constructivist backgrounds (Lysaker, Lysaker, & Lysaker, 2001). By *integrative* we refer to a psychotherapy that assumes that "the intentional creation of a narrative meaning" in psychotherapy calls for widely varying interventions interlaced in an internally consistent theory (Feixas & Botella, 2004, p. 196). Yet by this we do not refer to an atheoretical approach. The therapists' orientation emphasized the avoidance of authoritarian relationships and embodied many traditional psychotherapeutic values including the provision of a supportive environment that allowed reflection of affect-laden experiences and the pursuit of personal autonomy. Additionally,

the therapist held a constructivist narrative theory of self (Gallagher, 2000). Exploration of the intervention and change over time was possible because the therapist took extensive notes that captured most of each session verbatim. To explore those psychotherapy notes, we artificially divided them into eight segments with each individual block comprising the weekly sessions for a total of 6 months.

Months 1–6. Therapist interventions were mostly in the form of reflection, the contents discussed were relatively concrete, and there were many intrusions of delusional beliefs (framed as monologues). The therapist offered sympathy but little empathy as there was little to empathize with. It appeared that the therapist mostly noticed something about Grieg across his utterances, emphasizing a view of Grieg in the second person. Grieg, for instance, spoke of his car and the therapist noticed, "*You* have a car that needs repair" and "there is no one to help *you*." When the conversation turned to Grieg's account of his persecution or fame, the therapist reflected, "*You* are overwhelmed by these worries." Thus a small number of plausible self-positions were established and appeared across sessions, for instance, self-as-overwhelmed-with-worry and self-without-reliable-transportation. Grieg mentioned few affects and questions about his view of himself or others were met with delusional responses or blank stares. Grieg seemed unable to think about how he felt about the therapist. He fervently asserted that psychotherapy was invaluable to him, but these assertions had a quality of wishing to flatter the therapist so that the therapist would not abandon him. In fact, a common theme that arose across sessions was Grieg as abandoned by the world. Grieg mentioned few others during this period and his description of life events was difficult to understand.

Months 6–11. Grieg remained fairly concrete and although bizarre material continued to appear, its intrusion was less frequent. His monologue seemed to be shrinking. The therapist continued to notice that Grieg occupied a place both in session and in the events he recounted, by emphasizing "you": "*you* feel X" or "*you* think X." Grieg became more responsive to this method and much of the time in sessions was spent with Grieg's using the therapist's reflections about him in the second person to start to evolve a first-person perspective over the most basic events of his life.

Concurrently, he began to mention more people and descriptions of events became more coherent and understandable. Self-positions linked to others and potential action appeared. Greig began to appear as a character who had feelings and agency. He noted, for instance, that he was jealous of his adult daughter, who was not mentally ill, suggesting a newly available self-position: self-as-jealous-of-daughter. A larger theme evolved over this time of global inadequacy and what Grieg should choose to do about it.

Months 12–18. Grieg placed himself solidly for the first time as a person in an interpersonal landscape in the beginning of the second year. He noticed that he was "unable to love" specific people whom he wanted to love. As he discussed his life, it was alternatively from two increasingly defined self-positions: of self-as-envying-X and self-wanting-to-love-X.

Months 18–24. During the second half of the second year, the therapist moved beyond noting "*you* feel" and "*you* think" and noticed how angrily Grieg behaved in session: "*You* act as if *you* are angry with me," "*You* have a hard time with *your* anger," or "*You* would like to storm out, tell me to go to hell." Although Grieg denied these feelings, he noted that some of the therapist's behaviors irritated him. He also spoke at greater length of how powerless he felt about taking medications, which he thought he did not need, and

how he did not feel respected by his daughter's husband. As Grieg narrated his life from the vantage point of more self-positions (e.g., "self-as-without-control," "self-as-disrespected-by-K," and the previously evolved self-positions self-as-envious-of-X and self-as-wanting-to-love-X) he made some behavioral changes. He obtained a telephone so that he could talk to his family, he told his daughter about his sense of not being respected by his son-in-law, and he began to start participating in recreational activities where he lived. Also during this time Grieg began to name more affects and talked about his anger at his father because of his mental disorder and shared an awareness that he was "still too angry" to mourn him fully. With an increasingly multiple and shifting array of self-positions, Grieg finally appeared capable of processing the meaning of painful life experiences and considering the roots of his maladaptive ways of coping.

Months 24–30. During the first 6 months of the third year, something new appeared. Grieg stated that although he loved his adult children, they needed to have a life outside his needs. He noted visiting them less and taking it on himself to occupy his own time. The theme of mourning appeared here with affect linked to it.

Importantly, acceptance of the loss of dreams was also noted. Grieg spoke of the time his father's carpentry shop was sold to a distant relative. He once had dreamed that it was to be his but now knew it never would be. He recalled owning a home and spoke with sadness of how he wished to own a home again but thought it improbable. He recalled periods in his childhood when he was depressed and hid from others, feeling hopeless. For the first time there was a narrative that explained affects without recourse to delusions. The world in which Grieg acted was also described as including others who had affects.

During this period, the therapist continued to notice, "*You* feel" and "*You* think," but noticed Grieg's relationship to his positive symptoms and the effects of that relation on his lack of connection to others. The therapist noted, when Grieg made delusional assertions, for instance, "*You* are overwhelmed by this thought that. . . ." When Grieg resisted that the therapist noted: "*You're* only open to one explanation today," "*You'd* prefer not to talk today," or "*You're* here today to tell me one idea and to hell with anything I say." In these later stages the therapist used "you" statements that noted Grieg's relation to his symptoms in relation to the therapist. The self-position noted here, for instance, might be self-as-repelling-the-therapist. These statements often led a reflection by Grieg that he was powerless to know what was real.

Months 30–36. During the second half of the third year, Grieg's reflections about the needs of others began to include speculations about their thoughts about him. He reported trying to "get along" with his son-in-law and noted some of their problems were a result of his behavior. He related how social anxiety kept him away and sometimes he was too passive in interactions. The content of these sessions also involved Grieg actively trying to understand his "mental illness" and in particular several suicide attempts. "How could I have gotten that way?" He asked himself this question several times and was earnestly involved in a conversation with himself about himself both in the present and about the person he used to be. The therapist often noted, "*You* are trying to take charge."

Months 36–42. During subsequent months, Grieg verbalized an awareness of how he had hurt his adult children with his delusional accusations. In a prototypical exchange Grieg said he was to be hunted and hanged by a mob and the therapist noted, "You feel angry." Grieg went on to describe how he had done something at his daughter's home that had embarrassed him and then offered more delusional material. As the therapist contin-

uously returned to the "*You*" who had done things, Grieg noted how he knew that his in-laws tried to be kind to him but that he said odd things to hurt them and he longed to stop being angry with everyone.

He also noticed the therapist's state more often. On one visit he correctly perceived the therapist had a head cold, emphasizing the "you" when talking to the therapist: "*You* are ill . . . would it be better for *you* if we stopped?" On another occasion he noted: "*You* were right I wanted to stomp out of here but that was not *your* fault . . . it's what I do when I get mad, just quit and that always hurts me." Thus, more self-positions had become available and those self-positions were more complex, imbued with affects and connected to others. There was an audience in Grieg's mind whom he knew and who knew him. Though full of anguish and not symptom free, Grieg was now fully experiencing himself as a person in the world. There was a more fully fledged acknowledgment of the otherness of the other.

Months 42–48. Finally, Grieg began to be even more active. He observed for the first time that he spent too much time alone watching television and engrossed in fantasies that celebrities loved him. When the therapist emphasized, "It is safer for you to dream of celebrities loving you than to catch the bus and do something," Grieg accepted this idea and reflected that since a young age, he had perceived life as "horrible" and had always preferred to pretend. He offered the illustration that after his mother left the home he pretended in fantasy that one of his teachers was his mother. Here for the first time appeared what Hermans (2003) has called a meta-position, or a self-position about self-positions, that allowed Grieg to see different self-positions, including their interconnections, simultaneously.

Outcome and Prognosis

Although there was no cure, there were many positive outcomes observable in this case. With the growth of internal multiplicity a man with schizophrenia and multiple deficits including gross cognitive limitations began to see himself as an actor in the world and discovered he could love some of the people he wanted to love. As he noticed more people, internal multiplicity grew, and he became more active in social relationships, which included recognizing that others probably found certain behaviors of his disturbing. There was a reduction in the frequency and severity of discomfort symptoms, although these did not fully remit. He increasingly demonstrated an ability to think about his own thinking and to see others as having separate thoughts, affects, and a life course of their own. These appeared to be scaffolded in the therapeutic relationship.

On the other hand, there was no evidence of significant improvement in basic neurocognitive capacities. It is unlikely, for instance, that Grieg's capacities for storing and retrieving memory material improved or that his ability to focus his attention changed significantly. What seems more likely is that his improved function was a result of his finding ways to make accommodations for these deficits. In other words, once there were people to love and a world to act in, Grieg found ways around these previously crippling troubles.

Clinical Issues and Summary

We believe that dialogical self-theory offers a unique vantage point from which to understand among persons with schizophrenia (1) what is the self that has been diminished,

(2) how was the self diminished, and (3) what could psychotherapy offer. In particular we have suggested that if the self is a conversation among multiple aspects of self juxtaposed in a world of others, then a disruption in the hierarchies that organize it can lead to an experience of diminished self. Further, one form that a diminished self might take is that of a monologue in which few self-positions are available and organized in a rigid manner. Within this form of diminished self there may be little awareness of others as autonomous beings and consequently only a limited sense of self as linked to others.

To explore how psychotherapy might help reignite lost conversations, leading to recovery, we have presented a case example that drew on material gathered over several years. In this example the therapist continuously offered a second-person perspective to a client with schizophrenia who seemed unable otherwise to imagine himself in a plausible interpersonal space. As the therapist offered his view of the client to the client in the predictable environment of a weekly psychotherapy session, the client slowly constructed an increasingly diverse picture of himself. It was not that chaos coalesced into a singular self. Instead, the anguish of a singular self unconnected to others grew into multiplicity. There was greater accessibility of self-positions and a hierarchy formed, which allowed for Grieg's monological account of his life to be replaced with a dialogical one, that is, one told by various aspects of himself as tethered to other individuals in the world. Using the second-person perspective provided in psychotherapy, Grieg was able to establish a first-person perspective that allowed for adaptation to a most disabling disorder and for an understanding of the thoughts and feelings of others. Grieg became able to be the teller and protagonist of his own life story.

Several issues are worth considering. First, the treatment described took place over many years and represents a considerable investment of resources. Although ways may yet evolve to help people like Grieg more quickly, until then, it may be that for persons so ill and so socially disenfranchised, this level of commitment is needed. This suggestion runs counter to current trends toward the provision of short-term services or generic support. We think that it took years for self-positions to be accessible again and that even later awareness of the thoughts and feelings of others developed, allowing for opportunities for even more meaningful change and significant self-reflection. Second, change in this case did not follow a purely linear course. There were periods in which improvement was followed by decline, and there were moments of decline when the therapist wondered whether treatment was futile.

There are several ways in which the psychotherapy offered here may depart from other treatments that involve similar methods. For one, internal conflict and negative beliefs about self and others were not understood as matters to be treated. For instance, when self-as-expecting-rejection emerged, Grieg was not asked to evaluate the evidence and formulate other beliefs, possibly banishing this self-position. Instead greater internal conversation was sought, but not necessarily conversation that led to some resolution. Grieg's hatred of the therapist was not treated as a manifestation to be explained as only being a reflection of his unresolved anger at his father. Again, greater internal conversation without necessarily any resolution of conflict was sought instead. Furthermore with self understood as composed of multiple aspects, self-actualization was not a goal to be sought through positive regard. Unconditional positive regard for one self-position could be seen as risking the inhibition of others. In fact, once the relationship was fully developed interventions often involved the therapist's interjecting rather frank accounts of reality. For instance, it emerged that Grieg was angrily hiding from others and saying things that others took as "crazy" to harm them. Here the therapist stated directly the thought that Grieg was doing things no one would approve of, not to shame or banish these aspects of self, but to call attention to a self at odds with the requirements of

adaptation. In the tradition of Nietzsche, self-disquietude and contradiction were understood as natural and a key aspect of health.

Finally, there are limitations to this report. As with all case studies, it is unclear how generalizable our observations will be. It may be that treating persons in earlier phases of disorder or treating women or persons of other ethnic backgrounds require different processes. There is not comparative research to indicate that this form of psychotherapy is superior or even comparable in outcomes to other forms of therapy. It may also be that the differing conceptions and emphases placed on individuality between different cultures may also call for very different methods from a psychotherapy that seeks to promote internal multiplicity. This article can, therefore, only be a beginning of a larger dialogue about how to assist persons who have schizophrenia to recover a healthy and dialogical sense of self.

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