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Social positioning analysis as a qualitative methodology to study identity construction in people diagnosed with severe mental illnesses

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Abstract

Severe mental illnesses (SMI) in general, and schizophrenia in particular, have been characterized as alterations of the experience of self and identity. When first diagnosed with SMI, the subjective experiences and specific narrative challenges faced by this population are particularly important. Therefore, qualitative approaches which allow to analyze these subjective experiences should be developed. This article presents in detail a specific method, called Social Positioning Analysis (SPA), which makes the complexity of narratives and life stories with multiple turning points understandable. To develop this methodological proposal, it has been taken into account the performative aspects of social interaction in which narratives are constructed. The methodology has previously been used in other health contexts and is innovative in the field of mental health. Linguistic criteria, definitions, and multiple examples are included to facilitate its application, as well as some reflections about its potential and possible benefits.

Keywords: Self, Recovery, Mental Health and Illness, Stigma, Qualitative, Methodology.

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3 The first conceptualizations of schizophrenia described it as a disorder of subjectivity
4 which was specified as loss of a cohesive sense of the self and of connection with the
5 world (Bleuer, 1911/1950). The experiences undergone by individuals diagnosed with
6 this disorder cannot be explained exclusively by associated brain alterations, but span
7 psychological, social, cultural and even political dimensions. From a phenomenological
8 perspective, schizophrenia has been characterized as an alteration of self-experience,
9 which impacts on organization of the self, and in short, in identity construction (Sass &
10 Parnas, 2003). It has therefore been qualified as a disorder of ipseity, from the Latin *ipse*
11 (itself).
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24 Pérez-Álvarez et al. (2010) established three characteristics of the alteration of
25 subjectivity in schizophrenia: hyperreflexivity, diminished sense of self, and alteration of
26 awareness of the world. The first involves an intensified form of self-consciousness.
27 Thus, one may become aware of aspects implicit in psychological processes, transforming
28 them in objects of one's own experience. For example, the flow of thoughts may be
29 objectivized, breaking their silence, and thus they are re-experienced as hallucinations.
30 The second characteristic refers to a weakened or lack of sense of self as the subject of
31 experience. One no longer considers herself the subject-agent of her own experiences and
32 understands them exclusively as a passive observer. All of this leads to an alteration of
33 bodily experience and of continuity in time. Logically, the third characteristic, alteration
34 of awareness of the world, is a consequence of the previous one. A person diagnosed with
35 schizophrenia becomes disconnected from the world when it loses its naturalness, the
36 individual feels strange, lost, and without affective connection to the world or the people
37 who inhabit it.
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57 There is no doubt that these experiences alter the psychosocial construction of
58 identity and one's relationship with the social world (Sass & Parnas, 2003, 2007). The
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3 essential instrument for organizing and expressing subjective experience and identity
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5 construction are personal narratives, the stories we create about ourselves. There is much
6
7 empirical evidence demonstrating that although people with schizophrenia have not lost
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9 the ability to make narratives about themselves, it is very hard for them to do so (Lysaker
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11 & Lysaker, 2010; Saavedra et al., 2009). Their narratives are frequently incoherent and
12
13 simplified, do not include significant events in their lives and tend to contain few themes
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15 related to agency or communion. Furthermore, such individuals do not describe
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17 themselves as agents in them, and they usually include an abundance of negative emotions
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19 about the past.
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25 In the last few decades, the model of recovery in mental health has emphasized
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27 the need to prioritize identity reconstruction in people with severe mental illnesses (SMI),
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29 such as schizophrenia, beyond just symptoms. According to Anthony's (1993) classic
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31 definition, recovery is a personal journey which requires the reconstruction of identity
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33 with the goal of achieving, in spite of the illness, new significance and a meaningful life.
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35 Contrary to the traditional view of psychiatry and due to stories in first person of people
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37 affected, the recovery model considers that persons with SMI still are able to reconstruct
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39 their identity and connect again with others and with the world. This has led to
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41 considering that their voices are a source of knowledge and that the recovery model is
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43 fundamental for organizing services and defining professional practice (Slade, 2009).
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45 Considering the relevance of the voices of patients in defining their recovery, and beyond
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47 psychometric-type instruments, qualitative analysis techniques should be implemented
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49 that enable *in situ* analysis of identity reconstruction of people with SMI, such as
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51 schizophrenia, in their recovery process.
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57 From our perspective, the discussion above takes on special meaning to the extent
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59 that we assume that identity itself is a narrative construction. According to Bruner (1990),
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3 when people are asked what they are truly like, they usually tell a wide variety of stories,
4 using traditional elements of narrative. In a related vein, McAdams (2001; McAdams &
5 Olson, 2010), defines identity as a life-story, with characters, setting, scenes, plot and
6 theme. Identity is, then, constructed within the framework of the stories that we tell
7 ourselves and others in social interaction.
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15 In this vein, people who have been diagnosed with a mental illness are faced with
16 important narrative challenges. We deal with these narrative challenges in the following
17 section.
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21 22 23 **The severe mental illness diagnosis: Narrative challenges** 24

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26 There is no doubt that suffering a first acute episode or having been diagnosed with a
27 label as powerful as a psychiatric diagnosis profoundly changes the way the self is
28 defined. For some authors, the diagnosis of SMI represents a turning point (McAdams,
29 2001). This diagnosis, as well as later recovery, requires reworking identity narratives of
30 those affected. In such cases, where the diagnostic label comes into direct confrontation
31 with a whole system of values, beliefs or previous ideas, narrative elaboration becomes
32 necessary for one's social integration and mental health. Narrative elaboration can be
33 understood as the reconstruction of the individual's life-story (McAdams, 2001),
34 incorporating new meanings and, more specifically, the SMI as part of the plot of the life-
35 story. In fact, as mentioned above, most of the definitions of personal recovery refer to a
36 search for new meanings and the reconstruction of identity as core psychosocial processes
37 (Anthony, 1993; Leamy et al. 2011). Reasons, stories, examples and other support are
38 needed to help understand the unknown and make sense of the new experiences. Narration
39 is a particularly useful and relevant way of organizing experience when something
40 unexpected happens (Bruner, 1990). In the following we further develop these points in
41 greater depth.
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3 As mentioned above, some authors consider the narratives of people with an SMI
4 impoverished (Lysaker & Lysaker, 2002; Saavedra et al., 2009; Saavedra, 2010). Since
5 narratives are an essential instrument in the construction of identity, it is difficult to
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As mentioned above, some authors consider the narratives of people with an SMI impoverished (Lysaker & Lysaker, 2002; Saavedra et al., 2009; Saavedra, 2010). Since narratives are an essential instrument in the construction of identity, it is difficult to imagine how people who struggle to elaborate these narratives can actively participate in society. This is not only because of their clinical problems and symptoms, but also because of the pressure of public stigma and the tremendous challenge of dealing with all these issues.

In this sense, public stigma presents one of the most significant difficulties in this process of narrative elaboration. Widespread stereotypes and prejudices about people with SMI characterize them as dangerous, unstable or unpredictable and having extravagant and disorganized behavior (Brohan et al., 2010; Corrigan et al., 2012; Rüscher et al., 2005; Van Beveren et al., 2020). It is therefore particularly important to understand how the narratives of affected people deal with public stigma. People with SMI very often internalize the stereotypes, negative prejudices, and discriminatory behavior toward them, a process that has been called self-stigma (Corrigan et al., 2006, LeBel, 2008). For some authors, this can only be understood through a narrative approach (Kondrat & Teater, 2009). Similarly, active and effective resistance to the internalization of these discourses requires those affected to bring narrative resources into play.

From this perspective, we assume that a diagnosis of SMI presents many challenges that must be addressed. Identity and the medium and long-term past, present and expected life trajectory must be resignified in different domains, such as intimate relationships, employment, and friendships. In each of these contexts, conflictive situations and stress may arise. For example: When can or should a friend be informed of the diagnosis? And a potential romantic partner? Is it mandatory, beneficial or harmful to

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3 inform an employer of the illness? These and many other questions may arise during the
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5 recovery process.
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8 In short, these narrative challenges often require 1) deciding how much to agree
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10 with the diagnosis, and the label to be used in explaining the SMI; 2) exploring
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12 explanatory models and inserting them into the own life narrative; 3) negotiating how
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14 much agency or responsibility is acknowledged by the individual at the onset of the
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16 problems and in their current state; 4) posing strategies to deal with public stigma and
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18 self-stigma; 5) deciding the form and degree of disclosure and to whom; and finally, 6)
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20 managing expectations regarding the recovery process, i.e., projection into the future. In
21
22 the following sections, we present a proposal aimed at analyzing these narrative
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24 challenges.
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27 28 **Analyzing narrative identity: Social positioning** 29

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31 The concepts of positions and positioning (Davies and Harré, 1990; Bamberg, 1997;
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33 Harre & Van Languenhove, 1999) are central to the analysis of narrative identity. These
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35 concepts are based on the idea that identity emerges from the use of language in the
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37 framework of social interaction. In such situations, we are constantly managing our image
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39 (Goffman, 1967), negotiating and renegotiating our roles, as if we were performing on a
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41 stage. Goffman coined the term “footing” to point out to the different forms of
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43 “alignment” between a speaker and their listeners. Thus, different listeners may reject,
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45 accept, or question the role with which the same speaker presents him or herself.
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49 In a related vein, Harré and Van Languenhove (1999) described several properties
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51 of social interaction. The first is its moral character. This means that, in social interaction,
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53 participants negotiate the configuration of their personal attributes by allocating rights,
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55 obligations or responsibilities, thus legitimizing roles and practices. Secondly, all social
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57 interactions are historical in the sense that a past sequence of interactions is recreated in
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3 the current interaction. The third property refers to the capacity of utterances to redefine
4 the interaction at any time. This feature provides interlocutors with agency. In other
5 words, participants in any interaction can change and resituate their position in the social
6 space of the interaction at any time. Thus, the term “positioning” refers to the place in the
7 social space, for example, between a psychologist and his or her client. The interlocutors
8 claim this position for themselves as opposed to other subjects (who may or may not be
9 present in the actual context of the conversation) (Bamberg 1997; Lucius-Hoene &
10 Depperman, 2002). By claiming a certain social space in an interaction (self-positioning),
11 we place our interlocutors within that social space (other-positioning).
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24 Positioning can be understood as a “self-presentation”, an “act of identification” or
25 a “self-attribution”. These self-attributions indicate how people want to be understood
26 and recognized by their interlocutors. In our opinion, the notion of positioning is more
27 flexible than the “role” construct, as it can flow differently in the same conversation at
28 different levels. Although positioning analysis is closely related to the study of social
29 interactions in everyday life, what Bamberg (2006) calls “small stories”, we believe that
30 it can be applied to any text, as long as it is understood within an interactive framework.
31 From our perspective, the notions of position and positioning can be fruitfully applied to
32 understanding the narrative identity of people with SMI.
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44 This analysis addresses the way the dilemma of continuity vs change (Bamberg,
45 2011) is dealt with in the narratives of people with SMI. Since life always involve
46 changes, and often ruptures (turning points), narratives provide individuals with a sense
47 of continuity by making sense of them and preventing the dissolution of identity (Bruner,
48 1990; McAdams, 1993; Nelson, 2003). In the case of those diagnosed with SMI, whose
49 experience is characterized by an alteration of the sense of the self, how they face the
50 challenge of continuity becomes critical.
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3 According to previous studies (Prados et al., 2013; Santamaría et al. 2013; de la
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5 Mata et al., 2015), this qualitative methodological approach enables us to inquire how
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7 people face the challenges mentioned above. By analyzing the narratives produced in
8
9 social interactive contexts, the processes of identity reconstruction can be explored
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11 dynamically. In this sense, social positioning analysis provides us with conceptual and
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13 methodological tools that can be productively applied in this population. The following
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15 section systematically presents the Social Positioning Analysis methodology.
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20 **Social Positioning Analysis (SPA): a methodological proposal**

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22 In line with the theoretical ideas introduced above, this approach analyzes identity
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24 reconstruction in people diagnosed with SMI. It has been successful with other
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26 populations in health contexts (Genuis, 2013; Williams et al., 2015; Glintborg &
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28 Thogersen, 2021) as a tool to assist in understanding the complexity of their narratives
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30 and life stories with multiple turning points. Therefore, we are convinced that this
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32 methodology, which is a combination of techniques based on Social Positioning Theory,
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34 can be beneficial as a qualitative approach to SMI.
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39 The Social Positioning Analysis (SPA) methodology is described below by
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41 explaining the key steps in its application to an interview or any other fragment of
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43 discourse of a person diagnosed with SMI. This description gives some examples
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45 extracted from narratives of SMI patients, and includes a table summarizing the examples,
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47 linguistic criteria, and definitions. Table 1 summarizes the steps in Social Positioning
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49 Analysis. These steps are briefly explained below:
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53 **Table 1.**

54 ***Social Positioning Analysis application.***

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60 | <ol style="list-style-type: none">1. Identify the positions of the narrated self through other characters in the narrative.2. Identify the positions of the narrator in the interactive context of the narration.3. Analyze the sequence of positioning throughout the narrative to identify changes, core positions and possible conflicts. |
|----------------------------------|--|

4. Explore the influences/traces of cultural discourses in the positions found.
5. Answer the question: How does the narrator want to be understood? (“How can the narrating self be described?”).
6. Validation/reliability.

1) First, all the narrator positions taken as a character in the text are identified as opposed to other characters. Sometimes, there are direct references to how the narrators consider themselves and present their personality or identity. For example, in the same text, a person may be described as a strict and demanding father with his children, and as a very unruly son in the past. It is important to highlight and consider any reference to time or place that can contextualize positioning.

2) The narrator’s positions must also be analyzed in the interactive context, here and now, with the interlocutor. For example, in the context of a research interview, a participant may be defined as active and autonomous in their narration, but in the context of the interaction they may be submissive and passive.

One controversial aspect of SPA is related to the linguistic criteria that enable the positions in a text to be identified (de Fina & Georgakapolou, 2011). This is mainly because of the many possible indicators of social positioning, and the ways in which the same indicators can reflect the positions that the participants take at any given time and place. Some of the most common linguistic criteria that can help identify such positions in a text are presented in Table 2 as a non-comprehensive list of some particles and linguistic criteria that could be useful.

Table 2.

Linguistic criteria for social positioning analysis.

Linguistic criteria	Definitions and observations	Examples*
Own descriptions of themselves and/or others	Social categories, including nouns, verbs or adjectives used by the narrator to describe his or her personality, for example, are also explicit signs.	“father”, “academic”, “sick”

Use of pronouns and determinants	<ul style="list-style-type: none"> -The use of plural or singular indicates the extent to which the narrator considers himself part of a given social group. - Use of the second person to describe personal events distances the narrator from the episodes he or she is describing. - Use of possessive determinants indirectly positions and includes oneself in social categories. 	<p>“We, people diagnosed with schizophrenia, have struggled a lot to defend our rights”</p> <p>“YOU take an extra drink and some pills and, of course, you do a lot of stupid things”</p> <p>“MY diagnosis of schizophrenia”</p>
Use of direct or reported speech	<ul style="list-style-type: none"> -A direct style gives voice to other characters who position them in the narrative. This style usually denotes a stronger emotional component that can sometimes lead to problems integrating the positions or disagreement with them. - Analysis of reported speech is essential to analyze other-positions that appear in the narratives, and the way those others position the speaker. 	<p>“The doctor told me: I’m sorry to tell you that you have schizophrenia”</p> <p>“The doctor told me (laconically) I had schizophrenia”</p>
Use of verb tenses	<ul style="list-style-type: none"> -This helps understand different times during the narrative. -Past positioning reinforces present positioning by giving the narrative a progressive dynamic that is compatible with the narrative structures of accepted genres in Western culture. 	<p>“I suffered a lot in the past, but now, I feel I can control my life”</p>
Non-verbal aspects of language	<ul style="list-style-type: none"> - Prosodic: volume, frequency and tone of voice. - Paralinguistic: coughing, pausing or laughing. - They help interpret some positions better. - A transcription system that is sensitive to prosodic and paralinguistic elements is recommended, as shown on the right, following Schegloff et al. (1974). 	<p>“↑Do you a:sk me if I have felt discriminated against? NO::, of course NOT; They have NEVER neglected me, (.) they have always counted on my opinion ... (1.0) ... [ironically]”</p>

*All examples are extracted from Saavedra (2009a, 2009b)¹.

3) It is also essential to analyze the sequence of positions throughout the text to determine important changes, core positions, and any possible conflict. Often, in the same part of the discourse, different positions may be associated with very different points of view. Conflicts between positions and the way in which the narrator resolves them are essential to the study of identity construction, and are a fundamental part of the results. For example, there is often a conflict between the passive role of patient in the presence of a doctor or in a hospital, and the agency they are presumed to have in the recovery process.

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3 4) In the fourth step, the influence of cultural discourses on the positions found and
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5 used by the narrator to give meaning to his or her identity can be explored. Some have
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7 called this “*discursive genres*” (Bakhtin, 1986) or “*master narratives*” (McAdams &
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9 McLean, 2013). For example, the story of the self-made man who achieves success
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11 through his own efforts is a narrative structure accepted and understood in the USA,
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13 and its model can be used to validate certain positions. McAdams (2008) calls such
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15 self-construction “the redemptive-self”.
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19 5) The fifth step in SPA consists of trying to answer the specific question, “How does
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21 the narrator want to be understood?” as synthetically as possible, and strictly following
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23 the results of the analysis. In other words, how should the narrator’s self be described?
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25 (Bamberg, 1997). The answer to these questions is a synthesis of all the social positions
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27 detected in the analysis, and form the backbone of the narration. Social positions that
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29 appear repeatedly in the narrative, or conflicts among social positions may be
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31 indicators of a key role in identity construction. For instance, the core of the identity
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33 of a person diagnosed with schizophrenia in the context of an interview with a social
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35 worker might consist of two main social positions detected throughout the interview:
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37 father, responsible, and autonomous, and person with schizophrenia who needs help.
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39 In the context of this interview, these two positions confront each other and present
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41 very different perspectives and aims before the institutional presence of the social
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43 worker, who threatens the first position as responsible father.
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49 6) Finally, throughout this process some method of testing validation or reliability
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51 must be used. The positions found and the interpretations made must be based on
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53 empirical data (text) and verified by some method of reliability. Some of these
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55 qualitative validation methods are external audits, peer review, or member checking
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(Cohen & Crabtree, 2008). Any criticism, correction or innovation in the results at this stage should be explicitly added to the final report.

Examples of the Analysis

In this section we present four brief excerpts from interviews exploring the explanations given by four people diagnosed with SMI for why they live in a care home. The intention is not a systematic analysis, but to show how some of the criteria above may be applied to describe the differences in positions of the persons interviewed.

The extracts analyzed in this section belong to a broader study about the changes in the narratives of people with SMI who live in care homes (Saavedra et al., 2009; Saavedra, 2009b)¹. All participants were living in care homes for people with SMI at the time of study. The interviews, which were transcribed and analyzed, were conducted in the same care home by a researcher who had previously worked there as a caregiver. The questions answered by the participants in the extracts are: why do you think you are living here? How would you describe your problems? The analyses were audited as a group by team members who did not conduct the interviews.

Excerpt 1. Man, 30-40 years old. Paranoid schizophrenia.

I: And why do you think that you have these problems?

P: My illness, the problem with my illness is that I can't get organized on my own, like working and stuff like that, I don't, I don't know what I have to do and that's why I'm taking the medicine that Dr. L. gave me, and then I get a bit better. I go to the rehabilitation unit and I do cognitive exercises with some other patients, who go there on Fridays as well, to the same place I go.

In this excerpt, the positions related to the illness completely monopolize the participant's story. The participant internalizes the diagnosis, "my illness", positioning himself before the interlocutor as a person with problems to work and to be autonomous: "I don't know what I have to do". In the text he refers to the names of the clinicians and health services he goes to together with "other patients". In fact, the contents related to

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3 the illness and the relations with the health services took up a large part of the interview.
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5 The participant positions himself in the narrative in the light of the cultural discourse of
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7 biomedicine about mental illnesses. On the surface, this excerpt may seem coherent, but
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9 the lack of agency and the absence of diversity in the positions pose a risk to the recovery
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11 process (Leamy et al., 2011).
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15 **Excerpt 2. Woman, 20-30 years old. Paranoid schizophrenia.**
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17 **I:** ... Why are you here?

18 **P:** Well, I have schizophrenia.

19 **I:** Aha. And what's that?

20 **P:** I don't know what schizophrenia is. But you do, don't you?

21 **I:** Well, that's why I am asking, because people say lots of very different things.
22 I want to know what you think.

23 **P:** I don't know what schizophrenia is. I know that my nerves get at me.

24 **I:** Aha.

25 **P:** I am getting a bit nervous.

26 **I:** Right, OK.
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30 This participant positions herself as a patient diagnosed with schizophrenia to
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32 explain why she lives in a shelter. However, she neither understands, nor is she likely to
33
34 identify with that positioning. She answers what she thinks the interviewer expects to
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36 hear, interpreting the situation as a kind of examination or interrogation. The interviewer
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38 is positioned by the patient as an expert, "I don't know what schizophrenia is. But you do,
39
40 don't you?", an expert who is testing her. The brevity of the responses and the
41
42 interviewee's tone (which is not reflected in the transcript) indicate that she is
43
44 uncomfortable with the situation. Under pressure from the interviewer, the participant
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46 uses the colloquial term "nerves" to position herself: "my nerves get at me" and "I'm
47
48 getting a little nervous". The use of the present continuous and the prosodic aspects of the
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50 interaction allow us to interpret not only that the participant describes her problems as
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52 "nerves" but also that the interaction "here and now" is making her nervous. This is
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54 understood by the interviewer, who pauses the interview.
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3 **Excerpt 3. Man, 20-30 years old. Paranoid schizophrenia.**
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5 **I:** How would you describe your mental health problems? How do you explain
6 them [to yourself]? If you explain them [to yourself] in some way.
7

8 **P:** Man, I really, well, I entered into a psychotic break, according to them. Me,
9 what happened to me outside... but I'm really fucked, because they doubt me about
10 what I say, you know? It's fucked up, like anxiety and... because for me, well, it's
11 never happened to me. I see a green dog and if it's green I say "green" and I don't
12 say it's purple. You know? I don't know, it's never happened to me. And there I
13 am, trying to convince or be convinced that I'm ... Sure, I listen to you, but I have
14 my truth inside, you know?
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18 In the third excerpt, the participant uses a technical concept "psychotic break" to
19 describe his problems. The past tense of the verb "to enter" distances him from that
20 moment. In addition, he then adds "according to them" transforming the previous
21 sentence into the indirect style. That is, the participant is positioned by other people as a
22 psychiatric patient (psychotic break). By means of the above-mentioned linguistic
23 resources, the participant shows his reservations about this positioning. Moreover, the
24 participant positions himself as a reliable person in the face of the interviewer by means
25 of the expression "I see a green dog and if it's green I say "green" and I don't say it's
26 purple" (self-positioning). At the same time, he positions himself as a "fucked up" person
27 because "they doubt me about what I say, you know?" Through the description of an
28 action, the participant describes himself as an active person: "trying to convince...". In
29 short, the participant resists the other-positioning of "them", which is never made explicit,
30 but is understood to be the physicians. Nevertheless, he makes it clear that he "listens to
31 them". It is not a simple denial of the diagnosis. The participant is actively negotiating
32 with the health care providers and with himself in order to find the best way to build his
33 identity. Following Bruner (1990), this kind of active positioning would enable the
34 construction of an "agentive" self in the narrative".
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56 **Excerpt 4. Woman, 50-60 years old. Bipolar disorder.**
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58 **I:** Do you have a problem... with your nerves? What would you call it?
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3 U: I used to sleep very well all my life and one night I went to bed and I was a
4 little sick. I said, what is this? Let's see if they have put something in my..., is this
5 possible?

6 I: How?

7
8 U: I thought my mother didn't love me; she was my grandmother. The bricklayer
9 put...

10 I: The bricklayer?

11 U: And she says, leave him, leave him, I liked a boy who was there, I said let's
12 see if they are putting poison in my beer, all night. In bed, shivering, very bad,
13 me, she got up very early, at eight, Mom, what's wrong? And what do I know,
14 something's wrong with me, look, but what do you have? My legs. Let's see if a
15 nurse can come, or we call a taxi, we take a taxi...

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18 Social positioning analysis is also useful in interpreting texts with lack of cohesion
19
20 caused by communication problems that people with SMI may have. In the last extract,
21
22 the participant shows problems in coherently narrating the episode of her first psychotic
23
24 break. In the first line, the researcher asks if the user suffers from a problem with her
25
26 "nerves", a very general, little stigmatizing, and widely used colloquial term. Thus, the
27
28 researcher distances himself from positions that could identify him as a health
29
30 professional. The participant responds with a concrete experience: the moment in which
31
32 she identifies the beginning of her problems. She positions herself as a victim of
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34 poisoning, somebody put something in her drink: "Let's see if they have put
35
36 something...".
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41 The narrative is quite incoherent. We know that the user "slept very well all her
42
43 life" and that she was "a little sick". The disbelief in this first experience of illness is
44
45 translated into a set of weakly described and connected symptoms: sleeping problems,
46
47 shivering, cognitive problems, "I thought my mother didn't love me, she was my
48
49 grandmother", and problems with her legs. The participant expresses her inability to
50
51 understand what was happening to her. The proliferation of the direct style (voice of the
52
53 mother and participant in direct style) indicates a lack of control of speech and a high
54
55 emotional charge. The participant's discourse is a justification for her current state.
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3 However, the episode is vaguely narrated, and problems can be found in contextualizing
4 characters such as "the bricklayer", or with deictic expressions such as "there".
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8 The social positions shown in these four extracts are very different. The first
9 participant positioned himself as a person with an illness who had problems being
10 autonomous. Institutions and people related to mental health services were essential in
11 his answer to the researcher's question. The second one did not accept the social context
12 of the interview and tried to avoid it by giving a stereotyped answer. The third one used
13 a technical term to describe his problems, but then positioned himself as an honest person
14 discussing his social position as mentally ill with health professionals. This participant's
15 configuration of social positioning is probably the most complex. The last participant's
16 narration of her first episode of psychosis lacked coherence, but positioned her as a victim
17 of poisoning, which is what caused her psychiatric problems.
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31 In the excerpts above, the participants positioned themselves in complex
32 sophisticated manners that could hardly be captured from the classical concept of illness
33 insight, and require a qualitative microanalysis of identity construction in interactive
34 contexts. SPA reveals how people with SMI interpret their experiences of illness and how
35 they explain their diagnoses and their relationships with significant others, including
36 healthcare professionals. In addition, with this methodology, it is possible to explore how
37 they project themselves into the future and their ability to act in the world (agency).
38 Although the excerpts analyzed are very brief, several in-depth interviews using this
39 methodology would make it possible to analyze the recovery process of people with SMI.
40 We think the recovery process cannot be studied exclusively with psychometric
41 instruments, and that the level of analysis addressed with SPA provides highly relevant
42 information that is very difficult to access by other means. It is therefore an appropriate
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3 methodology that can help to better comprehend the recovery process for a particularly
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5 sensitive and diverse population.
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7 8 **Conclusions**

9
10 This article is based on the concept of identity as a fluid dialogue among different
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12 social positions in narratives, which constitutes an ever-changing process (Saavedra,
13
14 2010). Social Positioning Analysis is a methodological approach for capturing this
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16 dialogue, which can account for the dynamics of social positions in the narratives of
17
18 people with SMI in interactive frameworks.
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21 Social Positioning Analysis differentiates from other qualitative methodologies in
22
23 several respects. It is aimed at the analysis of identity construction. Other approaches to
24
25 narrative identity often focus on the content and the general structure of narratives (Kerr
26
27 et al., 2020), leaving its micro-interactional nature behind. Social Positioning Analysis
28
29 involves not only the person interviewed, but also the interviewer, who is frequently
30
31 ignored in research. As a methodological tool, it is useful for studying the dynamic nature
32
33 of identities during the course of a conversation, situating recovery narratives in specific
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35 social interactions. It can therefore account for how individuals (re)construct themselves
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37 in cultural settings. More specifically, it can account for the performative aspects, how
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39 identities are brought into play in the course of social interaction. It also helps understand
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41 the narrative construction of continuity-discontinuity in the individuals' life stories, or the
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43 way they appropriate cultural discourses, or master narratives, in their identity narratives.
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45 In this vein, SPA is close to conversational analysis and can be applied to "small stories"
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47 (Bamberg, 2006), that is, to informal interactions in daily life, not only the analysis of
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49 formal narrative interviews. Other qualitative mental health methodologies, such as
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51 Critical Realist Discourse Analysis (Sims-Schouten & Riley, 2019), have been published
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53 in this journal. This approach combines several methodological traditions to examine
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3 external material realities. However, our analysis, which is based exclusively on discourse
4 analysis and discursive psychology, is mainly focused on participant text and interaction.
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8 Since that identity reconstruction is the cornerstone of recovery, we must use
9 analytical tools which allow capturing all the complexity and dynamism of this process.
10
11 Although this methodology is too sophisticated to be employed *in situ* in the clinical
12 practice, it can be used *a posteriori* by therapists and supervisor teams as a qualitative
13 assessment procedure of recovery processes and implemented interventions. As it has
14 been pointed out previously, Social Position Analysis is perfectly applicable in the
15 context of the everyday interactions between therapists and patients, not being
16 necessary structured interviews, as in our examples, nor a specific focus on research. Our
17 methodology would have to be triangulated with other approaches to verify the accuracy
18 of our analysis. For example, longitudinal studies in which the narratives of affected
19 people are analyzed during their recovery, could be compared with other evaluations
20 using other methodologies (diagnostic interviews, psychopathological evaluations,
21 psychometric tests, etc.). This could determine the characteristics of the narratives and
22 the linguistic markers most closely associated with recovery.
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40 This methodology is not free of limitations. First, this analysis requires complex
41 linguistic explorations of the text to identify positions (semantic, syntactic and prosodic,
42 nonverbal, etc.) far from the usual thematic analysis, which requires the same narratives
43 to be reread several times. In this sense, we have tried to provide the reader with the
44 linguistic criteria most frequent in such analyses. Second, reliable determination of
45 positioning throughout the interviews is difficult, time-consuming and hard work. In
46 addition, reports on the results must be lengthy to demonstrate the depth and the reliability
47 of the analysis. Therefore, publication of this kind of analysis is frequently complicated.
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49 Also, due to its situated and qualitative nature, generalization can be achieved solely in
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3 terms of analytical generalization, not statistical Giménez, 2012; Yin, 2009). Analytical
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5 generalization would allow for the application of theory in a variety of contexts.
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8 Despite those limitations, we are convinced of the great potential of SPA and the
9
10 value of the information that it can provide, especially for the population with SMI. First,
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12 as discussed above, because schizophrenia is a disorder of the self, and second, because
13
14 the core of the prevailing model of recovery in mental health is identity reconstruction.
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16 Moreover, this methodology has been demonstrated to be effective in other vulnerable
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18 populations and health-related contexts, such as migrants (Calderón-García et al., 2017),
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20 women victims of gender violence (de la Mata et al., 2015), and patients recovering from
21
22 brain-injury (Glintborg, 2019). It has also been employed for analysis of identity
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24 construction of education and health professionals (Prados et al., 2013).
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28 We consider the narrative analysis of social positioning a significant contribution
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30 to the complex study of recovery and stigma, which requires the combination of
31
32 qualitative and quantitative methodologies to significantly advance in knowledge.
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45
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47
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55 ¹ All extracts included in this article belong to research projects in which informed
56
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