QUALITATIVE HEALTH COMMUNICATION
VOLUME 5, ISSUE 1, 2026
ISSN: 2597-1417

Is it or is it not? COVID-19 patients' (mis)understanding of self-talk

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QHC Qualitative Health Communication

ABSTRACT

Background: This study considered self-talk within the context of COVID-19 hospitalization, assuming that patients isolated from their usual social contacts would engage in self-talk to compensate for the change in social interactions. **Aim:** To explore how patients hospitalized with COVID-19 in select hospitals in Nairobi, Kenya, understood and experienced self-talk as a coping strategy during hospitalization. **Methods:** We employed a qualitative approach, gathering data through interviews with 15 recovered COVID-19 patients who had been hospitalized in prominent hospitals in Nairobi, Kenya. These were selected using both purposive and snowball sampling techniques. **Results:** Thematic analysis of the data shows that participants used self-talk, though some confused it with thinking and praying. Secondly, while descriptions of self-talk varied, there was a consensus among the participants that the concept refers to talking to oneself. Thirdly, the conversations with the self were either silent or loud. However, there were misconceptions regarding overt self-talk. **Discussion:** Although participants demonstrated an understanding of self-talk, persistent misconceptions about overt self-talk highlight the need for culturally sensitive health communication interventions. **Conclusion:** The above findings highlight the need to increase awareness regarding self-talk, especially in health communication and addressing misconceptions that link overt self-talk to mental illness.

KEYWORDS

COVID-19, interviews, patients, qualitative approach, self-talk.

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Introduction

Talk is central to the lives of human beings, especially considering its contribution to the development of the individual and society (Vocate, 1994; Guerts, 2018). There is no doubt that people are always talking; what raises debate is who they talk with or to. Geurts (2018) states that a considerable portion of 'talk' is directed to and done with others (social talk). This kind of 'talk' is so common that there is a tendency to equate 'talk' with communicating with others. Hence, the description of 'talk' as a dialogue between two people (Hardy, 2006). This is particularly evident in communication models (for example, Shannon-Weaver's model, Laswell's model, Schramm's model, and Osgood's model, among others), which represent the speaker and the receiver as separate entities (McQuail & Windahl, 1994; Narula, 2006). However, there is an aspect of talk that has not received much attention among communication scholars, yet it is of great significance. This is talk directed to the self (herein referred to as self-talk), a key element in intrapersonal communication.

Background

The concept of talking to oneself (self-talk) is said to have been first described by Piaget in what he labelled as 'egocentric speech' (John-Steiner, 2007; Winsler, 2009). Piaget considered talking to oneself a sign of immaturity, especially among children, because he felt it implied poor social speech (Winsler, 2009, p. 4; Huang, 2021). This position was later challenged by Lev Vygotsky, who saw self-talk (what he referred to as 'self-directed speech') as beneficial for self-regulation (Huang, 2021). In this case, self-regulation was considered as "...deliberate control of one's attention, thoughts, and actions..." (Fox & Riconscente, 2008, p. 385). This suggests that self-talk affects self-control and behaviour (Brinthaupt, 2009) and plays a role in problem-solving for the individual (John-Steiner, 2007, p. 138).

Defining self-talk

Self-talk is a concept that is not easy to define. The paragraphs below will review two critical definitions of self-talk to develop a working definition of the concept. These are definitions by Hardy (2006) and Latinjak et al. (2019).

After reviewing many definitions of self-talk, Hardy (2006) supposed that the concept should be understood as messages addressed to the self in a multidimensional and dynamic way for motivating or instructing the individual (p. 84). This definition captures self-talk's nature (multidimensional and dynamic) and purpose (motivating and instructing).

The second critical definition worth considering was offered by Latinjak et al. (2019), who presented self-talk as:

> [...] verbalizations addressed to the self, overtly or covertly, characterized by interpretative elements associated to their content; and it either (a) reflects dynamic interplays between organic, spontaneous and goal-directed, cognitive processes or (b) conveys messages to activate responses through the use of predetermined cues developed strategically, to achieve performance related outcomes (p. 16).

This definition, along with the aspects of self-talk conceptualized by Hardy (2006), introduces several essential elements. First, it presents self-talk as overt or covert verbalizations, meaning that self-talk is said silently and loudly to oneself. The second key element is the interpretative aspect of the self-talk content. Third is the categorization of self-talk as organic, spontaneous, and goal-directed. Organic self-talk can be either controlled (goal-oriented- where certain statements are used intentionally) or uncontrolled (spontaneous- where statements are not controlled) (Latinjak et al., 2019). Lastly, self-talk attracts feedback, which leads to an outcome.

Borrowing from the two definitions above, that is, the one by Hardy (2006) and the more recent one by Latinjak et al. (2019) and the purpose of self-talk introduced by Vygotsky (Brinthaupt, 2019; Huang, 2021), this study considers self-talk as messages addressed to the self either covertly or overtly for self-regulation when faced by a challenging situation.

Several scholars have supported the idea of self-talk as a tool for self-regulation. Some of these include Fernyhough (2016), Brinthaupt (2019), and Fritsch et al. (2022), among others. Brinthaupt (2019) saw this self-regulation function of self-talk as demonstrated in self-criticism, self-reinforcement, self-management, and self-assessment. All these affect the way an individual behaves or responds to situations. Building on this, Fritsch et al. (2022) presented self-talk as a strategy that can be used to cope with challenges. Individuals going through different types of problems are expected to use specific phrases to cope with their situation.

Categorization of self-talk

Scholars have conceptualized self-talk in diverse ways. This sub-section briefly discusses some of the major categories. A common approach is to distinguish self-talk as positive or negative (e.g., Kyeong et al., 2020; Zourbanos et al., 2016). Positive self-talk reflects an "inner fan" that reinforces confidence and motivation, whereas negative self-talk represents an "inner critic" that undermines self-belief. Van Raatle et al. (2019) observed this dichotomy particularly among athletes, noting that the dominance of the inner fan tends to enhance performance motivation, while the dominance of the inner critic often results in demotivation. Similarly, Upasen et al. (2020) reported that positive self-talk was one of the strategies nurses employed to cope with occupational distress. This suggests that individuals who appraise their abilities and circumstances positively are more likely to exert greater effort, whereas negative appraisals may hinder performance.

Empirical studies further substantiate this relationship (Atmoko et al., 2018; Hardy et al., 2001; Van Raatle et al., 2019; Zourbanos et al., 2016). Hardy et al. (2001), for instance, found that athletes perceived positive self-talk as motivating and negative self-talk as demotivating. Interestingly, their study also highlighted that negative self-talk could, in specific contexts, function as a motivator.

Beyond evaluative categories, self-talk is classified based on function (motivational or instructional; Chiu et al., 2019) and by mode of delivery (silent or aloud; Dickens et al., 2018). In addition, self-talk can also be considered from a linguistic perspective. This is particularly evidenced by reference to oneself in the third person (e.g., by name) versus the first person (e.g., using the pronoun "I") (Kross et al., 2017). The study by Kross et al.

(2017) found that third-person self-talk promoted psychological distancing and improved emotional regulation. They concluded that even subtle linguistic techniques may significantly influence cognitive appraisal and coping, with potential applications in reducing stress and mitigating perceived threats to health (Kross et al., 2017, pp. 387–388).

Collectively, these categorizations demonstrate that self-talk is not a uniform phenomenon but rather a flexible, context-dependent process that may yield divergent outcomes depending on content, function, delivery, and linguistic framing.

The COVID-19 context

The contextual setting presented by being hospitalized with COVID-19 meant that individuals were more likely to engage in self-talk. The pandemic led to losing control (Missel et al., 2021) and increased stress among patients (Amja et al., 2021), especially those hospitalized. Such individuals (hospitalized COVID-19 patients), who are socially isolated from their usual relationships, could use self-talk to compensate for their lack of or limited interactions with others (Brinthaupt, 2019).

Several studies have confirmed using self-talk as a compensation strategy for people in situations considered isolating. For instance, adults who grew up without siblings were reported to use self-talk more frequently than those who had siblings (Brinthaupt & Dove, 2012). This was supported by Brinthaupt, who hypothesized that "...spending more time alone or having socially isolating experiences..." was associated with a higher frequency of self-talk (2019, para. 1). On this social isolation hypothesis, the study by Brinthaupt (2019) concluded that the extent of social isolation affected self-talk frequency. This was also supported by Hardy et al. (2004), who confirmed that self-talk was more present in situations with limited interactions. Implying that patients hospitalized or isolated with COVID-19 were likely to use self-talk as a coping strategy, hence their relevance for focus in this study.

Aim

This article is part of a more extensive study on the self-talk experiences of COVID-19 patients. This part of the study aimed to explore how patients hospitalized with COVID-19 in select hospitals in Nairobi, Kenya, understood and experienced self-talk as a coping strategy during hospitalization. By focusing on patients' subjective meanings and interpretations of self-talk, the study sought to contribute to a deeper understanding of its role in coping with illness-related stress and uncertainty.

Theoretical framework

Hermans' Dialogical Self Theory (DST) guided this study. The origin of this theory is linked to the works of James and Bakhtin (Hermans, 2001) in the dialogic self. According to Meijers and Hermans, the theory emphasizes the 'self' (which is internal)

and 'dialogue' (which is assumed to be external). It bridges them together, making it possible to explain conversations involving only one person (2018, p. 7).

DST was preferred for this study for several reasons. First, it is said to transcend discipline boundaries (Hermans, 2008). Hence, appropriateness for this study considering the multi-disciplinary nature of self-talk. Secondly, this theory was preferred because of its propositions about the self. DST conceives the self as being able to occupy many I-positions (Hermans, 2001). This multiplicity of I-positions assumes that individuals can assume the roles of a sender and receiver when having conversations with themselves. In his description of this construct, Hermans argued that "... The 'I' fluctuates among different and even opposed positions and has the capacity imaginatively to endow each position with a voice so that dialogical relations between positions can be established. The voices function like interacting characters in a story, involved in a process of question and answer, agreement and disagreement" (2001, p. 248). This view was supported by Oles et al. (2020), who considered self-talk as dialogic and explained it as involving at least two 'I positions' (para. 3). This explanation is valuable in understanding self-talk.

Methods

We considered meanings and reality to be socially constructed. Hence, this study fits within the constructivist research paradigm. Thus, the realities and experiences of patients regarding self-talk were assumed to be varied and multiple. To understand these realities and experiences, the researchers employed a qualitative approach and generated data using interviews. This subsection briefly explains the study sample, how participants were recruited, the data gathering process, the data analysis procedure, measures taken to ensure quality, and ethical considerations observed.

Study sample

The study's population was patients who had been hospitalized with COVID-19 in select leading hospitals within Nairobi County in Kenya and had recovered and been discharged.

We conducted fifteen (15) interviews between February 2023 and March 2023. Preliminary data analysis showed saturation after the 12th interview (Nganda, Mwithia & Ugangu, 2025). However, we opted to include all 15 interviews in the final analysis. The sample included both male (6) and female (9) participants who were aged 18 years and above.

The study did not seek to determine the ages of the participants; however, from the researchers' observations and information captured from the interviewees' responses, the participants can be described as follows:

Table 1. *Summarized descriptions of the participants.*

Participant Code	Gender	Brief description of participant
001	Male	He described his age as mid-twenties and works as a cashier in a local supermarket.
002	Female	A middle-aged female who works as a professional model.

003	Female	A businessperson aged over 60 years.
004	Female	A businesswoman aged over 30 years who runs a boutique. She is married and has one child.
005	Male	Married businessman, around 30 years old
006	Female	Final year student at a local university
007	Female	Early twenties university student
008	Male	Adult male
009	Female	Female, over 30 years, who works in a real estate company
010	Female	Mid-twenties female
011	Male	A male adult who does part-time jobs in Nairobi
012	Male	A middle-aged man, who was working as a casual laborer
013	Female	A female aged over 40 years was working in a government agency
014	Female	Works as a pharmacist in Nairobi
015	Male	Aged around 30 years and works in a supermarket in Nairobi

The above participants were hospitalised with COVID-19 between 2020 and 2022 for varying lengths of time.

Recruitment of participants

We used a combination of purposive sampling and snowball sampling techniques to recruit participants. We sought assistance from the administration of the selected hospitals in identifying former patients who met the inclusion criteria. These were patients who had been diagnosed with COVID-19, were admitted in one of the selected hospitals, had fully recovered, could communicate in English, lived within Nairobi County, and were aged over 18 years.

From the initial request, the researchers received five potential participants. Four of them agreed to participate in the study and, after interview, recommended other potential participants (snowballing). This technique was preferred because of the stigma associated with being infected with COVID-19. Also, the researchers assumed that recovered patients were likely aware of other patients who had recovered from the disease. This aligns with Creswell and Poth's suggestion that the snowball method helps identify participants by asking people who know others who might meet the researcher's inclusion criteria (2018).

Interview guide

This study employed a qualitative descriptive research approach, which, according to Kiradakis et al. (2022), is best suited for exploring and capturing participants' perspectives. We believed that using an interview guide enabled us to probe for detailed responses and ask follow-up questions.

We pre-tested the interview guide on three participants who were excluded from the primary data analysis. As recommended by Buschle et al. (2022), during the pretest, participants were encouraged to be open and to say what came to mind when they heard the questions. Also, as Perneger et al. (2015) suggested, the researchers modified the research instrument after each pre-test and then pre-tested it on the next participant.

Data generation

Before the start of each interview, the purpose and nature of the study were explained to the participants, and measures taken to ensure the study did not harm them were expounded on. The participants who agreed to participate signed a consent form and were asked to permit recording. The interviews were audio-recorded and transcribed by two research assistants. Lastly, once an interview session was completed, the participant was requested to recommend other potential participants.

Data analysis process

Audio recordings of the interviews were transcribed verbatim. Each transcript was cross-checked against the corresponding audio recording and reviewed alongside field notes to ensure accuracy and consistency. To protect participant confidentiality, all identifying information was removed and replaced with code names prior to analysis.

The data was then analyzed thematically, guided by Colaizzi's seven-step process, which is widely recommended for phenomenological studies (Morrow, Rodriguez, & King, 2015). The analytic steps involved: (a) familiarization with the transcripts, (b) identification of significant statements, (c) formulation of meanings, (d) clustering of themes, (e) development of descriptions, (f) condensation of descriptions, and (g) seeking verification (Morrow et al., 2015, p. 643; Karimi et al., 2020).

Assuring trustworthiness

To ensure the study's trustworthiness, the researchers employed multiple strategies consistent with qualitative research standards (Lincoln & Guba, 1985; Nowell et al., 2017).

First, verbatim quotes from participants were prioritized when presenting the findings, thereby foregrounding participants' voices and grounding interpretations in the data (borrowed from Adisaputri & Ungar, 2023). Second, three participants were randomly selected and invited to review the emergent themes and interpretations to determine whether these accurately reflected their experiences and perspectives as part of member checking.

Furthermore, the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007) was employed as an internal audit tool. The study was systematically reviewed against the 32-item checklist to reinforce methodological rigor and transparency (Buus & Perron, 2020; Lee et al., 2020).

Ethical considerations

Prior to commencing the study, ethical clearance was obtained from the Daystar University Institutional Scientific and Ethical Review Committee (DU-ISERC). In addition, a research permit was granted by the National Commission for Science, Technology,

and Innovation (NACOSTI) under the Ministry of Education, Science, and Technology in Kenya (Permit No. NACOSTI/P/23/23220).

Participants were fully informed about the purpose and nature of the study, as well as their rights as research participants. Informed consent was obtained from all participants before interviews were conducted. Other ethical principles that were adhered to include voluntary participation, confidentiality, anonymity, privacy, and non-maleficence.

Results

Participants' use of self-talk

We sought to determine whether patients used self-talk while hospitalized. This study was anchored in the assumption that patients hospitalized with COVID-19 used self-talk. Hence, it was necessary to establish whether self-talk was applied. Several participants indicated that they talked to themselves while hospitalised with COVID-19.

For example, Participant 001 reported moments when he talked to himself. He explained that this was because he was not sure he could have survived, especially with the many reports of deaths related to the virus.

While participants reported using self-talk, differences might arise in the purpose of self-talk or the benefits associated with self-talk. Several themes emerged in relation to this. They include using self-talk to boost self-confidence, to instruct oneself, to regulate emotions, and for motivation.

From the responses received, it emerged that some of the participants used self-talk to boost their confidence. This was evidenced by the use of words that related to belief in their ability to handle the disease. For example, a participant reported that they were telling themselves that they 'could do it'.

> I can do it, I can do it, was my favorite phrase every time I tell myself I can do it, I can do it (Participant 002).

Some of the participants used self-talk as a way of dealing with emotions like fear, worry, and anxiety. This implies that self-talk is beneficial in controlling emotional aspects like anxiety, fear, and worry. This, by extension, could help patients suffering from conditions like COVID-19 have a better recovery.

Several participants reported how they used self-talk to encourage themselves because of the kind of situation they were going through. Perhaps that is why one of the participants described self-talk as a 'me to me.' During the interview, Participant 011 insisted that he had to be there for himself. In one instance, he declared that "I had to encourage myself, yes, in the long run, I knew it was me for me" (Participant 011).

Nevertheless, it is worth noting that not all the participants reported using self-talk. For example, one of the participants responded: "Not actually because now you were like, what if it gets worse and then still you are scared, now especially for me my worst scare was my baby" (Participant 009). On further probing, she added that: "I am not sure if it's talking to myself or it's talking to God. I am not sure if it is talking to me or when you

talk to yourself louder I think it's more of communicating to God or something" (Participant 009).

This tells that some participants may confuse self-talk with praying. As seen from the response of Participant 009, she had doubts about whether what she experienced was self-talk or communicating with God. This shows how it might not be easy to comprehend what is happening within the individual's mind.

In addition, talking to oneself can easily be mistaken for thinking. Since both self-talk and thinking originate in an individual's mind, it is easy to confuse the two. The above example highlights that self-talk can easily be confused with other related aspects, such as praying and thinking. This is comprehensible, considering that praying involves, in most cases, talking to beings that are not visible, either loudly or quietly. Even though both self-talk and thinking can be described as mental skills, their main difference lies in the dyadic nature of self-talk. In self-talk, the speaker and the receiver are located within the same individual, yet they are distinct in the way they perform their roles (Zell et al., 2012).

Terms used to refer to self-talk

Several terms emerged as participants explained how they talked to themselves. One of the terms that came up was 'monologues with yourself' (Participant 002), 'conversations with myself' (Participant 006), 'meeting with self' (Participants 005, 010 and 014), Whether seen as 'meeting with myself', 'conversations with myself', or 'monologues with myself', what strongly emerges from these labels of self-talk is individualistic and generally would refer to one sharing messages with themselves. This agrees with the definitions of self-talk presented earlier in the background section of this article. These were definitions by Latinjak and others who saw self-talk as verbalizations addressed to the self (2019, p. 16) and Hardy (2006) who considered self-talk as messages addressed to the self.

Covert and overt self-talk

The definition of self-talk adapted for this study and the definition by Latinjak and others (2019) indicate that self-talk can be either covert or overt, implying that one can talk to oneself silently or loudly. The paragraphs below present results from conversations with the participants concerning this.

Covert self-talk

Most of the participants who reported that they talked to themselves indicated that it was silent. These include Participant 005, Participant 007, Participant 008, Participant 009, Participant 010, Participant 011, Participant 014, and Participant 015.

Participant 005 said that everyone had some voice in their head that they talked to. This means the participant believed that everyone talks to themselves silently. This was

also implied by Participant 009, who said that she used to talk to herself silently when the pain was not extreme.

The participants' responses provide evidence that, among those who talked to themselves, there was agreement that the conversations were silent. This shows that there are limited or no misconceptions regarding covert self-talk among those who use it. Perhaps because no one else has access or is aware of the words one speaks silently to self.

Overt self-talk

Some participants reported talking to themselves loudly (e.g., Participant 005, Participant 008, Participant 009, Participant 014, and Participant 015).

To illustrate this, Participant 005 said that there were moments he would talk to himself loudly, just like he would engage in a conversation with another person. His words were that:

> [...] you know, sometimes I could talk loudly like you know I am in the room alone, but I am having a conversation with myself, and I am talking like I am actually talking like I am right now (Participant 005).

This agrees with the view that self-talk can be both covert and overt, as expressed in the definition by Latinjak et al. (2019), who presented self-talk as "... verbalizations addressed to the self, overtly or covertly..." (p. 16). Individuals can talk to themselves either silently in a way that no one else can hear what they are saying or loudly.

From the responses received, the researchers noted that overt self-talk was associated with pain or uncomfortable situations. For example, one of the responses was "[...] at times it was quietly ... mostly quietly, but when the trauma got to me, it started getting louder and louder" (Participant 015). This shows that pain can trigger loud self-talk.

However, not all participants considered talking to themselves loudly to be self-talk. One of the participants, even though she indicated that she understood the concept of self-talk and had used self-talk while at the hospital, in her response she seemed to suggest that only covert self-talk is real self-talk. She said that "[...] it was quiet like I could not talk to myself loudly, that's not self-talk like any other person can hear it, yeah so, it can't work" (Participant 010).

This view confines self-talk to only that which happens silently and ignores the fact that people sometimes talk to themselves loudly. This kind of perception could potentially be informed by the belief shared by Participant 008 that talking to oneself loudly might be seen as a sign of mental health challenges or being bewitched. This agrees with Brinthaupt et al. (2009) view that loud self-talk may lead to mental health concerns.

Some participants expressed concern that speaking aloud to oneself could be misinterpreted in their sociocultural contexts. In particular, they noted that loud self-talk might be perceived as a sign of mental illness, given that individuals with certain psychiatric conditions are sometimes observed speaking audibly to themselves. Such associations could expose patients to stigma or negative judgment from others. One participant further highlighted that, in some cultural settings, talking to oneself aloud might even be interpreted as evidence of supernatural influence, such as witchcraft. This perception reflects broader cultural tendencies to conflate mental health

challenges with spiritual or mystical causes. The fear of being misunderstood in this way appeared to influence how participants engaged in self-talk during hospitalization, with some preferring silent or internalized forms of self-talk to avoid drawing unwanted attention or judgment.

Positive versus negative self-talk

Another theme that emerged from the responses was categorizing self-talk as either positive or negative. This was seen in the response of one of the participants, who said:

> In my opinion, self-talk is good, and at the same time, it's not good, depending on what you're saying to yourself about because. I know people who were talking to themselves, for instance; maybe I could tell myself this is the last time I am going to be on this earth. Like I am going to die, you see, it could impact on me negatively, but to me, it was positive because I used to tell myself I am going to get out of this place (Participant 010).

This participant suggests that whether the words to self are positive or negative could have a bearing on one's well-being and recovery if one is unwell.

Another participant, while responding to a similar question, responded that:

> I believe that in this world, for you too, not even to make it, for you to succeed at some point in anything, be it a disease, be it a career, you have to keep on saying positive things to yourself and every time I was telling myself that you are going to make it (Participant 002).

Scholars like De Muynck and others (2020) present the valence of self-talk as either positive or negative. This relates to the kind of words or phrases one says to themselves. Positive self-talk is words of praise, while negative self-talk can be termed as self-criticism (Hardy & Zourbanos, 2016; Zourbanos et al., 2007). The study by Zourbanos et al. (2007) recommended that coaches should support athletes' use of self-talk by avoiding criticisms (negative self-talk) and instead using encouraging words (p. 64). Feeney (2022) also proposed this kind of learning strategy for differently-abled learners.

However, beyond the dimensions of self-talk as either positive or negative based on the nature of words or phrases (Zourbanos et al., 2007; Hardy & Zourbanos, 2016; Hasbi & Asni, 2023), there is need to consider the effect of the words said to the self. The effect of self-talk, as suggested by some of the participants in the current study, could be positive or negative.

First-person versus third-person self-talk

Another theme that emerged was on the use of first-person and third-person self-talk. Some of the participants would refer to themselves as 'I'. For instance, participant 002 gave "I can do it" as one of the statements she kept using while at the hospital. She further explained that "I can do it was my favorite phrase every time I tell myself I can do it, I can do it" (Participant 002). Also, she would at times tell herself that "I know I have the capability to fight this disease" (Participant 002).

The short phrases show that the participant was addressing herself as 'I' and the content of the statement shows emphasis on her ability to fight the disease. The use of

'I' in addressing the self when one is using self-talk has been referred to by some scholars as immersed self-talk (for example Gainsburg et al., 2022).

Some participants may refer to themselves by name when talking to themselves. Scholars have labelled this as distanced self-talk. In this study, only one participant reported referring to herself by name when talking to herself. This agrees with views of several scholars who have studied distanced self-talk. For example, Gainsburg et al. (2022) while describing it as seeing the self from a distance argued that it may promote rational self-interest during decision-making (Gainsburg et al., 2022, pp. 1-2).

Discussion

In summary, the results presented above indicate that, first, participants reported using self-talk even though some confused self-talk with thinking or praying. Secondly, while self-talk was described in various ways, there was a consensus among the participants that the concept refers to talking to oneself. Thirdly, the conversations with the self were either silent or loud. However, some participants had a misconception about talking to oneself loudly. Lastly, the participants demonstrated understanding that self-talk can be either positive or negative, and positive self-talk was associated with well-being.

This study aimed to determine whether participants used self-talk during hospitalization with COVID-19 and what they understood by self-talk. Some participants reported using self-talk while hospitalized. This finding aligns with a study by Gavin-Breier (2017) on multiple sclerosis.

However, not all participants reported using self-talk. This could imply that either some participants did not use self-talk or were unaware they had used it. Regarding the first possibility, studies confirm that self-talk is commonly used (Payne & Manning, 1998; Theodorakis et al., 2008), especially among people facing challenging situations (Bellomo et al., 2020; de Matos et al., 2021; Feeney, 2022). The literature reviewed for this study shows that self-talk is a commonly used strategy that begins early in childhood (Geurts, 2018; Winsler, 2009). Hence, the possibility that some participants were unaware of their self-talk seems more plausible. This presents a challenge on how to make participants aware of their self-talk. This kind of challenge, according to Brinthaupt et al. (2009), may be considered a clinical question that, from a communicator's perspective, may not be fully answered. This is further complicated by the fact that self-talk is a mental skill (Gammage et al., 2001; Atmoko et al., 2018), which means there is a likelihood of challenges in differentiating self-talk from thinking. This is supported by Kompa's declaration that "[...]some instances of inner speech are instances of thinking [...] some instances of thinking are instances of inner speech" (2003, p. 10).

The second key finding in this study concerns what participants considered self-talk. Several terms and phrases emerged from participants' responses as they attempted to describe the self-talk phenomenon. Some of these were "monologues with yourself" (Participant 002), "conversations with myself" (Participant 006), and "meeting with your own self" (Participant 010, Participant 014, Participant 015). While these terms seem diverse, they all connote one thing – talking to oneself. It is evident that the participants considered self-talk as communication involving only one person.

It is evident from the terms above that participants understood what self-talk is. These terms agree with descriptions of self-talk by various scholars. For instance, 'conversations with the self' (Brinthaupt & Dove, 2012), 'either inner monologue or inner dialogue' (Kompa, 2023), and considered it as statements said to the self and not other people (Cutton & Hearon, 2014, p. 478). These descriptions align with the tenets of DST as proposed by Hermans (2001).

Nevertheless, some scholars have challenged the view that self-talk is communication. Given that self-talk occurs within the individual, some scholars have argued that it is not communication, claiming that what occurs within the individual is a biological process (Alemoh, 2019). Deamer (2021) amplifies this thinking by positing that, generally, communication involves the transfer of messages and emotions from sender to receiver (p. 426). This assumes that the sender and the receiver are different entities. However, as suggested by De Muynck et al. (2020, para. 3) in their exposition of the dialogic nature of communication with the self, the individual can adopt two 'I positions' during their self-talk moments. This is further cemented by the propositions of DST regarding multiple I-positions, confirming that in self-talk, an individual can take the position of the sender and receiver (Hermans, 2001; Hermans, 2008). This perspective is supported by Oles et al. (2020), who conceptualized self-talk as inherently dialogic, involving at least two distinct "I positions" (para. 3). This conceptualization enhances understanding of self-talk's dynamic nature.

These findings align with Zell et al. (2012), who observed that individuals can adopt multiple identities during self-talk, effectively separating the "sender" from the "receiver" in intrapersonal communication. From this perspective, self-talk represents a complete communication cycle, encompassing message generation, feedback, and behavioral outcomes, such as coping with illness.

Some participants in this study referred to themselves using first-person pronouns, a form of immersed self-talk that situates the speaker at the center of their experience (Gainsburg et al., 2022). The linguistic structure of self-talk is crucial, as it can shape intentions and influence behavior (Senay et al., 2010). By contrast, distanced self-talk, which often uses third-person references or phrases, has been shown to enhance rational thinking, emotion regulation, and self-control (Afshord & Dana, 2022; Furman et al., 2020). Collectively, these insights suggest that both immersed and distanced self-talk play distinct but complementary roles in shaping cognition, motivation, and coping strategies, with implications for understanding how individuals cope with challenges posed by isolation.

The third key finding was that most participants understood that self-talk could be either loud or silent. Various terms are typically used to describe loud and silent self-talk. These include private speech for loud self-talk (Winsler, 2009) and inner speech for silent self-talk (Brinthaupt et al., 2009). Also, other terms used are covert and overt self-talk (Lee, 2011; De Muynck et al., 2020; Deamer, 2021). Some participants demonstrated an understanding that self-talk can be overt and covert.

However, not all participants considered overt talk as self-talk. Some participants limited self-talk to what is said silently to oneself, not to what is said loudly. This suggests a possible misconception about overt self-talk. Even though self-talk has been defined as verbalizations addressed to the self either overtly or covertly (Latinjak et al., 2019, p. 16), not everyone accepts messages spoken aloud to oneself as part of self-talk. This misconception regarding overt self-talk is further amplified by the tendency in some

communities to equate talking to oneself loudly as either a sign of mental health problems or being bewitched. Despite the misconception, and as demonstrated by most participants, self-talk can be both silent (covert) and loud (overt).

The findings discussed above carry several important implications. To begin with, recognizing self-talk as a standard and multifaceted coping mechanism underscores the opportunity for healthcare providers to integrate structured self-talk strategies into patient support programs, particularly in contexts of isolation. Secondly, encouraging positive self-talk could enhance resilience, foster emotional regulation, and support recovery. In addition, addressing misconceptions through culturally sensitive communication may help reduce stigma surrounding overt self-talk. Thus, practical applications may include embedding self-talk awareness in patient education or counselling interventions designed to support mental well-being. Future research should extend these insights by evaluating the effectiveness of guided self-talk interventions in clinical and community settings and exploring how cultural and linguistic contexts shape self-talk practices. Such efforts would deepen theoretical clarity and strengthen the practical utility of self-talk as a psychosocial resource in healthcare.

Conclusion

This study was carried out with the primary objective of exploring the understanding and use of self-talk among patients hospitalized with COVID-19 in select hospitals within Nairobi County. This study concludes that self-talk is applied among patients, especially those isolated from their social contacts. However, some people may need to be self-aware that they are talking to themselves. Secondly, this study concludes that there is a fair understanding of the self-talk concept. As noted from the various terms the participants used to describe what self-talk was to them, it was evident that they understood what self-talk is and its key attributes. However, some participants seemed to have misconceptions about overt self-talk, which they considered not self-talk. This shows that while most people may understand self-talk, some may be influenced by misleading beliefs about self-talk. This could affect appreciation and the use of self-talk. Given this, we recommend that health communicators should create awareness of the benefits of self-talk. In addition, there is a need to address the misconceptions about overt self-talk and delink its association with mental health issues.

Declaration of conflicting interests

The authors declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

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VOLUME 5, ISSUE 1, 2026