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A STUDY OF THERAPY FOR LANGUAGE IMPAIRMENT IN APHASIA: DESCRIPTION AND ANALYSIS OF SESSIONS IN DAY-TO-DAY PRACTICE

VOLUME 1

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Thesis submitted for the degree of PhD

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This thesis is dedicated to Karin. Without her wonderful unstinting support and encouragement it would never have been completed.

Karin – i' han di' 'was

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Finally, and most importantly, without the support of the participants this study would not have taken place. Therapists and people with aphasia generously allowed their therapy to be recorded, observed and analysed, and I hope that this thesis is a fair reflection of their generosity.

DECLARATION

I grant powers of discretion to the University Librarian to allow this thesis to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

ABSTRACT

The methods used by therapists in the process of language therapy with people with aphasia are often ascribed to 'clinical intuition', and are seldom explicitly described in therapy studies. Many of the problems surrounding replication of language therapy in aphasia and the understanding of what constitutes effective therapy centre around the implicit nature of how therapists make decisions about implementing therapy on a moment-by-moment basis.

Language impairment therapy is often reported in terms of tasks or activities. Reference to cueing or feedback may be made, but the role played by the person with aphasia in these processes usually goes unreported. It has been argued, however, that therapy is not synonymous with the task but takes place through the interactive work between therapist and person with aphasia.

In order to further our understanding of the process of therapy and to develop an explicit and consistent vocabulary for describing and analysing the enactment of therapy an observational study was carried out. Fifteen therapist-aphasic person dyads participated in the study, contributing video- and audiotape recordings of forty-one therapy sessions. Videotapes and audiotape transcriptions were subject to qualitative analysis using ethnographic methods in a process of analytic induction, in order to develop a descriptive framework. Methods derived from Conversation Analysis were also used in order to examine the detailed interaction between the participants.

In this study therapy is examined and the processes through which it takes place are made explicit in a systematic and orderly fashion, addressing the ways in which task-related work is enacted, and revealing the roles of the participants in the conduct of that work.

This study describes the enactment of tasks in ways which: 1) account for the interactive nature of therapist and aphasic person contributions; 2) demonstrate how processes of task-related work are distributed across the session as a whole; and 3) address task-related work as a technical and a social process.

This study confirms the scope of previous conceptualisations of the enactment of therapy, and provides empirical evidence. In addition, processes through which therapists gained and maintained control of sessions were found to be similar to those found in other healthcare settings.

TRANSCRIPTION CONVENTIONS

Standard English orthography is used in transcriptions from audio- and videotape. In the case of phonological errors broad phonetic representations are given between /   /, but International Phonetics Association (IPA) symbols are not used. Nearest approximations such as */?/* for glottal stop are used and are italicised. For example */fi:l/* for "feel".

Therapist is shown as T, and aphasic person as A. TP is a third party – if identity is known this will be described at their first utterance e.g. TP ((aphasic person's wife)).

Each line is numbered (1, 2, 3 etc). This is to help locate utterances or actions referred to in the body of the text . The numbers are generally of no other significance, i.e. they do not necessarily help to pinpoint an exact location in the transcription of the session as a whole.

(1.5) — Indicates time lapse in seconds and half seconds. This may be used to indicate a pause (within speaker turn) or a gap (between speaker turns). It may indicate time lag between utterances or other actions. Time lapse was measured from the video display counter.

(.) — Indicates a micropause.

pumpkin — Indicates emphatic stress.

( ) — Transcriber unable to hear what was said.

(word) — Indicates uncertain hearings.

((smiles)) — Indicates transcriber's descriptions.

A: not [sure]
T: [not]sure — [indicates the start of an overlap, and] indicates where the overlap ends.

= — Used to indicate continuity (no pause or gap between utterances). This is used in two main ways:

1) From one speaker to the next:

    A: I'm not sure=
    T: =not sure at all

2) To indicate a continuous major turn by one speaker, where there is a backchannel response by the other (which does not overlap):

    A: I'm not sure=
    T: mhm
    A: =at all

so::	: is used to indicate lengthening of sounds. Placed immediately after the relevant sound. The number of : used gives a rough indication of the length of prolongation.
quiet	* around a word indicates that it is spoken comparatively quietly.
...	Used to indicate that a part of the transcription has been omitted.

CAPITALS show written words or use of letter tiles

INTONATION

Symbols indicating intonation are placed immediately following the word/s containing the relevant tonic syllable.

\	A low falling tone, which may acknowledge a prior response for example.
↓	A high falling tone, which may show strong agreement, surprise or sympathy.
↑	A rising tone, which may question a point or an answer.
/	A low rising tone, which may signal something more is required or to come, or is an invitation to continue, or it may indicate some doubt by the speaker about their own utterance.
^	A rising falling rising tone which may imply doubt or reservation about a prior utterance.

Where there is an indication in the text of an approximate number of 'major turns', these are defined as all turns apart from "minimal turns", which contain tokens such as 'mhm', 'yes' or 'right' in isolation (Perkins 1995).

Transcription conventions have been derived from a number of different sources including: Atkinson and Heritage (1984); Goodwin (1981); Sinclair and Coulthard (1975).

CHAPTER ONE

INTRODUCTION

1.1 Background

It has been argued that much of what professionals in teaching and healthcare do in their practice, in the heat of the moment, is not premeditated but intuitive (Atkinson and Claxton 2000). 'Intuition' is described as being "tacit", "a gut feeling" (Atkinson and Claxton 2000: 1), or carries the implication that the individual professional has some inherently mystical power which allows him or her to identify something or provide the correct answer (Goldberg 1997). When the term 'intuition' is invoked in relation to clinical practice in the therapies – 'clinical intuition' – it raises questions of therapy as art or science (Nezu and Nezu 1995), or practice which defies objective analysis (Goldberg 1997).

With a focus specifically on speech and language therapy, 'clinical intuition' appears to be equated with 'traditional practices', which include a range of procedures or processes arising during therapy at the interface between therapist and client. These include "contingency thinking" (Goldberg 1997: 316) – the ability to anticipate a client's response; procedures to repair misunderstanding (Silliman 1984); or strategies such as "cueing", "shaping" or "facilitating" (Davies and van der Gaag 1992: 316). In the field of aphasia therapy Byng (1995) equated uncertainty about the precise nature of therapy with the suggestion that knowledge about therapy is implicit in the practice of therapists. Treatment techniques in day-to-day therapy practice appear too simple and have been compared unfavourably with the relative sophistication of the diagnostic tools available to aphasia therapists (Howard and Hatfield 1987). It is the issue of implicit or intuitive practice in aphasia therapy which is the focus of concern in this study.

Not only does aphasia therapy apparently have the appearance of being too simple, but therapists also seem to appeal to a "classical lore" (Lesser and Milroy 1993: 236), or a 'standard' approach to treatment (Mitchum and Berndt 1995) when referring to the implementation of therapy. At best the practice of aphasia therapy is reported in terms of tasks or activities, possibly with reference to technical skills such as cueing, facilitation or feedback. However, as Byng (1995) and Basso and Marangolo (2000) point out therapy is not synonymous with the task – it takes place at the interaction between the aphasic person and the clinician. The presentation practices, contingent responses and mutually informative work between therapist and aphasic person, which anecdotal evidence suggests is the actual stuff of everyday practice in aphasia therapy, are rarely evident in research reports and academic papers.

But, if the practice of aphasia therapy is understood and carried out by experienced and competent clinicians, even if it is not specified or reported in detail, why should that be a matter for concern? Concern has in fact been expressed in relation to a number of issues. Firstly the aphasic person's role in therapy is often neglected (Byng 1995). The important role played by feedback from aphasic person to therapist in the conduct of therapy has been pointed out (Simmons-Mackie *et al* 1999). Byng (1995) argues that, if therapy is considered to be an interactive process, then the role of the aphasic person has to be taken seriously. Secondly, if therapy is conveyed through the interactive work carried out by therapist and aphasic person (in the conduct of various tasks and applying various materials), then the process of this interactive work must surely be of great interest to those people wishing to understand what 'worked', and how it 'worked' (or did not). If the therapy did 'work' then we ought to be able to describe it explicitly and in enough detail for others to try. In other words treatment variables should be explained in enough detail to allow replication of therapies (Avent 1997), and to enable us to develop a deeper understanding of efficacy.

At present it generally appears that the understanding of interactive processes in therapy is implicit, with a range of tacit, non-specified assumptions. As such this understanding of therapy processes bears some resemblance to "lay theories" (Furnham 1988), which may differ from scientific ones in various crucial ways – for example lay theories are rarely explicit or formal, while scientific theories are set out in a logical, internally consistent manner. It seems vital therefore, that if the practice of aphasia therapy is to receive serious consideration, the processes though which it takes place should be made explicit in a systematic and orderly fashion. In order to do this and to develop an understanding of the interactive process of therapy we need to study how it is being carried out.

Therapy sessions in day-to-day practice between experienced clinicians and people with aphasia will be examined in this study in order to develop explicit and consistent descriptions of therapy. Various researchers have already undertaken work to study therapy process from a variety of perspectives, and these approaches will be reviewed in the following chapter and in the course of this study. This study aims to further develop the work of describing therapy process as it relates to therapy for language impairment in aphasia.

While acknowledging the value of intuition in professional practice (see Atkinson and Claxton 2000), it is argued here that we do not know enough about the skilful practice of aphasia therapy, as a speech and language therapy profession, to be complacent about the *status quo*. The concern to uncover what may be meant by 'clinical intuition', or 'traditional practices' in aphasia therapy, is the primary focus of this study.

1.2 Research questions

In order to try and further our understanding of the process of therapy, develop an explicit and consistent vocabulary for describing and analysing therapy, and develop an understanding of the conduct of sessions as a whole, the following questions will be addressed through the systematic observation of therapy in day-to-day practice:

1. What can the pattern of interactions between therapist and person with aphasia tell us about the ways in which sessions are structured and organised?
2. What are the characteristic features of the interaction between therapist and aphasic person during the course of the session?
3. Can a 'main business' of the session be identified and how do the participants orient to the 'main business' of the session?
4. What is the relationship between the 'main business' and other aspects of the session?
5. What evidence is there that will help provide more explicit definitions of certain therapy techniques such as those described in the literature as 'cueing', 'prompting', 'scaffolding', 'facilitation' and 'feedback'?

This researcher comes to the study of aphasia therapy as a practising therapist. For me, as for the clinicians and people with aphasia who participated in the study, aphasia therapy is not an academic abstraction. It is, as has been cogently demonstrated by various authors, a social process, taking place in the context of communication disability. As such, it rightly deserves careful investigation.

The following chapter will review how authors from a variety of methodological backgrounds and with various aims have explored the process of aphasia therapy, the process of related activities such as teaching, and the social processes of lay-professional interaction in general.

CHAPTER TWO

REVIEW OF THE LITERATURE

2.1 Introduction

As has been outlined and discussed in the previous chapter the questions which are the subject of this thesis are concerned in particular with therapy for aphasic language impairment and its enactment in day-to-day practice. Not only does the type of therapy, but also the focus and manner of the inquiry, have a bearing on the literature which will be reviewed in this chapter.

The review will therefore examine the literature concerned with:

- Therapy for aphasic language impairments in terms of the enactment of treatment
- Describing and analysing aphasia therapy sessions
- Describing and analysing speech and language therapy for children in clinics and in schools
- Approaches to the investigation of interactions in service or institutional encounters

In the spirit of the advice given by Wolcott (1990: 17) quoted in Silverman (2000: 230), that the literature should be "drawn upon...selectively and appropriately as needed in the telling of their story", reference to and consideration of the literature will not only be made in this chapter. In the course of the chapters on methodology and methods (Chapter Three), data analysis (Chapters Four, Five and Six), as well as in the Discussion (Chapter Eight), particular references from the literature will be used to support arguments and analysis, and to highlight contrasts with the data from this study.

2.2 Therapy for aphasic language impairments

The type of therapy under investigation in this study is specifically one which focuses on 'improving' the aphasic person's impaired language. There appears to be some agreement in the literature about the options available to the therapist in terms of a remediation strategy for addressing language impairments (although there is by no means a consensus or an agreed terminology). Howard and Hatfield (1987: 130) suggest three options: "restoration, reconstitution, or compensation". Lesser and Milroy (1993: 15) argue along broadly similar lines that: "direct therapy may be characterised as being directed at reactivation, reorganization and substitution", while Byng *et al* (1994) (quoting Seron *et al* 1991) describe the objectives of rehabilitation in terms of whether the components or representations in the cognitive architecture are to be "promoted, restored or reorganised" (Byng *et al*, 1994: 336).

However it is not the purpose here to examine these particular concepts in detail, nor to examine manifestations of these strategies in terms of a detailed review of individual treatment studies. The following two sections will examine the ways in which the process of enacting therapy have been considered and reported in the aphasia therapy literature.

2.2.1 Therapy process

As has been discussed in the previous chapter, much of the motivation for this study has come from a general awareness that much current knowledge about therapy is implicit in the practice of speech and language therapists. The literature on aphasia therapy (of any type) is not noted for its detailed description of the process of therapy (Byng *et al* 1994). Sparse descriptions of the process of therapy may be placed in contrast to the experimental design of therapy studies, which is usually reported in detail.

While continuing to remain under-specified as a concept the study of the 'process' of encounters between health professionals and their clients has received attention in fields other than speech and language therapy. 'Process' as a component of medical and therapy intervention has come to be treated as an entity in itself, and worthy of research in its own right. Ram *et al* (1998) consider 'process' – as opposed to practice management – to be the doctor's actual performance. Stiles (1989: 212) defines the process of medical interactions as the "verbal and non-verbal behaviour of patients and physicians". Within the field of psychotherapy, 'process' is considered in terms of therapists' verbal techniques – variously: reflection of feeling; transference interpretations; focus on affect (Stiles 1988; Stiles and Snow 1984). Other researchers have approached the study of 'process' in terms of sequences of problem solving activities (Rogers and Holm 1991). 'Process' research has also been approached in terms of a 'black box' image whose contents are to be unpacked (Ballinger *et al* 1999). As will be seen below (Sections 2.4.2 and 2.6.1) the study of what could be considered to be the 'processes' of lay-professional encounters have been approached from the perspective of various different traditions – for example, ethnography and Conversation Analysis (CA).

In terms of this study the working definition of therapy process owes much of its scope to Byng *et al* (1994) and Byng and Black (1995) who delineate aspects of the therapy process in terms of: 1) therapy procedures – methods of task presentation, "including the interaction between therapist and patient" (Byng *et al* 1994: 338), or "feedback and interactions that take place between the patient and the therapist in the course of the task" (Byng and Black 1995: 310); 2) control over the properties of the stimuli used; 3) types of facilitators – "e.g. feedback strategies, cues, inhibitory procedures etc" (Byng *et al* 1994: 338); 4) strategies for modifying tasks; 5) the timing and pacing of tasks. Byng and Black (1995) also refer to how the tasks are introduced

and explained. This might perhaps be considered somewhat peripheral to a consideration of impairment focused therapy, but in terms of the ways in which therapists seek to engage and involve people with aphasia in the language therapy they are undertaking, the interactions at 'the fringes' of the task are considered here to be an integral part of the process of therapy.

The review of the literature will now continue with a more detailed examination of how process components have been considered in reports of aphasia language therapy, bearing in mind the view that, despite the application of sophisticated theoretical models of language processing to therapies of this sort: "applying these models does not use any radically new methods... The techniques used are part of classical lore" (Lesser and Milroy 1993: 236). Mitchum and Berndt (1995) also suggest that in a 'standard' approach to treatment, once an impairment is targeted for attention, therapists traditionally rely on the armamentarium of techniques available for addressing different types of symptoms. The literature review will examine just how the 'classical lore' or the 'armamentarium of techniques' is described as operating.

2.2.1.i Therapy process in psycholinguistically-oriented impairment-focused therapy

As has been discussed above some authors have attempted to explicitly delineate the component processes of this type of therapy. This section will consider how other authors have referred, either explicitly, but generally implicitly, to the processes involved in enacting therapy.

Recent papers reporting on specific therapies or specific therapy approaches influenced by psycholinguistic models allude to interactions in therapy. For example, Visch-Brink *et al* (1997), describing BOX (a semantic therapy resource), talk about therapists' immediate reactions to patients' responses, or cueing the patient in various ways. In the Clinical Forum which follows this paper the contributors allude to the

process of therapy in various ways. For example Avent (1997: 1081) – quoting Byng (1993) states that the "'process of therapy' is interactive". She goes on to argue that treatment variables such as the language impairment, tasks and materials involved in treatment should be explained in enough detail to allow replication of therapies. Interestingly she mentions instructions to clients as an area that would hamper replication. Presumably this refers to a lack of specificity in delineating the content and manner of explanations about tasks and task procedures. Nickels (1997: 1086) refers to some of her own work (Nickels and Best 1996 – which will be considered in more detail below) and also argues that: "in the evaluation of BOX the role of feedback should be considered and, at the very least, therapists (participating in the evaluation study) should be encouraged to be consistent in their use of feedback". Shelton (1997) also refers to the importance of feedback – in particular specifying the type of feedback each patient receives. In her response to the contributors' comments Visch-Brink (1997) acknowledges the need for detailed information about the cues and feedback given by the therapist in the course of treatment, but that the speech therapist has to: "make it [BOX] vivid by using it creatively, which could result in a different approach for every patient" (Visch-Brink 1997: 1111).

Ferguson and Armstrong (1997: 1091) in their contribution to the Clinical Forum, make the point that: "there appears to be an assumption that if an aphasic person were to simply do the exercises as outlined in the materials, i.e. "practise", then improvement would occur", making it (i.e. the items – words, sentences etc contained in BOX) a very powerful set of materials. However, they go on to argue that "effective therapy" involves more than this.

As mentioned above, Nickels and Best (1996) report on an aphasic person who benefited from a semantic judgement task, but only when he was given feedback on his performance. This was in the form of his wife giving him feedback after he had made

the semantic judgements, discussing with him the reasons why things might or might not be related. They argue that this served to make the relationships between items explicit in those instances where he had been unable to perceive one. Nickels and Best (1996: 120) go on to argue that: "there could be interactions between the type of task and the need for feedback... or the mechanism by which the task is effective (facilitation of processes rather than items)". A type of feedback integral to their treatment approach is outlined by Byng *et al* (1994) as being the repeating back of the patient's production, or asking appropriate questions at appropriate moments. In a similar way Jones (1986: 74), referring to "Step 6" of her therapy study states that: "If the question word he produced was incorrect the author completed the sentence answering his question". There will be further consideration of 'feedback' in aphasia therapy (Section 2.4.2 below) from the very different perspective of a data-driven approach to investigating therapy interaction.

Byng and Black (1995) argue that the 'task' can be broken down into several components, and these include various levels of conscious and unconscious processing which are demanded of the aphasic person by dint of what s/he is being asked to do, and how. Schwartz *et al* (1994) allude to task demands, and resource demands, presumably referring to the information processing demands of tasks, for example simultaneous processing of the question and the sentence.

Byng and Black (1995) include the interaction between the therapist and the person with aphasia within the parameters of the concept of 'task', and this is implicit in the description of the 'task' in various therapy studies: Jones (1986: 72) describes "Step 1" of her therapeutic programme with BB in the following terms: "A written sentence was presented to him which he was requested to "block off" as before. Discussion and explanation then took place as to which word or unit was the verb ..."; Byng *et al* (1994), describe "Stage Two" of their mapping therapy as requiring the patients to

produce a description of the pictures used in "Stage One", within a structured format. Having produced any lexical item the participants were asked to identify the appropriate place for that item in the sentence frame – the therapist's task is described as being to enable the patients to monitor for themselves whether a potential sentence was viable or not and, if not, how it could be modified.

Other task descriptions specifically exclude therapist-aphasic interaction, apart from the actual presentation of the task. Schwartz *et al* (1994) describe their mapping therapy task as involving three probe questions being asked by the therapist, with the aphasic person responding by underlining the target, and turning over the card to check his/her response against the correct answer. They emphasise that: "*This immediate feedback was the primary mechanism of training*. We did not attempt to reconcile discrepancies for the subject, but instead encouraged the subject to try to understand why his/her response was in error" (Schwartz *et al* 1994: 30) (original italics). The exact way in which the patient was 'encouraged' is not specified, but this must also constitute an interaction between therapist and aphasic person which is not simply to do with "the primary mechanism for training".

Reference to methods that have a basis in accounts of 'learning' or 'training' programmes or schedules, is made by Schwartz *et al* (1994: 24) for example: "subjects were trained"; "the mechanism of training was corrective feedback"; or Schwartz *et al* (1994: 29): "the subject responded by underlining the appropriate word with a distinctively coloured pen" (i.e. use of a visual mnemonic strategy). Many of the methods in use, which are often included by authors in the task description and design, are ones which have their roots in theories of learning (e.g. treatment hierarchies; visual mnemonics; prescribed response-contingent feedback). There is implicit reliance on models of learning through the use of hierarchies of difficulty, which is found almost universally in therapy studies. This is so implicit that Howard and Hatfield (1987: 132)

take it for granted that once the assessment has been carried out, and the treatment focus selected, "we need a treatment hierarchy". However as Howard and Hatfield (1987) also point out the trouble with essentially unmotivated orders of difficulty is that they may bear no relation to the difficulties aphasic people really have.

In her paper on learning in aphasia therapy Ferguson (1999) quotes from a study by Horner *et al* (1994) which reviewed articles dealing with aphasia therapy. Of the models of treatment identified only one (stimulation/facilitation) describes the process of treatment as opposed to a theory of language impairment. As Ferguson (1999: 126) points out the specification of models "does not inform us as to the extent to which a particular therapy process (the 'how') is crucial to therapy outcome". Ferguson (1999) goes on to apply theories of learning to an explanation of the 'how' of aphasia therapy. These include a category of "neurobehavioural" in which aphasia therapy is described as being a good example of "non-programmed behavioural therapy", where it is possible to see "continued subtle adjustments in type and amount of cueing (whether on set tasks or in conversation) as part of this learning process by which the therapist adjusts the antecedent events and contingent responses to communication attempts" (Ferguson 1999: 129). One of the contributors to the Clinical Forum discussion that follows Ferguson's (1999) paper argues that categorising existing therapies – whatever the system of classification – does not advance our understanding of therapy since current therapies "consist of a conglomeration of 'principles', 'protocols', 'procedures', 'techniques', 'strategies' and 'approaches' which emphasise different aspects of therapy and make assumptions at different levels" (Gordon 1999: 138). Ferguson (1999) argues that theories of learning underpin the therapeutic process, and suggests that three predominant theories of learning - cognitive, cognitive-behavioural, and behavioural - may be applied equally to aphasia therapy. She points out that the current therapy literature either assumes or ignores the nature of the relationships between antecedent-

behaviour-consequences as part of the learning process. Examining 'cognitive-neuropsychological/information processing' therapies as one of the types of therapy in the category of 'neurobehavioural therapy', she argues that learning is seen as occurring essentially unconsciously. Aphasia therapy of this nature is described as a good example of non-programmed behavioural therapy, where it is possible to see the continued subtle adjustments in type and amount of cueing as part of a learning process by which the therapist adjusts the antecedent events and contingent responses to communication attempts.

Operant approaches to language therapy outline what is entailed by 'interaction' in a seemingly unambiguous way. Interaction subsumes among other things instruction, modeling, prompting, shaping, reinforcement. In effect, the therapy is the method (for further discussion of operant approaches see Section 2.3.1.i). The nub of stimulation therapy, however, lies in the elicitation of responses. The therapist's cue is the vehicle for the enactment of therapy – see Duffy (1994) Section 2.3.1.i (below), and Chapter Six for further discussion.

Schwartz *et al* (1994) implicitly allude to methods that apply to their therapy study as a whole, as well as to methods that apply to individuals within the study. In their study the former refers to the way in which, during pilot studies, they sought to establish the most appropriate form of probe question. The latter refers to the fact that, for some of their aphasic patients, they "found it useful to return to the pretraining photographs one or more times during the treatment phases as a means of assuring ourselves that the subject continued to understand the probe questions, and/or to strengthen this understanding where it proved to be weak" (Schwartz *et al* 1994: 30). In a similar way Jones (1986: 72) reports that: "BB was able to show some understanding of meaning relations when a question word had been used to recognise which constituent had answered which question".

2.2.1.ii Materials, tasks and therapy process in 'semantic therapy'

As Pring *et al* (1993) point out, the findings of early work on the benefits of semantic activation (e.g. Howard *et al* 1985a) have been influential. Many therapists are familiar with the view that semantic therapy tasks assist naming, whatever the theory or imputed mechanisms behind these interventions. Therapists have not been slow to take up and use semantic therapy tasks in everyday clinical practice. As the data from this study are drawn from sessions involving the application of 'semantic therapy' some of the 'semantic therapy' literature will now be considered, and discussion will begin to focus on how the relationships between therapy materials and the actions of therapists (in terms of facilitation, cues or feedback) have been considered.

It is probably true to say that much of any sort of treatment for aphasic language impairment actually involves semantic processing because of the pivotal role semantics plays in language (Nickels 2000). Nickels (2000) also points out the importance of distinguishing between the nature of the tasks used and the nature of the deficit that is to be remediated. Although the nature of the deficit and the specific goals of therapy are not of primary interest in this study many 'semantic therapy' tasks described in the literature rely on semantic processing, but do not necessarily have the remediation of semantics as their core aim, mostly being concerned with improving word-finding. The goal of some therapies has been to improve both language production and comprehension (Visch Brink *et al* 1997), while others have aimed at improving naming only (e.g. Marshall *et al* 1990). As Nickels (2000) points out the majority of the recent studies involving 'semantic therapy' have aimed to improve word-finding rather than improving semantic processing *per se*. The term 'semantic therapy' will be used with a deliberately broad definition – simply, therapy which targets processing of semantic representations as a means of achieving a variety of goals.

The following is a brief review of some of the studies in the literature on semantic therapy which report on the process of the therapy as it was carried out. Issues such as whether the tasks were performed effortlessly or whether there was a great deal of variability in responding will be addressed. Consideration will be given as to whether the aphasic people were asked to do things they could not do, and whether there is any suggestion that actual performance during therapy had any bearing on the outcome of the therapy. While it is clearly not reasonable to expect published studies to contain blow-by-blow accounts of the therapy as it was carried out, it will be argued that, for various reasons a proper compromise between brevity and loss of critical information – especially about therapy process – has not yet been reached. There will also be some examination of the relationship between use (or not) of theoretical models (of semantics or language processing) in treatment planning and observations of the aphasic person's behaviour in informing the choice of therapy task. A few studies will be examined in detail to exemplify issues which are typically left unaddressed in descriptions of therapy.

It is interesting to note that among the many tasks and materials that have appeared in studies of semantic therapy over the years, 'time' as a factor or therapy resource (or as a measure of outcome) receives very little attention. Howard *et al* (1985a) (citing various studies from the literature) note that additional time for lexical search is the most effective method that aphasic people use to aid word-finding in speech production. In a study of facilitative techniques Patterson *et al* (1983) found that given a second opportunity to name a failed item the aphasic people tested were successful on about 25% of occasions. It is these types of observations – essentially atheoretical observations of behaviour – that sometimes form the basis of a therapy treatment in studies that have been reported in the literature.

Hillis (1989) reports on therapy for two patients with impaired naming. She remarks that: "Since there is currently no theory regarding how (or if) the hypothesized underlying cause/s of naming errors in each patient might be treated, a behavioural approach to remediation was taken" (Hillis 1989: 634). The treatment for written and verbal picture naming made use of a cueing hierarchy devised through observation of the sorts of stimuli that sometimes elicited the correct names, in conjunction with an observation that both patients were able to write picture names when given anagrams to work from. The same treatment was carried out with both patients even though they had different underlying deficits.

Nothing is noted about the therapist's input except as set out in the cueing hierarchy, which is given in some detail. There is some detail which we assume is about the aphasic person's actual performance on the tasks – both aphasic people made frequent semantic errors in naming, but "Patient 2" was aware of those errors while "Patient 1" was usually not, and made semantic errors in both modalities. However this is no more than is already known from the diagnostic assessments, and patient performance as reported is not linked to stages in either cueing hierarchy in any way. One wonders how, given their significantly different underlying deficits, these two people could be observed to benefit from precisely the same cueing hierarchy. However, despite different underlying deficits, and receiving the 'same' treatment regime, both people benefited from the treatment – but in different ways. For both people written naming improved, but only "Patient 1's" naming showed generalisation across modalities and to untrained nouns.

Hillis (1989) argues that identical treatment can improve the performance of different patients for different reasons, however, only if the therapy works for someone by increasing the meaningfulness of trained words can it be expected to generalise across modalities. The written naming treatment hierarchy is not really clear on the

point of whether the distracters ("Level 5: scrambled anagram") act as a focus on word form or word meaning. If they are word-meaning, then the relationship to the target is unclear. It is not clear whether the picture stimulus was present throughout the cueing hierarchy or only at the entry level. In other words it is difficult to tell precisely what mechanisms were in play, except that, due to the simultaneous generalisation of improvement to oral naming with treatment of written naming alone, improvement through some sort of general word meaning mechanism is implied.

Basso (1993) reports on a person – BA – who was fluently aphasic and whose main deficit was semantic-lexical, including a semantic category effect. A decision was made that, as the main deficit was damage to the semantic system, therapy should be directed towards its restoration. This appears to be a version of an 'if-he-can't-do-it-get-him-to-do-it' approach to therapy, and this is perhaps confirmed by the author's note that one of the categories used in the semantic categorisation tasks, where BA was able to perform correctly, was soon abandoned. In other categories BA experienced many difficulties – "nothing that the therapist could do helped the patient" (Basso 1993: 260) – but we do not actually know exactly what the therapist did.

In odd-one-out tasks BA was given 5 pictures, four of which belonged to the same semantic category, but he could not pinpoint the odd-one-out. We do not know how closely the odd-one-out was related to the other items, or the nature of the relationship. We do not know if the therapist attempted to modify the task in any way, perhaps reducing the cognitive processing load by reducing the numbers of items and so on.

Therapy was stopped after five months. Some time later – nineteen months after the original injury – BA returned for advice, and an entirely different treatment regime was instigated, and three years after onset he was beginning to show improvement. One of Basso's (1993) conclusions (after presenting an outline of contrasting treatment for a

different patient with a different locus of deficit) is that while it is obviously necessary to identify a functional level of impairment in order to construct a rational therapeutic intervention, it actually provides no specific guidance as to how an effective therapeutic programme can be accomplished. This study illustrates firstly how the differential effects of different therapy regimes at different stages in recovery are underreported, and secondly, that identification of the 'functional locus' in the semantic system clearly does not, as Basso points out, necessarily help therapy planning at all.

In contrast to BA's (except in one category) early inability to carry out the semantic tasks entailed in the therapy, some patients reported in the literature have been able to carry out the tasks assigned to them with apparent ease. Franklin (1993) suggests that a reasonable prediction would be that a patient with a 'general semantic problem' would not benefit from 'facilitation' therapy tasks, whereas other patients (for example in the studies by Howard *et al* 1985b and as reported by Pring *et al* 1993) clearly do benefit in some way. Franklin (1993) argues that the latter patients may benefit from semantic activation as a prime to increase the likelihood of subsequent correct naming.

There seem to be two main points to make here in the first instance. Firstly we do not actually know exactly how the participants in these studies did perform the tasks. In a study by Marshall *et al* (1990) for example (also reported in Pring *et al* 1993), RS, who did not show a semantic deficit (although he did have more problems with low-imagery items on a synonym matching test), is not reported as making any errors in performing the task. IS did make errors, however, "which were pointed out and she was asked to correct herself" (Marshall *et al* 1990: 176). IS did have more pronounced semantic difficulties than RS. The authors note that IS did show substantial improvement in two of the semantic tasks during the therapy period. The conclusion they draw is that her original scores may be in some doubt, rather than that the semantic deficit may have improved through the therapy. Without knowing more about how her

error responses were facilitated, or what they were, no real conclusions can be drawn, and this rather interesting piece of data is lost.

The other point is that we know very little from the report about the nature of the semantically related distracters. What was the nature of their relationship to the target, and what significance could this have? We know that RS did have some semantic difficulties related to low imagery items – did this inform the choice of treatment items? We do not know from the report. Similarly we do not know about the nature of the distracter items used in therapy for IS, who had a more obvious semantic deficit, and who did make errors during the therapy tasks.

The whole subject of semantic relatedness is extremely cloudy, not only because relatedness could be considered to be in part a matter of individual difference in perception and experience, but also because there are so many different levels of relatedness just within proposed models of lexical semantics alone (see Funnell 2000). Nickels (2000) questions the assumption that the notion of 'graded difficulty' of tasks (for example the use of ever more 'closely related' semantic distracters) is valid for all aphasic people. She cites a study by Morris (1997) where rated similarity of target and distracter affected the performance of only one of two aphasic people on a word-picture verification task. Furthermore she cites studies of the facilitation of naming for people with aphasia (Barry and McHattie 1991; Howard *et al* 1985a) where no effect has been found on the 'depth of semantic processing'.

Despite uncertainty about semantic relatedness and the grading of semantic therapy tasks several studies have used these notions about semantic relations in therapy programmes to improve semantic processing. For example, Behrmann and Lieberthal (1989) reported a study of treatment that aimed to improve the comprehension of single items in an aphasic person who had a central semantic deficit. They base their treatment on the assumption that meaning is organised in a category-specific, hierarchical fashion,

and are neutral on the unitary versus multiple semantic systems' hypotheses, assessing and treating both visual and verbal semantics.

The treatment was in two major stages: the first aimed at teaching meaning at a general level of description (the superordinate features of each category); the second aimed at teaching specific details of items, leading to the precise identification of these items. The treatment was successful in several respects – better performance on treated items in treated categories, and carry over to untreated items within the same categories for example.

However one of the difficulties here – certainly for clinicians who might wish to use this particular approach to treatment – is the lack of specificity entailed in the term "teaching". On the basis of this report, it is generally very hard to know exactly how the authors went about the process of "teaching". To be fair they do go into some detail as regards progression through the hierarchy of different tasks, and give an example of how semantic features distinctive to each category might be explained – for example by actual manipulation of physical objects, identifying the parts as fulfilling certain concepts. Despite this it is very hard to see how this study could actually be replicated, and this illustrates one of the major problems with lack of specificity in reporting the therapy as it was actually carried out.

One plank in the bridge that will link theoretical concepts entailed in language processing models or theories of semantic memory, to the treatment of impairments related to semantic deficits must be a more precise specification of what is entailed in 'teaching'. The issues raised in this section are not specific to the studies described here, but rather illustrate the fact that there seems to be no well-articulated, explicit framework of information that needs to be provided: a) to describe the therapy; and b) to understand how therapy might have worked. There seems to be no baseline set of

descriptions to enable sharing of information and the development of theories about how therapy works.

Many therapy studies today are influenced by psycholinguistic models. They are reported in ways that acknowledge the presence of an interactive process. Authors even suggest that that process is an important element in the success of therapy. They do not however have anything other than a very broad and inexplicit vocabulary for communicating that process, let alone measuring it or its effects.

The following section will review some of the ways in which therapy interactions have been considered in terms of the 'skills' or 'techniques' used by therapists in therapy generally.

2.3 Describing therapy intervention: skills and techniques

This section will examine the literature in terms of the attempts that have been made to describe the process of therapy across therapy sessions generally rather than within particular treatment studies. In the first instance the review will examine some of the ways in which authors have developed general inventories of language (and other) therapy skills or techniques.

2.3.1 'Principles of treatment'

This section will (relatively briefly) examine the ways in which the specifics of therapy enactment have been considered by various authors. Approaches to principles of treatment vary from 'how to' treatment manuals, to consideration of treatments in terms of skills and techniques associated with approaches to therapy for aphasia, or therapy with children.

2.3.1.i 'Principles of treatment': aphasia therapy and other therapies in general

'How to' treatment manuals, such as that of Hegde and Davis (1995) identify any number of clinician-centred skills which are seen as relevant to the enactment of therapy – although Hegde and Davis (1995) do not just specify aphasia therapy. These range from "How to Model Effectively", to "Prompting" and "Increasing the Frequency of Responses". This type of approach to the delineation of therapist skills – whether these skills are based on behavioural principles or not – isolates those skills from the context in which they were identified. For example in Hegde and Davis (1995: 221) the authors advocate "prompting at the right time and with the right clue", which they argue will reduce the frequency of wrong responses. However, despite listing a set of guidelines for the application of prompts the reader is still left unclear as to what is the "right time" or the "right clue" because these notions are not set out with examples which demonstrate how they might function within an actual sequence of clinical interaction. This particular volume is clearly based on behavioural approaches to therapy (discussing, for example: "conditioned generalized reinforcers"; "fixed ratio schedule"; "differential reinforcement of other behaviour").

A different approach to the identification of clinical skills is taken by Goldberg (1997) (not specifically targeted at aphasia therapy). He takes the approach of first identifying skilled speech-language clinicians, and then, through a variety of means, determining what it is they are doing. His identification of "six critical characteristics of exemplary speech-language clinicians" is based on examination and analysis of the therapy of five clinicians. He examines videotape of sessions, conducts interviews and uses observation (although how this took place is not specified). The point is made that what is important is identifying the behavioural components of particular clinician qualities. He attempts to do this by listing skills in behavioural terms, stating that, for example: "...although it may be illuminating to say that a clinician is "compassionate",

it is more valuable to know that by using two or three specific skills, the impression of compassion is conveyed to the client" (Goldberg 1997: 313). Skills are outlined in terms of process (for example "Facilitator Skills": "Communicates at Client's level"; "Provides Ample Opportunity to Respond"), and at a "technical" level (for example "Facilitator Skills": "Age appropriate Material"; "Interesting Material"), as well as being set out at different skill levels.

While Goldberg (1997) has used an inductive approach to the identification of clinician skills, he is not specific about how he has actually reached the particular set of characteristics which he identifies. Therefore we are left uncertain about the validity of his conceptualisation. Not only are we uncertain about the validity of his skill concepts, but, despite his laudable aim of setting out to identify the behavioural characteristics of clinician skills, his approach suffers from the same problems as that of Hegde and Davis (1995) in that he presents a second-order analysis of behaviours (i.e. "Successive approximations"; "Multiple-Cuing"; "Stages of Learning") which is not explicitly related to examples from the data. Not only does this undermine the validity of his concepts, but it also undermines his own stated intention of identifying "the behavioural characteristics of clinician skills". We are not given examples, either out of or within the context of sequences of clinical interaction, and therefore the reader is actually left none the wiser as to how these concepts actually find their expression in day-to-day clinical practice.

Principles of treatment specific to aphasia are examined and outlined by Davis (1993). He cites copiously from the aphasia therapy literature to give examples of the ways in which researchers have reported on the enactment of therapy. A study by Brookshire *et al* (1978) is quoted as evidence of clinicians doing "basically the same thing when administering treatment" (Davis 1993: 266). Clinicians structured therapy tasks according to a standard framework of stimulus, response and feedback. Davis

(1993: 266) argues that "fastidious attention" to the functional components of treatment tasks – including the target-stimulus, target-response, items, and trials – allows clinical investigators to be guided towards consideration of treatment variables and to enable them to explicitly describe the treatment being studied. He goes on to outline and give examples from the literature of instances of various characteristics of aphasia treatment variables, such as "Cues and Cueing Strategies" (Davis 1993: 271), and programmed stimulation, which includes discussion of "Small-step progression" (Davis 1993: 275) and "Response Criterion" (Davis 1993: 276). The major problem that characterises this approach to the elucidation of the principles of language treatment is the same as that discussed above with regard to the work of Hegde and Davis (1995) and Goldberg (1997) – namely that examples are taken out of sequential context. In terms of the work of Davis (1993) this is not particularly surprising, relying as he does on studies from the aphasia treatment literature. As has been discussed above (Section 2.2.1.i Therapy process in psycholinguistically-oriented impairment-focused therapy) reference to the detailed process of therapy enactment is scant in the literature. In addition Davis (1993) uses evidence mainly from studies which examine certain phenomena in isolation – for example cueing the names of object pictures (e.g. Li and Williams 1989). In this sense his evidence is doubly decontextualised – in other words, examples from the literature are given out of their interactive context, and they are generally not examples from actual therapy studies.

An example of a very detailed examination of the principles of remediation comes in a chapter by Duffy (1994) on the stimulation approach to rehabilitation exemplified by the work of Schuell. General principles are outlined – for example: "Responses should be elicited, not forced or corrected" (Duffy 1994: 150) – and then the details of stimuli, cues and prompts, treatment targets, order of difficulty, response considerations and so on are addressed in great detail, supported by evidence from the

literature. Little more will be discussed here as further consideration is given to the work of Duffy (1994) in the analysis of data. Again however, examples are presented out of interactive context, and the approach is, not surprisingly, normative, in a way that parallels the prescriptive approaches of Hegde and Davis (1995) and Goldberg (1997).

Rehabilitation of aphasic language impairment is, unsurprisingly, not the only area of speech and language therapy to receive attention in terms of a search for the guiding principles and skills associated with intervention. The following section will briefly consider some of the work in other areas of therapy.

2.3.1.ii 'Principles of treatment': speech and language therapy with children

Speech and language therapy with children is variously considered here in terms of approaches to intervention within the classroom, or in groups, or in terms of individual work. This section does not aim to provide a comprehensive review of studies of speech and language therapy intervention with children in any of the settings described, but will sketch some of the approaches taken to reporting the type of skills and strategies used by speech and language therapists. Intervention considerations obviously differ in some major ways as far as work with children is concerned, not the least being the developmental dimension and thus the association with theories of language learning or language development (for example see Vigil and van Kleeck 1996).

While papers cover a variety of approaches to language intervention with children in various settings authors generally provide and discuss sets of strategies used by therapists to achieve their intervention aims. These are often described in terms of "scaffolding strategies" (e.g. Norris and Hoffman 1990; Boyle and Peregoy 1990). Scaffolding is seen as a collaborative process between child and speech and language therapist, which enables the child to communicate an expanded message or "more

effective message" (Norris and Hoffman 1990: 78). Boyle and Peregoy (1990) refer to scaffolding in relation to language acquisition research, where an adult may enable a child by facilitating effective communication at a level beyond the child's actual linguistic capability. Expansion and elaboration may ensue from a child's utterance where the parent provides a scaffold, "unconsciously modeling linguistic and conversational patterns through natural social interactions with the child" (Boyle and Peregoy 1990: 195).

When examining the nature of the interaction between clinician and child in the course of therapy sessions it is important to understand the distinction drawn between adult-centred and child-centred therapy (Kovarsky and Duchan 1997). In the former, clinicians dominate the interaction, asserting their interactional dominance to ensure that the goals of therapy are addressed (Damico and Damico 1997). The latter approach is founded on the principle that "the clinician should follow the child's interactional lead" (Kovarsky and Duchan 1997: 297). Bobkoff Katz (1990) points out that while the proposal to use client-oriented, interactive or naturalistic approaches in order to overcome problems associated with the generalisation of behaviours 'trained' in language intervention programmes implies the use of particular techniques (such as expansion, cueing and modelling) in the reality of day-to-day practice these approaches may become trainer-oriented and rigidly structured.

Norris and Hoffman (1990: 78) discuss scaffolding strategies in terms of various types of prompts, questions, information, restatements that "provide support to the child as the child is actively engaged in the process of communicating a message". They provide a substantial list of features, supporting these with citations from the literature. These "Strategies to Assist Communication" include "Cloze procedures", "Relational terms", "Phonemic cues" and "Summarization or evaluation" (Norris and Hoffman 1990: 78-9).

Vigil and van Kleeck (1996: 84) adopt a particular theoretical perspective which guides their view of when and how adult intervention is appropriate in response to children's "errors". They develop a set of general operating principles, which include the nature of the error and understanding the reasons for error, the stage a child has reached in the learning process, and clear teaching goals. They go on to elaborate types of errors in relation to variables inherent in intervention – for example errors arising from the situation in which the child finds him/herself are to be addressed for example by modeling the child's role in the task, simplifying or repeating the verbal instructions about the task, or otherwise modifying the task.

Further examples from these papers will be used to address issues that arise in the analysis of data in this study. It is clear that there are techniques in use which are similar, broadly speaking, in adult and child language therapy. For example direct language instruction in child therapy, which typically employs elicited imitation as a teaching technique (Cole and Dale 1986) can be compared with the type of structured therapy tasks identified by Davis (1993) and discussed above (Section 2.3.1.i). At a more detailed level therapies with the two groups certainly share a number of therapy techniques (for example cues of various types, various types of feedback and so on), but the contexts in which these techniques are employed clearly differ greatly.

The review will continue with a consideration of the different ways in which the enactment of therapy has been considered, not in terms of individual techniques but in terms of therapy sessions as an entity, and the structure of sessions. The review will consider work that examines both therapy for adults with aphasia and therapy with children.

2.4 Describing therapy intervention: therapy sessions

As was pointed out and discussed above, much of what has been proposed under the rubric of principles of treatment has been presented out of sequential context. In other words the nature of the interactivity inherent in therapy, while implicitly acknowledged (i.e. discussion of 'feedback' clearly implies an antecedent event), has not generally, in the examples above, been used to exemplify, or indeed justify, the concepts, skills and strategies proposed. The same can be said to be true, broadly speaking, of the following approaches to the study of interaction in aphasia therapy.

2.4.1 Categorical approaches to the study of interaction in aphasia therapy

Horton and Byng (2000) give a brief review of various systems which have been developed over the years to analyse the interactions which arise during the course of aphasia therapy sessions. They point out that systems such as the Clinical Interaction Analysis System (CIAS) (Brookshire *et al* 1978), the Analysis of Behaviour of Clinicians (ABC) (Schubert *et al* 1973) or The Communication Analysis System (Merbitz *et al* 1989) are all categorical systems which are designed to enable repeated measures to be taken. The types of category in each system will inevitably reflect not only the interests of the researchers but also contemporary trends in therapy (Horton and Byng 2000). Thus, for example, Johnson (1969: 28) describes analysis in terms of "Antecedent Events", "Movements" and "Subsequent Events". Interestingly he highlights one of the major problems inherent in categorical systems, namely multiple function. This is where one 'event' functions in more than one way, or as Johnson (1969: 29) puts it: "the problem of deciding whether certain subsequent events may be more accurately categorised as antecedent events". More will be said on multiple function both in this chapter and in the analysis of data.

As Horton and Byng (2000) point out the CIAS (Brookshire *et al* 1978) has categories which reflect contemporary therapy approaches, but it also attempts to accommodate other factors such as the complexity of therapist utterances and the nature of the therapy materials used. For example, the CIAS was used in a study of aphasia therapy to investigate the effect of clinician behaviours on patient responses (Brookshire *et al* 1979). The authors found, for example, that clinicians may have a general tendency to repeat and elaborate on any acceptable response by the patient, and that there was a strong tendency for clinicians not to provide feedback for unacceptable responses, but that this did not extend to acceptable responses which followed unacceptable responses.

Other systems, such as the Analysis of Behavior of Clinicians (ABC) System (Schubert *et al* 1973) also reflect the authors own preoccupations. They assert that their purpose is to provide "a method for the clinician and/or supervisor to objectively record what is occurring during a therapy session for immediate analysis or analysis at a later time" (Schubert *et al* 1973: 4), the ultimate purpose being to set definite goals in relation to future changes and determine if goals are being met.

The empirical basis for such systems is of course a matter of interest. Schubert *et al* (1973: 5) for example base their system "upon earlier research by Flanders and Boone and on two pilot studies" – which are unfortunately not specified. They go on to discuss their categories in some detail, and incorporated in the categories is implicit recognition of the interactivity of therapy sessions. For example, in relation to "Category 1: Clinician observes the client and modifies lesson appropriately", they observe the important skill for clinicians of being able to "modify the planned reaction, change a goal, or alter a strategy in terms of the response the client makes to his stimulus" (Schubert *et al* 1973: 8).

The Aphasia Therapy Interaction Coding System (ATICS) (Horton and Byng (2000: 361) is based on "aphasia therapy interaction data comprising ~ 800 turns of talk

between therapist and aphasic person during therapy for language impairments". The system incorporates a type of interactivity within the three-part exchange structure taken from the framework on which it is based (Sinclair and Coulthard 1975). The concept of the exchange developed by Sinclair and Coulthard (1975) formalises the tendency of speaker turns in interactive discourse to be grouped in more-or-less closely related pairs – for example question-answer, offer-acceptance, greeting-greeting (Lesser and Milroy 1993). A three-move structure was proposed for exchanges – Initiation, Response and Follow-up. One of the reasons Sinclair and Coulthard (1975) gave for considering this type of structure to be the normal form inside the classroom was that many questions asked by teachers in the classroom are ones to which the teacher already knows the answer, the intention being to discover whether the pupils also know. Often answers which are 'correct' in terms of the question are not the ones the teacher is seeking, and therefore it is essential for him/her to provide feedback to indicate whether a particular answer was the one he/she was looking for. Willes (1983) argues that this feedback is essential, distinguishing teachers' questioning of their pupils from the questions and answers that are engaged in other contexts. In these respects Horton and Byng (2000) obviously saw similarities between classroom discourse, and the discourse of aphasia language therapy.

However the concept of exchange as conceived by Sinclair and Coulthard (1975) was by no means without problems, even given the constraints on interaction of a formal classroom setting. In later work Coulthard (1985) questions whether there should be a fourth element of exchange structure, one that was both predicted and predicting. He gives the example of pupil responses which seem to be looking for an evaluatory follow-up from the teacher, where the pupil's contribution has the predictive characteristics of both response and initiation – functioning as a response to the preceding element and an initiation with respect to the following element. However, as

Lesser and Milroy (1993) point out although a more elaborate framework was developed by Coulthard (1985) the issue is not whether such a model can or cannot be extended to the analysis of casual conversation, but whether such a top-down model which characterises the structure of classroom and other institutional discourse types should be used as the basis for analysing casual conversation. They argue that such a model does not seem able to grant useful insights into the structure of multi-participant conversation for example, and point out that it cannot even deal with some types of dyadic conversation where neither party exercises overt control over the discourse.

ATICS is coded in part "in a manner stimulated by the literature on Conversation Analysis" (Horton and Byng 2000: 363), which leads the authors to claim that ATICS can accommodate aspects of therapy discourse which are essentially conversational in nature. ATICS categories are in part derived from empirical data (i.e. data from routine therapy sessions but developed within the framework of Sinclair and Coulthard (1975)). This would suggest that, at a certain level of description, the system will have a reasonable degree of validity . This indeed appears to be the case from the interrater reliability data presented in Horton and Byng (2000). The coding of categories which represent a higher degree of abstraction away from the data (ATICS 'Sequence' and 'Exchange') have a less reliable interrater reliability score than those which could be said to be more immediately associated with the raw data (ATICS 'Move'), although 'Act', the lowest ranking unit (i.e. below which there are no further units in the hierarchy) achieves approximately the same score as 'Exchange'. This is in some part due to the high number of units (categories) at the rank of Act (50+ distinct Acts), which while reflecting an attempt to capture as much as possible about the different and particular contributions of the therapy participants to the interaction inevitably leads to problems for the coder in making the necessary fine distinctions between the different units.

ATICS units at the rank of Act (as indeed at other ranks) are functional rather than formal, their prototype, in keeping with many models being the single act performed in speaking (Taylor and Cameron 1987). As far as ATICS 'Acts' are concerned attempts have been made to provide an exhaustive classificatory apparatus which does not leave segments unaccounted for, nor allow *ad hoc* categories to proliferate. This includes attempts to take the immediate context of interactions into account. For example the nature of 'test questions' is explored in terms of the relationship between question, stimulus and target response. Horton and Byng (2000: 363) argue that "there are subtle relationships between stimulus and question, which are not all-or-nothing". This and other similar considerations led to the development of distinct units such as 'test' as opposed to 'exploratory' questions in eliciting positions, and 'stimulus information' as opposed to 'target information'. However despite these considerations it is apparent that double coding does have to take place occasionally (Horton 1999) and that this puts the system in danger of allowing *ad hoc* categories to proliferate.

Ferguson and Elliot's (1999) motivation for developing an analysis of aphasia treatment sessions was to investigate the learning processes occurring in therapeutic interaction. They developed a sociolinguistic approach based on Systemic-Functional Linguistics (Halliday 1994), which has a session-level structure (e.g. "Greeting"; "Rapport building"; "Therapeutic activity"; "Leave taking"), an Exchange Structure which looks at speaker role in the exchange of information and services, and includes dynamic aspects (such as requests for clarification or correction). By applying this analytic system to three video recorded treatment sessions the authors found that they were able to make explicit the role of the clinician in, for example, offering and providing cueing for client responses, described as "a complex inter-play of the exchange of information and services" (Ferguson and Elliot 1999: 14). However the

authors' claim that the "analyses offer a way at looking in close detail at the interactive aspects of the clinical process" (Ferguson and Elliot 1999: 15) is surely not justified. In the first place the very nature of top-down approaches means that raw data is removed from its original context in the process of categorisation and counting and thus details of the interaction are inevitably lost. As Perkins (1995: 373) points out: "The collaborative nature of interaction is particularly vulnerable to being lost if, in the quantification, the actions of the two interlocutors are separated out from each other". Secondly, while the analysis at one level gives potentially useful information about the structure of sessions, the descriptive categories at the level of 'moves' is far too broad to be of use in doing anything more than confirming in some respects what is already known about therapy interactions. As is the case with other categorical systems, the general justification for their use lies in the application of quantitative accounts – i.e. aggregate scores of certain types of behaviours. This takes the form in Ferguson and Elliot's (1999) study, for example, of the potential to distinguish between the different levels of experience of clinicians, thus facilitating comparisons and opening up potential avenues for training initiatives.

Two rather different papers have examined specific aspects of the clinician-client relationship. In a study of the examination of the effects of various types of instruction on language performance in aphasia (Stoicheff 1960) participants were assigned to three different experimental conditions: "encouraging instructions", where favourable comments were given before and during performance on the tasks (reading and naming); "discouraging instructions", where unfavourable comments were made; "nonevaluative instructions", where task performance was preceded by simple instructions and no comments were made while the person was responding. The purpose was for the experimental participants to form some view of the experimenter over the three sessions in which they took part, and responses during the third session were

analysed. Participants were asked to self-evaluate their performance as well as the sum of correct/incorrect responses being tallied. It was found that there were significantly more error scores under the "discouraging instructions" condition that in the "encouraging instructions" condition, but that the difference between "encouraging instructions" and "nonevaluative instructions" did not reach significance. In addition participants who were discouraged rated themselves more poorly than those who were encouraged. It is interesting to note the author's comment that in the nonevaluated group "it is likely that more than one interpretation was placed on the experimenter's nonevaluative instructions by the subjects who received them" (Stoicheff 1960: 82) – in other words, neutral may not in fact be perceived as such. The author goes on to comment on the likelihood of a nonevaluative stance being misleading in the context of diagnostic testing (see also Marlaire and Maynard 1990), as well as the implications for clinicians.

In a somewhat different approach to the consequences of interaction between client and clinician Stech *et al* (1973) carried out a questionnaire survey of clinicians to examine the various effects of a range of client behaviours on the clinicians. The researchers generated 49 possible client responses (they do not say how these items were arrived at) and clinicians were asked to rate each on a semantic differential scale according to whether they were 'rewarding' or 'punishing'. The results show that clinicians are rewarded by certain client behaviours – for example: appropriate responses; evidence of motivation; compliance to clinician requests – and punished by others – for example: lack of motivation; inappropriate responses; negative emotional reactions. The authors argue that there is a reciprocal reinforcement process in therapy, and that some clinicians at least will tend to hear more responses as appropriate or correct than actually occur. As the authors comment: "Any practising teacher, therapist, or clinician has probably detected this kind of trend in his own judgements" (Stech *et al*

1973: 289). They also argue that the traditional view of the powerful clinician determining and controlling the process of learning should be modified and that more research should be conducted into the relationship between the client's behaviour and the clinician's professional and personal needs – a view that had to wait a number of years before this type of research really came into its own.

Finally in this section some rather different approaches to the study of interaction in aphasia will be considered. The first approach is that of the study of discourse patterns and social use of language in aphasia therapy sessions. The study by Ripich *et al* (1985) follows in the footsteps of a study by Prutting *et al* (1978) which used discourse analysis procedures to study topic control and speech act patterns of requests, responses and statements in clinician-child language lessons. Ripich *et al* (1985) set out to identify patterns of discourse occurring in aphasia therapy. They asked the four clinicians participating in the study to tape record a thirty minute session "which emphasised production training" (Ripich *et al* 1985: 2). The researchers randomly selected and transcribed a middle ten-minute segment of each taped session, and coded the interaction according to a set of categories, which included "Type of speech act", with the sub-categories of "Request", with sub-classes of "Known Information Request"/"Unknown Information Request"; "Response"; "Statement", with a sub-class of "Evaluation". As might be expected clinicians most frequently produced "Requests" and "Statements". Again not unexpectedly "Evaluation Statements" occurred most frequently in the "highly instructional Dyad 1" (Ripich *et al* 1985: 6). Interestingly these types of statements also occurred very frequently in the "highly conversational Dyad IV" (Ripich *et al* 1985: 6). As the authors point out, although Dyad IV demonstrated clinician behaviour apparently characteristic of everyday conversation (with "Unknown Information Requests") the frequent clinician evaluation suggests that the discourse was constructed as a variation of the tutorial interaction style. Ripich *et al*

(1985) distinguish between three different clinician styles – drill, therapeutic and interview. "Drill" is characterised by a consistent three-part discourse sequence (and here the authors refer to Mehan's (1979) observation that this type of sequence lies at the heart of all teaching-learning paradigms). "Therapeutic" is characterised by a style where requests for known information occurred much less frequently compared to "Drill", and with fewer evaluations, although the clinician showed a high degree of control over topic introductions. The "Interview" style was in evidence in Dyad IV (see above) where series of requests for unknown information were linked to a moderately high use of evaluation and high control of the topic. The researchers' point that descriptions of therapeutic discourse should help towards a better understanding of aspects of the therapy process which are not otherwise apparent is certainly born out by their findings, despite the small sample and short extracts studied from each session.

The second approach concerns the study of pragmatic abilities in aphasia – pragmatics being broadly defined as "the study of the use and understanding of language in context" (Perkins and Lesser 1993: 6, 211). While the general concern of this thesis is not the study of the language or communication abilities of aphasic people *per se*, some of the work which has attempted to analyse pragmatic abilities may be considered relevant to this review. For example some studies have examined pragmatic abilities through the development of categories of pragmatic behaviours. Sobiecka-Koszel (1991) developed a set of categories of communicative behaviours in order to "widen the descriptions available of the communication between aphasic patients and therapists" (Sobiecka-Koszel 1991: 198). She was able to use these categories to distinguish between therapist behaviours which, for example, "stimulate the desire and intention to communicate" and those which focus "specifically on performance itself" (Sobiecka-Koszel 1991: 199). Silvast (1991) also used what was essentially a quantitative approach to examine conversations between therapists and people with

aphasia. She videotaped fifteen minute samples from each of six therapist-aphasia person dyads as they "conversed... at the beginning of a speech therapy session" (Silvast 1991: 385). Five minute samples from each dyad were analysed using a combination of total speech time, number of "speech units" (words and other tokens) and conversational turns. Turns were examined in terms of a number of interactional properties such as self-initiated requests for information and requests for clarification. Silvast (1991) does not say whether these conversations arose naturally as a part of normal sessions or whether, for example, therapists were asked to 'have a conversation' at the beginning of the session. However, whatever the background, close examination of the communicative functions of the conversations suggested that there was a general structure through which therapists dominate the conversation and regulate its flow. Silvast (1991: 388-9) concludes that "therapists tend to ask questions, aphasics give extended answers... This distribution results partly from the context of speech therapy where the therapist is in the role of an expert, and partly from the approach of the therapist, who seem to be quite directive and to create a noticeably rigid framework".

While both Sobiecka-Koszel (1991) and Silvast (1991) examined therapist-aphasic person interactions in therapy, they both examined what were, in their terms, conversations rather than therapy. In Sobiecka-Koszel's (1991) study topics were especially prepared for the participants, chosen to reflect their actual activities. Silvast (1991) lists the topics, which range from personal relationships, through to leisure activities and sport, and also more medical and therapy-oriented topics, such as frequency of speech therapy. What is characteristic is that the notion of 'conversation' is either set up as a separate entity or separated out from the therapy session, and examined in isolation from the doing of therapy tasks. This is in part a reflection – as will be seen in the next section – of an interest in examining the pragmatic abilities of people with aphasia and their conversational partners in dyadic conversation as potential

therapy targets in themselves. It may also reflect the point made by Holland (1998) that therapists (and this could be taken to include therapist-researchers) view therapy and conversation as two entirely separate entities – conversation being something that happens at the beginning of sessions to help patients relax.

However it possibly also reflects the view that the three part structure of instructional dialogue (as discussed above), which is often found in therapeutic discourse (Perkins and Lesser 1993), is an adequate means to account for these structured interactions, and that therefore sequences of instructional interactions can be considered as separate entities whose characteristics have already been adequately described and delineated through the Initiation-Response-Follow-up structure.

In the section that follows consideration will be given to studies which have used a Conversation Analysis (CA) approach to the study of interactions between therapist and aphasic person.

2.4.2 Data driven approaches to the study of interaction in aphasia therapy: Conversation Analysis

The potential of Conversation Analysis (CA) to contribute to the understanding of aphasia and aphasia therapy has now long been recognised. CA is characterised by its attention to the collaborative nature of the interaction, the use of real interactions, and the emphasis on descriptions of observable behaviour, "with evidence of communicative success or failure being sought in the sequential context" (Perkins 1995: 373). CA methods have been used widely to examine the communication of people with aphasia in any number of settings and for a number of different purposes. For example several researchers have reported on aspects of therapist-aphasic person/aphasic person-spouse interactions. Lindsay and Wilkinson (1999) argue that the results of their investigation into speech and language therapist-aphasic person, and aphasic person-

spouse conversations have direct clinical implications – in terms of what should be assessed, where and with whom. They suggest that the results of their study (as well as others demonstrating the effects of different partners on conversational proceedings e.g. Kagan 1995; Perkins 1995; Lesser and Algar 1995) imply that results obtained in "clinically or SLT-based interactions may not readily translate to everyday conversations" (Lindsay and Wilkinson 1999: 323).

Generally speaking it is true to say that CA analyses of communication in aphasia – or CA derived approaches to the assessment of pragmatic abilities, such as the Assessment Protocol of Pragmatic-Linguistic Skills (APPLS) (Gerber and Gurland 1989) – do not lay emphasis on the separateness of linguistic and pragmatic impairments (Perkins and Lesser 1993). Indeed one of the powerful motivations for conducting CA analyses is their potential to uncover links between linguistic impairments and their impact on communication. This has been demonstrated in a study by Perkins (1995) where, for example, there were marked differences in the way that problems in conversations were resolved according to whether the aphasic person's speech was characterised by phonemic paraphasias, or by lexically empty turns arising from failures in lexical retrieval (purportedly from problems in the phonological output lexicon). Perkins (1995) also employed quantitative techniques, which are arguably controversial in CA (see Perkins *et al* 1999; Schegloff 1993), to demonstrate patterns of interaction in the data, such as a "passive role" taken by one aphasic person in conversation with her relative compared with a very different pattern of interaction with the researcher. Perkins (1995) also argues that the qualitative analytic findings of how different conversational participants deal with linguistic impairments differently – such as differential tolerance of pauses compared with evidence from normal conversation – suggests that "the use of normal conversation as the benchmark for aphasic discourse is unsatisfactory" (Perkins 1995: 382). This view is very much substantiated by

Simmons-Mackie and Damico (1997) in a study of compensatory strategies in aphasia. They found that both the quantity and quality of compensatory behaviours was often different from premorbid or expected usage.

It is generally also true to say that much of the study of communication in aphasia using CA has concentrated on features of conversational ability and repairs of trouble, either, as has been discussed, between therapists and people with aphasia, or between aphasic people and their partners, or other people with aphasia. Relatively little work has been carried out on examining aphasia therapy sessions as a whole using data-driven approaches. The implication is that by examining therapy sessions as a whole therapist-aphasic person interaction in 'conversation' and interactions which take place during the conduct of therapy tasks are all treated as being part of the phenomenon of 'therapy'. A brief review of two studies will follow – brief here, because reference to and review of these studies is also to be found in Chapter Three and the chapters which follow on analysis of the data. As was discussed in the introduction to this chapter, it is in the spirit of this thesis that reference to and discussion of the literature should also take place as the analysis and arguments unfold.

In their discussion of the application of ethnographic research methods to the study of aphasia and aphasia therapy Simmons-Mackie and Damico (1999a) describe the process of progressively narrowing the focus of interest in particular phenomena. In a study of aphasia therapy they report on the broad descriptive categories developed to describe aspects of the therapy session, such as setting, therapy routines, goals and materials, and how these broad categories were further analysed into subcategories. During this process the authors became aware of a particular phenomenon associated with inconsistencies between the stated goals of therapists and their feedback to clients during therapy. This lead to an investigation which used CA methods to examine structural mechanisms specific to feedback behaviour, including consideration of the

way adjacency sequences informed the identification of feedback (Simmons-Mackie *et al* 1999). Instances of feedback were examined to identify the characteristics of the discourse before, during and after feedback, as well as their content, sequential placement and temporal characteristics being examined. Simmons-Mackie *et al* (1999) describe in some detail one of the primary research findings – that feedback was multifunctional. It was found to fulfil not only the rather obvious functions of providing information on the accuracy or adequacy of responses, or providing encouragement to the person with aphasia. It was also found to play a significant role in establishing discourse routines (such as the ubiquitous request-response-evaluation sequences), soliciting co-operation and affiliation, communicating rules and attitudes, and consolidating social roles – for example, the clinician as expert, "helper or fixer" (Simmons-Mackie *et al* 1999: 226).

The subject of 'social role' is very much at the centre of a study by Simmons-Mackie and Damico (1999b). In their introduction they highlight an apparent paradox inherent in the design of 'traditional' speech and language therapy – namely that, while the goal of therapy is to build communicative competence, "the assumptions required for treatment demand that the client be incompetent" (Simmons-Mackie and Damico 1999b: 14, 313). In other words, in the frame of 'traditional' therapy, the client is expected to demonstrate problems with communication, presumably in the form of linguistic deficit. This casts 'traditional' therapy in the same manner as 'impairment focused' therapy. Their study focuses on the ways in which the structure of participation is established by both participants, and subsequently examines an instance of conflict arising in one of the sessions.

As the authors remark, the "pattern of request-response-evaluation is pervasively present in C's language therapy" (Simmons-Mackie and Damico 1999b: 14, 318). The client is seen as an active collaborator in the construction of this discourse pattern,

where side sequences are only initiated to repair misunderstandings or help achieve correct responses. For example, the client may solicit the help of the therapist to assist her in providing the correct answers, or look to the therapist for completion of the request-response-evaluation adjacency triad. Within the context of therapy, topic changes by the client or the client's refusal to perform a task are not observed (except in the case of the conflict situation). As Simmons-Mackie and Damico (1999b: 14, 320) argue, "routine therapy interactions between C and L simultaneously manifest and construct the social roles as therapist and patient", and the structure of routine therapy discourse (e.g. request-response-evaluation sequence) is seen as a powerful resource for constructing and maintaining the social roles of competent expert and incompetent patient. What is fascinating about the investigation of the conflict that arises between therapist and client is how it throws into sharp relief the rigid social roles which are constituted by the structure of routine therapy interactions, and how very difficult it is for both parties to establish patterns of interaction which are not consistent with those roles. The conflict situation also reveals competence "that has been masked by the institution of aphasia therapy" (Simmons-Mackie and Damico 1999b: 14, 334).

In the following section studies which have investigated the general structure of therapy and teaching sessions (or lessons) will be reviewed. The role of therapist (and teacher) as dominant partner in the course of such sessions/lessons will also be examined.

2.5 The structure of sessions and lessons

This section will review some of the work which has been carried out in developing descriptive studies of therapy sessions and of classroom teaching. Some of the literature will only receive brief mention here as it will be reviewed and discussed in later chapters. The reason for discussing therapy sessions and classroom teaching in the

same section lies not only in their structural similarity, but also because some of the early work on examining the organisation of classroom teaching has been highly influential in the sphere of speech and language therapy studies – not least the work of Sinclair and Coulthard (1975) and Mehan (1979).

2.5.1 Classroom lessons

Some of the characteristics and difficulties inherent in the analysis system developed by Sinclair and Coulthard (1975) have been discussed above (Section 2..4.1 'Categorical approaches to the study of interaction in aphasia therapy'). However, what was not discussed was the structure of a higher rank in their system which was intended to account for the overall structure of lessons. Although their general motivation was to develop further understanding of discourse per se, their study of the language of the classroom enabled them to propose a structure for lessons. Thus they noticed certain types of recurrent utterance by the teacher – "Okay", "now", "right"– which led them to propose a unit above the "exchange" which they called "transaction". They noted that boundaries between transactions were typically marked by what they called "frames" (which are often referred to elsewhere as 'discourse markers' – see Kovarsky 1990). "Frames" were followed by a "focus" – these latter are often realised by metastatements about the future content of the lesson, and are an indication of the control exercised by the teacher over the choice of topic. "Frame" and "Focus" are part of "Boundary Exchanges", which as the name implies function to mark boundaries in the discourse and indicate the direction in which the lesson is going to proceed. The following is an example of "Frame" and "Focus" (adapted from Stubbs and Robinson 1979: 41):

Teacher:	OK,	FRAME
	we're going to continue then from page sixty-nine	FOCUS

The other major type of "exchange" is the teaching exchange, whose structure is expressed in terms of Initiation, Response and Follow-up, although there are a number of different combinations where Follow-up may be optional or obligatory.

In his review of research strategies in the study of the classroom Mehan (1979) criticises the type of quantification systems such as that of Flanders (1970) for the way in which summary type data ignores issues regarding the functions of language. He also makes the point that the quantification of classroom behaviour ignores the multiple functions that can be served by any speech act. Mehan's (1979) approach is one of constitutive ethnography, the goal of which is to describe the social organisation of events in ways that are acceptable to participants, a process which starts with the explicit formulations of the participants in the scene under study (i.e. a data driven approach).

Mehan (1979) describes lessons in terms of a sequential and a hierarchical organisation – sequential describing "the flow of the lesson as it unfolds through time from beginning to end", and hierarchical being "the assembly of the lesson into its component parts" (Mehan 1979: 35). Unlike Sinclair and Coulthard (1975) who were unable to provide any structural statement of lessons in terms of "transactions" – Coulthard (1985) makes a parallel between 'lesson' and 'paragraph' i.e. any combination of sentences/any combination of transactions – Mehan (1979) proposes a set of component parts of lessons: opening, instructional and closing phases. Each phase serves a different function in lessons, with the instructional phase at the heart of the lesson, where academic information is exchanged. He stresses that methodologically the goal is to ground the structure in the interactional work of the participants that assembles it. Thus, for example, in "Opening the lesson" Mehan (1979: 40) makes the point that students' responses to introductory remarks on the part of the teacher are far from passive, and that "the successful accomplishment of these interactional sequences

requires active listening on the part of the students". The assembly of classroom events is seen as a joint accomplishment of teacher and pupils.

As well as a structure of lessons, Mehan (1979) considers how that structure is achieved, which is seen in terms of the problem of social order or social organisation. He proposes that this organisation is achieved through the operation of a turn-allocation machinery, which is a part of each act of initiation (on the part of the teacher). For example, in "individual nomination" the teacher nominates a particular next speaker by name:

INITIATION	REPLY	EVALUATION
Where were you born, Prenda?	San Diego	You were born in San Diego, all right

(From Mehan 1979: 84)

This approach mirrors that of Sinclair and Coulthard (1975), who also had a category of 'nomination'. In fact, as Mehan (1979: 183) acknowledges in the conclusion, the major speech acts identified by them "served as conceptual heuristics for this study". However, as he points out, Sinclair and Coulthard (1975) rely heavily on grammatical features and make distinctions between communication modalities. For example their "elicitation" is defined in relation to verbal response, while "directive" is a request for nonverbal action. Mehan (1979) also differentiates his approach to hierarchical organisation from that of Sinclair and Coulthard (1975). Theirs is a rank-scale, which Mehan (1979) (quoting Griffin and Humphrey (1978)) has units which are abstractions from the data, analysts' constructs which are not necessarily meaningful units to the participants. He argues that each level of his hierarchy – interactional sequences, topically related sets, and phases – is grounded in the data.

As a brief postscript to the review of Mehan's (1979) work, consideration will be given to a commentary on Mehan's work by Cazden (1988), who was the teacher

who took part in Mehan's study. Discussing the anomalous cases which do not fit the structural description of "nomination" (see above), Cazden feels that the "most compelling part of Mehan's analysis is his story of the 29 anomalous cases, the sequences of talk that don't fit the descriptive system, the times when the children talk out of turn or no one answers at all" (Cazden 1988: 45). She praises Mehan's analysis for acknowledging the existence of improvisation (born out in categories such as "Doing nothing"; "Getting through"; "Opening the floor") – not simply as a way of accounting for behaviour that does not fit the prototypical pattern, but as an acknowledgement of the teacher's competence in adapting to inevitable moment-by-moment variations in a complex environment.

2.5.2 Clinical lessons and sessions

This section of the review will examine a set of studies, which over the years have been devoted to furthering the understanding of speech therapy discourse, principally with children. There are distinct parallels between the discourse of speech and language therapy with children and with adults. These lie not only in the organisational structure of lessons or sessions, as will be seen below, but also in terms of the social structuring of sessions. In terms of the latter, the nature of the instructional context is considered pivotal in both cases. As has been discussed in relation to the work of Simmons-Mackie and Damico (1999b) social roles are constituted by the structure of routine therapy interactions. In relation to therapy intervention with children instructional settings are organised in ways that structure the teaching and learning of conceptual and social skills that are deemed appropriate by society (Silliman 1984), in ways that are guided by the theoretical orientation of the clinician, be it a trainer-oriented approach, or one that is informed by a whole-language, client-oriented approach (Bobkoff Katz 1990).

Panagos (1996) points out, in a review of work devoted to the study of speech and language therapy discourse, that the work has generally been descriptive, using the study of video- and audiotaped data taken from ordinary therapy sessions. He considers that examination of therapy in this type of context is essential if we are to understand how therapeutic interactions affect treatment considerations (Panagos 1996). He argues that therapy discourse, or speech therapy talk, can be considered as a social register, distinguishable in empirical terms. The empirical evidence suggests that, in comparison with ordinary conversation, therapy talk does not "go back and forth and allow for extended turns and expanded content" (Panagos 1996, 3: 47). There is a highly asymmetrical degree of control exerted by the clinician, who uses boundary or discourse markers (see also Kovarsky 1990; Sinclair and Coulthard 1975) to control sequences and turns. The clinician exerts control in assigning turns to the child and takes turns back whenever he or she wants to, has sole rights to interruption, and controls the sequence of instruction through "known-information questions", statements of praise and correction (Panagos 1996).

The notion of hierarchy has already been mentioned in connection with the work of Mehan (1979), and Sinclair and Coulthard (1975), and, by implication in the work of Simmons-Mackie and Damico (1999a). Conceptual hierarchies feature in other analytic approaches to therapy sessions. For example Letts (1989) used the notion of communicative act (c-act) (see also Silliman 1984: 14, 301) to capture the intended speaker effect and implications for the subsequent discourse, for example whether a response of some type is expected. Whatever the problems inherent in this approach to the analysis of discourse (for example the problems associated with inferring speaker intention), Letts (1989: 126) constructed a typology of c-acts in a hierarchical arrangement involving organising the session (setting activity in motion; ensuring activity does not break down), and "ongoing" (eliciting responses, providing

information, and providing feedback). Panagos *et al* (1986) also propose a hierarchical arrangement of discourse units for the structure of therapy sessions. They emphasise the importance of connecting the underlying and surface details through the description of clinical events. Their system is in a sense generated by a "grammar of discourse units with obligatory and nonobligatory rules" (Panagos *et al* 1986: 216). The hierarchy they propose is as follows: "Lesson" with three overall phases – "Opening", "Work" and "Closing phase". The middle phase includes the bulk of the clinical teaching, where "the clinician selects two or more learning tasks organised around the goal of eliciting target behaviours". Panagos *et al* (1986) suggest that between tasks there may be small talk or brief respites from the sustained task performance, at which point a non-clinical register surfaces. "Lesson tasks" in themselves involve three phases – "Opening", "Remedial" and a "Closing phase". In the "Opening phase" instructions are given and tasks initiated, while the "Remedial phase" consists of "rapidly paced chains of remedial sequences" (Panagos *et al* 1986: 218) which are either "Simple" or "Complex" according to the amount of work that goes on to help the child achieve a correct response.

Panagos *et al* (1986) discuss in detail a number of devices used by clinicians in remedial sequences, including clinician control of the process of turn-taking, use of regulatives – enabling the clinician to carry out their social role as speech teacher – and use of requests and statements.

Panagos *et al* (1986) present a comprehensive structure for the organisation of sessions. However, within this structure they address the issue of the nonverbal components of sessions separately. While they do link some of these components with features of the hierarchy outlined above, it seems misconceived to treat this aspect of the conduct of therapy sessions as a separate entity. While these behaviours can, of course, be analysed as separate entities, the nonverbal behaviour of clinician and client

should be considered as an integral part of the resource of behaviours available to the researcher for understanding the process of conducting sessions.

2.6 CA and interaction in lay-professional encounters

There is now a very large body of research which has applied CA methods to the analysis of interactions between professionals and their clients – loosely described in terms of "talk in institutional settings" (Hutchby and Wooffitt 1998). It is not the business of this study to enter into detailed discussion about what constitutes an 'institutional context', except to say that there has been a good deal of debate about the issue. Using common-sense descriptions of context – such as in a hospital (medical), or in a classroom (educational) – to characterise the nature of interactions is problematic (Schegloff 1987). Arguing that it is the talk of the participants that reveals how a particular setting as such may be relevant for them, Schegloff (1987: 220) exhorts the researcher to examine "the details of the talk and other behaviour of the participants to discern whether and how it displays (in the first instance to coparticipants but also to professional analysts) an orientation to context formulated in some particular fashion". This study will tend towards the concept of "activity type" (Levinson 1992: 2, 69) in the characterisation of 'context'. This refers to "goal-defined, socially constituted, bounded, events with *constraints* on participants, setting, and so on, but above all on the kinds of allowable contributions" (original italics).

The following is a brief review of some of the studies which could be considered to be relevant to the enterprise of this research. Further reference to some of these and other studies will be made in Chapter Three (Methodology and Methods) and the chapters concerned with the analysis of data.

2.6.1 Interaction in healthcare settings

Hutchby and Wooffitt (1998) point out that the types of settings where interaction is characterised by a strictly regulated question-answer turn-taking format are comparatively rare. More common are institutional settings characterised by less formally structured talk, such as doctors' surgeries, social service settings or, indeed, speech and language therapy settings. However, as has become very clear in the course of this review of the literature, certain sequences of interaction in therapy appear to be highly formalised, where to some extent "turn-type pre-allocation" (Atkinson and Drew 1979) rules apply. This refers of course to the ubiquitous 'Request-response-evaluation' sequence. Interaction in speech and language therapy settings, while displaying some of the characteristics of formal discourse, also clearly has other elements – for example small talk (Panagos *et al* 1986) or "Client/clinician relating irrelevant information and/or asking irrelevant questions" (Schubert *et al* 1973: 7). As will be argued in the following chapter, if the totality of therapy sessions is to be taken into consideration, a flexible approach must be taken to the analysis. Studies of interaction in other types of healthcare setting, where talk appears more conversational (Hutchby and Wooffit 1998) are thus highly relevant to this research.

Studies to be reviewed here deal with healthcare interactions from various perspectives – advice giving as a problem of competence and the acceptance or rejection of advice (Heritage and Sefi 1992); the definition of a healthcare encounter as such (Lomax and Casey 1998); the production of asymmetries in doctor-patient interaction (ten Have 1991); a comparison of the initiation of questions and answers between patients and doctors (West 1983); miscommunication in speech therapy (McTear and King 1991); control in medical consultations (Ruusuvuori 2000). These studies will be considered here only in the broadest of terms. The purpose is to demonstrate the applicability of this type of research to considerations of interaction in

therapy for language impairment in aphasia. Appropriate studies will be drawn upon in greater detail in ensuing chapters.

While it was pointed out above that talk in these types of encounters appears more conversational than in settings where formally ordered talk is more the norm (Hutchby and Wooffitt 1998) speech produced in these interactions is actually far more constrained by type of utterance and speaker identity than in casual conversation (West 1983). Inequalities in the interaction – for example West (1983) records that from her data of the 773 questions observed 91% were initiated by doctors, while 9% were initiated by patients – are perhaps unsurprising, given that patients are the best source of information on the experience of certain medical conditions (West 1983).

Consideration has been given to the distribution of questions and answers in doctor-patient interaction in terms of when patients' questions are most likely to occur. A model of the ideal medical consultation presented by Byrne and Long (1984) describes the interaction in terms of distinct phases, starting from the doctor establishing a relationship with the patient. Phases follow one another: attempting to discover the reasons for the visit, conducting verbal or physical examination, consideration of the condition, details of the treatments, and finally, termination of the consultation, usually by the doctor. The point made by ten Have (1991), that there are restrictions on patient questions in certain phases of the consultation suggests that the tendency of patients to ask questions would connect to an orientation to specific tasks or goals to be achieved in each phase of the consultation (Ruusuvuori 2000). The question of orientation to business is a matter of concern to Lomax and Casey (1998). They examine the ways in which the researcher and the research process (in this case the videotaping of midwife-client interactions) were resources in identifying whether and how the participants oriented to the business in hand. For example, it became clear that in the negotiation between midwife and researcher regarding the beginning of the consultation, for the

midwife "the beginnings of the *interaction* and the *consultation* were evidently different" (Lomax and Casey 1998: 5.10) (original italics).

In relation to questions asked by patients in medical consultations Ruusuvuori (2000) makes the point that presenting the illness experience is not only a question of giving information but also involves various barriers to be overcome, comparing this experience with that of troubles-telling in ordinary conversation (quoting Jefferson 1980a; 1980b) which requires preparation and negotiation. West (1983) notes that in her data patient-initiated questions failed to elicit answers from doctors more often than the reverse, and that "most notable still is that the highest number of physician failures occurred in the exchange in which the patient asked most questions" (West 1983: 91). West (1983) goes on to argue that patient questions are indeed "dispreferred" – that their initiation is marked by speech perturbations ("hitches or stutters") – and that her findings seem to indicate that patients treat self-initiated questions as somehow problematic. However these conclusions are in some ways cast into doubt by ten Have (1991). While he does not dispute the general case proposed by West (and here he cites a later work: West (1984) but which uses very much the same data) in terms of party-bound preference or dispreference for questions in consultations, he does call into question the general analytic category of 'question'. He cites his own observations to argue that patients often formulate ignorance or doubts in various medical matters in ways that do not have a question form and do not create a conditional relevance for an answer in the next slot. But, he argues, they do display what the patient would like to know, and that they are often ignored by the doctor. He goes on to argue that doctors, as well as other professionals use two main types of strategy "to achieve an ongoing asymmetric display of knowledge, feelings and functioning" (ten Have 1991: 6, 150). There is an active strategy in which the professional monopolises initiatives, and a passive one, where "they tend to refrain from commentary, utterances displaying

alignment, or any indication of their own information processing" (ten Have 1991: 6, 150).

The question of client competence arises in relation to interactions where the professional – as is very often the case – is cast in the guise of 'expert'. The nature of client competence has already been alluded to in the work of Simmons-Mackie and Damico (1999b) above. Here, however, the competence of the client is treated as an object of evaluation by the professional expert (Heritage and Sefi 1992). In this study advice giving by health visitors is seen as being essentially normative – in other words it is future oriented and prescriptive. The language of the professional uses overt recommendations, imperatives, and verbs of obligation. Generally, advice was initiated and delivered unilaterally by the health visitors, often with little effort to accommodate advice giving to the circumstances of individual mothers, and "to acknowledge their competences and capacity for personal decision making" (Heritage and Sefi 1992: 12, 410). The authors go on to make the point that three-quarters of health visitor-initiated advice met with either active or passive resistance.

West and Frankel (1991) point out that miscommunication is a threat to any form of interaction, and that given the generally benevolent and sometimes life-saving goals of interaction in healthcare settings "the stakes involved in 'good' communication are very high indeed" (West and Frankel 1991: 9, 166). McTear and King (1991) discuss miscommunication – referring to Grice's (1957) definition of intentional communication – as resulting from discrepancies between the beliefs of the sender and the receiver of a message about the communicative intentions behind an utterance. The authors adopt Reddy's (1979) view that communication between clinician and patient can be treated as an attempt on the part of each participant to achieve goals against a background of beliefs. Miscommunication can then arise due to discrepant goals or beliefs of the two parties. The discrepancy may be obvious or explicit, or the goals and

beliefs are discrepant without either party being aware of the discrepancy. Their chapter is set against a background of data taken from a speech and language therapy session. The participants are the therapist and a young boy, whose difficulty had been assessed as being largely a pragmatic problem.

Instances of different types of miscommunication are discussed. At one level miscommunication arises where the boy does not respond, or responds inappropriately to the therapist's initiations. McTear and King (1991) also consider miscommunication in terms of the negotiation of topic, stating that "topic selection tends to be under the control of the therapist and the topic is often made more concrete for the child by the use of materials that the therapist believes will promote discussion" (McTear and King 1991: 10, 205). In the examples from the data the therapist clearly had to compromise her control over the topic to give the dialogue the appearance of successful communication. The authors argue that the boy is not simply unwilling to co-operate with the therapist's topic choice, because he occasionally makes inappropriate responses in exchanges where he has chosen the topic. The authors attempt to elaborate their explanation of these features of the interaction against the background of therapist and client goals and beliefs. While they put forward an intuitively plausible scheme for an ideal therapy session plan based on "assumptions which underlie speech-therapeutic discourse" (McTear and King 1991: 10, 207), these assumptions remain just that, and are not grounded in the data. The nature of the "predetermined goals" is only discernible from therapist initiations at a local level in the interaction such as: "we're going to have a star" (line 3); "Y'going to see if you can get a star for each picture" (line 22); "Tell me about that one" (line 24) (McTear and King 1991: 10, 200-201). Just as it is not defensible to infer a set of high-level goals for the therapist from these data, it is also – and here the authors concede the point – impossible to infer such goals for the boy. While interpretation and explication of miscommunication grounded in the actual data

provides useful evidence of the way therapists control or attempt to control topic, and the difficulties that arise in the process with some clients are illuminating, attempts to invoke the intentions of the participants are misplaced.

2.7 Review of the literature: summary

In this chapter the literature considered to be germane to the research questions has been reviewed. This has included a review of the ways in which therapy process has been described and discussed, and how process components specific to aphasia therapy have been addressed. A number of papers and texts were discussed, which describe generic or specific skills and techniques in therapy generally, and specific therapies for children and adults with aphasia. These skills were generally found to be described out of the context in which they had been identified.

Categorical or 'top down' approaches to the analysis of aphasia therapy and aphasia therapy sessions were reviewed and the advantages and disadvantages of such approaches were discussed. In contrast to these approaches studies of interaction in therapy sessions using data-driven methods in the tradition of Conversation Analysis (CA) were reviewed. In general these studies addressed the nature of conversation in therapy sessions rather than task-related interactions.

A body of research into the description of classroom lessons and clinical sessions was reviewed, and ways in which descriptive hierarchies have been developed were discussed. Finally a brief review of some of the literature concerned with interaction in lay-professional encounters was carried out in order to illustrate the relevance of this body of literature to the aims of this study.

In the following chapter a rather different body of literature will be reviewed, discussed and invoked in order to address the methodological issues arising in this study.

CHAPTER THREE

METHODOLOGY AND METHODS

3.1 Introduction

The questions underlying this research study have already been outlined (see Chapter One), but will be set out again here for clarity. The methodology section will continue (Section 3.2 below) by exploring in more depth how these questions relate to what is being studied, and what will be put forward as evidence. This chapter will attempt to clarify the connection between what is being researched and the methodology and methods used for going about the research study (Mason 1996).

The sections that follow (3.3 onwards) will go on to cover the overall research strategy, design and techniques of the research, and will examine more detailed arguments about the theoretical assumptions underlying the choice of methodologies and methods. These will then link to the following chapters (Chapters Four, Five and Six) which set out and analyse the data produced in the course of this study.

Research questions

The aim of this research is to study what therapists and people with aphasia actually do in the course of therapy sessions for aphasic language impairments in day-to-day practice. The research questions to be addressed are:

1. What can the pattern of interactions between therapist and person with aphasia tell us about the ways in which sessions are structured and organised?
2. What are the characteristic features of the interaction between therapist and aphasic person during the course of the session?
3. Can a 'main business' of the session be identified and how do the participants orient to the 'main business' of the session?
4. What is the relationship between the 'main business' and other aspects of the session?

5. What evidence is there that will help provide more explicit definitions of certain therapy techniques such as those described in the literature as 'cueing', 'prompting', 'scaffolding', 'facilitation' and 'feedback'?

While these questions form the basis of this study, they should not be considered exclusive. In other words the approach adopted in this study is one that does not rule out the exploration of further questions as they might arise through closer examination and analysis of the data. In this respect this study has features of a "discovery driven" approach where "the investigator seeks to discover whatever emerges as important to understanding the phenomenon under study" (Simmons-Mackie and Damico 1999a: 683).

3.2 What is being studied and what will be put forward as evidence

3.2.1 What is being studied

The questions outlined above imply that what will be studied here are: 1) the people (social actors) involved in therapy – therapist and person with aphasia; 2) the words, actions, behaviours and events which constitute the therapy under study; 3) the interactions between participants in terms of the empirical patterning, regularity and organisation of the process of therapy sessions.

There are certainly other phenomena implied by these research questions:

1. The nature of 'therapy for aphasic language impairments' has been discussed at some length in the introduction to the thesis (Chapter One) and the review of literature (Chapter Two) – in terms of specific tasks and the items used in the type of therapy under study. The assumption here is that in order to develop more explicit definitions of certain therapy techniques these phenomena should be treated as part of the 'context' or social setting of the interaction that takes place between therapist and person with aphasia. The specific nature of the tasks and items used in therapy

is taken here as an integral part of the overall phenomenon of language therapy entailed in "the work of describing a culture" (Spradley 1980: 3), and will therefore be described in detail. Attention to tasks and use of therapy items by therapist and person with aphasia will be examined in depth.

2. Therapists and people with aphasia in 'day-to-day practice': the implication here is that people will be engaged in routine therapy, and not in therapy that is constructed or constrained by the researcher, and that this will take place in the places it usually does.

The study will address itself to the interactions between participants in terms of the empirical patterning, regularity and organisation of the process of therapy, which implies that there will be no attempt to describe or explain the intentions, thoughts or attitudes of the participants directly. In other words, analysis of the data will rely on observations of therapy as it is carried out, the interest being not in what the participants think and feel about the encounter, but what they do. Writing about constitutive ethnography of schooling (Mehan 1979: 18) places emphasis on the "interactional 'work'" that generates patterns of behaviour, and as in Mehan's (1979) study the behaviour displayed in the interaction is the primary source of data for this study.

This study will be interested in therapy as a social process – to paraphrase Sudnow (1967: 169-170): that while this is a study of therapy for aphasic language impairments, it is better summarised as a study of the activities of producing therapy for aphasic language impairments as meaningful events for the participants. The implications for the chosen methodologies and methods will be discussed in detail below.

3.2.2 Representing the evidence

Various characteristics of the therapy participants will be outlined, not in order for these characteristics to be treated in any way as input factors or variables in the therapy, but rather in order to give a sense of their relevance to the field of study (Mehan 1979). These characteristics will be set out in detail in Chapter Four, but broadly include aspects to do with: a) the therapist (e.g. experience of therapy, experience of aphasia therapy); b) the person with aphasia (e.g. language impairments, age, length of time since onset of aphasia); and c) participants' shared experience (e.g. length of time known to each other, therapy frequency). In order to give an overall sense of the relevance of this study, some data on the settings in which therapy takes place will also be outlined. The purpose of attending to these data is to build up a picture of the data as a whole in terms of what Lincoln and Guba (1985) quoted in Seale (1999: 4, 45) call "transferability" – where a detailed, rich description of the setting studied gives readers sufficient information to be able to judge the applicability of findings to other settings which they know.

Included in the 'rich description' will also be specific descriptions of the types of tasks and the items used in therapy. These descriptions will add weight to the notion of 'transferability' of findings from the data. The description and analysis of interaction between therapist and person with aphasia in this study will also be considered in relation to tasks and items used in therapy.

The interactions between participants – the words, actions and behaviours which constitute the therapy under study, and the social processes of therapy entailed in those interactions – will be studied through the systematic observation of videotapes of therapy sessions. The use of video- and audiotapes (and including transcriptions) will be discussed in more detail below (Sections 3.4.1 and 3.4.2). The goal will be to construct a data-driven descriptive framework that accounts for the organisation of each and every

interaction in the corpus of data (Mehan 1979: 1, 20), building explanations through various forms of grounded and interpretative data analysis (Mason 1996).

The research questions concerned with specific therapy techniques suggest the need to focus on particular parts of the data from therapy sessions. There are no *a priori* assumptions here about how those particular parts of therapy sessions are constituted, but clearly this study sets out with some notions of how therapy sessions are constituted broadly speaking. As has been discussed in Chapter Two there are a number of studies that have outlined frameworks for describing the structure of therapy sessions, and indeed the detail of interaction within sessions. The challenge for this study, while being conscious of the work that has gone before, is to examine in detail: 1) the processes of interaction as they relate to the tasks and items entailed in therapy specifically in these sessions; and 2) how those interactions take place, and when and where they take place.

To this end data will be analysed and evidence will be constructed using approaches which acknowledge the need to construct a 'big picture' framework, as well the need to examine the detail of moment-by-moment interaction. The need to build a 'big picture' framework and derive explanations through grounded and interpretative data analysis will entail using the type of analytic induction described by Mehan (1979) (see Sections 3.3.2 and 3.6.2.i below), but will also use the methodology and specific techniques of Conversational Analysis (CA) (e.g. Sacks *et al* 1974) (see Sections 3.4.2.iii and 3.6.3 below).

The detailed examination of interaction as it relates to specific tasks and items entailed in the therapy encounter presents a challenge which will be met by drawing on techniques derived from CA, but informed and supported by research into therapy interaction from other backgrounds. While acknowledging – and from time-to-time in the course of the analysis drawing on – a conceptual approach to the analysis of exchange structure which is essentially top-down (e.g. Sinclair and Coulthard 1975),

this thesis however would take issue with the suggestion that this approach "can successfully capture the means by which (for example) teachers, therapists and doctors control the discourse in classrooms or clinical situations" (Milroy and Perkins 1992: 28). The argument here is that this approach, while being able to capture in some measure the means of control in such encounters, falls far short of a full and empirically justified description of the characteristic features of therapist-aphasic person interaction throughout the course of the session.

The following figure outlines the main points of the discussion in this section:

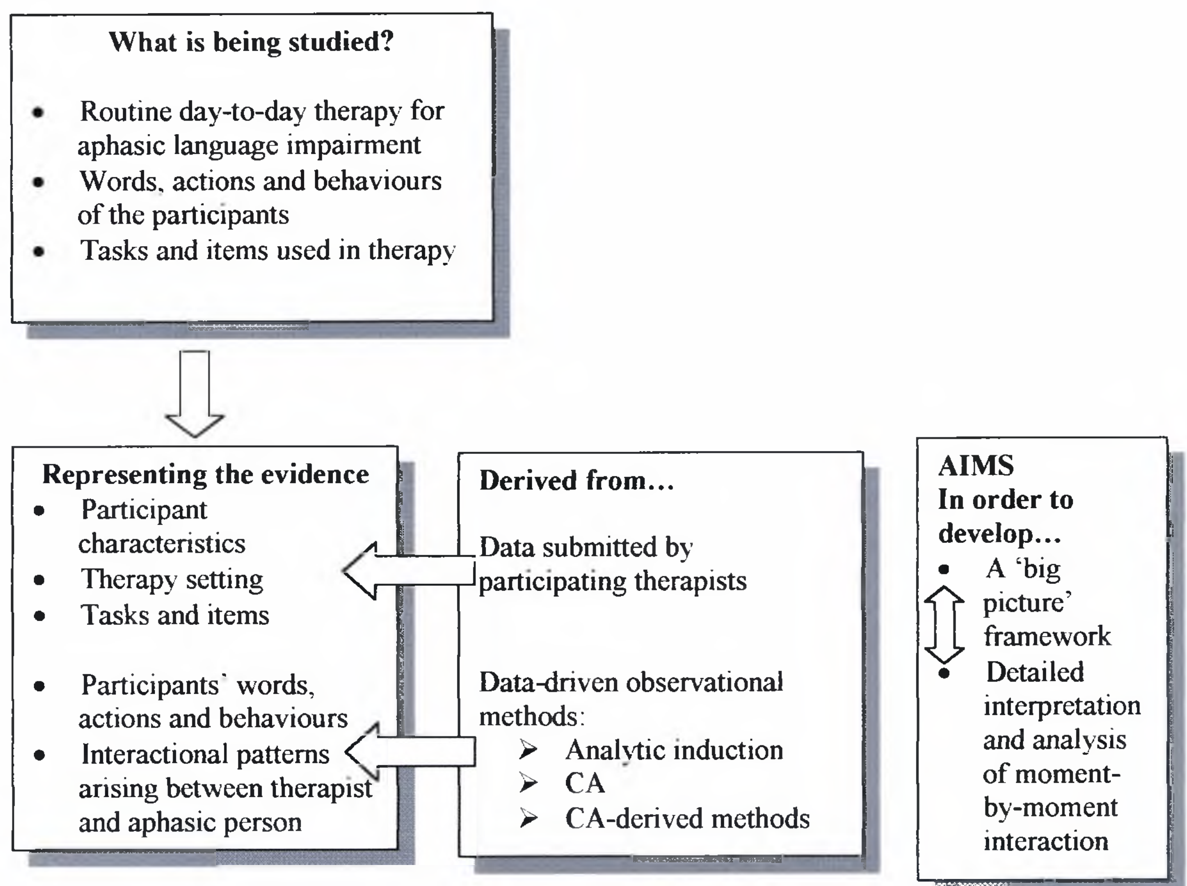

Figure 3.1 The relationship between what is being studied, the representation of evidence and the aims of the study

Figure 3.1 is an attempt to clarify the relationships between what is being studied, and how and through which means that evidence will be sought and represented, relating these to the aims of the study. As can be seen from Figure 3.1

evidence for certain characteristics of the participants and therapy settings, and descriptions of tasks and items are based on submissions from participating therapists. These will be examined and discussed in detail in Chapter Four. The two-headed arrow between the bullet points in the 'Aims' box is used to represent the interrelationship between the development of the 'big picture' and the moment-by-moment interaction taking place in the course of the therapy session. In other words, the 'big picture' framework is grounded in a close examination of interactions, which conversely take place within the framework of a bigger picture.

Issues around the research strategy, data production and specific methods entailed in this study of the phenomena outlined above will now be discussed.

3.3 Data production

3.3.1 Introduction

In the broadest sense of the question: 'What do therapists and aphasic people actually do in the course of therapy for aphasic language impairments in day-to-day practice?', the activity in process (i.e. therapy for aphasic language impairments) is being approached in this study "without any *particular* question in mind, but only the *general* question, 'What is going on here?'" (Spradley 1980: 73).

The concern to understand the nature of therapy for aphasic language impairments as carried out in day-today clinical practice accords with some of the defining parameters of ethnographic study. Bryman (1988) points out that the term ethnography, coined in the context of anthropology to denote literally an anthropologist's picture of the way of life of some interacting human group (Bryman 1988: 45), has come to be widely used to denote methods of participant observation. He describes participant observation as "the sustained immersion of the researcher among those whom he or she seeks to study with a view to generating a rounded in-depth

account" (Bryman 1988: 45). While participant observation is one of the major tools of ethnographic method, there has been considerable debate on how far researchers should or should not participate in the situations they study, and whether it is possible or desirable simply to observe without participation (Mason 1996).

This study, which, as discussed above, sees the actions and interactions of therapy participants as central, will make use of observation as its main method for producing data. The emphasis is on observing and producing naturally or situationally occurring data, rather than data which are artificially or experimentally manipulated (Mason 1996), beginning with a relatively broad question. In this sense the study is 'naturalistic' in that it seeks to minimise distortions of social reality and is concerned to reveal the social world (here the social world of a particular type of aphasia therapy) in a manner "consistent with the image of that world which its participants carry around with them" (Bryman 1988: 59).

While the study sets out with rather broad questions in mind, the intention is that insights gleaned from this broad descriptive approach will lead to a more narrow focus of inquiry. More specifically to a focus on the processes (whatever they turn out to be) entailed in 'the doing of' specific therapy treatments, entailing the application of certain tasks and manipulation of certain therapy items. The point of starting with a broad descriptive approach is essentially twofold: 1) to use the development of a structure or framework of categories to prevent being overwhelmed by the mass of interaction data. As Mehan (1979: 29) puts it: "Interaction is too massive to be addressed in its entirety all at once"; 2) to situate the more specific focus of inquiry in the whole, and to be in a position to answer questions about whether certain types of interactions only occur at a particular point, or whether they occur in different forms elsewhere in the sequence of events.

3.3.2 Data production: how much data?

Mehan (1979) (quoting Campbell and Fisk, 1959) points out the dangers of seeking only that evidence which supports researchers' orienting hypotheses or domain assumptions. He goes on to say: "When research reports include only a few exemplary instances that support a researchers' claims, it is difficult to entertain alternative interpretations of the data." (Mehan 1979: 20). The issue of 'anecdotalism' (Silverman 2000: 177) is one where questions are raised about the validity of qualitative research, and Silverman (2000) includes the principle of comprehensive data treatment as one of the ways in which to tackle the question of validity in qualitative research. Quoting ten Have's (1998: 135) observation about complaints that in CA, as in other kinds of qualitative research: "findings... are based on a subjectively selected, and probably biased, 'sample' of cases that happen to fit the analytic argument", Silverman (2000) argues that this complaint amounts to a charge of anecdotalism. He goes on to suggest that this can be addressed by 'comprehensive data treatment', where "one should not be satisfied until your generalisation is able to apply to every single gobbet of relevant data you have collected" (Silverman 2000: 180). Another approach to avoiding anecdotalism is proposed by Seale (1999). He argues that simple counting techniques are an important way of showing data to the reader in as full a way as possible, enabling them to judge "...whether the writer has relied excessively on rare events, to the exclusion of more common ones that might contradict the general line of argument" (Seale 1999: 128). However he goes on to point out that counting in itself is not enough, and that it should be supported by a self-critical mindset which is committed to examining negative instances (Seale 1999: 131).

This study shares the goal of various authors (e.g. Mehan 1979; Silverman 2000) in attempting to account for the organisation of all instances of therapist-aphasic person interaction in the data corpus. In this study comprehensive data analysis will be

achieved through a process of "analytic induction" (Mehan 1979: 21 quoting Znaniecki 1934: 232-233 and Robinson 1951) where a small batch of data is used to generate a provisional analytic scheme, which is then compared to other data, and modifications are made as necessary. This study uses methods of analytic induction in much the same way as described by Mehan (1979), as well as some of the methods described by Spradley (1980) in "the ethnographic research cycle" (see Section 3.6 below on specific methods). Peräkylä (1997) makes the point that, because researchers using inductive methods of data analysis do not necessarily know at the outset of the research which phenomena will be the focus of interest, it may turn out that these actually occur only rarely in each single recording. Therefore he argues that in order for the researcher "...to be able to achieve a position where he or she can observe *the variation of the phenomena*...in any reliable way, the researcher needs a large enough collection of cases" (Peräkylä 1997: 13, 206) (original italics). This study has worked towards this goal by recruiting fourteen therapists who contributed forty one sessions of videotaped therapy.

This study will follow Seale's (1999) advice and use simple counting techniques on occasions in order to present the fullest picture of the data. Tables will also be used in order to provide an overview of data and to make reference to and understanding of the analysis more transparent. Throughout the analysis of the data informal quantification will also be used (Schegloff 1993) – expressions such as 'rarely', 'often' or 'commonly' are used to suggest the relative prevalence of certain phenomena under consideration.

3.3.3 Data production: which data?

Many authors stress the importance of acknowledging that the researcher is never 'theory free' – in other words that researchers approach data with some world

view, some set of perspectives which perforce will have a bearing on what they observe and produce in terms of data. Dey (1993: 15) makes the point that any 'data', regardless of method, are in fact 'produced' – they have to be noticed by the researcher and treated as 'data' for the purposes of the research, whether this involves the preliminary activities of selection or the techniques of collection, tabulation and transcription.

It is quite clear in this study that certain constraints have been made on the production of data, and that 'therapy in day-to-day practice' is not any therapy, but a very specific type of therapy, as outlined and discussed in the introduction (Chapter One) and literature review (Chapter Two). This is in keeping with the specificity of the research questions, and has a direct impact on the type of data produced in the first instance. Thus this type of data, which will be set out in Chapters Four, Five and Six, relates to participant characteristics and characteristics of the tasks and materials that form the 'substance' of language impairment therapy.

While the focus of interest of this study is the nature of how therapy is carried out, it does not set out to try and isolate instances of such enactment *a priori*. This would be to assume knowledge about what enactment 'looked like' in the first instance, which of course would defeat the object of the study. However there is no claim that this study is being approached with the researcher as some sort of *tabula rasa*. As has already been outlined in the introduction and literature review, numerous studies (both empirical and theoretical) about the nature and substance of therapy treatment – for example in terms of the structure of therapy sessions, the notion of instructional sequences, feedback and so on – have been published, and it must be assumed that this researcher's world view is not a naïve one.

The issue of data production will be a continual one in this exploration of therapy, and will continue to be referred to in the analysis of data. The cycle of data inspection, thematic development, interim analysis and so on, and thence the

progressive narrowing of focus, implies that data of different types will be produced throughout the study. Sudnow (1967: 176) remarks: "The very noticing of a 'fact' can be seen as the most problematic of matters". Facts are only facts because they have been selected out of a wealth of information as relevant for a particular purpose – in other words, there is no way to remove the effect of the researcher from the research, as "they are part of the social context of the research" (Temple 1998: 208). In the light of these considerations (and of further ones that are discussed below) every attempt will be made to ground the noticing of such 'facts' in thorough analysis and justification. To this end, supporting arguments or contrasting cases from the literature will be cited and discussed throughout the analysis of data, where it is thought relevant in the 'telling of the story' (see reference to Wolcott 1990 in Chapter Two).

3.4 Research strategy

3.4.1 Participant/non-participant observation: videotaping

For various reasons – practical, logistical and theoretically motivated – this study has chosen to use a purely observational method. In other words the researcher has not participated in the settings under observation, and not carried out the "sustained immersion" described by Bryman (1988) – the exception to this being that the author is one of the therapist participants whose data is included in the study. The practical and logistical reasons were to do with the need to invite participation from therapists and people with aphasia from all around the UK. This is mainly due to the fact that expertise in aphasia therapy (one of the defining constraints on participation) is not necessarily concentrated in one geographical area, but also because therapists from all around the UK, and who were eligible, did agree to participate, and were consequently invited to do so. Therefore it was not possible for the researcher to sit in on and observe sessions directly. Another practical reason, and one which placed a further logistical barrier to

the researcher being a participant observer, was that each participant pair (therapist and person with aphasia) was asked to contribute three sessions to the corpus of study data. The reasons for doing this were: 1) to overcome, as far as possible, the effects of the presence of the camera and tape recorder on the phenomena being studied by, in a sense, habituating the participants to its presence. Goodwin (1981) argues that unobtrusive recording over a period of time may lessen the effects of the camera; and 2) to try and ensure that the interactive phenomena being observed were, as far as it is possible to say, 'true' to those participants – in other words that each participant dyad interacted as they did in some sort of predictable or consistent way which potentially could be confirmed or disconfirmed by studying interactions across sessions.

To get round these practical and logistical barriers to participant observation therapist participants were asked to video- and audiotape their own sessions with an aphasic person (though see exceptions outlined in Chapter Four and discussed in Chapter Five). Lomax and Casey (1998) point out that the value of audio-visual material has been well documented across various methodological perspectives, and "the ability to record the minutia of social life makes it an ideal method for a number of research objectives and theoretical approaches" (Lomax and Casey 1998: 1.1). It could be argued that placing the researcher in the position of being purely an observer by using video recordings as the basis for data production defeats the purpose of "sustained immersion of the researcher among those whom he or she seeks to study" (Bryman 1988: 45) which is characteristic of ethnographic participant observation. However the argument for the use of video- and audiotaped recordings of therapy sessions in this study is based on the argument that "audio-visual recordings of human social activity provide a record that is more accurate, more detailed and more complete than that obtainable by unaided human observation" (Lomax and Casey 1998: 1.1).

Lomax and Casey (1998) go on to argue that the reliability of the data is in a way self-evident, because it allows repeated replays, enabling analysis to be conducted away from the field, and allowing other researchers to conduct their own analysis. Mehan (1979: 19) argues that audio-visual materials preserve data "in close to their original form", serving as an external memory which allows researchers to examine materials extensively and repeatedly. "Retrievability of data" (Mehan 1979: 19) is one of the methodological policies of the type of constitutive ethnographic study carried out by Mehan (1979) and this study very much adheres to this principle. As will be discussed below (Section 3.6.2.iii), audiotapes were transcribed and available for use by the researcher. Video recordings and audiotaped transcriptions allow data to be viewed and reviewed, and this is a vital aspect in the methods used for developing interpretations.

Lomax and Casey (1998) suggest that there are two main approaches taken to the validity of video-recorded data: 1) denying the effects or influence of researcher and camera on the phenomenon being studied, presuming that the method does not threaten the epistemological status of the data; 2) suggesting that the research method inevitably intrudes upon and alters the representation of reality, so that "data has to be obtained covertly, or supplemented with respondent or comparative techniques." (Lomax and Casey 1998: 1.3).

This study acknowledges that the presence of the camera will inevitably have some impact on the phenomena being studied. Despite the fact that the researcher was not present and actually carrying out the recording, there is a sense that the video camera was a proxy for his presence as 'an outside other'. It certainly gave rise to comments from the participants, who visibly and demonstrably noticed the presence of the camera. While this will be acknowledged and accounted for in the presentation and analysis of data, it is argued here that the camera has not altered the presentation of

therapy reality to an extent that significantly affects the validity of the interpretations which follow.

The decision to use video-recordings of therapy in naturally occurring settings was also driven by the availability of methods of analysis and interpretation which are ideally suited to data produced in this way (see Section 3.6 below).

3.4.2 Observation and interpretation

As Bryman (1988) argues: "the commitment to explicating the subject's interpretation of social reality is a ...*sine qua non* of qualitative research" (Bryman 1998: 72) (original italics). Bryman goes on to point out the difficulties associated with providing an account from the perspectives of those who are the subjects of study, and the problems of substantiating the validity of interpretations of participants' perspectives. This view is echoed by Mason (1996), who points out that the observer-researcher has to engage in the criticisms that their explanations based on observational methods "...are subjective, unrepresentative and ungeneralizable." (Mason 1996: 62).

3.4.2.i Respondent validation

One approach to the problem of interpretation is 'respondent validation' where the ethnographer submits a version of their findings to the subjects themselves, and as Bryman (1988) points out this can be done in a number of ways. Lincoln and Guba (1985), quoted in Seale (1999: 44-45) argue that the most crucial technique for establishing the "credibility" of a research enterprise is through "member checks", such as showing interview transcripts and research reports to the people on whom the research has been done, so they can indicate agreement or disagreement with the way in which they have been represented.

However there are problems inherent in this approach – for example, inviting censorship or inciting defensive reactions from the participants (Bryman 1988). Other more fundamental difficulties are apparent in the context of this study. These concern the actual nature of the research questions, which arose precisely because of the concern (as discussed in Chapter One) that therapists had an implicit knowledge of the ways in which they were implementing therapy, but only had limited concepts and an inexplicit vocabulary for expressing that knowledge. As Spradley (1980: 11) puts it: "Informants always know things they cannot talk about or express in direct ways". This could be said to include "…interactional competencies…that are so taken for granted that members are unlikely to mention them to one another or to qualitative researchers" (Miller 1997: 3, 27). Logically therefore the potential problem arises that the researcher sets out to 'check' his account of therapy enactment using concepts that are so abstracted away from the actual data that they are incomprehensible to the participants. Bryman (1988: 79) argues that: "It is unlikely that respondent validation will greatly facilitate the ethnographer's second-order interpretation of subjects' first-order interpretations." Fielding and Fielding (1986: 43) quoted in Silverman (2000: 177) argue that: "there is no reason to assume that members have privileged status as commentators on their actions…such feedback cannot be taken as direct validation or refutation of the observer's inferences".

While this study has, in principle, not adopted any formal methods for respondent validation, an informal process of discussion, consultation and debate has continued over the course of the study. This has taken the form of discussion groups, researcher supervision, workshop presentations and discussion, and conference presentations. The exposure of the researcher's interpretations of the data to therapists from various backgrounds has contributed to continuous re-interpretations of the data.

3.4.2.ii Revealing data

Interpretative accounts in this study are drawn from observations of data produced from naturalistic settings. This strategy is based on the premise that "these kinds of settings, situations and interactions 'reveal data', and also that it is possible for the researcher to be an interpreter or 'knower' of such data" (Mason 1996: 61). There are several issues associated with the notion of the researcher as 'knower', and with how accounts can be provided and substantiated.

Some of the issues around the status of the researcher-observer as a 'producer of data', and which might seem to impact negatively on the impartiality and openness of the researcher have been discussed above. However, there is a further consideration which of necessity affects the researcher-researched relationship. This is to do with this particular researcher also being a speech and language therapist who is actively involved in working in this area of therapy. There are perhaps two major aspects of this fact that need consideration.

Firstly, given that the research questions are based on the premise that, in the current state of knowledge about therapy, therapists themselves only have implicit or tacit knowledge of the acts and actions they perform when carrying out therapy, how is this researcher to be any more enlightened? In other words, how can he become an objective 'knower' in these circumstances? The simple answer is certainly that he cannot be a totally objective 'knower'. However, attempts will be made through the methods applied to the research questions to maximise the objectivity of the observations and interpretations. These will be discussed below in the sections that follow. The other approach used to help clarify the researcher-researched relationship and to treat this relationship in an open and accountable way will be the process of critical self-scrutiny (Mason 1996). Here the actions and role of the researcher in the research process (especially in relation to production and interpretation of data) will be

made open to scrutiny, based on the premise that the researcher cannot remain detached from the knowledge and evidence they are generating.

The second point about this particular researcher also being a speech and language therapist is one that perhaps plays on the advantage of the insider knowledge which that fact brings. In this respect the researcher is a 'knower' because of his shared experience with the participants in the research. In part this is due to the fact that he is one of the participants in the study. He is also a speech and language therapist with experience in this particular field of therapy, knowing what the experience of that social setting feels like (though of course not necessarily from the perspective of all the participants), and in that sense he is "epistemologically privileged" (Mason 1996: 62). There is a constant tension between the status of objective observer, and participant, and as Mason (1996) points out there are criticisms of the simplistic point of view that you are a 'knower' because you share relevant experiences. However, there is no doubt that, despite the tension between objectivity and the insider perspective – the 'emic' perspective Pike (1971) – there are some potential advantages to the status of this researcher as therapist. These will be made clear when they are relevant to production and interpretation of the data, for example where one construction of social reality is open to contest and change (Miller 1997) as a result of the insider perspective available to this researcher.

Acknowledging and all the while maintaining "a healthy scepticism" (Mason 1996: 69) about the objectivity of apparently literal methods of audio- and videotaping, this study is based on the argument that participants "will make the researcher's phenomenon visible by their actions" (Mehan 1979: 23). In this sense this study accords with another of the premises of constitutive ethnography as described by Mehan (1979), namely that: "...the structure and structuring of events described by the researcher converges with that of the participants in the event" (Mehan 1979: 22). This addresses

the problems outlined above associated with providing an account from the perspectives of those who are the subjects of study, and the problems of substantiating the validity of interpretations of participants' perspectives. Bryman (1988: 78) quoting Mehan (1978: 36-37): "Constitutive studies therefore attempt an exhaustive analysis of behaviour in the flow of events", points out that the result is an intricate and detailed description of patterns of interaction, sequences of events and conversations "which allow alternative interpretations of what is happening and how participants understand their circumstances". Mehan (1979) argues that in order to determine whether the researcher's phenomenon is also the participant's phenomenon, consideration needs to be taken of the consequences of action in the course of events. In other words: "They [the participants] will make the researcher's phenomenon visible by their actions" (Mehan 1979: 23), and the researcher's phenomenon can thus be demonstrated.

3.4.2.iii Constructing a social reality

Constitutive ethnography claims that the researcher's phenomenon is made visible in the actions of the participants. This position is even more clearly outlined in the methodology of CA. The interest of CA as it has developed out of ethnomethodology is in the methodological resources used by the participants themselves. Ethnomethodology itself is an approach to the study of social processes which has as the central focus people's practical reasoning and the ways in which they make the social world sensible or intelligible to themselves (Bryman 1988). Detailed and repeated inspection of the ways in which actual activities are accomplished provides the resource for the researcher to begin to identify the practices and reasoning through which particular events are produced (Heath 1997). Peräkylä (1997: 13, 209) argues that "...in the unfolding of the interaction, the interactants display to one another their interpretations of what is going on", and that from this fact arises a fundamental

validation procedure that is used in all CA research, quoting Sacks *et al* (1974: 729): "But while understandings of other turn's talk are displayed to co-participants, they are available as well to professional analysts, who are thereby afforded a proof criterion...for the analysis of what a turn's talk is occupied with". Therefore, as Seale (1999: 70) argues, CA can be seen as a self-validating methodology, "...because the mode of analysis focuses on demonstrably true interpretations of members' reasoning".

Heritage (1997) describes how CA embodies a theory which argues that sequences of actions are a major part of what is meant by context, and that: "...the meaning of an action is heavily shaped by the sequence of previous actions from which it emerges, and that social context is a dynamically created thing that is expressed in and through the sequential organisation of interaction" (Heritage 1997: 11, 162).

CA techniques will be employed in the production, analysis and interpretation of data from this study in two main ways. Firstly, as an adjunct to the methods of analytic induction (which will be set out in more detail in Section 3.6.2.i below) and in order to help substantiate the claims made about how the participants understand and construct the social processes of therapy sessions. Secondly CA and CA derived methods will be used to help work towards the rich picture description and provide in-depth analysis. Methods, such as attention to turn-taking and sequence organisation, lexical choice, and close attention to pauses and timing, will be used to examine in detail therapist-aphasic person interaction throughout the session, including interactions associated with the types of therapy techniques outlined in the research questions. An outline and more detail of the main CA methods will be set out below (Section 3.6.3).

3.5 Data production and research strategy: summary

In this exploration of therapy for aphasic language impairment data in the form of videotape, and audiotape transcriptions of therapy sessions from day-to-day clinical practice will be produced and examined. Other data, in the form of information about the therapy participants and therapy settings will be produced in order to give a sense of the setting. Data made available by the therapist participants on the tasks and items used in therapy will also be produced and incorporated in the description and analysis of therapy sessions.

In the first instance, all available videotape and transcription data will be examined in an iterative analytic process. Themes and structures will be developed from the data, tested and re-tested and refined in a process of analytic induction. A structure for the organisation of therapy sessions will be presented and individual domains and features of this structure will be examined in greater depth. Therapy treatment interactions entailing the application of tasks and therapy items will be examined in depth using techniques derived from CA. A rich description will be elaborated, and the interaction process will be analysed in detail.

Data description and presentation will include, where appropriate, tabulation and quantification in order to give a sense of the breadth, relevance or scope of concepts or phenomena uncovered by the researcher.

3.6 Methods

3.6.1 Introduction

While the previous sections of this chapter outlined the broad conceptual approaches to data production and research strategy in this study, the sections which follow will turn attention to the detail of specific methods to be used in the production and analysis of data. These include the process of analytic induction, the use of the "Ethnographic research cycle" (Spradley 1980), the process of comprehensive data treatment, and how the rich picture description is enhanced through the use of CA.

3.6.2 Towards a comprehensive descriptive structure of therapy sessions

3.6.2.i Analytic induction

The method described and used by Mehan (1979) in his study of social organisation in the classroom of an American school aims at a comprehensive analysis of the data. It begins with the examination of a small batch of data, from which a provisional analytic scheme is developed. This scheme is then used in comparison with other data, and modifications are made to the scheme as necessary. The provisional scheme is confronted all the time with "negative" or "discrepant" cases (Mehan 1979: 21), and has to be modified until the data are accounted for.

This approach is very similar to the "constant comparative method" described by Silverman (2000: 179). Here the researcher begins analysis on a relatively small part of the data, and tests emerging hypotheses by steadily expanding the data corpus. All parts of the data must at some point be inspected and analysed, which ensures comprehensive data treatment.

The notions of comprehensive data treatment and the analysis and adaptation to negative and discrepant cases are part of the process of ensuring the validity of qualitative research according to Silverman (2000). This also includes the "refutability

principle" (Silverman 2000: 178), where the researcher actively seeks to refute initial assumptions about the data. Silverman (2000) argues that the researcher needs to overcome the temptation to jump to easy conclusions because there is some evidence, and argues that the researcher must subject this evidence to every possibility test.

3.6.2.ii The Ethnographic Research Cycle

This study must also acknowledge some of the methods described within the Ethnographic Research Cycle (Spradley 1980: 29) which entails: asking questions → collecting data → making a record → analysing data →, and so on in an iterative process. In his description of the Developmental Research Sequence Method, Spradley (1980: vii) argues that "...some tasks are better accomplished before other tasks when doing ethnography", and while this study has by no means adhered to the sequence of his methods, it has applied some of the techniques he describes.

In principle this study follows the pattern advocated by Spradley (1980) of starting with "grand tour" observations. These are observations which identify the major features of the objects under study, giving an overview of what is occurring. These are followed by "mini-tour" observations, which draw on specific information already discovered, and deal with smaller units of experience (Spradley 1980: 79). Descriptive observations are followed by focused observations, which are followed by selective observations. Domain analysis (Spradley 1980: 85) involves developing categories of meaning through systematic examination of something to determine its parts, the relationship among parts and their relationship to the whole. Simmons-Mackie and Damico (1999a), for example, used methods adapted from Spradley (1980) in a study of aphasia therapy. Initial observations lead to the development of broad categories, such as therapy setting, therapy routines and materials, which were further analysed into various subcategories, and investigated in turn in greater depth.

In this study, some principles of domain analysis have been used to develop a descriptive framework for the structure of therapy sessions. These include determining membership of domains (i.e. parts of the descriptive framework) through the use of the notion of "semantic relationship" (Spradley 1980: 93) which functions to define terms included in domains. The types of semantic relationships which are used in this study are: "Strict inclusion" (X is a kind of Y); "Function" (X is used for Y); "Sequence" (X is a step or a stage in Y). Other types of semantic relationship have not been used – for example: "Attribution" (X is an attribution of Y) or "Rationale" (X is a reason for doing Y) (Spradley 1980: 93) – as inappropriate to the ontological focus of this study (i.e. that the study is not seeking to determine or examine attribution or participant reasoning).

This study does not exhaustively and prescriptively follow the stages in the Developmental Research Sequence Method (Spradley 1980) because they are not all appropriate and pertinent to the conduct of this study. However, in this study as definitions emerge they sensitise the researcher to further instances of a phenomenon, and attention shifts from a focus on evidence to a consideration of the properties of categories, and a comparison of categories (Solomos 2001) in a way that is, broadly speaking not dissimilar to the methods described by Spradley (1980).

3.6.2.iii The process of comprehensive description in this study

This study approaches the comprehensive description of therapy sessions in very much the ways described above. All the videotaped data had been produced, or was in the process of production before inspection and analysis began – in other words, new video-taped data was not gathered dependent on an inspection of data already produced. In the first instance small batches of therapy data were examined and provisional descriptive structures were put forward. Further batches of data were then examined, where descriptive structures were put to the test, revised and refined. This process

continued until an adequate structure was arrived at. As has been mentioned above, a process of exposing preliminary findings has also taken place through various informal discussions and formal presentations.

There is no doubt that (as discussed above) existing work was a source of guidance in the first instance of data inspection and throughout the study. This included concepts at the level of the structure of therapy sessions, such as instructional sequences, and also, inevitably, concepts related to these structures, such as turn taking organisation, lexical choice or the use of discourse markers. Such concepts have not been used in such a way that instances of pre-existing structures and categories were sought out to be identified and confirmed. The process was used more in a rather pragmatic 'rule of thumb' way in order to begin a 'rough sketch' that could be taken forward to test on new sets of data.

Despite the use of such concepts mentioned above as heuristic devices – here in the sense described by Mehan (1979) as a way of assigning, in the flow of events, data to discrete categories, there is a sense that initially the inspection and analysis of data was not conducted 'in depth'. For example, this is apparent in the requirements made of the audiotape transcriptions. Audiotapes were transcribed in the first instance by an audiotypist, and instructions for transcription were such that, for example, pauses were not marked and vocal non-verbal utterances were generally not marked. This was due to entirely pragmatic reasons – namely that the burden of detail in the transcription should be reduced as much as possible for the audiotypist as there was such a quantity of material. The audiotypist was given the following instructions: 1) each spoken turn to be labelled by speaker (T [therapist] or A [aphasic person]). Very occasionally there is a third person on tape (for example a relative) whose contribution was also noted; 2) each line to be numbered; 3) uncertain hearings to be thus: (uncertain); 4) unheard or unable to recognise: (   ); 5) simultaneous talk was bracketed thus: [   ] at beginning and end.

An example of the closer transcription conventions used by the researcher are outlined below in Figure 3.2.

1. T right ok what I'm going to do this morning
2. A oh oh oh oh oh
3. T what do you want
4. A (give me my glasses)
5. T fine (right) you beauty you can see it now you didn't appreciate it before
6. now it's gone (5 hours) right do you think we could start right so what we
7. are going to do is to try and finish off these sentences with another sentence
8. alright

Extract from transcription: version submitted by audiotypist

1. T right ok (.) what I'm going to do this morning
2. A oh oh oh oh oh ((looks at glasses))
3. T what do you want
4. A (~~give me~~ clean my glasses)
5. T (slave) I'm a veritable slave to you ((cleans A's glasses)) ((laughter from T
6. and A)) fine (right) you beauty you can see it now you didn't appreciate it
7. before now it's gone (5 hours) (.) right do you think we could start right so
8. what we are going to do is to try and finish off these sentences with another
9. sentence alright↑

Same extract as annotated by the author after viewing video. Additions to the original are shown in red

Figure 3.2 Audiotypist, and author annotated transcriptions from D1 (1)[1]

[1] Each therapist-aphasic person dyad has a code e.g. D1. Numbers in brackets after the code refer to a particular session.

Figure 3.2 illustrates an example of a transcription submitted by the audiotypist and annotated by the author. Transcription conventions are set out and clarified following the thesis Abstract at the beginning of Volume 1.

Of course there was no non-vocal non-verbal action marked on the transcriptions from the audiotypist transcriptions, and the researcher was responsible for viewing the videotapes in conjunction with the transcriptions and marking them for non-vocal non-verbal, and vocal non-verbal actions. In the first instance this was carried out in two main ways.

Firstly, obvious turn-taking discrepancies were adjusted on the transcriptions. This means that, where the transcription was clearly wrong and misleading due to the fact that a participant's turn was missed out (for example because it was a non-vocal non-verbal turn), this was adjusted.

Secondly, the transcription was annotated with descriptions of vocal and non-vocal non-verbal actions where this was thought to add to the understanding of the transcription. This of course is potentially a rather haphazard process, as what might be considered or not considered to add to the understanding of the transcription at one viewing, might be entirely different at another viewing, for a variety of reasons. The process must also be considered to be highly dependent on what the researcher notices as 'a fact' or a matter of interest. However, practices in this study will follow Goodwin (1981) where only those distinctions necessary for the analysis being developed will be included in the examples given.

In the light of these points, inspection and repeated inspection of the data is essential, and as pointed out above, evidence must be tested and re-tested. One of the features described by Seale (1999) (after LeCompte and Goetz 1982) that potentially enhance 'internal reliability' is the use of low-inference descriptors, such as CA informed transcription practices as opposed to tidied-up transcriptions. Here Seale

(1999) argues that readers of such extracts are more informed about the basis of researcher's interpretations and are thus better equipped to evaluate their adequacy, but acknowledges that the degree to which readers are asked to rely on researcher inference is relative – the level of detail required to describe data remains a matter of judgement, taking into account the degree to which claims are central to the overall argument.

It also has to be said in defence of the process of data inspection and analysis, that, although the interaction data clearly have to be presented here in transcription format, they were never inspected and analysed in depth without inspection of the videotape.

3.6.3 Towards a rich picture: Conversation Analysis

In this study CA methods are applied to the management of a specific type of speech and language therapy "*in* interaction" (Heritage 1997: 11, 162), and strive to do so in a way that takes account of the various props and paraphernalia of therapy, as they can be shown to be used by the participants. Wilkinson (1999) points out that the widely used term 'talk-in-interaction' in relation to one of the objects of study in CA highlights the fact that the focus of study "...is not just casual conversation but includes interactions between participants in institutional roles" (Wilkinson 1999: 252). CA methods are also used to address particular actions within interactional contexts – i.e. CA does not just address 'talk' *per se*. As Heath (1986) points out actions and movement activity are accomplished and interactionally co-ordinated in order to accomplish various types of work in the context of the here and now – in other words actions and movement activity are seen as integral to the whole interaction.

As has been discussed above (Section 3.4.2.iii Constructing a social reality) CA embodies a theory that sequences of actions are a major part of what we mean by context. This involves three interrelated claims: 1) talk is context-shaped; 2) participants

create or maintain or renew a context for the next person's talk; 3) by producing a next action, participants show an understanding of a prior action in various ways, which are confirmed or which can become the objects of repair. Conversation analyses are therefore simultaneously analyses of action, context management and mutual understandings, because: "…all three of these features are simultaneously, but not always consciously, the objects of the participants' actions" (Heritage 1997: 11.163).

CA therefore has the potential for this study to help develop an understanding of the structure of sessions through the actions, context management and mutual understandings of the participants – in other words, how the participants manage their interactions as a therapy session. Ways of talking or acting which may be taken in one way in ordinary conversation, may be subject to entirely different interpretations in institutional talk (Drew and Heritage 1992). As Damico *et al* (1995) point out various contexts involve different goals, changing participant roles and different styles of talk and action that are actively manipulated in the course of the interaction.

Drew and Heritage (1992: 1, 22) propose that the following features should be taken into account when considering "institutional talk": 1) *goal orientations* by at least one of the participants; 2) *special and particular constraints* on what one or both of the participants will treat as allowable contributions; 3) *inferential frameworks* and procedures that are particular to specific institutional contexts (original italics). "Goal orientations" entail a manner of conduct by the participants which show an orientation to institutional tasks or functions (Drew and Heritage 1992: 1, 22). "Special and particular constraints" relevant to the type of interaction under scrutiny here entail "local and negotiable understandings about the ways in which the tasks or other institutional aspects of their activities may limit allowable contributions to the business in hand" (Drew and Heritage 1992: 1, 23). "Inferential frameworks" are considered to embody the ways in which interpretations of participants' contributions are particular to

these specialised institutional encounters. These features are seen as essential considerations to be taken into account in the work of developing a descriptive framework for therapy session structure.

Specific features of therapist-aphasic person interaction which will be examined in this study are set out in Heritage (1997: 11, 164-179), and include the following:

1) Turn-taking organisation: all interactions involve some sort of turn-taking organisation, but interactions in some settings involve special turn-taking procedures. There is a difference between turn-taking organisation that is oriented to in its own right (and can be shown to be so, such as in debates), and turn-taking that is the product of the task that participants are engaged in (for example, case history taking in medical examinations). In this study, turn-taking organisation will be examined in a way that helps point towards the type of activity which is currently under way between participants.

2) Overall structural organisation: Heritage (1997: 11, 166) points out that while it is not always possible to describe institutional interactions in terms of a "...phase structure, it is always worth making an attempt to do so". This study will attempt to do this, both in order to locate and examine in-depth the specific task focus which is one of the central research questions, and to examine the relationship between this task focus and other 'phases' of the session. Heritage (1997: 11, 167) gives an example of distinct clusters of activity which are used by participants to achieve a task – *opening; problem initiation; disposal; closing* (original italics) – and he goes on to examine how each section is jointly oriented to by both participants ("co-constructed" Heritage (1997; 11, 167)). Heritage (1997) continues by outlining how doing this sectional analysis can help identify other features of the interaction – for example, topic or item of business, the significant stages in the co-construction of tasks, progressive

development of a joint sense of task, and agreement (or disagreement) about boundaries. Heritage (1997) makes it clear however, that overall structural organisation is not a framework to fit data into, but it is looked for and at "*only to the extent that the parties orient to it in organising their talk*" (Heritage 1997: 11, 168) (original italics).

3) Sequence organisation: Analysis of sequences helps point towards how particular courses of action are initiated and moved on, and how in doing so how particular opportunities are opened up or closed down. Heritage (1997: 11, 170) gives an example of how a question posed by a teacher to a parent is not treated as a casual inquiry, but is characterised by "...a particular - and specifically 'institutional' - understanding of its relevance".

4) Turn design: Drew and Heritage (1992) make the distinction between: 1) the action that the turn is designed to perform; and 2) the means that are selected to perform the action. The first may be seen in the way, for example, a response is constructed, and which indicates the different activities it may be designed to perform – for example in accepting a statement as a casual remark, or rejecting an unstated implication or insinuation. The second can be seen in the way that participants in the interaction select among alternative ways of saying or performing the same action.

   Heritage (1997) points out that turn design is also analysed by looking at the detailed features of the turn's components. For example, whether a turn is designed as a question rather than a statement, and if so what sort of question, and what the turn does not say. As Heritage (1997: 11, 173) summarises: "The syntactic, lexical and other (e.g. prosodic) selections by a speaker are aspects of a turn that articulate with the performance of organisational tasks...".

5) Lexical choice: This includes selection of descriptive terms which are fitted to the institutional setting or to the role of a participant within it – for example, the use of "we" by a member of an organisation when referring to themselves, or, for example, what Heritage (1997: 11, 174) refers to as "institutional euphemism".

6) Interactional asymmetries: Heritage (1997: 11, 175-179) mentions four types of asymmetry: a) "participation" – where, for example, institutional participants in lay-professional encounters take and retain the initiative in the interaction, directing it in a way that is not found in ordinary conversation; b) "'knowhow' about the interaction and the institution in which it is embedded" – the organisational perspective may be one of treating an encounter or an individual as a routine case, in contrast to the possibly personal and unique nature of the interaction for the client. The client may have no, or a limited awareness of the professional objectives being pursued in the course of an encounter, or even though they do understand the overall purpose, they may not understand the point of a particular action; c) "knowledge" – this is typified by professional caution, where an institutional participant may avoid committing themselves or taking a firm position. It is also apparent in displays of "superior" expert knowledge; d) "rights to knowledge" – asymmetry of rights of access to knowledge arises when lay people in institutional encounters have limited resources to answer the questions: "What am I entitled to know?", and "How am I entitled to know it?" (Heritage 1997: 11, 178).

As Heritage (1997: 11, 161) points out, while the social world of institutions such as classrooms or courts (or speech and language therapy sessions for that matter) is invoked in talk, "their reality is not confined to talk", but also exists in buildings, documents and so on. This study, as its focus narrows in on the interactions between

therapist and aphasic person doing work specifically targeted at treating language impairment, will take into account the use of therapy items and other objects that are a central part of the business of doing therapy. It is seen as essential to the purpose of this study that these are described in detail and treated as being intrinsic to the interaction (where it can be so demonstrated).

As was pointed out above different goals arise in various contexts in the course of interactions (Damico *et al* 1995). It is to be anticipated that goals and contexts change over the course of the therapy session, and that the nature of "allowable contributions" (Levinson 1992: 2, 69) in therapy for aphasic language impairment as an activity type (Levinson 1992) will fluctuate – or be actively manipulated – during the course of the session. The methods described here are arguably the most flexible, powerful and therefore the most appropriate to describe and analyse therapy sessions in the depth necessary to address the questions that have been posed by this study.

3.7 Methodology and methods: summary

This study will seek empirical evidence in developing a rich picture description of the methods employed by therapists and people with aphasia as they interact during the course of therapy for aphasic language impairments. It will examine closely the conduct of therapists in order to further the knowledge of what might constitute 'doing, and displaying doing, being a language therapist' (after Schegloff 1987: 9, 220). Evidence will be sought from observations of therapy activity in naturalistic settings, mediated by the use of videotape, audiotape and transcription methods in the production of data. Through clear lay-out and description the relevance of the sample to the field of aphasia therapy will be demonstrated, and the transferability of the findings will be apparent through the detailed, rich description that arises from analysis of the data.

Observations will initially be unstructured by pre-determined categories allowing for the discovery of patterns of interaction in the data. The focus will be on what therapist and client actually do in the clinic rather than on what they think they are doing, or on their attitudes and opinions about therapy.

Data from all treatment sessions will be examined, and the field of inquiry will culminate in a focus on specific aspects of the interaction around treatment of language impairment.

Analysis is data driven and developed from phenomena which are in various ways evidenced in the interaction. How can the story be told through use of these data sources? To misquote Sacks (in Silverman 2000: 149), this will be achieved by having available for any given action or utterance those actions and utterances around it, and including the objects and artefacts which are the basis of or which are complementary to the current encounter in order to determine what was said and done.

Data production and presentation will include appropriate tabulation, and entail "counting the countable" (Seale 1999: 121). Any quantification used in the presentation and analysis of data will be interpretable in the light of qualitative descriptions or findings (Perkins 1995).

In general, the researcher will be explicit in his approach to data production and analysis, and will try and demonstrate the reliability or dependability of his interpretations "...discursively through argument and persuasion revealing how generalisations have been arrived at in a way that gives others confidence in the research" (Temple 1998: 209-210). This process will include particular references from the literature which will be used to support arguments and analysis, and to highlight contrasts with the data from this study where relevant.

The following three chapters are concerned with presentation and analysis of the data. Chapter Four outlines the background to the study, including the process of participation, and presents data concerned with the participants and the settings, and sketches the types of activity in which the participants were engaged. Chapter Five begins the process of outlining a descriptive framework for the therapy sessions, and examine and analyses parts of the structure in detail. Chapter Six is concerned with detailed description and analysis of task-related work taking place in therapy sessions.

CHAPTER FOUR

DATA ANALYSIS 1

4.1 Introduction

The main purpose of this chapter is to begin to create the rich picture description discussed in Chapter Three. In this chapter the following features of the data will be outlined and discussed:

- The background to the study
- Characteristic features of the participants: therapists and people with aphasia
- Characteristic features of the participants' work together: time working together and location of work
- The video- and audiotaping process
- The therapy sessions:
  - Language impairment therapy and semantic deficit
  - Therapy tasks and items used in therapy

4.2 Background

The data for this study are taken from a project entitled: "Identifying the behavioural components of 'clinical intuition' in the application of semantic therapy for aphasia: defining a commonly used therapy for evaluation by RCT". This project was funded by the Stroke Association, England as an award to Professor Sally Byng[1], the principal researcher. The author was employed as a research assistant on the project. The purpose of the project was to study "methods used by therapists to present tasks, and those used in therapists' contingent responses" in the application of semantic therapy for aphasia. The concern was to conduct a naturalistic study of therapists who

[1] Stroke Association research grant 18/98

were not engaged in research-motivated testing of the efficacy of particular types of intervention, but who were carrying out therapy for aphasic language impairment using the tools and skills at their disposal, according to circumstances that arose moment-by-moment.

4.2.1 Recruitment to the study

Therapists working in the field of aphasia were recruited using various methods. Therapists throughout Great Britain were approached through an advertisement in the British Aphasiology Society Newsletter; through personal contact by the author; and through recommendations to the author from other therapists.

In all twenty three therapists expressed an interest in participating in the study. Of these therapists eight were unable to recruit people with aphasia who fitted the inclusion criteria for participants or whose therapy did not fit the inclusion criteria for the study, one moved job, and one did not meet the minimum requirement for experience of working with aphasia. In addition, the author was also a participant in the study.

It is not possible to say whether those who said that they were not working with people with aphasia who fitted the inclusion criteria, or whose therapy did not fit the inclusion criteria for therapy, were actually not participating for other reasons. For example, they might have been anxious about appearing on camera and/or having their therapy scrutinised by researchers. This leads to a tentative conclusion that those therapists who did participate were likely to have been generally confident in their skills and to have had a commitment to the therapy they were undertaking.

4.2.2 Inclusion criteria for participants

Inclusion criteria for therapists were as follows: 1) at least three years experience of aphasia therapy treatment; 2) registration with the Royal College of Speech and Language Therapists; 3) membership of the British Aphasiology Society. Given that the object was not to study the development of skills in therapists, but to study therapists using a full range of tools and skills, three years was considered to be a reasonable period for therapists having developed a mature range of techniques. This should also be considered in conjunction with the stipulation that therapists should have demonstrated a particular interest in therapy for aphasia by being members of the British Aphasiology Society.

Inclusion criteria for the participants with aphasia were as follows: 1) at least one month following onset of a left CVA, and neurologically stable; 2) evidence of moderate-mild expressive aphasia with impaired oral and/or written naming and impaired reading; 3) evidence of lexical semantic impairment with impaired performance on sub-tests of the Psycholinguistic Assessments of Language Processing in Aphasia (PALPA) (Kay *et al* 1996) (spoken and/or written word-picture matching; word semantic association [High and Low Imageability]); 4) performance within normal limits on the three picture sub-test of the Pyramids and Palm Trees Test (Howard and Patterson 1992), but impaired performance on the three words or one picture-two words sub-test. Aphasic people were excluded from the study if they had significant cognitive difficulties (semantic or other dementia), severe comprehension difficulties, hearing impairment or concurrent psychiatric difficulties.

The rationale for these inclusion criteria were related firstly to the need for participants with aphasia to be relatively well in themselves – in other words physically robust enough to participate in the study. The criteria concerning aphasic language impairments were mainly governed by the purpose of the study – to investigate

'semantic therapy'. In other words the aphasic person should have a demonstrable semantic impairment, which would, it was presumed, be the basis for carrying out 'semantic therapy'. The assessment outcomes on the specified tests were intended to include people with lexical semantic impairments, but exclude those with visual semantic deficits (performance within normal limits on the three picture sub-test of the Pyramids and Palm Trees Test (Howard and Patterson 1992). In this way it was thought possible to more closely delimit the type of therapy which would be undertaken.

It was also felt that, for the purposes of this particular study, people with severe comprehension difficulties or concurrent psychiatric difficulties would not be able to give informed consent to participate. It was also felt that the interaction taking place during therapy with people who had a significant hearing impairment and aphasia might be skewed towards accommodating the aphasic person's hearing loss.

4.2.3 Therapy sessions

The content of therapy sessions was based on therapists' own assessments and choice of tasks, being representative of what they would normally carry out at that stage in their client's treatment. Therapists were not directed to carry out any particular tasks, but they were informed that the study was primarily concerned with 'semantic therapy' – therapy designed to address the semantic system in some way – which could be carried out in any modality, using input or production tasks. Thus therapy sessions recorded and submitted to the study are to a certain extent a reflection of therapists' understanding of what constitutes 'semantic therapy'. However, this should not in any way be taken as a representative reflection of the participants' understanding of what constitutes 'semantic therapy', nor be taken to reflect an understanding of what constitutes 'semantic therapy' by therapists in general.

4.2.4 Ethical approval for the study

Due to the fact that the study was to be carried out at more than four sites in Great Britain ethical permission had to be sought in the first instance from the North Thames Multi-Centre Research Ethics Committee [MREC] (application ref: MREC/99/2/18). When MREC permission had been granted, individual Local Research Ethics Committees [LRECs] responsible for the areas of participating therapists/aphasic people were approached. Ethics committees reviewed the study protocol, information sheets and consent forms, and recruitment process.

4.2.5 Participation process

Once a therapist had expressed an interest in participating in the study, and met the inclusion criteria, they were sent a pack containing information about the study for themselves and for potential aphasic participants. If they were working with somebody who met the criteria for participation, they discussed the study with them and their family, and invited them to participate in the study. If the aphasic person agreed and consented to participate, the therapist was sent blank video- and audiotapes and asked to video- and audiotape three consecutive sessions. Therapists were asked to provide information about themselves, the aphasic person and the content of the sessions which they video- and audiotaped (forms used to gather this information from participating therapists are set out in APPENDIX ONE).

The participants (therapists and people with aphasia) consented both to their therapy sessions being video- and audiotaped, and to tapes being retained after the end of the project.

4.3 Data summaries and displays

Section 4.2 and its sub-sections above give a broad outline of the field of inquiry, where certain constraints were placed on the collection of data in the first instance. The following sections will provide more detail about the participants, the circumstances of their therapy work together and the therapy undertaken.

4.3.1 The participants

4.3.1.i Therapists

As outlined above, therapists who participated had to have at least three years' experience of working with people with aphasia. There was in actual fact a large range among therapist participants both of years since qualification and years of experience in working with people with aphasia. At the time of the study only two of the participating therapists (D1T and D2T[2]) were working solely with people with aphasia. The other therapist participants described themselves variously as working in the fields of 'neuro rehab' (neuro-rehabilitation) or 'adult acquired disorders', 'TBI' (traumatic brain injury), 'CVA' (cerebro-vascular accident), aphasia, dysarthria, aphasia/dysphagia. The majority of therapist participants (twelve out of fourteen) therefore could be said to have general neuro-rehabilitation caseloads (sometimes described as "complex" by the participants from specialist centres).

In terms of years experience of working with people with aphasia, the mean (11 years) is well above the minimum requirement for recruitment to the study, and generally represents a sample of very experienced therapists. Even excluding the high extreme (29 years experience), the mean is 9.6 years experience.

Over 21% therapist participants being male is a relatively high proportion in comparison with the national proportion of male:female therapists in Great Britain.

[2] Reference to individual therapists is made by using a -T suffix to the dyad code

The following table sets out therapist characteristics in terms of their relative experience:

Therapist code	Years since qualification	Years experience of aphasia therapy	Gender
D1T	38	29	F
D2T	7	7	F
D3T	18	18	M
D4T	8	8	F
D5T	6	6	F
D6T	11	11	F
D7T	15	12	F
D8T	3	3	F
D9/10T[3]	13	13	F
D11T	7	7	F
D12T	13	13	F
D13T	12	12	M
D14T	14.5	8	F
D15T	7	7	M
Mean	12.32 years	11 years	
Range	3 - 38 years	3 - 29 years	
N = 14			78.6% F; 21.4% M

Table 4.1 Therapist participant characteristics in terms of years since qualification, number of years experience of aphasia therapy and gender.

Eleven of the fourteen therapists had experience of working with people with aphasia since they first qualified, although details of the different types of clinical environment therapists had experienced over the years are not available.

4.3.1.ii People with aphasia

The inclusion and exclusion criteria for people with aphasia participating in the study have been outlined above. There is a large range of time since onset of aphasia for both men and women participants (and therefore clearly overall). D9A[4] (9 months), D8A (7 months) and D10/11A (5 months) were all attending an in-patient rehabilitation unit (see Table 4.3 below), where one would generally expect people to have shorter

[3] The same therapist worked with two different people with aphasia, i.e. was part of two dyads
[4] Reference to individual participants with aphasia is made by using an -A suffix to the dyad code

time since onset than people in out-patient rehabilitation. However this was a unit where people were admitted from home for time-limited therapy programmes. D6A (8 months), D13A (8 months) and D15A (3 months), who had also become aphasic relatively recently, were all attending out-patient therapy. These details about the aphasic person participants are set out here in Table 4.2.

Aphasic person	Gender	Age (years)	Time since onset of aphasia (months)
D1A	F	53	60
D6A	F	67	8
D7A	F	60	18
D2/3A[5]	F	50	24
D9A	F	63	9
D13A	F	59	8
D15A	F	85	3
D14A	F	83	24
N = 8	Women	Mean age = 65 years Range = 53-85 years	Mean time since onset = 19.25 months Range = 3-60 months
D8A	M	63	7
D5A	M	64	19
D10/11A[5]	M	40	5
D12A	M	75	28
D4A	M	59	24
N = 5	Men	Mean age = 53 years Range = 40-75 years	Mean time since onset = 16.6 months Range = 5-28 months
All participants (N = 13)		Mean age = 63.15 years Range = 40-85 years	Mean time since onset = 18.23 months Range = 3-60

Table 4.2 Aphasic person participants: gender, age and time since onset

More specific details about aphasic person participants' language and communication abilities will be set out below as part of the background context to the therapy sessions (Section 4.3.2.ii).

[5] Worked with two different therapists

4.3.1.iii Therapists and people with aphasia working together

There is a very large range (0.25 [one session] – 48 months) in terms of the length of time that each therapist and client had been working together at the time the videotapes were made. This is perhaps partly indicative of the different types of location represented in the data. In-patient neuro-rehabilitation units (i.e. D8, D9, D10, D11) for example tend to have relatively short stays and a quicker 'throughput', and therefore shorter therapist-client therapy episodes. However the length of time therapist and client had been working together at the time of recording is also due to the chance factor of what stage in their therapeutic relationship participants became aware of and were recruited to the study.

The high end of the range represents the only example here of privately funded therapy work together (D1). Anecdotal evidence (and personal experience of the author) suggests that 4 years is an unusually long therapy time in Great Britain.

The data overall therefore represent a large range of therapeutic relationships in terms of 'time known to each other'. Table 4.3 below sets out data associated with location of sessions and length of time working together for each dyad. It should be noted again – as will be evident from the coding of individual participants and dyads – that two participants with aphasia worked with more than one therapist, and one therapist worked with two of the participants with aphasia.

Therapist code	Aphasic person code	Location of videotaped sessions	Time working together (months)
D1T	D1A	Domiciliary (private)	48
D2T	D2/3A	Out-patient rehabilitation clinic	6
D3T			24
D4T	D4A		4
D5T	D5A	Out-patient rehabilitation clinic	1
D6T	D6A	Out-patient rehabilitation clinic Domiciliary	7
D7T	D7A	Out-patient rehabilitation clinic	0.75
D8T	D8A	In-patient rehabilitation clinic	0.75
D9/10T	D9A		0.75
	D10/11A		0.25
D11T			1
D12T	D12A	Out-patient aphasia rehabilitation clinic	4
D13T	D13A	Out-patient rehabilitation clinic	5
D14T	D14A	Domiciliary	9
D15T	D15A	Out-patient rehabilitation clinic	2.75
14 therapists (including the author)	13 people with aphasia	11 different individual locations (3 different types of location)	Mean = 7.62 months Range = 0.25 – 48 months

Table 4.3 Therapists and people with aphasia: time working together and location

The length of time therapist and aphasic person have known and worked with each other should be considered from two major viewpoints: 1) the implication for this sample as representative of therapists working with people with aphasia; and 2) the implications for this sample as representative of the range of therapy treatments and therapist skills associated with those treatments. What also has to be born in mind is the fact that for each dyad the recording of each session represents just a snapshot of the therapeutic relationship. For those therapist-aphasic person dyads where three video recorded sessions are available (all dyads apart from D9, D10 and D13), the sessions spanned on average about five-and-a-half weeks (range: 1-20 weeks).

The wide range suggests that even given the proviso mentioned above that the recordings represent snapshots in the stream of individual therapeutic relationships the

data are likely to constitute a wide ranging and comprehensive representation of the skills and therapeutic techniques of therapists (of comparable levels of experience).

The data represent a number of different dyad combinations. The majority of therapists worked with only one aphasic person, and *vice versa*. However, as has been mentioned above there were some instances of the same aphasic person working with two different therapists, and one of the same therapist working with two different aphasic people. Thus D2/3A worked with both D2T and D3T; D10/11A worked with both D9/10T and D11T. D9/10T worked with both D9A and D10/11A. These conditions arose quite by chance, and were not imposed in any way.

There is an intuitive feeling, and certainly anecdotal evidence from informal discussions with therapists that the length of time of a therapeutic relationship impacts on the nature of the interaction between therapist and person with aphasia. How this is evidenced in actual practice is not a primary focus of this study, and no conclusions will necessarily be drawn from particular types of interaction or interactive style according to the length of therapist-client relationship.

4.3.1.iv Videotaping, audiotaping and transcribing

The number of sessions videotaped for each dyad, and where these took place is outlined in the following table.

Participant dyad	Location of videotaped sessions	Number of sessions videotaped	Number of sessions audiotaped
D1	Domiciliary	3	3
D2	Out-patient rehabilitation clinic	3	2
D3		3	3
D4		3	1
D5	Out-patient rehabilitation clinic	3	3
D6	Out-patient rehabilitation clinic	2	2
	Domiciliary	1	1
D7	Out-patient rehabilitation clinic	3	3
D8	In-patient rehabilitation clinic	3	3
D9		2	2
D10		1	1
D11		3	3
D12	Out-patient aphasia rehabilitation clinic	3	3
D13	Out-patient rehabilitation clinic	2	1
D14	Domiciliary	3	3
D15	Out-patient rehabilitation clinic	3	0
Total = 15 dyads	11 different locations	41 sessions	34 sessions

Table 4.4 Therapy dyads, location and taping of sessions

As can be seen from the table above, the fourteen therapists and thirteen people with aphasia formed fifteen therapist-aphasic person dyads. Out-patient rehabilitation clinics (N=7) were either a part of a specialist rehabilitation unit or a hospital out-patient department, and one was a specialist aphasia therapy clinic.

D2, D3 and D4 were videotaped working at the same location (an out-patient rehabilitation clinic), as were D8, D9, D10 and D11 (an in-patient rehabilitation clinic). D6 worked both at an out-patient clinic and at the aphasic person's home. D14 worked at the aphasic person's own home, while D1 worked at the therapist's home.

As can be seen from Table 4.4 not all sessions that were videotaped were successfully audiotaped. Eight audiotapes were either missing or unusable (speeded up recordings). Audiotypist transcriptions of these sessions were therefore not available. D3 sessions were audiotaped but not transcribed by the audiotypist. In addition, one of D13's videotapes was blank when it was sent in.

Generally, for the reasons outlined in Chapter Three (Section 3.4.1), therapists were responsible for video- and audiotaping their own sessions. There were some exceptions – for example where the author took responsibility for recording the D2 sessions, or where there was a student therapist or assistant present. The implications of videos being made by the therapist themselves or another person, and the impact on subsequent data analysis will be made clear in Chapter Five (Section 5.3.5).

The lack of audiotaped recordings of sessions has obvious implications for transcription. As discussed in Chapter Three an audiotypist was employed to transcribe audiotaped sessions, but where these were not available, transcriptions were made from the videotape by the researcher as was deemed necessary (for further discussion see Chapter Five). In any case, transcriptions from the audiotape by the audiotypist were viewed and adjusted by the researcher in conjunction with the videotape (see discussion in Chapter Three, Section 3.6.2.iii).

Length of taped sessions varied from about thirty minutes to just over an hour. Although there is clearly no way of knowing what was <u>not</u> taped, there is a sense that, although beginnings and ends of sessions were clearly often cut into or cut off ("I'll switch off that" as therapist moves to turn off the machine; or in some instances the tape runs out – for example: all D1 sessions; all D5 sessions), what is represented by the video- and audiotaped data, is generally therapy 'in the whole' - i.e. there is no general evidence that there has been editing of tape on- or offline. It was made clear to

participants that if at any time they wanted to turn off the recording, for whatever reasons, they were free to do so.

There are instances of this happening. For example in D3 (1)[6] the therapist is in the process of trying to sort out which pictures to use for that session, but cannot locate the pictures needed. Saying: "this is very annoying" the therapist moves towards the camera to switch it off. The recording resumes, presumably after the pictures have been located. There are also occasional interruptions to audio-recordings, apparently where the tape is turned over (and this can be corroborated by viewing the videotape of the corresponding session), and, as mentioned above several instances of failure to audiotape the session – for example D2 (1).

The relationship of the participants and researcher to the recording devices and the process of recording has been discussed in Chapter Three (Section 3.4.1). There are certainly instances of the camera being noticed, noted or used by the participants. For example: D3 (1): the therapist holds up a picture to the camera saying: "I'll just show the camera"; D3 (later in the same session) holds up a different picture to the camera saying: "((name of local shop)) for the camera".

In D1 (1), at one point, after a brief disagreement about the date, the therapist half turns to camera and putting on a different accent says: "'scuse my friend". In session (2) of the same dyad, the opening shot is of the aphasic person sitting at the table:

1. T: ((talking from behind the camera and putting on a 'posh' accent)) smile please
2. A: ((flutters eyelashes at the camera and grins))
3. T: ((still with 'posh' accent)) thank you madam ((crosses room to get a file and
4. then sits down at the table))

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[6] Reference to particular sessions, either to the written record in APPENDIX THREE, or to the video-/audiotape/transcription will be made thus: dyad code + (session number)

A little later in the same session the therapist addresses the researcher/camera (lines 2-3):

1. A: mmm ((sniffing and wiping nose with the back of her hand))

2. T: ((handing a tissue to A)) I do apologise for my patient's (1.0) (snot nose

3. characters)

4. A: ((grins and blows nose))

In D12 (1) the therapist lifts a stimulus picture up towards herself and the aphasic person as she talks, remarking: "I don't know whether the camera can see that" – the camera is in fact unable to "see" the picture in question.

The study itself is also 'noticed' through the presence of the recording devices. In D15 (1) for example, the aphasic person asks, pointing to the camera: "do you do that every week" and the therapist replies: "no we don't normally record (.) it's only because of this research project". In D12 (2) the therapist remarks: "you're allowed to take your time now...look don't worry about it I mean I know it's it's a bit intrusive to have a camera on you but um you can take the whole hour to write one sentence if you want to...it's not your problem...some other poor devil is having to transcribe this". The therapist seems to be saying that the aphasic person should not worry about performing for the camera or for the study.

The tape recorder is also noticed and remarked on in various sessions. In D3 (3), the therapist checks the tape recorder on the desk, saying: "I keep on leaving the pause button on" and points to the tape recorder. In D1 (1), the therapist is seen to reach across to turn on the tape recorder, saying: "...right I'm sorry I forgot ((puts on a different accent)) right (.) it's all working now". In D7 (1) the therapist pauses the tape recorder while she goes to get a glass of water for the aphasic person, but the videotape is still running.

4.3.2 Therapy sessions

4.3.2.i Background

As has been mentioned above therapists were informed that the study was primarily concerned with 'semantic therapy' – therapy designed to address the semantic system in some way – which could be carried out in any modality, using input or production tasks. This stipulation (and the associated ones concerning evidence of semantic impairment in the people with aphasia) was put in place in order, in a sense, to reproduce in the sample what was, anecdotally at least, supposed to be a type of therapy commonly undertaken in the population of therapists and people with aphasia as a whole. That being said, as has been made clear in Chapter Three, the methodology employed in this study does not allow claims to be made about the representativeness of this sample of participants.

The stipulation about the type of therapy undertaken was also put in place to create the potential for comparing, in one sense at least, 'like with like' in the analysis of data. In other words, it seemed more likely, if the particular type of therapy (i.e. 'semantic') was common to all participants, the same sorts of tasks and the same sorts of procedures were more likely to occur across therapists given that the possibilities within 'semantic therapy' are not limitless. If these same sorts of tasks did occur across therapist-aphasic person dyads comparisons might be made between therapists in the way that they carried out those tasks.

4.3.2.ii Participants with aphasia: semantic impairments, linguistic and communicative strengths and general aphasia related difficulties

The stipulations about the nature of the aphasic person's impairment are, in one sense, merely a means of attempting to ensure a particular type of uniformity to the context of the ensuing therapy interaction. In another sense they are essentially co-

terminus with the general stipulation about the type of therapy, i.e. therapy designed to address the semantic system, although as has been discussed in the review of the literature (Chapter Two), the actual purpose of so-called 'semantic therapy' is by no means uniform. In other words, in order to observe 'semantic therapy' you probably need to involve people with aphasia who have some sort of semantic impairment.

The aphasic person participants had a broad range of impairments, as can be seen from close inspection of APPENDIX TWO. Participating therapists provided details about assessments undertaken with the aphasic person by them and in the past with previous therapists (where they thought it relevant), and some summaries of treatments undertaken in the past and comments about the aphasic person's communication and linguistic abilities. These summaries can also be seen in APPENDIX TWO. Some of the original entries have been removed or altered in order to preserve participant anonymity. Removal or alteration of these items does not materially affect understanding of the data.

By no means all the aphasic participants actually fitted the specific criteria of semantic deficit set out in the study requirements. There are also a number of 'unknowns' due to missing assessment data. All-in-all it is quite difficult to gain a broad impression of the aphasic participants as a group, due to the complexity of the impairments and abilities of each individual with aphasia. This is to be expected, given the complex and varied nature of aphasia itself.

It is perhaps worth noting the problems of interpretation associated with both the Psycholinguistic Assessments of Language Processing in Aphasia (PALPA) (Kay *et al* 1996) and The Pyramids and Palm Trees Test (Howard and Patterson 1992) in relation to semantic deficit. Kay *et al* (1996) and Howard and Patterson (1992) both acknowledge that their particular view of the organisation of the semantic system is not universally accepted. The PALPA assumes a common semantic system for words and

pictures/objects, and incorporates a visual object recognition system analogous to the orthographic and phonological input lexicons for written and spoken words respectively. In this respect it differs from Pyramids and Palm Trees, which outlines a view of semantic knowledge organisation that postulates partially independent representational systems for words and objects, while also including a picture recognition system. As Funnell (2000: 25) points out no current model of semantic memory can be applied to all data and all relevant theoretical questions in an even partially satisfactory way.

The PALPA is neither fully standardised, nor reliability tested, although there are data from non-brain damaged subjects. This can make interpretation of test scores problematic. In some sections of the test battery deciding whether actual performance differs from chance is a simple statistical matter. However problems in interpretation of test scores arise when a person scores quite poorly, but still manages to give a reasonable number of correct responses. Pyramids and Palm Trees was pre-tested with groups of non-brain damaged adults and the authors claim that someone who scores 90% or better (on any particular presentation) does not have a clinically significant impairment. However they describe patterns of performance which 'look' the same on the test, but which could arise from different loci of impairment. For example, impaired performance on the three picture version could arise from impairment in picture recognition, impairment in access to object semantics from the picture stimuli, or impairments in the object semantic system itself.

Marshall (1996) takes two of the PALPA sub-tests as examples of the relative lack of specificity of the language model on which it is based. Tests 47 and 48 explore the ability to match a spoken or written word to a target picture in the presence of semantic, visual and unrelated distracters. The semantic distracters hold a variety of relationships to the targets, and poor patterns of performance on these assessments

would suggest a 'semantic deficit', but the precise nature of the deficit remains a mystery. As Marshall (1996) argues, we have only a relatively tenuous understanding of the normal workings of the semantic system and the diverse range of semantic associations tapped by these PALPA sub-tests reflect this lack of understanding.

Therefore it is with a good deal of caution that evidence of semantic deficits is put forward from the data in this study. Evidence in the following table is shown in terms of scores on various tests and sub-tests of the PALPA and Pyramids and Palm Trees, and an interpretation of those scores is proposed. The table also shows, in very broad terms types of difficulties experienced by the aphasic person participants, and some of their abilities as reported by their therapists.

Person with aphasia	Semantic difficulties	Evidence of semantic difficulties	Other aphasia related difficulties	Particular abilities noted by therapist
D1A	Yes	• 40/52 on Pyramids and Palm Trees	• Severe problems accessing lexical/sentence semantics • Problems organising articulation	• Beginning to use sentence structure in spoken output
D2/3A	Yes	• Semantic errors on PALPA spoken and written word-picture match	• Severe jargon aphasia	• Beginning to use written messages and drawings in conversation
D4A	Yes	• 35/52 & 44/52 on three pictures and three words (respectively) of Pyramids and Palm Trees	• Moderate-severe dyspraxia	• Uses facial expression, vocalisation, writing and drawing and some gesture
D5A	Possible	Weak evidence • 39/40 on PALPA word-picture match • Odd-one-out (moderate level) = 10/10; (advanced level) = 6/10 (Informal assessment)	• Severe word-finding difficulties (exacerbated by dyspraxia)	• None noted
D6A	Yes	• 33/40 & 26/40 on spoken and written (respectively) word-picture match of PALPA	• 'Written comprehension of functional material is not good'	• Auditory comprehension appears relatively good in conversation
D7A	Yes	• Significant errors on PALPA spoken and written word-picture match	• Unable to write or gesture; 'dyspraxic' • Comprehension variable with verbs and with two spoken words	• Generally good auditory comprehension of concrete high-frequency nouns
D8A	Yes	• Significant errors on PALPA spoken and written word-picture match	• Unable to write or say names, read aloud or repeat words	• Is more reliable at functional single word reading (than on testing)
D9A	Yes	• Significant errors on PALPA spoken and written word-picture match & on Pyramids and Palm Trees	• Reduced attention • Unable to read aloud or name • Unable to assemble CVC anagrams	• None noted
D10/11A	Yes	• Significant errors on PALPA spoken and written word-picture match & on Pyramids and Palm Trees	• Naming only with significant phonemic cueing • Moderate receptive and severe expressive aphasia	• Able to follow verbal information in context but inconsistent at two word level on testing. • Communicates by yes/no + facial expression.
D12A	Possible	Weak and equivocal evidence • Most recent PALPA score on word-picture match = 39/40 (unknown version) • Pyramids and Palm Trees = 36/40 ie not completed	• Severe dyspraxia • Unintelligible out of context	• Good auditory comprehension and excellent pantomime skills • Emerging sentence level written output
D13A	Yes	• Significant errors on PALPA spoken and written word-picture match & on Pyramids and Palm Trees	• Fluent neologistic jargon aphasia	• Writing to dictation • Using writing, when prompted in a conversational setting
D14A	Uncer-tain	Weak and equivocal evidence • Scored 47/52 on Pyramids and Palm Trees (unknown version) • Possible semantically related errors on Mnt Wilja Test	• Slow and stilted expressive output • Difficulties with inferential material • Some word-finding difficulties	• "Unimpaired semantic access"
D15A	Probable	• Informal verb comprehension test = 29/40 with 9 semantic distracter errors	• Fluent aphasia with a mixture of jargon and formal paraphasias	• Auditory comprehension reasonable in conversation

Table 4.5 Aphasic person participants: evidence of semantic deficit, other aphasia related difficulties, and particular abilities noted by the therapist

Nine out of the thirteen aphasic person participants had strong evidence of a semantic deficit – an interpretation based on the test results from PALPA or the Pyramids and Palm Trees Test or both. Of the other four, it looks very probable that D15A does have a semantic impairment (although the assessment evidence is informal); there is a suggestion that D5A may have mild difficulties with semantically related materials; for D12A and D14A the evidence is weak or uncertain.

In terms of an overall broad picture of the participants' aphasia related difficulties, ten people were non-fluent – for example they had difficulties organising articulation, with moderate or severe dyspraxia – and three were fluent. All three people with fluent aphasia were described as having some sort of jargon aphasia (either: "severe", "neologistic" or "a mixture of jargon and formal paraphasias"). The following figure provides a summary overview of evidence of semantic deficit and broad category type of aphasic impairment.

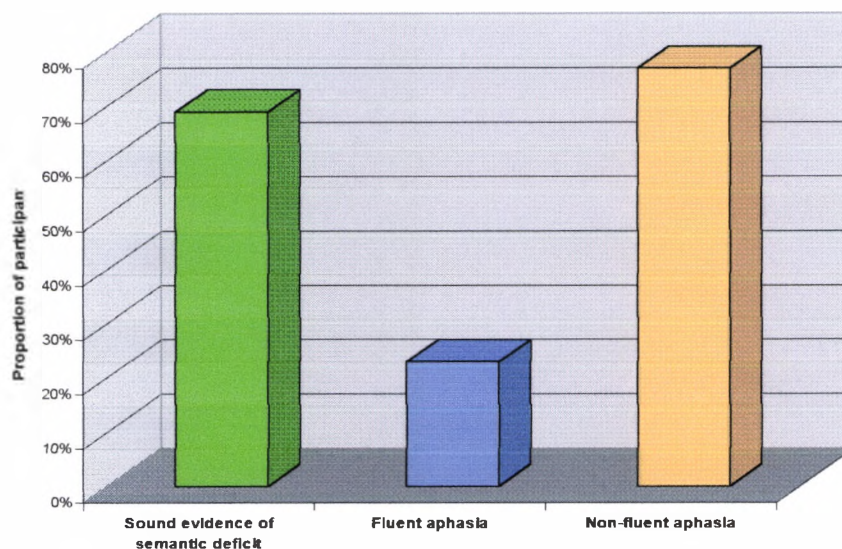

Figure 4.1 People with aphasia participating: proportion with sound evidence of semantic deficit, and with fluent or non-fluent aphasia.

The observations outlined above are reported in order to establish a feeling of the overall context of the study of interactions – a study of the enactment of semantic

therapy, but clearly a study where, among the aphasic person participants there is a wide range of semantic and other impairments, as well as communicative abilities. In the analysis of interactions arising in therapy more detailed observation of people's particular impairments and abilities will be made as they are evidenced in the actual interaction.

4.3.2.iii Therapy tasks

As has been outlined above, therapists were asked to submit some details about the therapy they were carrying out. These details were submitted on the form 'Information about therapy sessions' (see APPENDIX ONE Form 'C'), and include items and tasks used in the sessions. Details of information submitted by therapists in terms of items and tasks used, as well as written comments they may have made about considerations born in mind when carrying out therapy are in APPENDIX THREE.

The table below sets out - in broad categories - the types of tasks carried out by therapists and people with aphasia. It is designed, once again, to give a feel for the data as a whole rather than to provide any sort of detail about the tasks or how they were enacted. Details of therapy sessions as submitted by therapists can be referred to in APPENDIX THREE. The issues to do with categorising the tasks and items as they are set out in Table 4.6 (below) are discussed in the paragraphs that follow the table. Note that no written information about Tasks or Items was submitted for D14.

Type of task	Therapy dyads using this type of task	Typical items used (all dyads)
1. Category sorting	D9 D7 D8 D6 D10 D11	• Object pictures (commercial and other) • Written words (e.g. high and low frequency) • Spoken words
2. Odd-one-out	D6 D11 D13	• Object pictures (commercial and other) • Written words • Spoken words
3. Word-picture matching	D10 D11 D8 D2 D3 D7 D13 D5	• Object pictures (commercial and other e.g. personal pictures: varying word frequency) – written words • Object pictures (commercial and other e.g. magazine cuttings) – spoken words • Action pictures (stick figures; commercial pictures) – written verbs
4. Word-word matching	D11 D13	• Written + spoken words
5. Choosing verb to fit sentence	D4	• Personal pictures + written sentences and written word choice
6. Choosing word to fit sentence message	D3	• Written sentences + choice of first letter stimulus
7. Word associations/semantic links	D7 D6 D5	• Verb and object written words • Line drawings (commercial)
8. Identifying attributes	D9	• Spoken questions
9. Word choice from definition	D8	• Written words + spoken definition
10. Sentence processing: identifying and ordering agent and theme	D5	• Pictures and written stimuli • Written nouns (agent-theme relationships)
11. Identifying semantic anomalies	D5	• Written sentences
12. Sentence/clause completion (spoken)	D1	• Sentences (read aloud by therapist) • Sentences (read by aphasic person)
13. Reading aloud	D1 D5 D2 D3	• Written sentences (created by therapist; created by therapist and aphasic person) • Written words
14. Listening and answering questions	D1	• Written paragraph spoken aloud by therapist
15. Repeating words	D3	• Spoken words
16. Spoken word-finding to definition	D1	• Spoken verb definitions
17. Spoken word-finding with picture stimulus	D1 D8 D15	• Object pictures (commercial and other e.g. therapist drawing) • Object pictures + questions or choice of spoken word
18. Spoken verb-finding with given agent and theme	D5	• Written words
19. Written word-finding	D2 D13 D3	• Pictures (commercial and other e.g. personal pictures) • Anagrams • Sentence stimulus
20. Stories: sequencing, writing	D12	• Picture sequence cards (commercial) • Personal pictures
21. Drawing	D9 D10	• Paper, pencil or coloured pens
22. Copy written word	D2	• Written words

Table 4.6 Types of task, items and therapy dyads using task types

4.3.2.iv Categorising task types

It is not the intention here to describe the tasks outlined above in any great detail. However, in order to give a comprehensive feeling for the data some mention will be made about the process of categorisation which has led to the categories of task and items in Table 4.6 above.

To some extent task types as described in the aphasia treatment literature have been used to develop these categories. For example (numbers in [ ] refer to Type of Task in Table 4.6 above): 'Word-picture matching' [3]; 'Sentence processing'[10]; 'Odd-one-out'[2]. In other instances expressions typically found in the literature (e.g. 'word-finding') have been used in conjunction with an additional descriptor – thus for example: 'Spoken word-finding' [16, 17], which is used to describe the task modality. In other instances the type of stimulus has been added to differentiate between tasks – for example: 'Spoken word-finding to definition' [16]/'Spoken word-finding with picture stimulus' [17].

Wherever possible the actual expressions used by therapists in their submissions have been used to describe task types. Therapists were not given any prompts as to how to submit descriptions of tasks or therapy materials, except under the broad headings on the forms they received (i.e. sections headed 'Items' and 'Tasks'). Not surprisingly, familiar expressions from the literature such as 'Odd-one-out' (for example: D6 (2) – see APPENDIX THREE), or 'Word-to-picture match' (for example: D2 (1)) are used by therapists. These specific expressions are by no means always used – for example: "...asked to select unrelated distracter from choice of /4 written words" (D6 (1)) is classified here as 'Odd-one-out'[2]; "To provide semantic information about the pictured objects in response to my questions" (D15 (1) (2) (3)) is classified here as 'Spoken word-finding with picture stimulus' [17]. In the latter example information under the 'Typical items used' column in Table 4.6 has been used to try and create a

more complete and accurate representation of the therapist's task description. Thus 'Spoken word-finding with picture stimulus' [17] can be understood in conjunction with: 'Object pictures + questions'. The purpose is to try and avoid a massive proliferation of task descriptions which give no coherent sense of the data, while trying not to lose dimensions which do give a feel for the actual tasks undertaken as a whole. Formal linguistic descriptors have not been used, but rather where possible, as mentioned above, the actual expressions used by therapists – for example: 'Word associations/semantic links' [7] rather than 'Syntagmatic and Paradigmatic Relationship' (e.g. Visch Brink *et al* 1997: 1074).

Task types [1-11] above are all 'input' type tasks. In other words, they do not require spoken or written output from the aphasic person, except in so far as some of the tasks require a 'Yes/No' response (which may also be indicated non-verbally in some way). So for example, in the 'Category sorting' tasks using object pictures [1] the aphasic person is usually asked to sort a set of pictures into piles of distinct categories ('fruit', 'vegetables' and 'meat' for example – see D6 (2) among others). This very often does not require any expressive output by the person with aphasia. However the therapist may have set up such a task in a way that the decision to assign to one category or another requires the aphasic person to respond or indicate "Yes" or "No" (for example: D11 (3)).

Task types [12-22] above all require some expressive output by the aphasic person[7]. So, for example, there is a fundamental difference in the requirements between 'Word-picture matching' using pictures and spoken words [3], and 'Spoken word-finding with picture stimulus' using object pictures and a choice of spoken words [17].

[7] In Task type [20] (Table 4.6) "sequencing" has been included for the sake of brevity. Although "sequencing" does not require expressive output it is the only instance of this type of task and intrinsic to the "Stories" work carried out by this dyad.

In the former the therapist typically says a word and the aphasic person has to point to a picture from a choice array. In the latter, the therapist presents a picture and asks (for example): "Is it a train or a bus?" and requires the aphasic person to say the response (for example D8 (1) Task 2). This latter type of task is also distinguished from the type where one picture is presented, the therapist says two words and the aphasic person is asked to indicate (by pointing for example to one hand or another) which is the right word for that picture (for example: D11 (2) Task 6).

Word-finding type tasks [16-19] are grouped together and divided into spoken [16-18] and written [19] tasks, although it could certainly be said that "Stories: sequencing, writing" [20] also contains a strong element of what is traditionally called 'word-finding'.

4.3.2.v Categorising and enumerating items used

'Items' is used here as the collective expression for what might more usually be referred to as 'materials'. This is deliberately chosen in order to include a range of stimuli which might not normally be included in the term 'materials', such as spoken words and sentences, written words and sentences, and drawing/writing materials.

Types of items used vary considerably across the data, but types of tasks such as 'Category sorting', 'Odd-one-out' and 'Word-picture matching' typically use commercially available picture sets or line drawings often taken from published papers (such as Snodgrass and Vanderwart 1980).

Occasionally personal picture sets are used - for example D2 and D3 ('Word-picture matching' and 'Written word-finding'), D4 ('Choosing verb to fit sentence'), and D12 ('Stories: sequencing, writing').

Figures or pictures drawn by the therapist (for example: D5; D1) are used from time-to-time as items in the therapy, and some work is done with therapist and aphasic person drawing together (Table 4.6 'Drawing' [21]: D9 and D10).

The actual number of items used (e.g. the number of pictures or words in a task of the 'Category sorting' task type) tends to vary across task types. Thus for example the large numbers of items often used in tasks of the 'Category sorting' task type (both pictures and written words) can be contrasted with the relatively small number used in tasks of the 'Odd-one-out' task type (pictures and written words). 'Word-picture matching' tasks, using both written and spoken words, come in a sort of in-between position. The differences between numbers of items used seem almost inevitable given how these contrasting tasks are generally set up.

'Category sorting' tasks might simply require the aphasic person to divide a stack of cards into two piles (i.e. sort into two categories), and more items tend to be dealt with than in an 'Odd-one-out' task, where the therapist lays out sets of three or four cards (or words) including an odd-one-out in each set for the aphasic person to target. In other words an 'Odd-one-out' task tends to be not only more costly of specific items (i.e. for each odd-one-out target there need to be two or three other cards available, perhaps with more-or-less distant semantic relationships to the target), but also more costly of time and, presumably, preparation effort. 'Word-picture matching' tasks, which may employ a number of pictures + one word (spoken or written), or *vice versa*, a number of words (generally written) + one picture, are also relatively costly on preparation, especially where the distracters (words or pictures) have been carefully considered in terms of 'semantic relatedness'. However the numbers of items dealt with is relatively much higher than on 'Odd-one-out' tasks – 'Odd-one-out' (all tasks and all modalities) has a mean of approximately seven items per task (range 4 – 8 items), while

'Word-picture matching' (all tasks and all modalities) has a mean of approximately nineteen items per task (range 7 – 49).

In 'Category sorting' tasks where the distinctions between categories become more refined with each separate task, the number of items used may get smaller. Thus for example D9 (2) 'sort animals from transport' uses 44 items (picture cards); the next task set (same session) – 'sort transport into sea, land, air' – uses 17 items. Now in this instance it is inevitable that the number of items is less, because they are using a subset of the 44 picture cards used in the first task. This is made even more clear by the next task in the same session where the aphasic person is asked to sort 'land transport' into 'private' vs 'commercial' – now a subset of a subset, and reduced to nine items. This pattern is very similar in the other dyad involving D9/10T (i.e. D10) using "Category sorting" tasks, where 'sorting fruit from vegetables' uses 28 items (picture cards), 'sorting fruit from UK/from abroad' uses 14 items, and 'fruit growing on trees/bushes' uses 5 items. Again the number of items is reduced as a subset of the previous set.

Other dyads do not use this type of stepwise work in 'Category sorting' tasks, and the numbers of items do not tend to vary in this way exactly. The table below sets out examples of numbers of items used in consecutive 'Category sorting' tasks within and across dyads.

Therapy dyad	'Category sorting' tasks (all modalities): numbers of items in consecutive tasks		
	Task 1	**Task 2**	**Task 3**
D9 (1)	44	17	9
	19	8	
D10	28	14	5
D11 (3)	27	27	27
	27	27	27
D6 (2)	10	8	

Table 4.7 Number of items used in consecutive 'Category sorting' tasks

Of course 'Category sorting', 'Odd-one-out' and 'Word-picture matching' are not the only task types represented in this body of data. However, setting out and discussing some of the considerations entailed in the use of items associated with these tasks perhaps gives an indication of the relevance generally of items and their use in therapy tasks across the data as a whole. More detailed accounts of items and their use in the enactment of therapy tasks will follow in Chapter Six.

4.3.2.vi Distribution of task types

It is clear from scrutiny of Table 4.6 above that by no means all the tasks are ones that would normally be recognised as 'semantic therapy' tasks. The actual data suggest that 'semantic therapy' either has a wide range of interpretations among the therapist participants, and/or that the participants would not necessarily consider all the therapy tasks encompassed by the recorded data to come within the definition of 'semantic therapy'. It is not possible to infer the therapists' perspectives on this from the data available. Therefore it is not possible to make any generalisations on the basis of these data about what therapists take to mean 'semantic therapy'. Indeed, even in the academic literature on therapy interventions which are designed to address the semantic system there are a wide range of goals and approaches. It is possible however to note the relative prevalence of certain types of task in this data set. The relative prevalence of types of task across all sessions is set out in Figure 4.2 below.

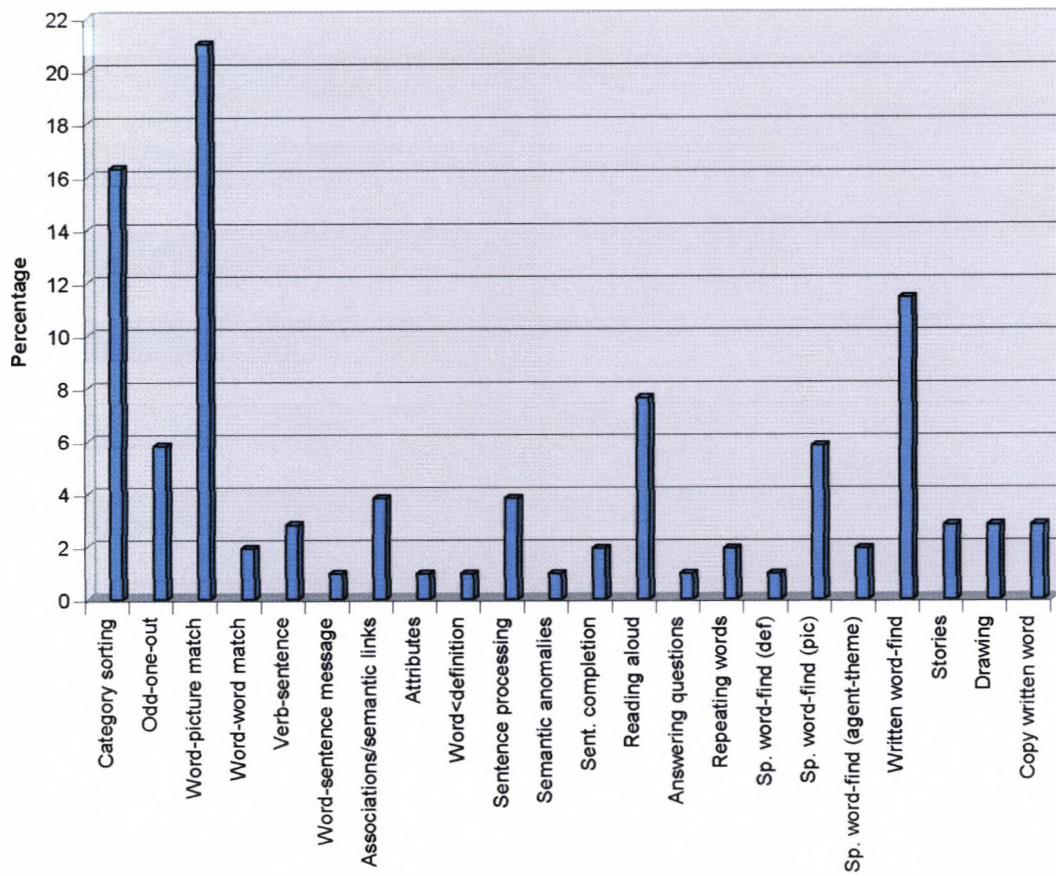

Figure 4.2 Relative prevalence of types of task across all sessions (Total number of tasks = 105)

Categories along the x-axis of Figure 4.2 refer to the same categories as are described in Table 4.6, and they are set out in the same order, but here from left-to-right. While Figure 4.2 is intended to give a feeling for the overall distribution of task types in this study, interpretation of the data in the figure should be treated with caution.

Firstly it is derived from the written information submitted by the participating therapists (i.e. as set out in APPENDIX THREE). While this information is generally accurate in terms of how the written outline of sessions (i.e. tasks undertaken) correlates with what is observable on videotape, the correspondence is by no means one hundred percent. This 'source of error' occurs for two main reasons: 1) the therapist-aphasic person dyad may not always carry out the tasks set out in the written outline; 2) the

process of 'mapping' the therapists' descriptions of tasks onto categories created by the author cannot be taken as infallible; 3) the problem that lies at the heart of this thesis – i.e. what actually constitutes a task – suggests that it is problematic to set out with an *a priori* definition of 'task', or to attempt to define where 'task' begins and ends. It is because of this that the term 'task type' was deliberately chosen here – in other words an attempt, in the first instance to delineate a broad area of activity which would be recognisable and which would serve to orientate the reader.

The second note of caution relates to what is being counted here, given the caveats outlined in the paragraph above, and how it is being counted. The purpose of counting here and presenting the data in graphical form is to give an overall impression, not simply of activity, but of 'representation of type'. Thus the following steps have been taken:

1) All sessions (where written information was available) have been taken into account. Thus, if the same type of task was carried out by a therapist-aphasic person dyad in all three sessions, it was recorded three times. For example in all three sessions for D15 'Task' is recorded as: "To provide semantic information about the pictured objects in response to my questions", and this has been entered three times under 'Spoken word-finding with picture stimulus' [17]
2) Where the same type of task is used more than once in the same session, it is recorded only once (for that session). For example: D9 (2) Task 1: "sorting fruit and vegetables" and Task 2: "sorting fruit, vegetables and other foods" is recorded as one instance of 'Category sorting' [1]. However, if the same type of task is used, but in a different modality, it is recorded as another instance of that task type. For example (see APPENDIX THREE for reference to numbered 'Tasks' for each dyad): D11 (1) Task 3: "written word to picture matching", and Task 4: "spoken word to picture matching" are recorded as separate task types here. The same is true

of 'Odd-one-out' [2] for example, where the odd-one-out is being chosen from a group of pictures (for example: D6 (2) Task 3), and a group of written words (for example: D6 (2) Task 2). The latter is a good example of potential source of error – the therapist has noted under 'Task': "Choice of 4 pictures/words – asked to select OOO[8]" – in other words, it is difficult to decide if this should really be counted as one or two instances of a task type, i.e. 'Odd-one-out' (pictures) +/- 'Odd-one-out' (written words)

3) Within the category 'Word-picture matching', where there are instances of several pictures/several words, or several words/one picture in the same session, these have been counted as separate instances of this task type. An example of this can be seen in D2 (1) (Tasks 1 & 2i). In a similar vein, instances of one word/several pictures, and several words/one picture have been counted as separate instances (e.g. D2 (2) Tasks 1 & 2i).

Leaving aside any discussion of what type of tasks would or could be considered to be 'semantic therapy' tasks, there are clearly some tasks which are more prevalent here than others. 'Word-picture matching' [3] is used by eight out of the fifteen dyads and is also the most prevalent task type (21%). 'Category sorting' [1] is also used by a relatively large number of dyads (five out of fifteen dyads) and accounts for 16.3% of task types. The relatively high proportion of 'Written word-finding' [19] (11.4%) is accounted for by only three dyads, and 'Reading aloud' [13] (7.6%) by four. The other most prevalent task type ('Spoken word-finding with picture stimulus' [17] (5.8%)) is also represented by only three of the fifteen dyads. It is perhaps not surprising given that ten of the thirteen aphasic person participants were non-fluent, and some severely so, that 59% of tasks were input ones, and in addition, 20% of the 'production' tasks were non-oral (writing or drawing).

[8] OOO = 'Odd-one-out'

In the Chapter Six, where the task-related interaction between therapist and aphasic person is addressed, actual items and in some cases numbers of items will be subject to closer scrutiny as part of the detailed analysis. The production of data here in this chapter – in terms of task types – should be considered as an entirely different undertaking. Not least, no account has been taken here of the sequence of work in sessions.

As has been noted above and discussed in Chapter Two, in the academic literature on therapy interventions which are designed to address the semantic system there are a wide range of goals and approaches. Some approaches are designed to address semantics per se, whereas others appear to be designed to address semantics as a means of improving word-finding abilities. Again here without going into the detail of how tasks were enacted, it should be noted that therapist-aphasic person dyads worked through tasks in many different sequences (and with greatly varying amounts of items per task – see above Section 4.3.2.v Categorising and enumerating items used). It is not the purpose here to impute any particular purpose to the sequences of tasks as enacted by the various dyads, but to note that merely setting out the task types and relative distribution of task types is only one part of the general background picture. Closer scrutiny of tasks as they were enacted by therapist-aphasic person dyads – including some note of the sequence of tasks – will follow in Chapter Six.

4.4 Data analysis 1: summary

Chapter Four provides a contextual background to the detailed analysis of interactions between therapist and aphasic person to follow. The background includes broad issues such as the process of recruitment to the study, information on inclusion criteria for participants, ethical approval and the process of participation.

Further and more detailed contextual data is summarised and displayed in various tables and figures. These include information about the participants: therapists in terms of time since qualification and experience of working with people with aphasia for example; people with aphasia in terms of time since onset of aphasia and age for example; and therapist-aphasic person dyads in terms of length of time working together and location of work for example.

Therapy sessions are reported on in terms of aphasic participants' aphasic impairments and therapy tasks and items used; items and tasks are broadly categorised into types and the distribution of task types is presented and discussed.

As has been emphasised elsewhere this study does not seek *a priori* to delineate task constituents and boundaries, but rather seeks to explore in depth and detail how the types of task, as outlined in this chapter, are situated and implemented in the actual practice of therapy sessions as a whole. This exploration will continue in the following chapter where the work of describing and analysing therapy sessions as they are conducted will begin.

CHAPTER FIVE

DATA ANALYSIS 2

5.1 Introduction

The methods described in Chapter Three (Sections 3.6.2.i, ii, and iii) were used here to develop, in the first instance, a broad descriptive framework for the structure of therapy sessions. Methods described under Section 3.6.3 (Conversation Analysis) were also used to ground the analysis in the detail of the interactions between participants. The descriptive framework originated from observations of a relatively small number of therapy sessions from the data corpus. Observations of subsequent sessions were then used to test its descriptive adequacy, to substantiate or refute initial assumptions, and thus make further developments and refinements, returning once again to the first data fragments to 'test' the framework in an iterative process.

In the following section the broad descriptive framework will be outlined and briefly discussed. Subsequent sections will then examine in detail the following domains (see discussion of methods proposed by Spradley (1980) in Chapter Three, Section 3.6.2.ii):

- The 'Settling down period'
- The 'Closing down period'
- 'Opening up the business'

In addition a separate feature of 'Inserted conversation' will be described and examined in the final section of this chapter.

The aim of establishing a rich picture of the work of language therapy sessions will continue in the following chapter by considering how this descriptive framework, and the process of its development, may help lead to a closer understanding of what is meant by therapy for aphasic language impairments and how it is enacted.

5.2 A descriptive framework for the structure of therapy sessions

Outlined below (Figure 5.1) is a sketch of the general domains for the structure of therapy sessions. The purpose of the outline figure is to give an overview and some initial account of the types of domains in question before moving on to a more detailed examination of each domain in turn.

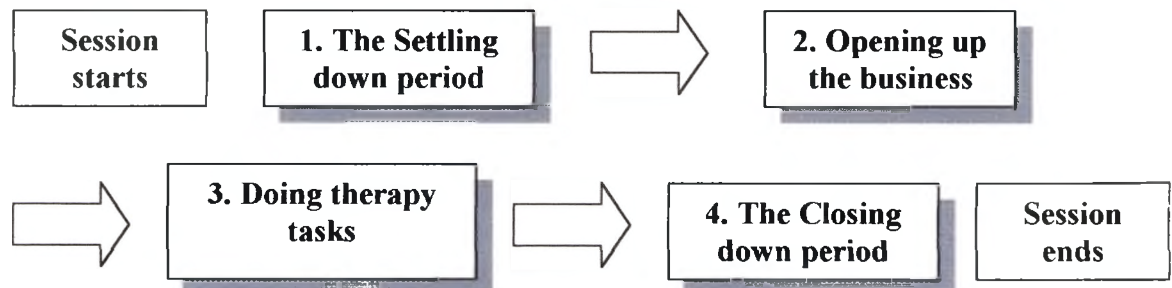

Figure 5.1 General domains for the structure of therapy sessions

Clearly Figure 5.1 outlines a very broad schematic framework for therapy sessions, and it needs expansion and explanation. The framework is not prescriptive and does not describe an 'ideal session'. Generally speaking, however, there are domains representing phases of the session that do not recur, and there are ones which are or may be repeated. Thus the 'Settling down period' and the 'Closing down period' do not recur. 'Opening up the business' – where the transition from the 'Settling down period' to the business of 'Doing therapy tasks' is managed generally does not recur. However, there are instances which blur the boundaries of this domain and these will be discussed below and in Chapter Six.

Domains will be described in terms of their key features, each of which has one or more types of representation. In the case of 'Doing therapy tasks', one of the features has, in addition, a set of sub-features with various associated dimensions. These are

addressed in detail in Chapter Six, but in order to give a sketch of how 'Doing therapy tasks' fits into the framework illustrated in Figure 5.1, a brief outline will follow here.

A cycle of features entailed in 'Doing therapy tasks' generally recurs throughout the session – after 'Opening up the business' and before the 'Closing down period'. Types of feature entailed in 'Doing therapy tasks' include: 'Task introductions'; 'Task management'; 'Enacting tasks'. 'Response management' is a sub-feature of 'Task management', and is the process through which aphasic people's responses in therapy tasks are contingently managed. 'Response management' entails a combination of work by therapist and aphasic person which includes features of various types and sub-types with their associated dimensions. All of these will be examined in much more detail in the course of the next chapter. The following figure attempts to clarify how those features described above and entailed in 'Doing therapy tasks' may recur in a cyclical process:

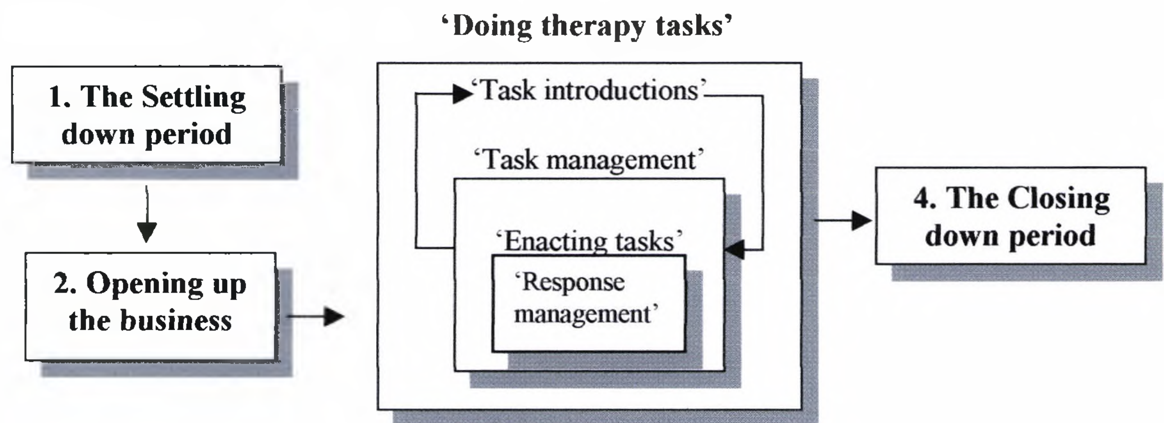

Figure 5.2 'Doing therapy tasks': a cyclical process

As was pointed out above this broad framework is not prescriptive and does not describe an 'ideal session', and thus the sequence of phases implied by Figure 5.2 should not be taken as a definitive position on what happens in sessions.

A further feature of these data – 'Inserted conversation' (ten Have 1991: 6, 151) – will also be examined towards the end of this chapter. As the examination of data

becomes more refined and detailed it will become apparent that certain types of feature – such as those entailed in 'Doing therapy tasks' – are not necessarily confined to the limits of the domains outlined above, and that the structure of sessions as outlined in Figures 5.1 and 5.2 should be taken only as a rough guide. As Drew and Heritage (1992) point out the overall structure of lay-professional encounters may be disordered by a range of contingencies which arise during the course of the meeting.

The overall purpose of developing and exploring the framework as outlined in Figure 5.1 is to provide a structure which enables the process of developing a rich description to be managed as coherently as possible. It has to be remembered that this framework is not a recipe for the structure of therapy sessions, but has been developed on the basis of observing and analysing certain data.

As has been mentioned elsewhere, the author has not entered into the process of description and analysis of therapy sessions as a *tabula rasa*. The broad schema outlined above owes much to various authors – Panagos *et al* (1986); Panagos and Griffith (1981); Kovarsky and Duchan (1997); Simmons-Mackie and Damico (1999a); and Sinclair and Coulthard (1975) among others. In the analysis that follows more specific and particular references will be given as appropriate. In addition tabulation will be used in the sections that follow in order to give an overall impression of the domains under analysis. Tables will outline the features of various types and will provide illustrative examples. Reference will be made in the analysis that follows to features and examples from the various tables, but additional examples will also be given.

The 'Settling down period' is the first domain to be considered. As with all the other domains the analysis will consider:

- What features are included as evidence of the domain
- What typifies these features

Description and analysis will be grounded in how participants' interactions are seen to contribute to the development of the different domains. Participants' interactions will be analysed in terms of how they contribute to an understanding of the functions of a domain. Further analysis will examine how domains actually function as part of a sequence in the therapy session as a whole.

5.3 Starts of sessions: the 'Settling down period'

Analysis will focus in the first instance on the starts and then the ends of sessions. This is for two main reasons. Firstly, in terms of this study, relying as it does on observations of videotape and the use of audiotape recordings, there are special considerations to do with the impact of the recording devices which are especially apparent at the starts and ends of sessions as they are recorded. This has been discussed in Chapters Three and Four, but will be examined here in terms of how the data from this study can be considered to be representative of day-to-day practice.

Secondly, starts and ends, fixed anchor points as they are, seem to be convenient places to make a start at looking at session structure.

In the first instance tapes from the following sessions were examined: D1 (1) (2) (3); D5 (1) (2) (3); D2 (1) (2) (3); D6 (1) (2) (3). The most compelling reason for using this order was simply that these tapes were submitted first and more-or-less in this order. The structures outlined here have been developed on the basis of these sessions in the first instance, but as further data were inspected additions have been made, until data from all sessions were included in the analysis. Divergent cases are outlined and discussed in detail as they become relevant.

In Section 5.3.5 below the analysis will also consider how the recording devices impact on the 'Settling down period'.

The following table sets out the key features of the 'Settling down period':

Features	Type	Examples	Ref.
A: Organising talk	About organising the environment	1. T: let's have some light on the matter	D1 (1)
	About the session	58. A: how long is this 59. T: about half an hour	D6 (1)
	About other meetings	5. T: I forgot to phone TP yesterday to 6. confirm about the family ([meeting]) 7. A: [oh okay] 8. T: but she knows [that]= 9. A: [yes] 10. T: =it's all sorted	D11 (2)
		3. T: I'm gonna pop in this afternoon= 4. A: right 5. T: =to see you because um I've at last got 6. together this booklet I keep 7. promising= 8. A: oh yes 9. T: =with some useful words and things in	D11 (3)
	Orienting to time and date	7. T: where is it (.) the eighteenth ((writes date on notes))	D1 (1)
		1. T: okay (1.0) so we we're about half an 2. hour late ( ) mainly my fault 3. A: ((points to herself and smiles)) 4. T: ((laughs)) both of us 5. A: ((smiles))	D9 (1)
B: Settling talk	Banter	2. A: ((after T has turned on light)) 3. oh↓ ((turns head away and grins)) 4. T: too early in the morning ((both 5. laugh)) ( ) show your wrinkles (dear) 6. T: no ↓ ((laughs))	D1 (1)
	Noticing the environment	39. A: yeah yeah (.) that's nice ((points out of 40. the window)) 41. T: it's lovely isn't it yes summer has 42. finally arrived	D2 (2)
C: Topical talk	Asking after the other (the aphasic person)	1. T: how are you (feeling) alright 2. A: m:: m:: ((nods))	D1 (2)
		13. T: anyway how are you since we last 14. A: ((turns towards TP)) yes 15. TP: ((woman's voice)) yes (fine)	D5 (3)
		22. T: how have you been generally 23. A: yeah 24. T: okay ↑	D2 (1)
		9. T: oh how are you (.) alright yeah 10. ((nodding)) 11. A: thank you yeah	D2 (2)
	Asking after the other (family/friends)	21. T: I think ((raises finger)) B's 22. looking well 23. A: aye he's no bad (.) some days 24. [( )]= 25. T: [up and down ((clicks tongue and 26. frowns))] 27. A: =you know (.) you know 28. T: sleeping a lot	D6 (1)
	What has been happening?	11. TP: ((woman's voice)) we've done some 12. bits [( )] 13. A: [pieces]	D5 (3)

Features	Type	Examples	Ref.
	What has been happening (cont)	15. A: ((leans down to her right to something 16. on the floor)) yeah so so we went to 17. /ri:vers/ the morning 18. T: m:: 19. A: and I said to the that ((gestures over 20. shoulder with thumb))	D2 (1)
		6. T: I haven't seen you over Easter 7. A: oh yeah I was going to get one this 8. weekend but they had got to come now 9. er so got to come away	D2 (3)
	What is going to happen?	3. T: are they going out for a night 4. A: ah ( ) 5. T: are you going	D6 (1)
	About myself	13 A: cause we've got no problem me 11. ((gestures with hands towards self))	D2 (2)
	Your/my communication	41. T: ( ) the shops that you go to A is it 42. self-service ((gestures towards herself 43. with right hand)) 44. A: uhu 45. T: you just pick it up 46. A: yes 47. T: and put it in your basket ((mimes)) 48. A: yes (.) aye 49. T: you don't have to ask for anything 50. ((gestures hand moving away from 51. mouth)) 52. A: no↓ not really 53. T: m: 54. A: quite good	D6 (1)
D: Organising talk and action	The recording devices and process	See Section 5.3.5 The impact of the recording process on the settling down period	
E: Action	Doing something to organise the environment	1. ((T switches on table lamp))	D1 (1)
	Organising therapy notes	5. T: ((writes date on notes))	D1 (1)
	Doing something to enable participant	16. A: oh oh oh oh oh ((looks at her glasses)) 17. T: what d'you want 18. A: (clean my glasses) 19. T: (slave) I'm a veritable slave to you 20. ((cleans A's glasses))	D1 (1)
F: Ending the 'Settling down period'/beginning 'Opening up the business' or 'Doing therapy tasks'	Therapist initiates	14. T: right okay (.) what I'm going to do 15. this morning	D1 (1)
		21. T: fine (right) you beauty you can see it 22. now you didn't appreciate it before (.) 23. now it's gone (five hours) (.) right 24. d'you think we could start 25. right so what we are going to do	D1 (1)
		7. T: (.) okay (1.0) right let's have a look 8. now what I'd like you to do A	D5 (1)
		28. T: good (.) and you've seen D3T and 29. done some work with the pictures	D2 (1)

Features	Type	Examples	Ref.
	Therapist initiates (cont)	13. T: remember last week when you came to 14. see me 15. A: yeah 16. T: we were doing more of the same (.) we 17. were talking about words	D6 (2)
	Aphasic person initiates	51. A: now and again it stops ( ) altogether 52. (.) any ( ) what use have I done (.) 53. any( ) (what) we going to do today 54. ((looking up to T)) 55. T: something very similar to what we did 56. last time	D15 (2)

Table 5.1 The 'Settling down period'

5.3.1 General features of the 'Settling down period'

Before turning to a closer analysis of the 'Settling down period', the structure and content of the domain as set out in Table 5.1 above need some consideration. Much of the interaction in this phase of the encounter is achieved through talk, although action on the part of therapists (and occasionally on the part of the aphasic person) is notable For these reasons the key features concern the ways in which talk and action are structured.

'Organising talk' (Table 5.1 Feature A) – talk that fulfils an organising function – clearly relates to matters around the mechanics of the session, some of which is given to 'asides' by the therapist talking themselves through an action. The feature 'Organising talk and action' related to 'The recording devices and processes' (Table 5.1 Feature D) is dealt with in its own section (Section 5.3.5 below). 'Settling talk' (Table 5.1 Feature B) (which could be equally termed 'small talk'), consists of 'Banter', often with a good deal of laughter from both parties, or the type of "setting talk" discussed by Maynard and Zimmerman (1984: 304) – for example, 'Noticing the environment' (Table 5.1 Feature B). In this analysis the discussion of the recording devices or the process of recording is deliberately excluded as part of "setting talk", although it is indeed quite clearly part of such a thing (see parallels in Maynard and Zimmerman

1984: 304 in relation to "setting talk" about the laboratory environment in which the subjects in their study found themselves). This analysis has treated 'noticing recording devices or processes' as a separate issue because the process and devices are demonstrably noticed in various ways and in various contexts throughout the sessions, and not just in the settling down period.

The use of the expression 'Topical talk' here in many ways does not do justice to the complexity of 'topic' as a conversational phenomenon. Atkinson and Heritage (1984: 165) suggest that 'topic': "...may well prove to be among the most complex conversational phenomena to be investigated and, correspondingly, the most recalcitrant to systematic analysis". In using 'Topical talk' here as a feature of the 'Settling down period' the issue of what should or should not be included within 'topic' is not generally addressed in any detail. However, in the broadest sense of what gets talked about in therapy sessions – as Schegloff and Sacks (1973: 300) put it: "mentionables" – 'topic' here includes matters which have not generally been accorded the status of 'a topic'. Schegloff and Sacks (1973) and Button and Casey (1984) for example treat initial greetings or "how are you"s as conversational openings or opening components which are not heard or treated as first topics.

Button and Casey (1984) argue that the turns prior to topic initial elicitors – which are used to begin a movement into a first topic – are occupied with components which make up a conversation's opening. These turns then, would not have the status of being a "preservable and reportable feature of the conversation" (Schegloff and Sacks 1973: 301).

The reasons for including these so-called opening components here within a set of 'mentionables' (i.e. within the realm of 'topic') are that: 1) 'Asking after the other' (Table 5.1 Feature C) in the context of healthcare interactions is potentially a basis for 'doing business' of some sort, and not necessarily a mere opener. While addressing the

well-being of the aphasic person may not be necessarily the therapist's own perception of his/her core business, general inquiries after their health have the potential to open up business which would merit the status of 'topic' in the terms talked about by Schegloff and Sacks (1973) or Button and Casey (1984) (see examples and discussion in Section 5.3.4 below); 2) certainly in the context of this study, what are usually considered to be opening components of conversations (i.e. initial greetings) are not necessarily visibly and demonstrably in opening positions in the data in this study, i.e. they may not have been recorded on video- or audiotape.

Button and Casey (1984) argue that there is an interactive turn-by-turn process between participants which is necessary in order to complete the process of topic generation. Topic initial elicitors operate to segment talk and open up inquiry into "a newsworthy event" (Button and Casey 1984: 170). For a topic to be addressed by both participants the topic initial elicitor is followed in the next turn by a "newsworthy event report" (Button and Casey 1984: 177) followed by a "topicalizer" (Button and Casey 1984: 182), which operates to transform a possible topic initial into an item for shared talk. Maynard and Zimmerman (1984) discuss pre-topical sequences which may lead to the generation of topical talk. However as Drew and Heritage (1992) point out lay-professional interactions are generally characterised by professional control over the agenda of talk. Indeed professionals: "...strategically direct talk through such means as their capacity to change topics and their selective formulations" (Drew and Heritage 1992: 1, 49).

The data from this study tend to show, and indeed this is reported in the literature on healthcare interactions generally, that there is a general "order of phases" in the encounter (Drew and Heritage 1992: 1, 43), over which the professional has control. The notion of this control and how it is evidenced will be discussed in the sections that follow. In general 'Topical talk' as it is used here deals with "topical content (what is

talked about)" (Maynard and Zimmerman 1984: 301). Analysis and discussion will also focus from time-to-time on the organisation of topic talk – that is both the organisation of the unit 'a topic' and the organisation of a set of such units within the various phases of a session (see Schegloff and Sacks 1973: 300).

General features of the 'Settling down period': summary

- Key features concern 'Organising talk', 'Settling talk' and 'Topical talk'
- The therapist generally exerts control over the topic agenda
- The recording devices and processes in this study have an impact on the 'Settling down period'

5.3.2 Time and the 'Settling down period'

In a paper on quantification in the study of conversation Schegloff (1993) argues that it can be highly problematic to consider a statistic even as simple as a proportion – for example the proportion of time taken doing a particular something. In terms of considering any significance attached to the time taken for the 'Settling down period' there are a number of reservations. Quite apart from the impact and intrusion of the recording devices which will be discussed below, the time taken will always be dependent on various chance circumstances which arise between the participants. For example, 'Asking after the other person' may open up extended sequences of narrative or question and answer, but does not necessarily do so. In D2 (2) (Table 5.1 Feature C: 'Topical talk' 'Asking after the other') the topic sequence is initiated and completed within two turns (lines 9-11). In contrast to this in D6 (1), a series of topics occurs one after the other – 'What is going to happen?'; 'Asking after the other family/friends'; 'What has been happening?' and 'Your/my communication', each shifted one to the next in "stepwise fashion" (Sacks, Spring 1972, lecture 5, quoted in Jefferson 1984: 9,

198) by the therapist. The 'Settling down period' in this latter example lasts for about two minutes fifteen seconds from the start of the tape. In D6 (2) and (3), however, there is no such extended 'Settling down period' (each lasting 29 and 20 seconds respectively on the tape). It would be wrong to draw any particular or general conclusions about the significance of these widely differing time periods – firstly in relation to the observation above that chance may produce very different sequences of events, and secondly in the light of the fact that we do not know about the preliminary interaction between therapist and aphasic person that is not on tape, and about which one can only surmise.

Time and the 'Settling down period': summary

- The length of the 'Settling down period' is unpredictable
- It is inappropriate to attempt to quantify the 'Settling down period' in terms of time taken
- The recordings in this study do not necessarily reflect the real time taken in the 'Settling down period'

5.3.3 The 'Settling down period' as part of the structure of sessions

The settling down period by its very nature comes first and is not recursive during the course of the therapy session. It generally has a clearly marked ending, which is, as far as the data in this study goes, almost exclusively initiated by the therapist (apart from the one exception: Table 5.1 Feature F: 'Ending the settling down period' 'Aphasic person initiates' (D15 (2)). The ending of this period is very often signalled by the therapist's use of discourse markers such as "right", "okay" or "good", often preceded or followed by a brief pause, before the next piece of business is opened up. This phenomenon has been well documented in the work of Sinclair and Coulthard (1975) among others on how classroom lessons are divided into different phases and how the transitions between phases are managed by teachers. As Kovarsky (1990)

points out 'okay' can function to release the other participant from a prior turn, but in its capacity as a link between two stages or phases it also acknowledges the speaker's obligation to make the next move in the interaction (Kovarsky 1990: 31) – here to exercise control over the process of moving on to and setting the agenda for the next business. This is evident in the extracts in Table 5.1 Feature F: 'Ending the settling down period': D1(1) lines 14-15: "right okay (.) what I'm going to do this morning"; D1 (1) line 25: "right so what we are going to do"; D5 (1) lines 7-8: "okay (1.0) right let's have a look now what I'd like you to do A". The therapist exercises control over the business by either using the "I" form with a statement of intent, or by joining him/herself with the aphasic person pronominally, as in D5 (1) line 8: "let's"; D1 (1) line 24: "we could start", and re-establishing shared experience in the past (Simmons-Mackie and Damico 1999b). Simmons-Mackie and Damico (1999b: 14, 317) also argue that use of such constructions in a routine manner signal the beginning of a familiar series of turn constructional units which allow the aphasic person to prepare for his/her role in the upcoming interaction.

Although, as mentioned above, the 'Settling down period' is not recursive, its transition to the next phase may be 'interrupted'. In D1 (1) the following sequence occurs (these examples also appear in Table 5.1 Features E and F):

14. T: right okay (.) what I'm going to do
15. this morning
16. A: oh oh oh oh oh ((looks at her glasses))
17. T: what d'you want
18. A: (clean my glasses)
19. T: (slave) I'm a veritable slave to you
20. ((cleans A's glasses))
21. T: fine (right) you beauty you can see it

22. now you didn't appreciate it before (.)

23. now it's gone (five hours) (.) right

24. d'you think we could start

25. right so what we are going to do

The cleaning glasses episode (lines 16-20) immediately follows the therapist's first transition attempt (lines 14-15). Apart then from a brief jocular aside (lines 21-23), the therapist returns to control the transition to the next business (lines 23-25): "right d'you think we could start right so what are we going to do".

Transition to a next phase of the session is not always signalled in quite the same clear cut way. For example in the extract from D2 (1) below the therapist shifts from the topic of 'Asking after the other' (lines 22-24) to the next phase of the business by continuing to refer to the recent past but in terms of work done on the therapy tasks with another therapist:

22. T: how have you been generally

23. A: yeah

24. T: okay↑

25. A: I didn't (2.0) no I didn't we too bad

26. T: ( ) [too bad] (.) good

27. A: [yeah] m::

28. T: good (.) and you've seen D3T and

29. done some work with the pictures

It seems likely that the therapist's "good" in lines 26 and 28 function both as a positive encouragement in terms of how the aphasic person has been (line 25: "no I didn't we too bad"), and as a marker of the change of topic to "work with the pictures" (line 29). A very similar pattern is apparent in D2 (2):

44. T: just starting to feel like Spring

45. A: yeah it's lovely isn't it

46. T: m:: m:: ( ) good (.) and D3T says you've been continuing

47. to work on the pictures

48. A: yeah

It seems more likely here that the therapist's "good" (line 46) is functioning as a discourse marker in the way that "okay" or "right" might do, but it could also be reflective of an appreciation of the good weather, or perhaps this therapist's personal style of softening the way that the transition to 'therapy business' from settling down is marked.

In the extract from D6 (2) below the transition to the business of therapy is signalled by a marker:

9. T: so we'll just focus on what we're doing (.) so (1.0) that's all set up ((T points to

10. camera))

11. A: uhu

12. T: I've got that on I've just reminded myself ((points to tape recorder)) (.)

13. remember last week when you came to

14. see me

15. A: yeah

16. T: we were doing more of the same (.) we

17. were talking about words

The marker signalling the start of therapy business (line 9: "(.) so (1.0)") is in this case split from the opening of talk on the business (lines 13-14: "remember last week when you came to see me"), by brief reference to the camera and tape recorder – seemingly a type of thinking out loud about whether everything is up and running and ready.

The 'Settling down period' as part of the structure of sessions: summary

- The 'Settling down period' is the initial phase of the session
- The 'Settling down period' does not recur
- The therapist is in control of ending the 'Settling down period' and opening up the next phase of the session

5.3.4 The function of the 'Settling down period'

The expression chosen for this domain aims to embody what appears to be the major function – to enable the participants to settle down and be ready for the business of therapy. In a way it is a buffer period between whatever has gone before (and this is not really known from the data in this study, except where it is directly referred to – for example reference to the car journey on the way to the clinic in D2 (3)), and what is to come.

Interaction in this period (however brief) may have some of the appearance of casual conversation, functioning perhaps to help the aphasic person feel at ease. This is apparently true of some of the topics: 'Asking after the other'; 'What has been happening?'; 'What is going to happen?'. However, although the topics could be said to be the stuff of casual conversation, the initiative is almost exclusively taken by the therapist. This is almost always true of 'Asking after the other'. It would not be true to say that there are no instances of the aphasic person asking after the therapist, but it is very rare. In the 'Settling down period' when the aphasic person has responded, they do not in turn reciprocate with an inquiry into the therapist's well being, which is the pattern that might be expected in casual conversation. Here the inquiry by the therapist appears to be part of the ritual of welcome into a setting where the aphasic person does not have rights of control or of taking the initiative. ten Have (1991) points out that of course – and here he is referring to patients' visits to doctors – it is the patient's

condition that is under review and not the health practitioner's (ten Have 1991: 140), thus introducing an automatic asymmetry of topic. Simmons-Mackie and Damico (1999b) remark on the way the aphasia therapy sessions in their study began with a period of casual conversation. They note that the structure of participation, where the therapist is in control of the flow of activities is clearly established in this opening phase of the session, where: "...the participants cast a casual conversation in a loose form of elicitation sequence in which L asked and C responded" (Simmons-Mackie and Damico 1999b: 14, 316).

However, the "summary rule" alluded to by McHoul (1978: 188) that: "Only teachers can direct speakership in any creative way" (and here his study of formal talk clearly refers to classroom interactions), cannot be said to hold true of therapists and aphasic people in the settling down period of therapy sessions. In certain topic areas initiative taking does vary. In D2 (1) (Table 5.1 Feature C: 'Topical talk' 'What has been happening?') the aphasic person takes the initiative in opening up the topic (lines 16-20). In D5 (3) (Table 5.1 feature C: 'Topical talk' 'What has been happening?') it is the aphasic person's wife who initiates talk about work that she and her husband have done together. In D15 (2) the aphasic person initiates a story about 'how she has got on' – where and with whom is never quite clear:

10. A: anyway (.) I've got on very well

11. T: yeah

12. A: and they're very pleased with me

13. T: good

14. A: <u>very</u> pleased with me (.)

Aphasic person and therapist continue with collaborative work (Milroy and Perkins 1992) to establish the nature of problems with her speaking. The aphasic person continues with an account of problems with her hand/finger movements, and <u>she</u> is the

one to initiate the end of the 'Settling down period' (Table 5.1 Feature F: 'Aphasic person initiates').

Elsewhere the therapist generally initiates with questions about what has happened or what is going to happen. These exchanges usually take the form of 'Question and Answer' sequences – questions by the therapist and answers by the aphasic person. As is pointed out by Peräkylä (1995), the interaction may look quite different from mundane conversation. He refers, quoting Drew and Heritage (1992), to a type of institutional environment which is *informal* (original italics), where the turn-taking may be managed on a local basis, as in ordinary conversation. However, the interaction may look very different from mundane conversation in that there may be aggregate asymmetries in the types of action between the participants, such as an uneven distribution of questions and answers (Peräkylä 1995: 44).

This phenomenon is apparent in the data from the 'Settling down period' in this study. The following is an extract from D6 (1):

24. T: are you still going up there every day

25. A: aye

26. T: ((nods))

27. A: (doesny bother) ( )

28. T: mhm

29. A: (quite nice) ( ) (a shame too) you know

30. T: mhm (.) */wo?/=*

31. A: =(what can you do)

32. T: what d'you do when you go up

33. A: well (1.0) ((sits back and gestures forward with both hands))

34. say (.) get go the (1.5) ((gestures over right shoulder))

35. T: (cooking) dinner

36. A: uhu (.) no he does that (.) [so he does](.)

37. T: [(he does that)]

38. A: so just go you know go the

39. T: shops

40. A: aye

41. T: ((nods)) mhm (1.5) ( ) the shops that you go to A is it

42. self service ((gestures towards herself

43. with her right hand))

44. A: uhu

45. T: you just pick it up

46. A: yes

47. T: and put it in your basket ((mimes))

48. A: yes (.) aye

49. T: you don't have to ask for anything

50. ((gestures hand moving away from

51. mouth))

52. A: no↓ not really

53. T: m:

54. A: quite good

55. T: mhm ((intake of breath)) (.) okay what I thought

The therapist starts by asking about what has been happening (visits to a friend who is not well) – line 24. In line 30 the therapist's "/*wo?/*" is the interrupted start of a further inquiry, which is resumed in line 32. The sequence from lines 41-55 is about the aphasic person's ability to communicate when shopping. The therapist's question in lines 41-42 is followed up by a series of checks (lines 45 and 47), getting to the point in

line 49 of directly asking about the burden of shopping on the aphasic person's ability to speak.

In this extract it appears to be the case that the therapist chooses not to follow up with questions about the aphasic person's expressed attitude or stance to matters. In lines 27 and 29 the aphasic person expresses feelings about visiting her friend (line 27: "doesny bother"; line 29: "quite nice"), and about her attitude to or opinion of the situation or the person – line 29: "(a shame too) you know". In a similar way she expresses her stance towards not having to say anything when going shopping (line 54: "quite good"). These expressions are acknowledged, but not followed up in themselves and topicalised by the therapist, who has the option to do so by displaying interest and actively promoting topical talk related to the utterance (Maynard and Zimmerman 1984: 308). This is in contrast to the sequence beginning at line 32 and ending at line 55 (above). The therapist's pre-topical question (line 32: "what d'you do when you go up") invites the aphasic person to offer a topic initial utterance (Maynard and Zimmerman 1984: 306). It is only when the aphasic person (with collaborative work from the therapist) mentions going to the shops, that the therapist displays an interest and turns 'going to the shops' into a topic through the use of a series of questions and checking statements, with an underlying theme to do with the aphasic person's ability to communicate in such circumstances. In this respect the sequence of questions about shopping posed by the therapist rather parallels the notion of "category-activity sequence" described by Maynard and Zimmerman (1984: 306). The question part of the question-answer pair in "category-activity sequences" invites the other participant to describe activities relating to their status or membership of a category. Thus in the sequence above, there appears to be a mutual (but unstated) understanding that the therapist's questions about shopping relate to the activity of shopping by the person as a person with aphasia, and in no other respect. This is made explicit by the therapist's

emphasis: "you don't have to ask for anything" (line 49), and the aphasic person's: "quite good" (line 54) confirms that there is a mutual understanding that this topic was to do with the potential problems faced by her as an aphasic person going about her normal business in the community.

As has been mentioned above the length of the recorded settling down period varies considerably. Where there are more extensive sequences, as in the extract above, they tend to be of the 'therapist question, aphasic person answer' format. This type of apparent imbalance could be construed as a natural consequence of the aphasic impairment itself, in that the therapist must do more question asking in order to make sure that s/he has understood correctly. This is apparent in a sequence in D2 (2) where there is a series of therapist questions, often in the form of checks – the therapist displays what she has understood, offering them to the aphasic person to be confirmed or otherwise:

12. T: we're leading up the cook the cooking hasn't started yet is that right
13. A: yes we're you know ( ) cause we've got no problems me
14. ((gestures with hands towards self))
15. T: right ((nods))
16. A: but you see they're ((gestures to heads and pulls a face))
17. T: so you're waiting for them
18. A: yeah
19. T: yeah
20. A: yeah they you know they can't see why ( ) to get me somewhere
21. T: (have) you got to wait for a space on a the course
22. A: yeah
23. T: yeah
24. A: yes so

25. T: so it's a bit frustrating isn't it

26. A: well you know it would you know it'd help me you know=

27. T: m::

28. A: =you can sit me with (working) then they'll be going down together=

29. T: m::

30. A: =here you know but he say to me oh dear they keep sorting out the (fare)

31. oh you know I been there [(I really)] don't mind

32. T: [yeah] you've been and tried m::

33. A: you know and cause I I I don't mind but you know I got to

34. suffer (with them) you see

35. T: so you're raring to go and they're kind of delaying things a bit

36. A: yeah a bit (.) never mind

The sequence starts with the therapist's opening question about a cookery class (line 12), and a series of checks by the therapist ensues. These are based around the facts of the matter – line 17, line 21, line 32, line 35 ("they're kind of delaying things a bit"), but also around how the aphasic person is feeling – line 25 ("so it's a bit frustrating isn't it") and line 35 ("so you're raring to go"). It's difficult to know whether the therapist actually understands what has been happening about the "cooking". The aphasic person's expressive language is generally quite empty of substantive meaning, and the therapist appears to be engaged in a strategy very familiar to therapists in this type of situation, very much akin to the "hint and guess" cycle described by Lubinski *et al* (1980). The aphasic person does not appear to disconfirm any of the therapist's checks, but it is not entirely clear on what evidence the therapist is basing her checks. Lines 17 and 21 are both about "waiting", which the aphasic person has not mentioned or apparently inferred. In a similar way in lines 32 and 35, the issues of the aphasic

person having tried, and "delaying" respectively, have also not been mentioned or apparently inferred by the aphasic person.

Interestingly, the most concrete and substantive meanings are apparent in the aphasic person's gestures in lines 14 and 16. In line 14, the gesture, taken in conjunction with what she says: "cause we've got no problems me" – underlines what she is really talking about, said in contrast to the "they" in line 16, combined with the gesture to her head and the pulled face. Here the contrast is between herself as a person with "no problems", and "they" (a set of other people) who have 'head problems'. This issue (about which the author has privileged information) is not picked up by the therapist, even though the means of its expression is the most apparently concrete in this sequence.

There is a clear sense, referring to the two extracts above (D6 (1) lines 24-55; D2 (2) lines 12-36), that the therapist's control over the interaction in terms of leading the question-answer sequences, choosing what to topicalise or not, shapes this phase of the session as a preliminary before the 'real work' to come. There are obvious 'getting on with the business' topics and actions in the settling down period – 'Talk about organising the environment'; 'Talk about the session'; 'Organising therapy notes' and so on. This has parallels in other healthcare settings as has been noted by Lomax and Casey (1998), where during the "preliminaries" they argue that talk facilitates preparation for healthcare activity but at a point where healthcare talk is not yet appropriate or possible (Lomax and Casey 1998: 5.5).

There is, in apparent contrast, a conversational turn-taking structure to the exchanges to do with 'What has been happening?' or 'Asking after the other', but as has been shown above, there are asymmetries in these sequences, which suggests that characterising these turn-taking sequences as "quasi-conversational" (Peräkylä 1995: 43) is quite appropriate.

There are some interesting variants of the types of features discussed above in sessions recorded in the one in-patient rehabilitation facility (D8, D9, D10 and D11). 'Organising talk' (D11 (2) and (3) Table 5.1 Feature A above) often concerns more immediate arrangements (D11 (3) line 3: "I'm going to pop in this afternoon") or ones in which there is a degree of flexibility (D11 (2) lines 5-10: "I forgot to phone ((wife's name)) yesterday to confirm about the family meeting but she knows that it's all sorted") – presumably due to the physical proximity between therapist and aphasic person (or family members) in the facility itself. 'Topical talk' about 'What has been happening' is most likely to be about the organisation or opportunities in the facility itself: D11 (1): "did you get to workshop yesterday afternoon"; D8 (1): "what have you what have you done this morning so far…you saying you have or you haven't had any sessions", but may be about time spent away from the facility at weekends: D9 (2): "how many nights did you sleep at home"; "did you go out anywhere". Talk about 'What is going to happen?' again is generally focussed on the facility itself and therapy opportunities – D11 (1): discussion about what the aphasic person will be making in the therapeutic workshop, or on matters to do with leaving – either for the weekend or permanently: D8 (1): "I think you're going just that week the week of your birthday is when you're leaving".

Another noticeable feature which distinguishes the 'Settling down period' in these sessions is the therapist's attempts to get the aphasic person to use particular strategies or resources as an aid to 'working through' this phase. This quite often entails 'testing' the aphasic person – in other words getting them to produce known information. For example, in an extract from D8 (1):

3. T: what's the date today A (2.0)

4. A: ((chuckles))

5. T: d'you know

6. A: /wens/ (wensey)

7. T: yeah it's Wednesday ([ ])

8. A: [Wednesday]

9. T: brilliant ((reaches for folder on the table and offers it to the aphasic person,

10. who opens it)) (d'you) know what date it is as well

11. A: (I don't know) ((turns pages)) Thursday

In the extract above the Initiation-Response-Evaluation sequence of formal instructional dialogue is apparent[1]. In line 3 the therapist asks a question to which she already knows the answer. Her question in line 5 has a twofold function – to check whether he really knows the date, and whether he can express that fact. Positive evaluation follows in line 9: "brilliant" (although he has not actually answered her question correctly – more detailed discussion and analysis of the sequences entailed in 'Doing therapy tasks' will follow in Chapter Six). The therapist passes the communication folder to the aphasic person, rather than him reaching for it spontaneously. Having established the date (and month) using the communication folder, the therapist reverts to a quasi-conversational type of interaction:

22. T: Wednesday 12th May (.) that's not a particularly special day for you is it

23. A: no

24. T: not your birthday or anything no

25. A: no no no

26. T: okay but it's not long until your birthday is it

27. A: no

28. T: can you remind me (1.0) when it is

29. A: um

30. T: what month

[1] A detailed discussion of the turn-taking structure of formal instructional dialogue follows in Chapter Six

31. A: (senning)

32. T: the 9th of

33. A: (3.0) ((points to list in folder)) [August]

34. T [August] that's it

Having opened with a conversational gambit (line 22): "that's not a particularly special day for you is it", the therapist reverts to a 'test question'[2] at line 28 (the use of "remind me" is surely disingenuous here) – again this functions to bring the communication folder into the 'conversation'. The quasi-conversation/test question sequence continues with 'Topical talk' about what the aphasic person has been doing this morning – the communication folder is brought into use, both by the therapist as a checking device and by the aphasic person. The 'Settling down period' (D8 (1)) ends thus:

103. T: okay shall we put this away ((reaches for the folder))

104. A: yes

105. T: for now yeah

106. A: ( )

107. T: okay that's brilliant (.) so A what we're gonna do this morning

The therapist's use of "okay that's brilliant" (line 107) suggests that the 'Settling down period' has fulfilled the function of a series of tests on the use of the communication folder rather than any other function.

In a different session with the same dyad (D8 (3)) the communication folder is used collaboratively by the aphasic person and the therapist in a spontaneous way to help explore a difficulty:

5. T: how you doing today

6. A: (no) ((shaking head))

---

[2] 'Test question' refers to the phenomenon of requiring the questioned person to produce 'known' information. A detailed discussion follows in Chapter Six.

7. T: you alright

8. A: (no no no no no no)

9. T: you're not good

10. A: (no no no)

11 T: what's going on then

12. A: (no no no no no)

13. T: what's the matter

14. A: (no no no no) (2.0) (no no no) ((last two spoken very quietly)) ((takes glasses

15. out of case and puts them on))

16. T: you having a bad morning A

17. A: no no ((quietly))

18. T: (have you) got anything in your book

19. A: (no no no no no) ((sighs))

20. T: ( )

21. A: no no ((turning pages and pointing))

22. T: bad morning

23. A: no no ((shakes his head))

24. T: oh↓ A

25. A: no no

26. T: why↓

27. A: no no

Here the therapist chooses to topicalise the aphasic person's obvious distress, and proposes the folder as a communicative device, rather than as a vehicle for testing communicative competence as was seen in the extracts from D8 (1). Whilst the therapist is clearly sympathetic and affiliates with the aphasic person's distress – seen in the high falling intonation patterns (Heritage and Sefi 1992) in third position: "oh↓ Frank" (line

24) and in questions: "why↓" (line 26) – it is not for approximately 72 turns after the initial inquiry that they get to the bottom of the trouble, with a combination of closed questions by the therapist and use of the communication book by therapist and aphasic person. The 'Settling down period' (D8 (3)) ends thus:

105. T: Sunday okay so a quiet day tomorrow then

106. A: yeah

107. T: yeah

108. A: yeah

109. T: okay good stuff

110. A: yeah

111. T: right shall we do some work then

The therapist here is clear that the work of achieving mutual understanding and the uncovering of a piece of information that was causing distress is not the stuff of therapy work *per se* (line 111: "right shall we do some work then") – despite the fact that it clearly was 'hard work' for both participants, and that they, between them, made use of the communication folder in a way that probably fit its purpose perfectly.

In the dyad D9 the therapist is more explicit about the value of the use of a communication strategy in the 'Settling down period'. The following extract from D9 (2) is near the beginning of a sequence of 'Topical talk':

25. T: okay would you be able to tell me what you cooked

26. A: ( ) ((reaches for a pen))

27. T: see if you can draw something for me

The aphasic person apparently has very limited expressive speech and the therapist has been asking her a series of closed questions to do with what has been happening on a weekend away from the rehabilitation facility, gradually establishing how many nights she spent away, whether she went out, whether she did any cooking.

The therapist's question in line 25 is the first one in the 'Settling down period' which requires the provision of new and substantive information. The aphasic person reaches for the pen spontaneously, and with prompting from the therapist draws something which becomes the basis for another series of closed questions around what the drawing actually represents. Having established this, the therapist continues with more closed questions to do with the circumstances around the use of the object at home. The 'Settling down period' (D9 (2)) concludes thus:

132. T: okay (.) right (.) so that's brilliant that's drawing to communicate to tell me
133. something
134. A: yes
135. T: which is exactly what we want (.) and I am delighted about
136. A: yes
137. T: 'cause that's really our goal

The therapist talks about use of communicative drawing being "our goal" (line 137), and "exactly what we want" (line 135). She is thus explicit about the use of drawing as a communicative tool, and joins herself with the aphasic person pronominally ("we" and "our") in an alignment strategy (Simmons-Mackie and Damico 1999b: 14, 317) which cements the aphasic person's co-operation with this particular goal.

Evaluation of the aphasic person's use of particular techniques in the 'Settling down period' is not confined to sessions in the in-patient rehabilitation facility. In D2 (3) the aphasic person uses writing and drawing in conversation about 'What has been happening', describing – with collaborative work with the therapist – a visit to friends in another part of the country. The conversational interaction is relatively long (*pace* Section 5.3.2 Time and the 'Settling down period') – 10'15" – and at the end of the sequence the therapist says: "that was brilliant (.) A that's excellent the drawing ( )

excellent and this look the words as well doing the writing". Some turns later the therapist puts her evaluation into context: "that's exactly all this work we've been doing with you and myself and D3T has all been about hoping to get some writing going for help in conversation". She is clearly keen to stress the functionality of the impairment-based therapy work they have been doing, and it is perhaps not surprising then that she turns to the evaluation of ostensibly non-task related interactions. Whether this is done in order to reinforce her role as the 'one who knows best' about the focus of treatment and to justify continuing work on impairment-related therapy can only be a matter of conjecture.

In the next section, the question of the participants' orientation to what constitutes 'the business of the therapy session' will be discussed in relation to the presence of the recording instruments and process of recording.

The function of the 'Settling down period': summary

- The therapist generally controls the interaction and topical content
- The aphasic person occasionally but rarely initiates explicit 'Topical talk'
- The therapist may choose to actively promote certain types of 'Topical talk' and ignore others
- The interaction appears to be a preparation for the business of 'Doing therapy tasks'
- The 'Settling down period' may function for the therapist to demonstrate the aims and objectives of therapy
- The therapist may use the 'Settling down period' as an occasion to test the aphasic person's communicative abilities or use of communication strategies
- The participants' orientation to what constitutes therapy 'work' is revealed in the 'Settling down period'

5.3.5 The impact of recording devices on the 'Settling down period'

The potential intrusiveness of the recording devices has been discussed in Chapter Three, and some examples have been outlined in Chapter Four, Section 4.3.1.iv. However, the impact of the process of recording and the intrusiveness of the recording devices on the process of developing a descriptive framework has not yet been discussed, especially here in relation to the 'Settling down period'.

At one, perhaps rather simplistic level, what is actually seen on tape depends on who is doing the recording and how it is being carried out. In cases where the therapist is in charge of the camera in the therapy room, s/he tends to switch on the camera once the aphasic person is in the therapy room and seated, perhaps adjusting the shot to get everything in the frame. Then s/he walks towards the table and sits down too. The noticing of the camera is embodied in the action of the therapist ('therapist as recorder'), a persona which almost has to be 'shaken off' before the work of the therapist as health professional can begin. Some examples are given below in Table 5.2:

Therapist as recorder: dyad and session	Examples
D1 (3)	1. ((therapist emerges from behind camera)) 2. T: must be lovely to have a video that's kind of 3. permanently ( ) (on the wall) 4. A: oh oh 5. T: ruddy thing ((sits down at table)) oh god (3.0) 6. right (2.5) as I said (.) ((switching on tape 7. recorder)) sorry (1.0) I always forget that 8. damn thing (1.0) what I want to do is to have a 9. look at that business again of trying to tell me what 10. might be happening in the park
D5 (1)	1. ((A is seated at left of table and looking towards 2. camera)) 3. T: just carry on (.) they really just want a normal 4. session 5. A: yeah 6. T: ((walks to table and sits down)) alright (.) okey 7. doke (.) we'll forget about it after a few minutes 8. I'm sure (.) okay (1.0) right let's have a look now 9. (.) what I'd like you to do A

Therapist as recorder: dyad and session	Examples
D5 (3)	((A is seated at left of table)) 1. T: check that's actually working (.) think so (.) where 2. are you ((camera pans to left to take in all of A)) I 3. much prefer the other video 4. TP: ((woman's voice)) ( ) is this a different one 5. T: no the (.) er second video I did 'cause you couldn't 6. see me so much it was more you ((leans across to 7. switch on tape)) 8. A: ((chuckles)) 9. TP: ( ) I'm with you now yes (.) that's 10. [right] (.) 11. T: [( )] film 12. TP: you did say didn't you 13. T: anyway how are you since we last 14. A: ((turns towards TP)) yes
D6 (2)	7. T: uhhu I'm not sure whether they'll want to see us 8. or whether they'll want to see what we're doing 9. A: right 10. T: so we'll just focus on what we're doing

Table 5.2 Therapist as recorder: impact of the recording process on the 'Settling down period'

In D1 (3) the therapist voices her impatience of the recording device or process (lines 2-3, and 5: "ruddy thing"). In lines 6-8 it is apparent that the therapist has also just remembered to turn on the tape recorder, and again voices her frustration. She only then begins to set out plans for the session (Table 5.2 D1 (3) line 8: "what I want to do is..."). In this case the business of the recording – the actions and comments about the process – appear to constitute the 'Settling down period' itself (as far as these data are concerned). There is a clue in line 6 ("as I said") to a previous discussion of some sort – at the very least about the therapy – prior to the recording starting.

In D5 (1) (Table 5.2) the therapist appears to distance herself from the business of recording the session through the use of "they" in "they really just want" (line 3). She then directs the interaction to the business of therapy work – line 8: "okay (1.0) right let's have a look now". Similarly in D6 (2) the therapist uses "they" (lines 7 and 8) which distances her from the researchers who are carrying out the recorded observation. There is a suggestion that the interaction in the 'Settling down period' is not considered to be part of the real business of doing therapy work, and therefore not what the

researcher would want to see. There is negative evidence of this in terms of what has not been recorded (although this is admittedly very weak), but also the suggestion that, as above: "they really just want" (D5 (1)) the actual business of therapy work, followed by a rapid transition to 'business'. There are parallels again here to the work of Lomax and Casey (1998), where they remark on several occasions of midwives in their study making it clear that the work of initiating the consultation, doing greetings and informal chat and so on were not important and therefore would not need to be recorded (Lomax and Casey 1998: 5.10).

The therapist (D5 (1)) also refers to the intrusion of the recording device (lines 7-8: "we'll forget about it after a few minutes I'm sure") before turning to the business in hand (lines 8-9: "okay (1.0) right let's have a look now (.) what I'd like you to do"). In D5 (3) the reference to the other video is presumably to D5 (2) (i.e. the previously recorded session), and that she would prefer not to be filmed, but that it's all right for the aphasic person to be on film (lines 5-6: "you couldn't see me so much it was more you").

It would be wrong to place too much emphasis on evidence from remarks from single instances, and there is a lot of uncertainty about the status of remarks and actions in the 'Settling down period' of these sessions due to the equivocal and variable starts introduced by the process of recording. There are instances of another person setting up the recording, and also the use of a remote camera, some of which are set out in the following table:

Other or remote recorder: dyad and session	Examples
D2 (1)	1. ((T and A seated at table)) 2. T: you should have had an advantage 3. A: ((laughs)) oh god 4. TP: ((the recording therapist 5. - appears briefly at bottom of the picture)) 6. if I can sneak you together a cup of tea 7. A: [oh that would be lovely] 8. T: [m:: ( )] 9. ((both T and A turn to look at TP)) 10. TP: I'll knock discreetly 11. ((T and A laugh)) 12. T: ( ) the tea order arrive 13. A: oh yeah 14. T: oh dear 15. A: ((leans down to her right to 16. something on the floor)) yeah so 17. so we went to /ri:vers/ the morning 18. T: m:: 19. A: and I said to the that ((gestures over shoulder with 20. thumb))
D2 (2)	1. ((T and A seated at table)) 2. TP: ((the recording therapist)) bet you secretly turn 3. that off 4. T: as you go out of the [room ( ) and switch it off 5. A: [((laughs)) 6. TP: I'll pop back ( ) 7. T: all right then 8. ((TP leaves the room)) 9. T: oh how are you (.) alright yeah 10. ((nodding)) 11. A: thank you yeah
D2 (3)	1. ((T and A seated at table)) 2. A: ((pointing to her bag)) ( ) 3. TP: ((the recording therapist)) one of the blokes said 4. oh my 5. A: god 6. T: see you in a bit (.) was that the driver 7. said that
D6 (1)	1. ((T and A seated at table as the video starts)) 2. T: uh huh 3. A: ( ) no good 4. T: are they going out for a night

Table 5.3 Other as recorder or remote camera: impact of the recording process on the 'Settling down period'

The only occasion when the recording process/equipment is mentioned here is when the recording therapist initiates the topic (Table 5.3 D2 (2) lines 2-3). The therapist being recorded and the aphasic person join in the banter (lines 4 and 5), but thereafter there is no mention of the recording process or the equipment in the 'Settling down period'. The therapist (D2 (2) line 9) immediately opens up an 'Asking after the

other' topic, having said goodbye to the recording therapist. In D2 (1) lines 6-14 (Table 5.3) there is a sequence between the recording therapist, the therapist and the person with aphasia, which is about the intrusion of the person and the tea making process rather than the recording process, and again straight away the aphasic person (line 15-16) initiates a new topic - 'What has been happening?'.

In D2 (3) (Table 5.3) again the process of the recording therapist withdrawing is dealt with (line 6: "see you in a bit"), and the therapist goes straight in to pick up the topic (originally initiated by the recording therapist) about 'What has been happening?' (here on the aphasic person's journey to the clinic in the car).

In D6 (1) [remote camera] (Table 5.3) it looks as though the settling down period had started before the recording – the therapist's first utterance (line 2) sounds like an acknowledgement of a preceding remark. However, no mention is made of the recording and therapist and aphasic person are straight into a 'What is going to happen?' topic.

<u>The impact of recording devices on the 'Settling down period': summary</u>

- The impact varies according to who is in control of the recording process
- Therapists tend to distance themselves from the researchers and the research process
- There recording process itself may give some insight into what is considered to be the 'business of therapy'

5.4 Ends of sessions: the 'Closing down period'

As has been discussed above ends of sessions were also prone to the intrusion of the recording devices. This was, as one might expect, in a rather different way to starts of sessions. Starts of sessions were prone to various recording mishaps, such as the audiotape not being switched on or being switched on later than the videotape. The recording mishaps at ends of sessions tended to be ones where there was a mismatch

between audio- and video-recording. In some cases the audiotape runs on longer than the videotape. In others the audiotape stops before the video. For example in all D1 sessions the videotape stops abruptly (in D1 (1) in mid task), and there is no complete video record of the closing down period (also true of D10). This is also true of D5 (2) and (3), where the audiotape also stops mid task. In D2 the ends of sessions appear to be signalled by the recording therapist entering the room – for example: D2 (2): "I've come to tell you the driver's ready". Where only audiotaped data exist for the ends of sessions, this will be made clear in the analysis. The audiotypist transcription was checked by the author as for all parts of the transcription, but clearly without recourse to the videotape.

In a very similar way to the 'Settling down period' the following broad analysis will consider what features are included as evidence of the 'Closing down period' as a domain and what typifies these features. Description and analysis will be grounded in how participants' interactions are seen to contribute to the development of this phase as a domain, how they contribute to an understanding of the functions of this domain, and how the domain actually functions as part of a sequence in the therapy session as a whole. Examples are set out in Table 5.4 below:

Features	Type	Examples	Ref.
A: Starting the 'Closing down period'	Therapist initiates	1. T: good they're all types of meat 2. A: ah 3. T: that's ( ) fruit 4. A: ( ) fruit 5. T: okay 6. A: quite good 7. T: so well done (.) A what I'll do is 8. once we've finished and we go out	D6 (1)
		1. T: yeah okay (.) right ((looks at her 2. watch)) (1.5) um I think we'll stop 3. there (2.0) ((looking down at papers on 4. the desk)) today	D5 (1)
		1. T: one more (.) what about golden 2. delicious (1.0) app[les] 3. A: [( )] ( ) ((points to one 4. card)) 5. T: usually green (1.0) okay (.) I think 6. we'll leave it because you tire quite 7. A: ( ) ( ) 8. T: you okay 9. A: aye 10. T: you've just been at the group as well	D6 (2)
		1. T: so that's out and [that's out] 2. A: [( )] that's true 3. T: okay (3.0) well done okay well I'm 4. just going to switch this off now 5. ((switches off audiotape)) and I'll 6. switch the video off as well (.) 7. ((starting to get up))	D6 (3)
B: Organising talk	Arrangements for the next session	10. T: I'll have a look at my diary and I'll 11. arrange to come out and see you: 12. which house would be easier your 13. house or B's 14. A: no no her mine ((gestures to self)) 15. T: your house 16. A: is because she is always ((mimes 17. sleeping)) 18. T: sleeping okay	D 6 (1)
		23. T: but I'll have to bring the video 24. A: aye that's all right	D6 (1)
	Arrangements for other meetings	20. T: a fortnight I want you to come back 21. and I'm going to work (1.0) not 22. work I'm going to try and work with 23. you and Mary= 24. A: =uhu 25. T: um (.) just so that the volunteers 26. [know]= 27. A: [that's true] 28. T: =how they can help you speak	D6 (2)
	Therapy work in the next session	32. T: and we'll be doing more of this 33. A: aye sure 34. T: to try and keep that part of the brain 35. stimulated	D6 (1)
		57. T: so what we'll do at that point is just go 58. through them all and kind of get a taster 59. (.) of where we are	D2 (3)
	Setting 'homework'	1. T: (4.0) but what I'll do (1.0) ((leafing 2. through the papers on the desk)) would 3. you be happy to do [some]= 4. A: [yes] 5. T: =of these at home	D5 (1)

Features	Type	Examples	Ref.
C: Topical talk	How you cope with the work (generally)	8. T: if you do too much I think you start to 9. tire= 10. A: =aye 11. T: 'cause it's a lot of [concentration]= 12. A: [that's true aye] 13. T: =that's involved	D6 (3)
	How you/I coped with the work (specifically)	11. T: A it's coming on it's coming on 12. A: yeah right 13. T: we're getting there	D2 (2)
		14. T: I think (2.0) I think what what that's 15. showing us is there are some of them 16. (.) like Gill and Eva (1.0) and Paddy 17. and Steve (2.0) and pub 18. A: yeah 19. T: and football that are they are 20. completely right or very very close to 21. being right they're nearly there aren't 22. they 23. A: yeah	D2 (3)
		1. T: you weren't really [focused] there= 2. A: [m:] 3. T: =[were] you 4. A: [m:] 5. T: okay (.) a duck (1.0) swim ((cuts 6. word off abruptly)) shall we go back 7. and do that on Thursday= 8. A: =m: 9. T: okay 10. A: m:: 11. T: you've had enough I think this 12. morning you've worked very ((tape 13. cuts out))	D1 (2)
	Your/my communication	34. T: to try and keep that part of the brain 35. stimulated 36. A: true that's lovely 37. T: see if it helps you get more words out 38. A: yes I mean I'm not bad I'm not daft or 39. anything for goodness sake you know 40. ( )	D6 (1)
		48. T: so you do things that are gonna be 49. helping you 50. A: that's right aye 51. T: but also just to have a gab in the 52. groups= 53. A: mhm 54. T: =as well 55. A: that's true aye	D6 (2)
		38. A: I mean you know ( ) should ( ) is you 39. know like you know um (2.0) ((writing 40. or drawing)) you know get (1.0) ( ) 41. they get a person in (.) aah like (s) um 42. you know a ( ) you know a ( ) you 43. know ( ) [something] like that 44. T: [right] right you get a 45. bit of the word ((gestures holding 46. thumb and finger tips a little apart)) 47. A: yeah 48. T: and you can work around the rest 49. A: yeah 50. T: yeah that's right (.) I'm gonna see you 51. next Wednesday	D2 (3)

Features	Type	Examples	Ref.
D: Ending the 'Closing down period'	Therapist initiates	85. T: but you get by 86. A: I do 87. T: well that's great (.) okay well I'm 88. going to switch this off now 89. A: yes 90. T: ((switches audiotape off)) I'm going to 91. switch the video off ((points up)) and 92. I'll go and get my diary 93. A: that's ( ) 94. ((T leaves room)) ((A puts on coat)) ((T 95. returns)) 96. T: d'you want to come through here and 97. have a look A 98. A: aye sure ((A leaves room)) 99. ((muffled voices heard and videotape 100. stops))	D6 (1)
E: Parting talk	Goodbye	38. T: have a good Easter if I don't see you 39. before 40. A: okay bye 41. T: yeah take care bye bye	D2 (2)

Table 5.4 The 'Closing down period'

Clearly some of the closing down period is taken up with the mechanics of parting. 'Organising talk' concerns itself with arrangements for the next session, the therapy to be addressed or the setting of 'homework'. In some instances discussion of arrangements for other meetings are quite extensive, especially where therapists have a broader organisational or key-worker role in an in-patient setting. There is some recorded evidence of 'Parting talk' – goodbyes and so on. Despite there being only scant recorded evidence in these data, personal experience of the author serves also to substantiate the occasional impact of transport systems on the delivery of therapy. Drivers arrive to pick up the person with aphasia (or in the case of D2 (3) the therapist herself), discussions ensue about whether they should go now while there is an opportunity, or continue with the session and be condemned to a long wait for transport home. However, there is little evidence here of this happening, but a suggestion of the impact on the session when it does. For example an extract from D2 (2):

1. TP: ((the recording therapist)) I've just come to tell you the driver's
2. ready and he's just going he won't be able to

3. come and pick you up til two

4. T: oh right so we'd better skip this

The therapist's: "so we'd better skip this" (line 4) suggests that the therapy work would have gone on for longer had it not been for the early arrival of the transport.

Unsurprisingly perhaps much of the topical talk in the 'Closing down period' is taken up with reflection – almost exclusively led by the therapist – on the work done in the session.

5.4.1 The 'Closing down period' as part of the structure of sessions

Rather obviously, as the converse of the 'Settling down period', the 'Closing down period' is situated at the end of sessions. The two domains being at opposite ends of sessions in terms of a period of time elapsed and experiences shared, appear to have, again rather obviously, topical content that respectively reflects these facts. As has also been mentioned the process and devices of recording are demonstrably noticed in various contexts throughout the session, and indeed they are also noticed in the closing down period as will be shown below.

As mentioned above there are topics in the closing down period that clearly reflect the shared experiences over the course of the session just past – for example 'How you/I coped with the work (specifically)' (Table 5.4 Feature C) – and talk (Table 5.4 Feature E: 'Parting talk') which by its nature is an integral part of endings – for example 'Goodbye' (Table 5.4 Feature E).

As was almost exclusively true of the 'Settling down period' it is the therapist who initiates the start of the 'Closing down period'. This is signalled in various ways. Often, as has been discussed above (Section 5.3.3), this is by the therapist's use of "okay", "right" or some other discourse marker. This may occur in conjunction with some other signal, such as the therapist looking at their watch (Table 5.4 Feature A: D5

(1) lines 1-2), and it is often followed by the therapist explicitly announcing the end – D5 (1) lines 2-3: "I think we'll stop there"; D6 (2) lines 5-6: "I think we'll leave it" (Table 5.4 Feature A).

This is not always the case. In D6 (1) line 7 (Table 5.4 Feature A) the therapist's "so well done (.) A what I'll do is once we've finished and we go out" has no apparent marker to signal the start of the 'Closing down period'. The therapist appears to imply that they have not finished ("once we've finished"). This is interesting for two reasons, one of which will be dealt with here, the other will be examined below (Section 5.4.3). The reason for the lack of reference to the finish of work (and perhaps too the reason for the lack of a discourse marker to signal the transition to the 'Closing down period') can perhaps be found a little earlier in the session. Here, some thirty turns before line 7 (D6 (1)), the therapist says: "can we do this one to finish off", referring to doing one more task. In other words the start of the closing down period has been signalled some time before, thus creating the potential for a different structure for initiating the 'Closing down period'. This type of 'marker' is not necessarily separated from the start of the closing down period by many turns. In D6 (2) (Table 5.4 Feature A) the therapist's "one more" (line 1) is only two turns before the start of the closing down period. This parallels the point made about an "interactional model" by Mehan (1979: 76) in his study of classroom interaction. An interactional model, as opposed to a stochastic model of behaviour, which assumes that the next event is affected most by the immediately preceding event, allows for behaviour to be influenced by events in the distant past, and those that are to come. As Mehan (1979: 77) argues, not only is each observed behaviour between participants a function of the interconnected behaviours that retrospectively precede it in time and those that are prospectively possible, but also that behaviour between participants is reciprocal – in other words each has the potential to influence the other in turn.

These examples also serve to highlight another major difference between the 'Closing down period' and what precedes, namely the change from the formal exchange structure of 'Doing therapy tasks' (see Figure 5.1 above), which mostly follows an Initiation-Response-Feedback/Initiation-Reply-Evaluation pattern (see Sinclair and Coulthard 1975; Mehan 1979; McHoul 1978; Chapter Two for a review of the literature; and Chapter Six Section 6.2.4.iii.III) to the (generally) less formal turn-taking structure of the 'Closing down period'. As has been argued by ten Have (1991) variation in topic (and here he refers to topic in terms of the main business in hand such as "the main medical agenda" or "episodes which have a marked 'conversational' quality and in which non-medical topics are discussed" (ten Have 1991: 151)) corresponds to a variation in interactional style. This is clearly the case in these data, where the starts and ends of sessions (the 'Settling down' and 'Closing down' periods) have a style that is more akin to conversation, although as has been discussed in Section 5.3.4 (above), there tend to be aggregate asymmetries between the contributions of the participants.

There are some other things to notice about the start of the 'Closing down period' and how it is signalled. In D1 (2) (Table 5.4 Feature C: 'Topical talk' 'How you/I coped with the work (specifically)') the therapist has started a new task (line 5) but cuts off the initiation abruptly, signalling the start of closing down by referring to work in the next session (D1 (2) lines 6-7: "shall we go back and do that on Thursday"). As in other examples in these data, she refers to the aphasic person's tiredness – this brings this discussion on to how the closing down period functions as a part of therapy sessions as a whole.

The 'Closing down period' as part of the structure of sessions: summary

- The therapist signals and controls the ends of sessions
- The 'Closing down period is marked by a change in turn-taking structure

- The topical content of the 'Closing down period' reflects its final position in the therapy session

5.4.2 The function of the 'Closing down period'

As was mentioned above, the therapist may announce the end of the session after some sort of discourse marker, but also in several cases in these data, the therapist also makes mention of how the aphasic person is coping – either generally, or with reference to this session in particular. For example in D6 (3), having announced the end of the recording (Table 5.4 Feature A: 'Starting the closing down period' D6 (3) lines 3-4: "I'm just going to switch this off now"), the therapist starts by asserting (Table 5.4 Feature C: 'How you cope with the work (generally)') lines 8-13: "if you do too much I think you start to tire". Her use of the present tense here could either be construed as a comment in general about people doing too much and the consequences thereof, or a particular reference to shared experience between the participants. The aphasic person's ready agreement, indicated by the latched "=aye" (line 10) and overlapped "that's true aye" (line 12) suggest that it is the latter that is true. Here the aphasic person is ready to accept the therapist's assessment, and the therapist adds justification of her "too much" (line 8) by mentioning the need for concentration (presumably when doing the therapy work): "'cause it's a lot of concentration" (line 11). Mention of tiring occurs in the same dyad (Table 5.4 Feature A: 'Starting the closing down period' D6 (2) line 6), where the therapist also gives additional justification for her assertion by mentioning that the aphasic person has been "at the group as well" (line 10) prior to the session with her.

The abrupt cut off of the therapy work in D1 (2) lines 5-6 (Table 5.4 Feature C: 'How you/I coped with the work (specifically)') has been mentioned above. The therapist goes on to assert that: "you've had enough I think this morning you've worked

very" (here the tape cuts off), referring specifically to this session ("this morning" lines 11-12).

These instances illustrate on the one hand that the therapist is the one who is in control of the limits and overall structure of the session (*pace* transport and other imponderables) On the other hand these examples suggest that the therapist also assumes responsibility for ensuring the well-being of the aphasic person, and that their control of events may be used sensitively in the aphasic person's best interests generally. In the example given above in D6 (1), where the closing down period is signalled some way before the actual completion of therapy work, the therapist checks with the aphasic person about doing one more:

1 T: can we do this one to finish off

2. A: that's right then

3. T: okay

4. A: aye

They only proceed with more therapy work once the aphasic person has given her say-so (line 2: "that's right then")

Thus entailed in the talk about "you've had enough" or "you start to tire" is the suggestion that the therapist is keen to stress the hard work that the aphasic person has put in, or the exacting nature of the work that they are doing.

As has been mentioned above, it is generally the therapist who is in control of the structure and limits of sessions. Therapist control is also in evidence in the mechanics of arranging next sessions, other meetings or future work (Table 5.4 Feature B: 'Organising talk'): "I'll arrange to come out and see you:" (D6 (1) lines 10-11); "I want you to come back" (D6 (2) line 20); "so what we'll do at that point" (D2 (3) line 57); "but what I'll do" (D5 (1) line 1). There are some instances where the therapist engages in a type of self-repair which suggests that they have reservations about: 1) the

vocabulary they have chosen to express a point: "and I'm going to work (1.0) not work I'm going to try and work" (D6 (2) lines 21-22); or 2) about a lack of consultation: "but what I'll do (1.0) would you be happy to do" (D5 (1) lines 1-3). In each case the one second pause indicates a thinking/reflection time given to noticing a repair target and preparation for repair[3]. In the first example it is difficult to see how the repair substantively changes the meaning or impact of the therapist's utterance, while in the second, the repair leads to the statement of intent being rephrased as an invitation to accept/reject the proposal.:

2. T: would

3. you be happy to do [some]=

4. A: [yes]

5. T: =of these at home

In this instance the fact that the aphasic person's "[yes]" (line 4) overlaps with the therapist's continuation of the proposal suggests that it is: 1) not something that the aphasic person has to think long and hard about, 2) that the object of the proposal was clear even before being explicitly stated (perhaps from the therapist's attention to papers on the desk, perhaps from previous experience of work together). It might be stretching a point too far to suggest that the therapist's general exercise of control (seen through use of vocabulary and the general pattern of initiations) does not allow the aphasic person much option in exercising a veto.

Mention has been made of the therapist's attention to the aphasic person's stamina in relation to the work of therapy. As has been mentioned above the 'Closing down period' also functions as a phase in which the participants can assess the work of the session. This can range from the very general (Table 5.4 Feature C: 'How you/I coped with the work (specifically)'): "A it's coming on it's coming on" (D2 (2) line 11),

[3] "Repair" is used in CA to refer to different ways interactants deal with trouble sources in conversation (see Perkins and Lesser 1993)

to the very specific, dealing with an item by item assessment in D2 (3) (lines 14-23). In the latter case it is the therapist again who is in control of the assessment, inviting agreement from the aphasic person through the use of a tag question (D2 (3) lines 21-22).

It is unusual for the aphasic person to initiate or make explicit reference to coping with the work or to their own communication in a very specific way in the 'Closing down period'. However it does happen in D2 (3) (Table 5.4 Feature C: 'Your/my communication') where the aphasic person initiates and sustains a narrative which is clearly about her communication. Although she supports the narrative with use of pencil and paper, she is clearly finding it hard to express specific meaning. As Wilkinson (1995a) points out aphasic people's word-finding difficulties are a common source of repair initiatives in conversations between aphasic people and others. Here the aphasic person's frequent use of "you know", pauses and non-specific references are indicative of word-finding troubles, although the general topic – this turn following on as it does from the therapist initiated talk about 'How you coped with the work' – is fairly clearly defined as being to do with either the work just completed or with an association between the work and her communicative ability. Here the principles of collaborative repair work between therapist and aphasic person as described by Milroy and Perkins (1992) appear to be operating. The aphasic person attempts to provide additional information using drawing or writing (lines 39-40), while the therapist contributes to the repair by demonstrating her understanding (using the "strongest initiator consistent with (her) current state of understanding" Milroy and Perkins 1992: 32). The therapist supports her portrayal of a current state of understanding with a gesture (lines 45-46). The therapist's contribution is accepted and thus the repair is completed.

A different interpretation of this passage (D2 (3) lines 38-51) might be that the therapist has deliberately used an initiator which demonstrates an understanding of what the aphasic person meant, despite not really knowing what she meant. Due to the prevailing structure of the talk, where the therapist has rights of control, the aphasic person accepts the therapist's demonstration of 'knowing', rather than invest more effort in a lengthy and taxing explanation. The therapist certainly takes control of the topic agenda again quickly (lines 50-51), with no further reference to the aphasic person initiated topic.

The following extract from D6 (1) demonstrates a similar point:

38. A: yes I mean I'm not bad I'm not

39. daft or anything for goodness sake

40. you know ( )

41. T: that's what I've been saying to you

42. all along that all those words are in there

43. A: aye

44. T: you just can't get them when you [want them]

45. A: [that's true] (1.0)

46. but I'm saying to myself ( ) I'm no daft or anything

47. I hope not you know

48. T: it's a <u>very</u> <u>very</u> specific problem

49. A: aye

50. T: with words

51. A: it is

52. T: caused by the stroke=

53. A: =it's terrible (.) my goodness

54. T: uh a lot of people get it

55. A: I never knew that

Here the aphasic person initiates talk about the relationship between her aphasic impairment and how she sees herself as a person (lines 38-39: "I'm not bad I'm not daft or anything for goodness sake"). Initially the therapist takes up the point (lines 41-42: "that's what I've been saying to you all along"), but continues with talk which is more related to the actual aphasic impairment (line 42: "all those words are in there") than to do with the aphasic person's implied expression of doubt about herself (and perhaps her own sanity). This pattern is repeated (lines 46-54). The aphasic person again expresses notions of stupidity and anxiety (lines 46-47: "I'm no daft or anything I hope not you know"), and again the therapist focuses on the topic of impairment (lines 48, 50, 52: "it's a very very specific problem"; "with words"; "caused by the stroke"). Again in line 53 the aphasic person initiates an expression of feelings ("it's terrible (.) my goodness"), which the therapist does not directly acknowledge, moving on to the topic of the prevalence of the condition. As ten Have (1991) points out, patients may formulate their doubts in various medical matters in ways that do not set up the conditional relevance for an answer in the same way as a question does. This echoes the point made by West and Frankel (1991) that patients do not necessarily express concerns as direct questions, but may do so as a tag response. The data discussed above suggest that through the aphasic person's repeated initiation of doubt and expression of feelings she appears to be asking very different questions to the one that the therapist chooses to answer. One can only speculate on what they might be, but the evidence is clear that the therapist is setting the topic agenda here, and ignoring those aspects of the aphasic person's utterances which are to do with subjective personal experience (see ten Have (1991: 141) quoting Mishler (1984:164) on "context stripping"; see also discussion above in Sections 5.3.1 and 5.3.4).

There are parallels between the 'Closing down period' and the 'Settling down period' in relation to the topic of 'Your/my communication'. The data is from the same dyad and session in both instances (D6 (1)), so perhaps any conclusions should be treated with caution. The following extract is from the 'Closing down period':

65. T: and you're a fit healthy woman

66. A: aye

67. T: so people aren't aware that there's maybe some (.)

68. difficulty with your speech

69. A: mhm that's true they don't

70. T: aha (2.0) so when you go to the hairdressers

71. do you speak to them

72. A: ( ) ( ) ( ) ( ) fine this that ( ) ( ) really fine

73. you know that done this and

74. done that you know

75. T: mhm (1.0) do they say anything to you are

76. you alright A

77. A: no

78. T: no

The therapist initiates the subject of the aphasic person's communication disability being noticed in public – in the 'Settling down period' the talk was around shopping and the need to have to speak or not, here it is around visits to the hairdresser, and whether the aphasic person's disability is noticed. The implication is that the therapist has the right to explore any issue to do with the aphasic person's communication, whether it relates to the here-and-now of the clinic, or whether it relates to everyday life. As discussed above, the therapist also exercises the right to limit that exploration to perspectives which s/he considers relevant.

Mention has been made of setting 'homework' as part of 'Organising talk' (Table 5.4 Feature B above). Several sessions show setting 'homework' in the 'Closing down period', but there is also evidence of the 'homework' being demonstrated in a 'Doing therapy tasks' type manner. For example in D11 (3) the therapist sets some 'homework', mentioning: "it's the same sort of thing that I gave you before". They then go on to try out briefly some items from the 'homework':

1. T: some of them may be more tricky (.) so types of dogs
2. A: aha
3. T: so a bulldog
4. A: yeah ((points))
5. T: yeah that would be a tick for that one (.) canary
6. A: mm yes ((points))
7. T: is a canary a type of [dog]
8. A: [no] no no no no
9. T: no
10. A: okay
11. T: so it's like that

Turn-taking sequences have a formal Initiation-Response-Evaluation structure, starting here in line 3 (Initiation), with triads of turns, with a type of repair sequence inserted in lines 7-10 after the second initiation in line 5 ("canary"). The fact that it was a demonstration or model of the work to be done is made explicit by the therapist (line 11).

The function of the 'Closing down period': summary

- The 'Closing down period' is the occasion for mention of the 'hard work' in the session

- Topics include discussion of how work in the session has gone, including talk about the impact of aphasia
- The 'Closing down period' is an occasion for making future arrangements, setting and demonstrating homework

5.4.3 The impact of recording devices on the 'Closing down period'

In ways that parallel what seems to happen in the 'Settling down period', the recording devices and the presence of a third party as recorder, go some way to suggest what therapists construe as the 'business of therapy'.

The following is an extract from D5 (1):

37. T: ((looks through the papers on the desk)) switch that off ((therapist walks
38. around the back of the camera)) they only needed um (2.0) twenty ((videotape
39. stops here, audiotape continues)) minutes or so of that so they're not gonna
40. look at all of it anyway
41. A: yes ((audiotape stops here))

An extract from D6 (2):

17. T: (1.0) oh I think that's just good timing
18. I think that's just stopped

In the extract from D5 (1) (above) the therapist's assertion (lines 39-40): "so they're not going to look at all of it anyway" suggests that she feels that the kernel of the therapy (the doing of tasks), already having been captured on tape, makes it acceptable to switch off the tape now.

In the extract from D6 (2) there is a not dissimilar occurrence, except that the videotape stops of its own accord soon after the 'Doing therapy tasks' part of the session has been completed, and the therapist appears to be implying (line 17: "that's just good timing") that the substantive and important part of the session has been

captured. Despite this, the audiotape actually records a further thirty turns of talk, covering: 'Organising talk': 'Arrangements for other meetings'; 'Topical talk': 'Your/my communication'; 'How you cope with the work (generally)'.

In D2 (1) the recording therapist enters the room towards the end of the session and the therapist in the room with the aphasic person remarks: "here we go we're done (1.0) we're just talking about the course" (lines 12-13). The therapist's "we're done" presumably refers to the work of therapy tasks being over. Again the session actually continues for many more turns.

One exception to the suggestion that therapists view only the doing of tasks as the true stuff of therapy sessions is the sequence alluded to above in Section 5.3.1 and in Table 5.4 Feature A: 'Starting the closing down period' under D6 (1). The start of the closing down sequence begins: "A what I'll do is once we've finished and we go out" (lines 7-8). The suggestion is that the session is not finished ("once we've finished and we go out"), and that what is to come, before they stop and go out, is still perceived to be part of the business of the therapy session. The session continues with 'Organising talk': 'Arrangements for the next session'; 'Therapy work in the next session', and 'Topical talk': 'Your/my communication' before the recording ends.

The impact of the research and recording process can give insights into how therapists define their work (and what they perceive as appropriately researchable) – this point is brought out strongly in Lomax and Casey's (1998) study of midwifery work – but it is also clear there are exceptions, and one cannot make definitive statements about what therapists do and don't perceive as important parts of sessions generally.

The extract from D2 (1) that follows below illustrates a slightly different permutation of the impact of the research process on the production of data:

1. ((knocking heard))

2. T: ((speaking quietly and turning towards the door))

3. there's D3T ((writing)) is ( )

4. are you talking about the transport

5. A: yeah=

6. T: =yeah

7. A: yes

8. T: yeah

9. A: [( )]

10. T: [( )] organising that yeah (3.0)

11. ((TP enters the room))

12. T: here we go we're done (1.0) we're just talking about

13. the course [(.) college course]

14. A: [yeah we had] ((laughs)) ( ) ((grins))

15. T: with that ((points to the camera)) blasting away at us

16. A: ((laughing))

17. T: (we've had) a few interruptions

18. A: yeah ((laughing)) yeah

19. T: ((laughs))

20. TP: yea (.) yer man yer man's here

21. now

22. A: yeah yeah ((opens her bag and takes out a mobile phone

23. and shows it to the camera, grinning)) (look)

24. TP: oh ( )

As has been pointed out above, the fact of the recording therapist (TP = D3T) entering the room signals the noticing of the end of the session 'as fit to be recorded'.

The therapist's remark that "we're just talking" (line 12) suggests that the conversation is perceived to be of little significance. The presence of the recording therapist also allows the therapist and aphasic person to draw attention to the presence of the camera – the therapist makes a general (and pointed) comment about the camera "blasting away at us" (line 15), the aphasic person (lines 22-23) shows the camera the source of the interruptions mentioned by the therapist (line 17) (i.e. the mobile phone). Thus there is mention of the recording process which would not have occurred had it not been for the presence of a third person who was not party to the occurrences during the session.

The sequence of discussion and telling of the 'mobile phone going off' story continues:

29. A: I had to stop it you see 'cause he was
30. ringing ((T is laughing))
31. TP: who was that (.) Steve
32. A: no no it wasn't her he'd gone round to m: (2.5)
33. ((grins and laughs))
34. T: can you write for D3T ((pointing to pen and paper))
35. who it was
36. A: yeah (.) one he wanted to go ((gestures up
37. with right hand)) so I I'll tell him when
38. he ( ) (is) important ((shaking head))
39. not very much
40. TP: [oh all right]
41. T: [((nods)) ( )] (want to try) ((writing))
42. A: ((looks at what T is writing)) yes
43. T: it was Gill

As in the model of collaborative repair of aphasic conversation proposed by Milroy and Perkins (1992) and discussed above, TP's contribution (line 31) demonstrates that he is not in a state of having understood what the aphasic person meant. However through their shared experiences (Maynard and Zimmerman 1984) he is able to offer a 'best guess', which the aphasic person can then confirm or deny (see also Perkins 1995). At this point the therapist who has been working with the aphasic person intervenes with a proposal to write down the name of the person who called, using the formulation: "can you write for D3T who it was" (lines 34-35). The aphasic person does not take up the proposal to use pencil and paper, and some lines later the therapist tries again: "want to try" (line 41). The therapist is clearly trying to use this piece of conversation as an opportunity for the aphasic person to actually use a written word she has been practising as a therapy task, in a 'real' conversational situation with a person in a position of true ignorance. However the suggestion is not taken up, and this could be for two possible reasons – the aphasic person has understood the suggestion but chosen not to take it up; the aphasic person has not really understood the suggestion. The latter reason could possibly be due to the fact that the boundary to this new topic – one of noticing communication and use of a particular procedure (i.e. using pencil and paper) – is not sufficiently marked to alert the aphasic person to the change of topic (Green 1984, and Leiwo 1994 quoted in Llewellyn 1999: 10).

<u>The impact of recording devices on the 'Closing down period': summary</u>

- The recording process in the 'Closing down period' allows further insights into what therapists construe as the 'business' of therapy
- Therapists make reference to the recording process specifically at the ends of sessions

5.5 'Opening up the business'

As was mentioned in Section 5.2 above, any proposed structure for lay-professional encounters is liable to be disordered by contingencies that arise during the course of interactions. As has also been mentioned the structure proposed here is not a formula for how sessions should be conducted, and as has been demonstrated above, different types of interactive structure are liable to occur in places which render them conspicuous by their difference – for example sequences which have a formal structure (Initiation-Response-Evaluation) occurring in a phase of the session where a quasi-conversational (informal) structure is more usual. 'Opening up the business' is a domain that appears to be elusive in some ways – partly because as will be seen below it is often fleeting, partly because it is arguably problematic to distinguish from other domains, and partly because it is hard to establish whether it exists at all.

5.5.1 'Opening up the business' as part of the structure of sessions

As was demonstrated and discussed in Section 5.3.3, the end of the 'Settling down period' is usually signalled by a marker and a statement of purpose by the therapist. This is simultaneously the point in the structure of sessions at which the domain 'Opening up the business' generally begins. Generally speaking it marks the point of transition, and with all reservations and divergent cases born in mind, between introductory niceties, greetings, small talk, setting talk and the mechanics of settling down into the session, and the business of therapy as defined by the actions and interactions of the participants. Table 5.5 below sets out the major features and types of feature which typify the domain 'Opening up the business', and gives some examples:

Features	Type	Examples	Ref.
A: Beginning `Opening up the business`	Therapist initiates	3. T: we're all set (1.0) now (1.0) just carry 4. on from where we left off= 5. A: yes 6. T: =the other day	D6 (3)
		51. T: yeah yeah brilliant (.) now (2.0) is 52. there anything (.) from last from the 53. session with D3T that you need to 54. show me this session or not	D4 (1)
		3. T: right now (.) d'you remember what 4. you asked me to do this week (.) I 5. gave you a choice of opportunities 6. (.) here what would you like to do do 7. you remember what what you 8. suggested 9. A: holid:ay 10. T: that's right yeah because you said 11. you were very good at one thing 12. (2.0) you said you always (.) packed	D14 (1)
	Aphasic person initiates	57. A: now and again it stops ( ) altogether 58. (.) any ( ) what use have I done (.) 59. any( ) (what) we going to do today 60. ((looking up to T)) 61. T: something very similar to what we did 62. last time 63. A: oh are we (.) oh I'm so pleased (.) I'm 64. very pleased	D15 (2)
B: Reference to previous meetings	Therapy work together	13. T: remember last week when you came to 14. see me 15. A: yeah 16. T: we were doing more of the same (.) we 17. were talking about words	D6 (2)
		113. T: you've got these pictures here 114. A: ( ) 115. T: now I know with the other pictures 116. we've been working on you got a bit 117. fed up with them didn't you 118. A: no no no 119. T: you said you wouldn't mind a change 120. A: no no 121. T: which is fair enough really 122. A: yeah 123. T: I was a bit bored with them too (.) 124. okay so we've got some new pictures	D8 (3)
	Therapy work with another	1. T: so on er on Friday you did some more 2. work with D2T on er on these (.) I'm 3. just going to have a quick look to see 4. ( ) we got to (.) what we're doing (.) is 5. for each session= 6. A: yeah 7. T: =for this work D2T and I are keeping a 8. record of which ones you do (1.0)	D3 (1)
C: Progress	Therapy work	46. T: good (.) and D3T says you've been 47. continuing to work on the pictures 48. A: yeah 49. T: how is that going 50. A: yeah it ( ) too much ( ) but not too 51. bad	D2 (2)

Features	Type	Examples	Ref.
	Therapy work (cont.)	91. T: fantastic so there's four there now 92. A: yeah 93. T: come pretty much okay don't they= 94. A: yeah 95. T: =and (then) the shorter ones	D2 (2)
		84. T: (can I) just have a quick look again at 85. um what you did with some of those 86. verbs= 87. A: aha 88. T: =last week to see how you are getting 89. on today (2.0) these ones you did quite 90. well didn't you last time (.) they didn't 91. really cause a problem but we'll look 92. (.) again (2.0)	D7 (2)
		32. T: okay fruit and veg again 33. A: okay 34. T: 'cause it was a bit more tricky wasn't it 35. last time ( ) some of the other 36. categories we've done 37. A: yeah ((laughs))	D11 (2)
D: Planning	Future work together	98. T: well we took the photos of that ((a cooking session in the unit)) 99. A: yes oh 100. T: and I was going to show you before 101. we get on to doing some of our other 102. work (.) these are the photos that we 103. took ((showing photos to A)) ((intervening exchanges of T showing A individual photos)) 113. T: so we're gonna make this into= 114. A: yes 115. T: =a recipe book	D9 (2)
	Later in this session	3. T: we will get started on the stuff we were 4. doing last week= 5. A: ((nods)) 6. T: =with the pictures ((high pitch held)) 7. A: ((vigorous nod)) 8. T: and the drawing (.)= 9. A: ((nods)) 10. T: =okay (.) and we'll talk about the 11. weekend (.) later 12. A: ((nods)) 13. T: yeah/ 14. A: ((nods))	D9 (1)

Features	Type	Examples	Ref.
E: Reference to aphasia	Aphasic impairment – aphasia therapy relationship	42. T: and it's a bit like on this side of your 43. brain 44. A: yeah 45. T: this is where your wee dictionary is 46. with all your words 47. A: yes 48. T: now what's happened is that your 49. pages are all mixed up 50. A: uh yeah 51. T: so when you want to say a word you 52. can't always find it 53. A: that's true 54. T: so we're trying to help you get things 55. back in order again 56. A: yes 57. T: so that ultimately 58. A: uh 59. T: when you want to say a word (.) it 60. might be easier for you to find it 61. A: yes aye 62. T: so this is why we're doing lots of word 63. games	D6 (2)
F: Ending 'Opening up the business'/beginn-ing 'Doing therapy tasks'	Therapist initiates	17. T: okay (.) so what I'm going to do to 18. begin with is make it a bit easier and 19. show you some pictures	D6 (3)
		90. T: (.) they didn't really cause 91. a problem but we'll look 92. (.) again (2.0) so look carefully	D7 (2)
		38. T: I'll give them a good shuffle (.) they 39. are more difficult because they're 40. they're a very close category	D11 (2)
		77. T: okay so so this time A you've got 78. the same picture but you've got four 79. words to choose from okay	D8 (2)

Table 5.5 'Opening up the business'

Control over the move to 'business' is almost exclusively in the hands of the therapist. The one exception in these data is from D15 (2). Here it would be difficult to argue that the aphasic person has actual control over the transition to 'business', even though she has employed a feature typical of therapist control – use of a marker (Table 5.5 Feature A: 'Aphasic person initiates' line 59: "any( )" – presumably for 'anyway'). She has marked a point of transition, but she continues with a question to the therapist and it is to the therapist that she looks (line 60) to move the session on to 'business'. Interestingly the implication of her question (line 59: "(what) we going to do today") is

that they haven't started to "do" anything yet – in other words the real business of the session has apparently not yet begun (i.e. the 'Settling down period' does not count as being to do with the business of doing therapy).

The transition to business, or perhaps more appropriately, a different sort of business, represents a key pivotal point in the session for the therapist. It is at this point in the session that the therapist sets up business for the session today, but places that business in the context of prior work together. For example, in Table 5.5 Feature A: 'Beginning Opening up the business': D6 (3) lines 3-6: "just carry on from where we left off the other day"; D14 (1) lines 3-4: "d'you remember what you asked me to do this week". 'Opening up the business' sits Janus-like not only between the 'Settling down period' and 'Doing therapy tasks', but also between the previous session and the current one. In the case of these data the previous session may have been with this therapist (Table 5.5 Feature A: 'Beginning opening up the business': "where we left off" D6 (3) line 4), or with another therapist: Table 5.5 Feature A: 'Beginning opening up the business' D4 (1) lines 52-53: "from the session with D3T"; Feature B: 'Reference to previous meetings' 'Therapy work with another' D3 (1) lines 1-2: "on Friday you did some more work with D2T on er on these (.)". Even in the case of D15 (2) where the aphasic person initiates the beginning of 'Opening up the business', she mentions "today" (line 59), with the implication that "today" is not a first meeting. This is confirmed and the topic moved on by the therapist who refers explicitly to past work together (D15 (2) lines 61-62: "something very similar to what we did last time").

As will be discussed below (Section 5.5.2 The function of 'Opening up the business') the sequential position of 'Opening up the business' in a way defines its functions (or allows its functions), or perhaps, the functions (the mentioning of certain subjects, the exploration of certain topics) determine the sequential position. There are a number of instances in these data where the domain 'Opening up the business' cannot

be said to exist as a substantive entity, where to all intents and purposes the 'Settling down period' ends and 'Doing therapy tasks' begins. For example:

4. T: well we'll just get started then

5. A: aye sure

6. T: what I'm going to do is show you a selection of pictures

D6 (1)

31. T: right this first task

D5 (3)

In D6 (1) above there is brief mention of 'Doing therapy tasks' about to get under way (line 4: "we'll just get started then"), but in D5 (3), transition to 'Doing therapy tasks' is even more perfunctory. The lack of reference to the past as a contrast or complement to the here-and-now somehow serves to highlight the functions served by 'Opening up the business' as a pivotal point in the session (or in a series of sessions of joint work between therapist and aphasic person). There are however instances of transitional talk which have many of the characteristics of 'Opening up the business' and which occur within 'Doing therapy tasks' – see Chapter Six Section 6.2.2 'Task Introductions' for equivocal examples and thus possible instances of 'Opening up the business'.

'Opening up the business' as part of the structure of sessions: summary

- 'Opening up the business' generally marks a transition between the 'Settling down period' and 'Doing therapy tasks'
- The therapist is in control of the transition to 'business'
- 'Opening up the business' takes place at a key pivotal point in the session, sequentially situated between past and future work

5.5.2 The function of 'Opening up the business'

Although 'Opening up the business' does not fit neatly with any of the "lesson components" outlined by Panagos *et al* (1986: 216) it does in part fulfil one of the functions of the initial phase of therapy sessions outlined by these authors, namely as a "harbinger of work to come" (Panagos *et al* 1986: 216). In this respect, and where there is some justification for 'Opening up the business' as a domain in itself, there is evidence in these data that therapists differentiate between reference to therapy work generally (in the past), and the specific work that is about to start now today. Thus for example, in Table 5.5 Feature B: 'Reference to previous meetings' 'Therapy work together' D6 (2) the therapist refers to "last week" (line 13) and to "talking about words" (line 17); in D8 (3) the therapist refers to "other pictures we've been working on" (lines 115-116).

In contrast with general references to therapy work, the 'Ending of Opening up the business' is concerned with a transition to the specifics of this session now. For example Table 5.5 Feature F: 'Ending opening up the business': D6 (3) lines 17-19: "okay (.) what I'm going to do to begin with is make it a bit easier and show you some pictures"; D7 (2) lines 91-92: "we'll look (.) again (2.0) so look carefully"; D11 (2) lines 38-40: "they are more difficult because they're they're a very close category"; D8 (2) lines 77-79: "you've got the same picture but you've got four words to choose from". In all these examples the sense of continuity from past work together is there. This is brought out in the use of the comparative – for example "easier" in D6 (3) or "more difficult" in D11 (2); in reference to repetition - "again" in D7 (2); "the same picture" in D8 (2). What is also brought out is how reference to previous work together – now specifically – relates to the here and now. Thus in D6 (3) the therapy work is now going to be "easier" because the therapist is going to use pictures (as opposed to not having used pictures in conjunction with this therapy work before); in D7 (2) the

injunction to "look carefully" relates to what is to be done now, but using the same materials as in previous work together; in D11 (2) the materials now are "more difficult" and the therapist gives a specific reason – "because they're they're a very close category"; in D8 (2) the work is around the "same picture" but now used in a different configuration – "you've got four words to choose from".

Even where there is apparently no substantial evidence of an 'Opening up the business' domain, therapists use the point of transition to 'Doing therapy tasks' to relate present work to past work together. Thus for example:

1. T: what I want you to do is have a look at that business again of trying to tell me
2. what might be happening in the park

D1 (3)

25. T: right so what we're going to do is to try and finish off these sentences with
26 another sentence alright↑ (.) with two clause structures you know them we have
27. done this kind of thing before (.)

D1 (1)

3. T: okay (1.0) right let's have a look now what I'd like you to do A yeah we've
4. done this before but in a slightly different way

D5 (1)

Thus in D1 (3) and (1) the reference is to past work which is the same as that which is about to happen, while in D5 (1) the reference is to past work which is going to be done "in a slightly different way" (line 4).

While generally speaking reference to past work together in 'Opening up the business' tends to be more general than specific there are exceptions. For example, in D3 (3):

10. T: so what we're going to do today is um:: still thinking about writing the words

11. that you have been

12. A: yeah

13. T: but (2.0) the ideas (.) behind each of those words are different today (1.0) and

14. we're just going to take them in any old order (.) so before we were doing

15. (them) together (.) er people together (.) and (1.0) er (.) places together (.) now

16. we're going to jump all over the place

17. A: okay

18. T: ( ) have to be prepared

19. A: yes alright

While the reference to "thinking about writing the words that you have been" (lines 10-11) is generally to do with previous work together, the therapist then becomes more specific about the actual configuration of the task as it was previously carried out. It looks as though this is done in order to make the link to the here-and-now more explicit. Thus reference to "we're just going to take them in any old order" (line 14) is clarified by more specific reference to how the task was configured before – "doing (them) together (.) er people together (.) and (1.0) er (.) places together (.)" (lines 14-15).

This use of reference specifically to the configuration of tasks in previous work is echoed in D13 (2):

1. T: okay (1.0)

2. A: hello

3. T: right (1.0) ((claps hands together)) we're going to do (.) similar things (.) to

4. what we've done the last couple of times

5. A: oh yeah

6. T: okay (.) so you remember I'm going to show you a picture (1.0) I'm going to

7. say two words ((gestures 'two'))

8. A: right ((holds up two fingers))

The "similar things" (line 3) that they are going to do are grounded in specific reference to how the task has been carried out in previous sessions (lines 6-7). Reference to "going to do" refers to this session now, as it usually does in 'Opening up the business'. For example in D7 (3):

37. T: ( ) okay we're going to look at some um more (.) verbs today=

38. A: aha

39. T: =some more words about doing things

Again the connection is made to past work together, implied by "more" (line 37). Reference to future work together can take the form of reference to work in future sessions. Thus for example in Table 5.5 Feature D: 'Planning' 'Future work together' in D9 (2) the therapist and aphasic person are looking at photos that have been taken, and which are to be used at some future stage. It is uncertain whether "we're" (line 113) refers to the therapist and the aphasic person (i.e. D9) or whether it is used to represent the therapy department or the facility more generally.

The domain 'Opening up the business' may also allow for the possibility of discussing the business of progress, either in a rather general way as in Table 5.5 Feature C: 'Progress' 'Therapy work' D2 (2) (lines 46-51) or in a much more specific fashion. The extract from D2 (2) below continues on from the example given above from Table 5.5:

52. T: does it go up and down a bit (.) some days it's good some days it's harder

53. A: yeah yeah but (sometimes) you know it seems to be quite little (.) you know

54. and you can (find) one [little]=

55. T: [right]

56. A: =(verb)

57. T: yes you've only got one letter=

58. A: yes

59. T: =the way it should be

60. A: yeah yeah

61. T: yeah good

62. A: it's like my um ( ) ((writes GILL))

63. T: Gill (.) yeah fantastic

64. A: I done that one

65. T: that one's good isn't it

66. A: and then (there's) um ((writes EVA))

67. T: Eva (.) brilliant

68. A: that's (nice) see

69. T: and there's another short ((gestures small using thumb and forefinger)) one (.)

70. d'you know that that we eat ((mimes eating)) (1.0) a (little) one that we eat (.)

71. I'm not sure if I've got a picture ((shows A a picture)) do you remember that

72. one in your head

73. A: oh right (yeah) ((writes)) um

74. T: you got the first letter right

The interaction in lines 52-61 is evidence of collaborative work between therapist and person with aphasia as they work towards a more specific explication of "how is that going" (Table 5.5 Feature C: 'Progress' 'Therapy work' D2 (2) line 49). Then in line 62 the aphasic person begins to initiate specific examples of "how is that going" by writing words that have been the subject of therapy work together – i.e. 'Gill' and 'Eva'. Although the therapist has not elicited the aphasic person's production of these words with a request for her to perform or produce any evidence, there is most certainly an evaluative follow-up in lines 63 and 67 on the part of the therapist, causing

the structure of the interaction to more closely resemble that of a formal intervention sequence. It then does become a formal intervention sequence as the therapist initiates an elicitation starting in line 69, and the subsequent turn-taking structure, the use of a picture stimulus (line 71) and the use of evaluative feedback (line 74) confirms the change of structure. This structure although formal and as such the structure typical of 'Doing therapy tasks' (as will be analysed and discussed in detail in Chapter Six) does not necessarily signal that what is being done through the structure is the 'main business' of the session. D2 (2) lines 91-95 (Table 5.5 Feature C: 'Progress' 'Therapy work') follow on from the extract above. When it has been established that those four particular words practised in previous therapy work together have achieved a certain status, the assertions by the therapist in lines 91-95 function to reflect on that status (line 91: "so there's four there now") as a measure of the aphasic person's progress.

In a not dissimilar way the matter of 'homework' that has been done in the period between the previous and current sessions, serves to establish a bridge between prior and present work together. When the matter of 'homework' arises it always occupies at least some time at the beginning of sessions – whether this constitutes part of 'Opening the business' or not is certainly debatable. Attention to 'homework' is often a feature of sessions from the in-patient facility but is also evident elsewhere. The type of interaction which typifies the matter of homework generally has a formal Initiation-Response-Evaluation structure, is placed after some sort of initial greeting or 'Topical talk', and the change to 'homework business' is usually signalled by a marker such as "okay" – D11 (1): "okay how did you get on with the homework". The therapist and aphasic person go over the homework as a 'Doing therapy task' piece of work, the 'results' may be summarised (generally by the therapist) and talk about future homework may also arise: "that was fine (.) I haven't actually got you any more to do

for the weekend but I'll get some after this" (D11 (1)); "good okay (.) how did you find that...would you like to do more of that sort of thing for homework" (D8 (2)).

In out-patient sessions attention to 'homework' may serve as a bridge to the present work from the last session together. For example in D14 (3): "now you've had two weeks since I last saw you". As such the therapist may begin the work on reviewing 'homework' with a summary of what it was about, in much the same way as talk about previous therapy work functions in 'Opening up the business'. For example in D14 (3): "we were thinking about different foods that you can get from different shops"; D12 (1): "what you've been doing is taking home a series of (sequence) cards (this is a holiday) activity has increased so (just putting them in order) (remember) thinking about the (vocabulary) you use and then writing it in sentences". In the latter example there is some doubt as to whether the very explicit reference to what the aphasic person has been doing for 'homework' (habitual action is made clear through the use of the present continuous tense: "what you've been doing is taking home"), is not directed more at the camera (and thus the researcher) than being for the benefit of the person with aphasia and the therapist.

The sense that going over 'homework' is a preliminary to the 'real work' of the session (and therefore belonging in its own niche at the starts of sessions) is signalled by the therapist preparing the aphasic person for the next work: "okay excellent now I've got your pictures here...but seeing as you did so well yesterday" (D8 (2)); "okay we're gonna do the same as we did yesterday" (D11 (1)). The reference to "yesterday" gives a sense of continuity about the work which they are about to embark on, a thread running through their therapeutic relationship, and consequently the real business of the meeting. However there are also instances where 'homework' becomes or is the business of the session. In D14 (2) 'homework' review and discussion takes up the whole session. At the end of this particular session the therapist remarks: "well the other

thing I was going to do today but we didn't have time was I was going to do some some recipe work with you but we'll do that next time". All the work done by D12 revolves around materials that the aphasic person has prepared as 'homework' and the sessions are generally taken up by review and use of these materials.

In a way that is not dissimilar to the function of talk about 'Progress' in 'Opening the business' there are also occasions for talk or recap about the relation between the aphasic person's impairment and the purpose of the therapy work being undertaken. In Table 5.5 Feature E: 'Reference to aphasia' 'Aphasic impairment – aphasia therapy relationship' (D6 (2)) the therapist justifies the therapy work (lines 62-63: "lots of word games") by using an analogy with a dictionary full of words where the pages are mixed up. The therapy is aimed at: "trying to help you get things back in order again" (lines 54-55). The therapist uses a strategy familiar to therapists working with people who have had brain injury, relating the brain structure in the left side of the head to the therapy being undertaken by use of a dictionary metaphor (and thus relating the concrete physical structure to the intangible of language and word use).

The function of 'Opening up the business': summary

- 'Opening up the business' is a point of transition from the general to the particular work of this session today
- 'Opening up the business' generally functions as the occasion for reference to therapy work in the past and work to come, and may be the occasion for reference to progress
- 'Opening up the business' functions to give a sense of continuity to therapy work together
- 'Opening up the business' may be the occasion of attending to 'homework' which is not the main business of the session

5.6 'Inserted conversation'

5.6.1 Introduction

There is no doubting the need to create a further category for certain types of verbal behaviour that arise during the course of therapy sessions. These kinds of behaviours are ones that usually arise unannounced, and which often appear tangential to the current 'business' or topic. This type of feature has been recognised in categorical systems developed for the analysis of aphasia therapy. For example, Brookshire *et al* (1978) have categories for "Clinician-Initiated Discourse" where "that discourse does not constitute a request for a response"; or "Patient Discourse" where the patient "initiates communication behaviors that are not in response to a request from the clinician" (Brookshire *et al* 1978: 441). Schubert *et al* (1973) have categories for both clinician and client "relating irrelevant information and/or asking irrelevant questions" (Schubert *et al* 1973: 7). Admittedly these categories could be said to include any number of the behaviours that have already been outlined and discussed in this chapter, but the flavour of 'off-task' appears to be inherent in their conceptualisation.

This particular feature of therapy sessions will be described and discussed under the heading of 'Inserted conversation', after ten Have (1991). The term 'conversation' is potentially problematic, in that it can be understood to have a range of meanings. For example, it may be used in an "inclusive way" (Schegloff 1986), such that it includes a range of activities, from service encounters to casual chatting. It is often, however, understood to have a casual flavour, where "both speakers ask questions, make responses, neither evaluates comments, and both raise topics of interest" (Ripich *et al* 1985: 9). ten Have (1991) includes "small talk" as typifying episodes which are not concerned with the main business (of medical encounters). The style tends to be less formal in terms of the way people address each other, or the general asymmetries of interaction.

Sequences of talk that have the appearance of casual conversation may arise at any time during the therapy session. The ways in which some talk in the 'Settling down period' or the 'Closing down period' has a locally managed and ostensibly conversational structure has been discussed above, and mention has been made of the aggregate asymmetry of questions and answers. It is also the case that in these environments some initiations by therapists have the potential to lead to 'business' (however that may become defined).

However, 'Inserted conversation' as it is outlined here does not tend to lead to 'business', indeed it often leads away from it. The examples outlined and discussed below will concern 'Inserted conversation' in the phases of the session discussed above – namely the 'Settling down period', the 'Closing down period' and 'Opening up the business'. 'Inserted conversation' arising during the course of 'Doing therapy tasks' will be discussed in the following chapter.

5.6.2 'Inserted conversation' in the 'Settling down period', 'Opening up the business' and the 'Closing down period'

The first thing to say is that 'Inserted conversation' may arise and develop in a number of ways. The following extract is from a phase of 'Opening up the business' in D14 (1). The therapist is asking a series of questions of the aphasic person in order to elicit holiday place names to be 'worked on' in the ensuing task:

28. T: where's the farthest you've been

29. A: (2.5) Switzerland

30. T: Switzerland

31. A: yes I like it (there)=

32. T: =you like that one

33. A: yes

34. T: oh I've never been to Switzerland so you'll be able to [tell me]=

35. A: [oh]

36. T: =all about it

37. A: lovely

The sequence begins (line 28) with one of a series of what are, to all intents and purposes, 'Elicitations' by the therapist. The first three turns (lines 28-30) have the appearance of a typical three part instructional sequence, except that the therapist is eliciting truly 'unknown' information. The aphasic person makes the first conversational gambit – a "newsworthy event report" (Button and Casey 1984: 177) – with her initiation in line 31, but the therapist chooses not to turn this into a topic, merely reflecting back the statement. Her use of "that one" (line 32) is interesting in that it appears to emphasise "Switzerland" as a therapy item, rather than a holiday destination with a personal meaning for the aphasic person.

The therapist's initiation (line 34) is in one sense a conversational gambit like the aphasic person's, but she follows up with a return to 'therapy-business' (lines 34 and 36: "so you'll be able to tell me all about it"). The therapist's self-disclosure could be construed as a way of "informalizing" (ten Have 1991: 6, 152) the business of therapy.

Therapist self-disclosure is used in other environments – for example in the 'Settling down period'. The following is an extract from D7 (2):

13. T: you went outside in into the [garden]

14. A: [aha] yes

15. T: yes oh well that's good

16. A: aha aha

17. T: yeah yeah (you need) to get out (.) I got sunburnt

18. A: ooh

19. T: ((laughs)) I went to France

20. A: oh↓

21. T: for the weekend

22. A: aha

23. T: yeah (.) do you and ((husband's name)) go to France

24. A: ah no↓

The sequence begins in the middle of a 'What has been happening?' topic (see Table 5.1 Feature C). The therapist then offers a newsworthy event (line 17: "I got sunburnt") which she topicalises herself (lines 19-21). The aphasic person demonstrates appropriate reactions in lines 18 and 20, showing that, despite her apparently severe expressive aphasia, she is quite competent to join in and contribute to the development of a conversation. The topic of travel becomes a point of departure for a series of questions about the aphasic person's travel habits and experiences. The aphasic person's expressive language is very impaired, and there is a sense that the therapist is using self-disclosure to try and restore the conversational balance in a situation where there is very little opportunity for the aphasic person to initiate an inquiry – whether this is due to linguistic or other reasons.

The aphasic person participants in this study rarely initiate inquiries about the therapist but there are some examples. In D6 (1), for example, while the therapist is cutting out pictures in preparation for 'Doing therapy tasks' she initiates a casual inquiry about what the aphasic person has been doing:

1. T: okay so I'll just ( ) cut these up ( ) ( ) been up to A

2. A: alright I just (where) everything about you know and

3. T: have you been out and about

4. A: aye ( ) so how did you ( ) ( ) how do you

5. T: I got on great (.) of course I haven't seen you since I got back

6. A: oh that's oh you did not

7. T: I had a lovely time I only got back last Monday

8. A: aye

9. T: it was a long flight

10. A: uhu

11. T: twenty seven hours

12. A: oh my God that's terrible ent it

13. T: oh you just I just switch off (.) you can watch videos=

14. A: aye

15. T: =so it's not so bad

16. A: true enough

17. T: okay I'm going to move these pictures away just now

In line 4 the aphasic person reciprocates the therapist's inquiry with one of her own ("so how did you ..."). This question is about something which they both obviously understand to be about the therapist's recent holiday. While the aphasic person has obvious word-finding difficulties (as evidenced here in the construction of her question in line 4, and elsewhere in the data) she is able to be a competent conversational co-participant. As the therapist recounts her story, the aphasic person interjects contributions such as: "oh my god that's terrible in't it" (line 12) or "true enough" (line 16). These are the types of "affiliation markers" which "inform speaking partners of their willingness to listen and interact" (Simmons-Mackie and Damico 1996: 41).

There are sequences between some of the dyads in this study where the status of the interaction is uncertain – it could be construed as being part of 'business', or as 'conversation', or both. This uncertain status usually arises where therapy tasks or items are more loosely developed or constructed, such as in the example from D14 (1) above, which was construed as being in an 'Opening up the business' phase. It may also arise

where, in addition to this less formal development of task and item, therapist and aphasic person have to engage in extensive collaborative work to establish the topic or 'facts' within the topic. In the following extract from D4 (3) therapist and aphasic person are trying to establish common ground in understanding a picture that the aphasic person has brought in as a therapy item. In a sense this sequence constitutes a 'pre-task', where the participants are trying to establish facts which will become the object of therapy work later in the session:

1. A: ((writes and then looks up at T))
2. T: twenty-nine\/ ((pointing at page with index finger and looking at A))
3. A: er ((adds more writing and then looks up at T))
4. T: twenty-ninth ((high level pitch held)) ((looks up to A and makes a gesture with
5. her right hand and index finger across her body to the left)) (1.0) */o::v/* (0.5)
6. twenty-ninth of
7. A: er (([writes]))
8. T: (([looking at paper])) right (.) oh not very long ago (.) twenty-ninth of July
9. ((looking up to A))
10. A: er ((adds more writing))
11. T: ah h::: the fete ((half smile))
12. A: ah ((gives thumbs up gesture))

The aphasic person has been using a combination of writing, speech and gesture to communicate the meaning of the picture items to the therapist. Here he writes a number (line 1), which the therapist acknowledges in her turn in line 2, but she requests further clarification through a combination of falling-rising intonation and pointing to the trouble source. The aphasic person responds by adding relevant further information in line 3, enough to indicate that the number is a date. The therapist's response in lines 4-5 is in some ways rather typical of the type of 'Elicitation' found in task-related

routines (and which will be discussed in detail in Chapter Six). She holds the pitch of "twenty-ninth" high – the sort of 'cloze' device often found in task-related routines; after a pause she reformulates the 'Elicitation' using the drawn-out last word of date expressions (i.e. 'of') which comes before the substantive word she is seeking; she repeats the whole phrase, again in a sort of 'cloze' routine. However, her next turn (lines 8-9) has more 'conversational' characteristics again – for example the use of "oh" (see ten Have (1991) for a discussion of "oh" in doctor-patient interaction) in conjunction with a comment on the information content of the aphasic person's response (line 8: "not very long ago"), rather than on the performance of that response, as is often found in task-related sequences in third position. They complete the collaborative work with expressions of mutual satisfaction.

In a sense this extract typifies one of the challenges faced by therapists and people with aphasia, and that is one of having 'conversations' which resemble "every day dyadic conversation" (Ripich *et al* 1985: 9) in the context of therapy for language impairments. The therapist, as was seen in the extract from D4 (3), may use, for whatever reasons, devices that typify task-related routines. This also includes follow-up in third position, which turns what has ostensibly been a 'conversation', into something more resembling a task. Thus for example, when the aphasic person uses communicative strategies in 'conversation', which have been the object of task-related work during the session, the therapist may comment on the fact – for example: "brilliant, you've got some more verbs coming out there" (D4 (1)). The types of contributions that are 'permissible' for any type of activity give an insight into the goals of the participants (Levinson 1979 quoted in Ferguson 1994), and therefore this type of occurrence in 'conversations' perhaps indicates that the goal of testing and rewarding certain behaviours is never very far from the therapist's mind.

'Inserted conversation': summary

- 'Inserted conversation' may arise and develop in a variety of ways
- Therapists usually, but not exclusively, initiate 'Inserted conversation', and generally control the ways in which it develops and is brought to an end
- The aphasic person may be a competent co-conversationalist despite speech and language difficulties
- Therapists often use self-disclosure in 'Inserted conversation'
- 'Inserted conversation' may have combinations of task-related and less formal features

5.7 Data analysis 2: summary

This chapter has introduced a broad descriptive framework for the structure of therapy sessions, and gone on to examine and analyse three domains from that framework. These domains – the 'Settling down period', 'Opening up the business' and the 'Closing down period' – have been examined in relation to their key features and functions as part of a sequence in the therapy session as a whole. An additional feature – 'Inserted conversation' – has also been examined.

Description and analysis have been grounded in how participants' interactions are seen to contribute to the development of the different domains. Discrepant cases have also been examined and discussed.

In addition the impact of the recording devices on the data has been examined and discussed, as have the insights afforded by the recording process itself.

In the following chapter the business of task-related work will be examined in detail. The domain 'Doing therapy tasks' will be described and analysed in terms of its key features. The main purpose of this process will be to explore dimensions of task-related interactions in ways which aim to provide a comprehensive and detailed account of how therapy is being enacted in day-to-day practice.