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

VOLUME 2

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CHAPTER SIX

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6.1 Introduction

As has been discussed in the previous chapter the main business of the therapy session which participants orient to in this study (with all the exceptions and discrepancies which have been discussed in Chapter Five taken into account) is 'Doing therapy tasks'. In various accounts of language therapy this business has been referred to as the "work phase" (Panagos *et al* (1986: 217), "the intervention event" (Kovarsky and Duchan 1997: 299), or as a shift, signalled in various ways, to the introduction of therapy tasks (Simmons-Mackie and Damico 1999b).

McTear and King (1991) argue that one of the very basic assumptions underlying speech-therapeutic discourse is that the purpose of the interaction is to focus on the talk itself (or in relation to these data, on language not necessarily involving speaking *per se*). McTear and King (1991) contrast this purpose with the achievement of some other goal or goals associated with conversation generally. McTear and King (1991: 208) talk about: "high-level goals that will determine how the therapist plans the details of the therapy session", and argue that the therapist, during the course of the session, is likely to be guided by these goals. They go on to discuss the ways in which a therapist might operationalise these goals – for example by introducing stimuli, getting the client to respond, respond contingently her/himself, and then moving on to the next stimulus. This type of therapist plan for an idealised session is very similar to the structure proposed by Panagos (1996) and Panagos *et al* (1986). This structure is hierarchically presented – as mentioned above the "work phase" represents the main business. This consists of "Task", which consists of "Opening", "Remedial" and "Closing" phases, where in "Remedial" the introduction of stimuli, response by the

client and contingent responses by the therapist are represented in the "Remedial sequence" (Panagos 1996: 51).

There are certain expectations about the structure of therapy interventions associated with teaching discrete speech or language skills, which may differ fundamentally from more naturalistic approaches (Norris and Hoffman 1990). While it is not the business of this thesis to attempt a detailed examination of the goals of the therapy under observation (nor is this seen as an achievable enterprise given the scope of the data collection methods employed here), the analysis which will follow below is based on the assumption that the overarching goal of the therapy undertaken by all the therapists represented in the data is to address aphasic language impairment and attempt to help improve impaired linguistic ability. To use the current shorthand – 'impairment-based therapy'. This is in contrast to therapy that attempts to improve or enable communicative ability – in other words the ability to use language in interactional (or even transactional) contexts (for a discussion of transaction and interaction in the conversation of people with aphasia see Kagan (1995)).

The assumption about impairment-based therapy referred to above is in part implied by one of the inclusion criteria for the submission of data to this study. This was concerned with the fact that the therapy recorded should be designed to address the semantic system or lexical representations in the semantic system. This would necessarily exclude therapy which is designed directly to address the communicative ability of a person with aphasia – that is not to say that therapists engaging in semantic (or other impairment-based) therapy do not have as a long-term goal the improvement of their client's communicative ability in interactional or transactional contexts. It would also not be true to say that all sessions are entirely devoted to impairment-based therapy. There is a good deal of evidence of communicative work together, but it is never the main purpose of the therapy in these data.

Evidence for the actual global goals of therapy in this study is empirical. Sessions are all devoted – albeit in a great many different ways – to addressing the language (or speech and language) systems of people with aphasia. As has been demonstrated and discussed in Chapter Five, interactional and transactional communication does take place in other phases of sessions. As will be seen below such communication continues to take place in the phase primarily devoted to 'Doing therapy tasks', but it is demonstrably not the main focus of the business.

6.2 'Doing therapy tasks'

Description and analysis of 'Doing therapy tasks' will begin with a broad outline of the domain. There are some similarities with other structural descriptions of the task-related phase of therapy sessions (for example Panagos 1996; Panagos *et al* 1986; Simmons-Mackie and Damico 1999a), but analysis of data here will not necessarily seek to verify existing structural descriptions or features of therapy treatment that have been studied and reported elsewhere. Where evidence for such features and structures exists in these data it will be alluded to. However the main purpose will be to explore dimensions of therapy treatment in these data in ways that, hopefully, provide a comprehensive and detailed account of how therapy is being enacted. Methods proposed by Spradley (1980), and methods derived from CA will be used in the first instance to construct the broad outline of 'Doing therapy tasks' as a domain.

It is not the purpose here (as it was not the purpose in the previous chapter) to develop a categorical system for describing 'Doing therapy tasks' or indeed a prescription for how to carry them out. Unlike a categorical coding system such as ATICS (Horton and Byng 2000), which in common with other coding systems "provides a template against which to set the raw material of interaction" (Law *et al* 1999: 273), and which attempts to define what we need to know about the interaction,

qualitative description and analysis here will continue to use the process of 'analytic induction' aiming at a comprehensive analysis of the data.

Comprehensive analysis of the data will form the basis for a broad outline of 'Doing therapy tasks'. Detailed analysis of data from across the body of therapy sessions will provide evidence for the variety of features and dimensions associated with the process of putting tasks into operation.

6.2.1 General features of 'Doing therapy tasks'

As has been described and discussed in Chapter Five that part of the session which is characteristic of 'Doing therapy tasks' is preceded, often but by no means always, by 'Opening up the business'. Figure 5.2 in Chapter Five gives an outline of the process in which a cycle of features entailed in 'Doing therapy tasks' generally recurs throughout the session. This is broadly true, but as has already been demonstrated, there are no invariable 'rules' for the conduct of sessions, and 'Doing therapy tasks' is no exception. The broad outline of 'Doing therapy tasks' is set out below in Table 6.1 in terms of typical features, and examples of those features. This outline and its layout does not attempt to show how certain features may be entailed or inserted in others. A further level of description, where one particular type of feature – 'Enacting tasks' – is broken down into a further set of sub-features, is displayed in Table 6.2. The complexities of how the various features of 'Doing therapy tasks' are manifest in actual practice will be discussed in detail in the sections which follow below.

An outline of the general nature of therapy items used by therapists in the study has already been set out in Chapter Four (Tables 4.6 and 4.7; Section 4.3.2.v Categorising and enumerating items used) and there will be no further broad description of these items. In a similar way some discussion of task types and distribution across sessions has already taken place in Chapter Four (Table 4.6; Figure 4.2; Section 4.3.2.iii

Therapy tasks; Section 4.3.2.iv Categorising task types; Section 4.3.2.vi Distribution of task types). This chapter will not address tasks in this way, nor will it seek to explore the reasoning behind the choice of tasks in particular instances. This chapter will seek to provide a detailed and rich description of the enactment of tasks generally. What this implies is a close examination of the interaction between the participants with each other and between the participants with the therapy items. This will provide the basis initially for the broad framework outlined below, and will be developed through the detailed examination of instances throughout the data.

Features	Type	Examples	Ref.
A: Beginning 'Doing therapy tasks'	Task introductions	15. T: ((gives thumbs up and turns away to 16. organise papers on table top)) righty 17. ho (.) okay (2.5) we're going to start 18. with ones that you know ((maintains 19. high pitch)) 20. A: ((nods)) 21. T: the animals 22. A: ((nods)) 23. T: okay (.) but actually ((takes picture 24. cards out of packet)) (1.0) I've put 25. some more: (the) animals here ((places 26. stack of picture cards on table)) (2.5) 27. and I've put something you haven't 28. seen before ((places and displays 29. picture cards on table in front of A)) 30. A: ((nods)) 31. T: okay (2.0) vehicles 32. A: ((nods)) 33. T: things to travel in (1.5) so that's what 34. we're going to (1.0) ((gathers in 35. cards and puts together in one pack)) 36. start with okay (.) (you're) going to 37. tidy these up for me (1.0) in the usual 38. way 39. A: ((nods)) 40. T: okay ((shuffling cards)) (1.0) and then 41. we'll start doing some drawing 42. ((continues to shuffle cards)) (6.0) 43. o:kay: (2.0) so let me get you going 44. (1.0) (we've) got things like this ((lays 45. card on table in front of A)) 46. A: ((nods and places finger tips on card)) 47. T: and this ((lays a second card on top of 48. the first)) 49. A: ((nods)) 50. T: and then we've got some animals 51. ((lays card on the table)) 52. A: ((nods)) 53. T: (1.0) okay ((hands next card to A))	D9 (1)
		210.T: ( ) shall we start off with this set here I 211. thought what we'd do just like before 212. (if) I give you the three pictures we'll 213. be working on 214.A: yeah 215.T: and three words although not 216. necessarily in the right order 217.A: uhu 218.T: yeah (.) I'll muddle them up so they're 219. not correct	D2 (3)
B: Task management	Overall management of tasks	• when are tasks introduced? • what tasks are introduced and enacted? • which tasks follow each other? • when are tasks curtailed, prolonged or repeated?	see Section 6.2.3.i
	Enacting tasks: *Elicitation*	53. T: (1.0) okay ((hands next card to A))	D9 (1)
		3. T: ((puts picture in front of A)) right (.) 4. d'you recognise that	D15 (1)
		220.T: can you work out which of the words 221. goes with each picture	D2 (3)

Features	Type	Examples	Ref.
	Enacting tasks: *Elicitation* (cont)	85. T: onto three pictures (.) music (.) pub (.) 86. and football (.) I'm gonna give you the 87. three words okay (.) can you put the 88. right word with each of the pictures	D2 (2)
	Enacting tasks: *Elicitation-response*	54. A: ((places card immediately on 'vehicles' pile))	D9 (1)
		5. A: (2.5) ((leaning forward to table)) yes er 6. erm milk	D 15 (1)
		222. A: um ((puts word card with picture))	D2 (3)
		89. A: ( ) ((moves word card onto picture))	D2 (2)
	Enacting tasks: *Elicitation-response – follow-up*	55. T: they're not very well shuffled ((placing 56. pile of cards in front of A)) but it 57. doesn't matter	D9 (1)
		7. T: excellent (.) that's a good start isn't it	D15 (1)
		223. T: good yeah	D2 (3)
		90. T: yeah that's it football for that one	D2 (2)
	Enacting tasks: *Summary*	1. T: ...now a little while ago you would 2. never have been able to do that 3. A: uh 4. T: so that means that you're listening to 5. words and that you're able to sort them 6. out and it's very important for you to 7. get the words out 8. A: d'you think I'm I'm alright getting 9. T: I think you I think there's an 10. improvement 11. A: uhh yes 12. T: slowly but surely	D6 (1)
	Enacting tasks: *Information and clarification* Check	2. A: is that a vegetable 3. T: no it's not a vegetable	D14 (2)
	Offer	5. T: (the) verbs words that talk about what 6. people are doing	D7 (1)
E: Inserted conversations	Therapist initiated	1. T: ((taps A on the arm)) did I ever tell 2. you how I get to work 3. A: no 4. T: ((gestures holding handle bars)) 5. A: on your bike oh:↓ do you:	D15 (1)
	Aphasic person initiated	1. A: yes ( ) so how did you ( ) ( ) how do 2. you 3. T: I got on great (.) of course I haven't 4. seen you since I got back	D6 (1)
F: Response management	Therapist and aphasic person	Application of various features of 'Overall task management' and 'Enacting tasks' including dimensions associated with 'Enacting routines', 'Summary' and 'Information and clarification'	Section 6.2.6

Table 6.1 'Doing therapy tasks'

Table 6.1 outlines the main features of 'Doing therapy tasks' which are to be discussed in this chapter. However, what is not apparent from this table is that there are a number of dimensions related to 'Enacting tasks' which will also be identified and

analysed. These dimensions as part of 'Enacting tasks' (Table 6.1 Feature B) are ultimately related to the 'Elicitation', 'Elicitation-response' and 'Elicitation-response – follow-up' features as set out in Table 6.1. These dimensions represent a level of description which does not readily fit into the table above. The following tabulation attempts to demonstrate how these dimensions relate to 'Enacting tasks':

<table>
<tr><th>Features</th><th>Types</th><th colspan="3">Sub-types and dimensions</th></tr>
<tr><td rowspan="8">Task management</td><td>Overall management of tasks</td><td colspan="3">• when are tasks introduced?
• what tasks are introduced and enacted?
• which tasks follow each other?
• when are tasks curtailed, prolonged or repeated?</td></tr>
<tr><td rowspan="7">Enacting tasks</td><td colspan="3">Task procedures</td></tr>
<tr><td rowspan="6">Task demands</td><td colspan="2">Dimensions associated with task-related responses</td></tr>
<tr><td colspan="2">Dimensions associated with stimulus items</td></tr>
<tr><td rowspan="4">Dimensions associated with enacting routines</td><td>Elicitation:
a) responding routines
b) information content and response demands
c) the structure of tasks</td></tr>
<tr><td>Time and timing:
a) Elicitation
b) Elicitation-response
c) Elicitation-response – follow-up</td></tr>
<tr><td>Elicitation-response – follow-up:
a) multiple function
b) explicitness/ implicitness
c) directives and response process
d) specificity
e) calibration
f) therapist & aphasic person stance
g) indications of trouble – emotional responses</td></tr>
</table>

Table 6.2 'Task management': 'Enacting tasks' – further sub-types and dimensions

The table above is set out in order to demonstrate how the various sub-types of features and dimensions associated with them and which are entailed in 'Enacting tasks' ultimately relate to the overall feature 'Task Management', and thence to the domain of 'Doing therapy tasks'. In other words, 'Overall management of tasks' and 'Enacting tasks' are types of 'Task management', which is a feature of 'Doing therapy tasks'.

'Overall management of tasks' has a number of dimensions associated with it – related, for example, to when tasks are introduced, which tasks follow each other and so on. 'Enacting tasks' has two sub-features – 'Task procedures' and 'Task demands'. The latter in turn has a number of associated dimensions.

'Overall management of tasks' will be addressed below (Section 6.2.3.i). Each of the features, sub-features, as well as associated dimensions entailed in 'Enacting tasks' will be analysed in detail below (Section 6.2.4).

6.2.2 'Task introductions'

Introductions are situated, when they do occur, in what is essentially a transition from either: 1) 'Opening up the business'; 2) the 'Settling down period'; or 3) from the completion of a prior task. As was discussed above, what may distinguish 'Opening up the business' from 'Task introductions' is that the latter are more specific, with reference to specific items or procedures to do with the work that is about to commence. For example the extract from D9 (1) in Table 6.1 (Feature A) above is preceded by the therapist opening up the business thus: "so we will get started on the stuff we were doing last week with the pictures↑ and the drawing (.) okay (.) and we'll talk about the weekend later yeah". This contains general reference to previous work ("stuff we were doing") with pictures and drawing, as well as a brief 'plan' for later in the session. The 'Task introduction' by contrast makes specific reference to items (line 21: "the animals"), and reference to some quality about the items (lines 27-28 and 31:

"something you haven't seen before... vehicles"). Of course the aphasic person has seen vehicles *per se* before, but not as therapy items in work together with this therapist. She refers to a familiar routine in lines 37-38 ("tidy these up for me (1.0) in the usual way"), thus invoking past experience of therapy routines and confirming the roles that therapist and aphasic person will play (Simmons-Mackie and Damico 1999b), as well as preparing the aphasic person for what she is to be required to do. The therapist also uses a metaphor for the task of categorisation ("tidy these up") which perhaps reflects her style as a therapist, which throughout her sessions is generally quite light hearted.

Therapists are often in the position of having to explain therapy routines or the properties of language and communication. They may use jargon to display professionally privileged knowledge. For example in D12 (2): "you're not getting the (.) the endings because they're what we call unstressed", the therapist includes herself in a professional group of 'knowers about language' by using "we" (not meaning 'you and I here now'), and displaying the jargon term "unstressed", which she then proceeds to explain.

The 'Task introduction' in D9 (1) (Table 6.1 Feature A) continues with a rehearsal of the routine (line 43: "so let me get you going") and the aphasic person displays her understanding and compliance by nodding as the therapist lays down the cards in the two categories (lines 46, 49 and 52). The actual elicitation starts in line 53 as the therapist hands the next card to the aphasic person.

The extract from D9 (1) above is quite lengthy in comparison with others in these data. The extract from D2 (3) ('Task introductions') in Table 6.1 (Feature A) follows on from a lengthy 'Settling down period' and 'Opening up the business', in which the therapist has talked about: "today we'll just spend some time practising writing them as normal". In the 'Task introduction' the configuration of the task is spelled out (lines 212-3, 215-6 and 218-9): "the three pictures we'll be working

on...and three words although not necessarily in the right order...I'll muddle them up so they're not correct".

In one sense too, the 'Task introduction' may be where the impending challenge – linguistic or cognitive – is either implied or spelled out. In D2 (3) it is essentially veiled and implied through the therapist's: "muddle them up so they're not correct", but elsewhere therapists are rather more specific. Some examples have been given in Chapter Five (Section 5.5.2) of swift transitions to 'Doing therapy tasks'. The extracts from Chapter Five also demonstrate explicit reference to the relative challenges of the various tasks. For example: 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"; 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 D6 (3) and D11 (2) the therapist is referring specifically to the relative ease of the tasks, and gives the reason why the tasks might be easier ("show you some pictures") or harder ("they're a very close category"). In D8 (2) the relative ease/difficulty is implied through the therapist's "but" and thus reference to prior work together and different task configurations.

As mentioned above therapists make efforts to provide explanations about tasks, but it is hard to see from these data how anyone other than a professional insider could really understand the reasoning behind the relative difficulty of tasks. As will be discussed below in various sections therapists (and aphasic people) do frequently refer (implicitly or explicitly) to the relative ease with which a task has been carried out, but this is based on empirical evidence and shared experience.

'Task introductions' are not necessarily present just at the starts of sessions. While the same type of task may run through the whole session using different items, sessions also consist of numbers of different tasks. Tasks may be broadly similar, but

have slightly different requirements. For example in D9 (1) the first task is a two-category picture sorting task using 'vehicles' and 'animals' (see Table 6.1 Feature A). The task that follows it is introduced thus:

1. T: I thought (2.0) we could do: (3.0) ((picking up cards and placing one card on
2. the table)) land ((taps card and looks up at A and points down to the floor))
3. A: ((nods))
4. T: okay (4.0) ((reaches for next card)) and the sea
5. A: ((nods))
6. T: you're used to that aren't you ((looking at A))
7. A: ((nods emphatically))
8. T: ( ) been on some cruises: on the sea (2.0) an:d (2.0) ((shuffling through the
9. cards and placing the next one on the table)) air
10. A: ((nods))
11. T: okay ((looks up at A)) (1.0) (you've) got the land ((points down to the floor))
12. A: ((nods))
13. T: [sea]
14. A: [((nods))]
15. T: [and the air ((pointing up))]
16. A: [((nods))]

The actual categories are specifically spelled out by the therapist, reiterated and supported by use of gesture. As in the task which precedes this one the aphasic person is given a 'target' category to aim for, both verbally and in the form of a card exemplifying that category already placed on the table in a type of 'model' of the task.

The reason for introducing a new task may be given at the same time as the items are specified. For example in D5 (1) (lines 511-6): "let's do this one actually because this uses some of the verbs that we've seen here but in slightly different ways

(.) one the picture's different but the verb is the same". The therapist refers to items just used, but prepares the aphasic person for a new configuration and a different requirement for thinking about "the verbs".

In contrast to the rather careful and precise transitions above other next tasks may receive a cursory introduction. For example in D2 (3) the aphasic person has just finished matching written words to pictures, and the therapist follows with: "okay (will you) have a go at writing them" by way of introduction to the next task. In a sense the length or otherwise of an introduction may be an indication of the familiarity of that task, or it may indicate something about the therapist's confidence in getting across the requirements of the task, and in the aphasic person's ability to understand and fulfil the requirements.

A new task, for example one requiring a different type of response from the aphasic person, may not be signalled explicitly at all. In D7 (1) therapist and aphasic person have been engaged in a spoken word-picture matching task, and have completed work on three items. With the next item the following ensues:

230. T: this one do you know what this one's doing (.) he's (.) */s:/*

231. A: ((no response))

232. T: */s:k/*

233. A: */skrei/*

234. T: s:kating (.) this one

The therapist uses an entirely different type of elicitation in line 230 to the ones with previous items in the task. After work on this item is completed, she reverts to the spoken whole word elicitation for picture matching. There is no explanation or preparation. This type of sudden transition to a new task is rare in these data and can be considered quite differently from various and contrasting elicitation techniques used by

therapists in the process of completing one particular task. These types of elicitation will be discussed in detail below in Section 6.2.6 ('Response management').

Beginning 'Doing therapy tasks' may be signalled quite cursorily too, with no real evidence of 'Task introduction'. In D15 (1) for example the therapist ends the 'Settling down period' by producing a picture card, placing it in front of the aphasic person and saying: "right (.) d'you recognise that". In D5 (1) the therapist moves to start 'Doing therapy tasks' thus: "okay (1.0) right let's have a look now what I'd like you to do A".

It is by no means always obvious whether there is a clear distinction to be made between 'Opening up the business' and 'Task introduction'. The following is an extract from D7 (1):

82. T: good (.) well last week we were looking at verbs=
83. A: =aha
84. T: (can I) just just have a quick look again at um what you did with some of those
85. verbs
86. A: aha
87. T: last week to see how you are getting on today (2.0) these ones you did quite
88. well didn't you last time (.) they didn't really cause a problem but we'll look (.)
89. again (2.0) so look carefully
90. A: aha
91. T: some of the pictures look very similar

In a sense the sequence above typifies the features of both 'Opening up the business' and 'Task introductions' which have been discussed above and in Chapter Five (Section 5.5.2 The function of 'Opening up the business'). In many respects the difficulties with the extract above relate to the problems inherent in the domain 'Opening up the business' which have already been addressed. The extract addresses

work generally in the past (line 82: "last week") and how it went (lines 87-88: "these ones you did quite well"), but also refers specifically to the items (line 85: "verbs") and the work that is about to happen now (lines 88-89: "we'll look again") with a caution about the demands of the work (line 91: "some of the pictures look very similar").

As in any attempt to draw general conclusions about a large body of data or to distil such data into a set of domains there are bound to be a number of discrepant cases, as in the example in the previous paragraph. In a sense this is of no matter – as has been made clear before, this study does not aim to produce a prescription for the conduct of therapy sessions. Therapists can and do say almost anything at any time. They are in control of sessions, but also responsive to the person with aphasia, and freely refer back and forward in time, generally and specifically at various points throughout the session. The tendency is for certain features of therapist talk to be present at the start of 'Doing therapy tasks' (or in mid-session between items or tasks) whether it be judged to be part of 'Opening the business' or 'Task introduction'. Both of these domains can be considered to be types of transition which exhibit a certain set of features, marking a boundary between different types of interaction, or interactions with different functions or goals. For example the generality which was discussed as a feature of 'Opening up the business' is also a feature of some transitions in mid-session. The following is an extract from D7 (2) following on from a spoken word-picture matching task:

182. T: okay let's look at these ( ) we looked a little bit at these last week as well
183. didn't we you did one of these
184. A: um
185. T: the trouble with me sitting here is sometimes I I don't know whether they're
186. upside down or not
187. A: aha
188. T: okay ((laying out photo-type pictures)) there's quite a lot of pictures here

189. A so we'll see how you go right now some of them are very similar again

190. A: aha

191. T: so look carefully there's a lot of pictures (.) one two three four five six seven

192. eight nine ten pictures

193. A: aha

194. T: see how you go

The therapist's turn (lines 182-3) is the type of bland statement of purpose, including reference to previous work which is typical of 'Opening up the business'. This transition, in common with many others from these data, includes an aside from the therapist (lines 185-6), a commentary on an action or a state, which features pervasively all across the data. The transition becomes much more focussed on the 'work here now' as the therapist lays out the pictures and prepares the aphasic person for the work to come (line 191: "look carefully there's a lot of pictures").

Other transitions may included very simple statements of purpose about moving on, often framed as indirect requests (D5 (1): "okay right shall we try the next one"), reference to the completion of the previous task (D8 (2): "okay let's put that one away"), or reference to some omission (D1 (2): "oh I'm sorry I meant to do something else") and hence to a description of the next piece of work.

'Task introductions': Summary

- 'Task introductions' occur at a point of transition – either from 'Opening up the business', the 'Settling down period' or from the completion of a prior task
- 'Task introductions' function to give specific information, referring in particular to items or procedures to do with task-related work
- Therapists may rehearse task-related routines in 'Task introductions'
- 'Task introductions' are where the therapist tends to prepare the aphasic person for the impending challenges of the task

6.2.3 'Task management'

The process of enacting tasks can be considered in the first instance in terms of the overall management of tasks across the session as a whole. In a way that is perhaps parallel to the control that therapists exercise over the structure of sessions as a whole, 'Doing therapy tasks' is globally managed. It is managed in terms of when tasks are introduced, what tasks are introduced and enacted, which tasks follow each other and when tasks are curtailed, prolonged or perhaps repeated. In addition to thinking about 'Task management' in terms of the overall management of tasks in the session, it will also be considered at a more local level in terms of the ways in which tasks are enacted, in both pre-planned and extemporised ways.

6.2.3.i 'Overall management of tasks'

Therapists may put in a good deal of work in preparing therapy tasks. This is clear in the way that pictures, words or sentences are taken from packs, pre-prepared and ready for use in distinct groups or sets. This could also be said to apply to 'homework' that has been prepared and handed out in previous sessions and is the subject of work in the current session. Therapists also come to sessions with prepared concepts (in other words ideas about tasks or type/s of task/s) while the choice of actual items to be used may depend on discussion/negotiation with the aphasic person in the session now. This then entails preparation of items during the session, writing out word cards or cutting out pictures and preparing them for use in task procedures.

In the overall management of 'Doing therapy tasks' certain types of tasks – for example categorisation tasks – may follow each other in a succession of apparently ever more refined discriminations. For example D9 (1) work on a series of category sorting tasks using picture stimuli where: 1) transport and animals are categorised; 2) transport

is categorised into sea, land and air; 3) land transport is categorised into private versus commercial (see Table 4.7).

There are other features of the global management of tasks. For example D11 (1) work on a two-category sorting task using picture stimuli (clothing and body parts), followed by a two-category sorting task using written word stimuli (referring to the same objects as the first task). This pattern is repeated in D11 (3) where for each type of category (electrical goods: Yes/No; furniture: Yes/No; and kitchen items: Yes/No) the picture modality precedes the lexical one.

Sequential management of tasks does not just feature comparable tasks, but also ones which could be said to be complementary. For example in D2 (1) for each item addressed in the therapy work together, there is: 1) written word-to-picture match within category group (all words, all pictures); 2) written naming of each item: i) choose one of two written words for single target item (picture) ii) copy target word iii) enter anagrammed letters into target grid iv) [optional] write word from memory; 3) read word aloud.

In D2 (1) and the other D2 sessions, overall task management appears to be strictly controlled and essentially invariable. This is more-or-less true of the work of many of the other dyads (D1, D3, D5, D6, D7, D8, D9, D10, D11, D13) in these data, and is probably reflective of the type of therapy work that was sought out in terms of the parameters of the study.

However, as mentioned above, tasks are also extemporised. That is to say, for example, the therapist may judge that in order to steer the main task in the 'right' direction, or to make a point about the main task, a series of unpredicted subtasks first have to be addressed. For example in D5 (1), the current main task requires the aphasic person to choose a verb (from a selection) to match a picture. He is then asked to answer questions from the therapist about the agent and theme of the sentence. In order to

clarify a point about the nature of a particular verb the therapist asks the aphasic person to draw a picture of the object which caused the action to occur. He attempts to write instead of draw, and work ensues to identify the object in different ways .

'Overall management of tasks': summary

- The implementation of tasks may be based on considerable preparation of items and conceptual strategies
- Tasks may follow each other in sequences of comparable or complementary sets
- The 'Overall management of tasks' may be strictly controlled, but tasks may also be extemporised

6.2.4 Enacting tasks

6.2.4.i Introduction

As has been discussed above and in Chapter Five, 'Doing therapy tasks' is the business that the therapist and the person with aphasia generally orient to in these sessions. The dominant feature of 'Doing therapy tasks' is the actual process of the therapist initiating tasks, the aphasic person responding and the therapist making some sort of contingent response – 'Enacting tasks'. The major observable features of 'Enacting tasks' are as set out in Table 6.1 (Feature B) – 'Elicitation', 'Elicitation-response' and 'Elicitation-response – follow-up'. Therapists are in control of 'Elicitations' and because 'Enacting tasks' is such a central feature of 'Doing therapy tasks', this may lead to misunderstandings about the status of therapist initiations, as is shown in the following example from D5 (1):

3. T: okay (1.0) right let's have a look now what I'd like you to do John yeah we've
4. done this before but in a slightly different way
5. A: yes
6. T: okay can you see somebody doing something there ((indicates paper))

7. A: (washing) ((gestures with one hand))

8. T: right hang on hang on [hold your horses]=

9. A: [((chuckles))]

10. T: =um yeah (2.0) you could say he's washing

11. A: yeah

12. T: but I want you to choose one of these words (.) alright (1.0) there are some

13. these are all verbs you'll notice

14. A: yes

15. T: the verb thing

16. A: yes ((A and T both laugh))

17. T: as you said last time

18. A: yes

19. T: um and one of these (wor) verbs you might find is the best one to describe what

20. he's doing=

21. A: =((points to paper on desk)) ( )

22. T: right

23. A: ( )

24. T: that one

25. A: yes

26. T: okay

The therapist's turn in lines 3-4 has been discussed in Chapter Five (Section 5.5.2 The function of 'Opening up the business') in terms of how it might or might not belong to the domain 'Opening up the business'. The therapist's turn in line 6 appears to be taken by the aphasic person as an 'Elicitation', as evidenced by his contribution in line 7: "(washing) ((gestures with one hand))" – both a verbal and non-verbal response that has all the appearances of an 'Elicitation-response' (see Table 6.1 Feature B, and

Section 6.2.4.iii.III Dimensions associated with 'Enacting routines' below). His response to the therapist's turn in line 6 is understandable in two ways. Firstly, her turn occurs at a place in the sequence of the session where an 'Elicitation' could be expected – after a transition that has the characteristics of 'Opening up the business', and more specifically, after a therapist utterance that refers to task-related items on the table top. No doubt he has been in this situation before, where therapist initiation plus item requires an 'Elicitation-response'. Secondly, while the therapist's utterance in line 6 has the syntactic form of an inquiry, and invites a Yes/No response, therapists' 'Elicitations' often take the form of an indirect speech act requesting a contingent response (Panagos *et al* 1986) and are thus understood to require an 'Elicitation-response' – for example D15 (1) line 4: "d'you recognise that" among many others.

That there has been a misunderstanding as to the status of her utterance in line 6 becomes clear in the therapist's turn (line 8): "right hang on hang on [hold your horses]". This clearly does not refer in an evaluative way to the adequacy or otherwise of the aphasic person's response in line 7 as would be expected in a typical task-related exchange, but rather to the fact that he has responded thus, and this becomes clear in line 12 when she refers to the actual task procedure she had wanted to address.

Meanwhile however, she does acknowledge the fact that the aphasic person has made an 'Elicitation-response' through her turn in line 10: "um yeah (2.0) you could say he's washing". This has some of the characteristics typical of an 'Elicitation-response – follow-up', including acknowledgement, evaluation and reflection of the aphasic person's actual response ("washing"). The aphasic person's chuckle in line 9 suggests that his eagerness to dive in and get started with task-related work might be a feature of his style that has been subject to remark in the past. The therapist certainly directs him to stop in a light-hearted way ("hold your horses") and they appear to share the light-heartedness.

As has been mentioned above the therapist picks up the business in hand (her agenda) in line 12 where she continues with an exposition of the task procedure. In other words, a 'Task introduction', which features specific reference to the task requirements: "I want you to choose one of these words (.) alright"; the items: "there are some these are all verbs you'll notice". It looks as though she tries to complete the 'Task introduction' in lines 19-20, but this appears to function for the aphasic person as an 'Elicitation' judging by his 'Elicitation-response' in line 21 immediately latched to the therapist's preceding turn.

The example and subsequent discussion above serves to illustrate some points about an approach or approaches to addressing therapy discourse data. In the first place approaching therapy discourse data with a set of pre-determined categories such as ATICS (Horton and Byng 2000) may make for problems in coding such sequences as the extract from D5 (1) above. As has been discussed, there is a mismatch between therapist and aphasic person agendas which is actually almost impossible to capture with a categorical system.

However reference to certain structures and dimensions which can be shown to be grounded in the actual data of therapy sessions – conceptual structures or dimensions perhaps – can be very usefully applied to the analysis and interpretation of therapy interaction data. Thus for example, the triadic task-related structure (to be discussed in Section 6.2.4.iii.III Dimensions associated with 'Enacting routines') where certain turns project the occurrence of a next turn, which is dependent on the occurrence of the preceding turn, has been shown to be useful in illustrating features of therapy discourse as in the example above from D5 (1). In a similar way 'Task introductions' may be applied to develop an understanding of therapy discourse, but it may be most helpful, within the framework of such domains, to think in terms of the processes or features

typical of these domains. Processes and features associated with various aspects of 'Enacting tasks' will be analysed and discussed in the following sections.

6.2.4.ii 'Task procedures'

The notion of managing tasks may also be addressed at a less global level, essentially at the level of procedures. The concept of 'Task procedures' addresses issues to do with the planned management of the task as it is put into practice. 'Task introductions' often represent opportunities for therapists to clarify 'Task procedures' and the demands of tasks, as in the extract from D7 (1) (lines 191-2): "so look carefully there's a lot of pictures (.) one two three four five six seven eight nine ten pictures", or in the following extract from D6 (1):

150. T: so what we're going to do today is try and think how we can put words in some
151. order
152. A: uhum
153. T: so we're going to put all the similar words together (.) I've got all the words
154. written down here
155. A: yes
156. T: and we're going to sort out all the vegetables
157. A: ah
158. T: all the fruits
159. A: right
160. T: and the different meats
161. A: ah
162. T: those are the three things we're going to think of today
163. A: yeah yeah
164. T: fruit (.) vegetables (.) meat

165. A: meat

166. T: and we're going to sort these words out

This 'Task introduction' follows on from a sequence in which the therapist has been addressing the issue of the aphasic person's impairment – essentially an 'Opening up the business' phase, but which actually occurs after a piece of task-related work. The therapist has used a 'dictionary' metaphor in relation to the aphasic person's word-finding difficulty. This is represented as a difficulty accessing the "right page" and being "all mixed up". The 'Aphasic impairment – aphasia therapy relationship' (see Table 5.5 'Opening up the business' Feature E: Reference to aphasia) is addressed in terms of trying to "put those words into some order again". Thus the 'Task introduction' above in lines 150-166 is a logical step in relating the explanation of impairment to the planned management of the task to come. The therapist spells out the essential ingredients of the task: "put words in some order" (line 150-1); "similar words together" (line 153); "all the words written down" (lines 153-4), and she delineates the item categories one by one – "vegetables", "fruits" and "meats". The items have been selected by the aphasic person from a list of things she might buy, which was presented to her by the therapist. So for example she chose "eggs" but not "fish", "banana" but not "cherries" (line 40: "eh well we don't need") and so on. In other words, there is an implicit (if not explicit) relationship between the items and procedures of the task, and a real-world communication need (being able to ask for things in shops).

'Task procedures' are laid down or specified on what seems to be a continuum from very rigid and quasi-experimental to very loose and exploratory. The range varies from the strict procedures mentioned above and enacted in D2 to more loosely fashioned exploratory work, such as in D4, D14 or D15.

In D4 the therapy tasks appear to be based on sentences spoken by the aphasic person, which have been elicited in 'conversation' between the two participants and

transcribed by the therapist. This then leads to a type of sentence processing work, which also involves verb choice from a range of distracters.

In D14 the aphasic person is variously required to produce spoken words in response to pragmatic and semantic clues given by the therapist; produce words to definitions given by the therapist; produce spoken lists of items associated with certain activities.

In D15, in all three sessions there is a relatively small number of very simple items (black and white line drawings of objects or people), and the task is for the aphasic person to name those items. However there is a good deal of extemporised work undertaken by therapist and aphasic person together, interspersed with conversational and anecdotal asides which have varying relevance to the task and items in hand.

'Task procedures': summary

- 'Task procedures' are to do with the planned management of the task as it is put into practice
- The relationship between impairment and the planned management of the task may be explained in 'Task introductions'
- 'Task procedures' are on a continuum from rigid and quasi-experimental to loose and exploratory

6.2.4.iii 'Task demands'

Briefly, 'Task demands' refers to the linguistic, communicative and cognitive demands placed on the aphasic person by the task procedures. These are the challenges that essentially set in motion the language and cognitive processing work through which the goals of therapy are achieved. Wallach and Miller (1988: 58), for example, refer to "information-processing demands". These relate to a number of variables – explicit instructions; nature of the materials used; information presentation; and a number of

factors related to therapist-student interaction. As was mentioned above therapists operationalise goals by introducing stimuli, getting the client to respond, respond contingently themselves, and then move on to the next stimulus (McTear and King 1991). In other words 'Doing therapy tasks' is the means through which therapy goals are designed to be achieved. Thus how 'Doing therapy tasks' is achieved should logically impact upon the degree of success in achieving therapy goals.

'Task demands' have a number of parameters each with associated dimensions: Dimensions associated with task-related responses; Dimensions associated with stimulus items; Dimensions associated with enacting routines. These three sets of dimensions are set out in the following table and will be discussed in detail in the sections that follow.

Parameters	**Dimensions**				
Task-related responses	Response mode	Response content	Respon-ding routines	Precision	
Items as stimuli	Types of items	Combin-ations of item types	Numbers of different items (simul-taneously)	Workload: numbers of items (consec-utively)	Item clarity or ambiguity
Enacting routines	Content and manner of therapist Elicitations	Time and timing in Enacting routines	Elicitation-response – follow-up	Responding process	

Table 6.3 Task demands: dimensions associated with three parameters

6.2.4.iii.I Dimensions associated with task-related responses

The following dimensions will be discussed:

1) the mode of the response required from the person with aphasia – for example: spoken word; pointing to a picture; written response; gesture and so on
2) the response content – for example: a particular word, and only that word; a particular type of word (e.g. verb vs noun); a particular gesture; a sentence (not just a word); a fully grammatical sentence
3) responding routines
4) precision or clarity

1) Response mode inevitably varies considerably across the data, due of course in part to the variation in impairment represented by the different aphasic participants. Generally speaking, people with severe expressive difficulties affecting speech are not asked to respond with spoken output, but this varies according to the work in hand. A task requiring judgements and pointing responses may be followed by one which requires a spoken output. People with severe speech difficulties may be asked to say 'Yes' or 'No', but may also indicate 'Yes' or 'No' by moving a word card (D7 (1) for example). Pointing to one or other of the therapist's hands to indicate a category is used in D9 and D10. In D12 the majority of 'Doing therapy tasks' is carried out through writing, but as in the work of other dyads where writing is the focus of the work together, the aphasic person usually speaks or attempts speech during the task and in conversations.

Mode of response may be a matter for negotiation between therapist and aphasic person. In the extract from D6 (2) below, the following occurs in 'Opening up the business':

45. T: so this is why we're doing lots of word games

46. A: uh yes

47. T: and I'm mainly concentrating on you looking at the words

48. A: uh

49. T: and hearing the words

50. A: uh

51. T: okay I'm not too bothered about you saying the word just now

52. A: no

53. T: but we can practice that if you want to

54. A: aye true

In line 47 the therapist makes her intention clear: "I'm mainly concentrating at you looking at the words". The "I'm" (lines 47 and 51) signals that this is the therapist's agenda, and that saying the word at this stage is not a necessary requirement. She proposes a compromise between therapy that only requires judgements ("looking at the words...and hearing the words") – her agenda – and work on saying words (line 53: "we can practice that if you want to"), which she imputes might be the aphasic person's agenda. The implication is that saying words is not necessarily a core activity right now in relation to the aphasic person's impairment. The apparently contradictory situation for the lay person, where having difficulty with expressing words does not necessarily mean that they should practice saying words, poses an explanatory problem for therapists. The main problem is one of explaining the logic behind the type of task and chosen response mode dictated by a particular model of impairment and remediation. Personal experience of the author gives the situation represented by the extract from D6 (2) above a very familiar feel.

The therapist may invoke an alternative mode of response to the one that is the prime target of the task requirement. Generally speaking this occurs in task-related

repair sequences[1], rather than being a stated and explicit requirement of the task. For example in D1 (2) the aphasic person is required to say a well-formed sentence as a secondary clause in response to a written sentence stimulus. She works word by word:

184. T: so it's

185. A: I

186. T: good (1.0) show me what you're do

187. A: ((hand turning gesture)) um lock

In line 186 the therapist proposes a different response mode – gesture as opposed to speech, and the aphasic person responds with both.

2) The content of the response required is highly representative of the apparent purpose of the therapy. Thus in therapy work where a spoken word is required (for example the name of a picture) as the end product of doing the task, only the spoken name of that picture is sufficient. For example in D15 (1) the aphasic person is asked to name various pictures. A picture of a bicycle proves difficult to name – she names various parts of the bicycle ("bars"; "wheels"; "pedals") and actions associated with it ("make sure it make goes"; "stop it"). A considerable amount of work takes place until finally the name itself – "bicycle" – is achieved. As Kovarsky and Duchan (1997: 298) argue a great deal of work and effort goes in to the management of perceived errors. They quote van Kleeck and Richardson (1986: 25), that clinicians "will change anything and everything in an effort to get that ultimate plum of teaching – the correct response".

The requirement for a particular word may have something to do with the level of demand the therapist feels s/he can make of the aphasic person. The following is an extract from D12 (2):

[1] "Repair" is used in CA to refer to different ways interactants deal with trouble sources in conversation (see Perkins and Lesser 1993). "Task-related" repair relates to 'errors' that arise as tasks are enacted.

95. A: er ((writes))

96. T: go on brilliant (.) okay so you're writing making lunch

97. A: yes=

98. T: =right okay (.) is there a better word that (you'd like)

99. A: (4.0) m: oh no ([ ])

100. T: [no alright] fair enough

The aphasic person has written a perfectly grammatical and meaningful phrase ("making lunch" as reported by the therapist in line 96), which receives strong positive evaluation from the therapist (line 96: "brilliant"). However in line 98 she clearly tries to push him to produce a different word as an alternative to either "making" or "lunch" – we are not sure – but he declines, and the point is not pursued here. However it is picked up again by the therapist some turns later – "you were saying making lunch how d'you know it's lunch" (lines 104-5), so one might assume that the motivation for the therapist's "better word" (line 98) has something to do with doubt about the accuracy of the relationship of "lunch" to the actual referent.

The requirement for specific content may relate to a particular stage in a task-set. In D5 (1) there are a series of stages in a sentence processing task-set. The first requires the aphasic person to point to a word from a choice of words to match an action picture. In other words mode and content are embodied in one response requirement. He transgresses the requirement firstly by saying a word ('mode' error), and secondly by saying a word that is not one of the choices ('content' error), and he is brought to book for this and asked to do the task again in the required manner. The second stage of the task is elicited by the therapist asking: "who's wiping" (D5 (1) line 29). The response: "wiping his er" (line 30) is deemed not acceptable and the therapist initiates repair work to target a response consisting of a subject for the sentence (the agent).

The requirement for particular and specific content is not necessarily restricted to pre-planned task routines. In D5 (1) for example, in a sequence which is essentially related to 'Response management' (see Section 6.2.6 below), the following ensues:

375. T: what's he hitting there

376. A: ( )

377. T: m: it looks as if it's the front (1.0) at the front of the house

378. A: (what)

379. T: the front

380. A: the knock knock ((laughs))

381. T: right right yes this is the front

The therapist is trying to get the aphasic person to say "door" (as transpires a few turns after this sequence). In line 380 the aphasic person uses an onomatopoeic expression as a communicative device apparently to demonstrate his understanding of the intended target. He also displays his attitude to the utterance through the laughter immediately following the utterance (line 380). The therapist displays her lack of acceptance of the response by not sharing the laughter, merely acknowledging the aphasic person's utterance and moving the work along swiftly. In his study of therapist-patient conversations Wilkinson (1995b) found a recurrent pattern of therapists appearing to be resistant to fully affiliating with the patient's laughter when they displayed some non-competence in talk.

3) Responding routines refers to the type of supportive routines that may be inherent in the task set-up or proposed by the therapist as a type of self-help routine. These are not the same sort of support mechanisms as will be discussed below in 'Response management', which generally arise in a spontaneous fashion contingent on the aphasic person's response/s, although 'Responding routines' may be drawn on as a resource within 'Response management'. One type of 'Responding routine' is the one

used to help support the construction of written sentences, which is proposed (and re-proposed) by the therapist in D12 (2):

331. T: see it might be worthwhile doing what I suggested to you in the first place

332. which is writing down some of the words first and you've got them available

333. and they don't keep slipping away

The routine has clearly been proposed before this instance (line 331: "I suggested to you in the first place"), and here the therapist re-invokes the routine in response to the aphasic person's trouble with sentence construction.

D12 also make use of a synonym dictionary as a self-help routine both in the sessions on video, and as a resource in homework tasks (as evidenced by observable talk in the session). Again in this dyad the therapist is generally the one who initiates use of this resource, and mostly in 'Response management' – in other words contingent upon a difficulty with accessing a target word:

484. A: (gabbling) /*bae?*/ er ((reaches for pen)) oh

485. T: aha ((points to dictionary and looks at A with questioning expression))

486. A: ((searches through dictionary))

In D2 (all sessions) in the word-writing part of the task-set, the aphasic person has the target 'word grid' set out as a number of dashes representing the number of letters in the word (i.e. for PUB it is: __ __ __). In addition she has the letters of the word jumbled in an 'anagram' next to the word grid, and she is encouraged to cross off each letter as she enters it into the grid. The following is an extract from D2 (2):

109. T: yep okay here we go

110. A: ((writes first letter))

111. T: ((nods))

112. A: ((writes next letter))

113. T: ((nods))

114. A: no ((looks thoughtful))

115. T: good cross off the ones that (could be) used in the

116. A: um I think it's E ((writes next letter))

In actual practice therapist and aphasic person both exercise the privilege of flaunting this routine. In the extract above the aphasic person does not, as is suggested by the therapist, cross off the letters in the anagram, but goes straight on to write the next letter (line 116). On occasions, the target word is one which the therapist or aphasic person feel it is appropriate to write 'unsupported'. The following is an extract from D2 (3):

223. T: now are there any of those three that you think you could probably write

224. straight off

225. A: right

226. T: if I cover what I'll do is cover up the words ((turns cards over)) there we are (.)

227. right what about starting with this one (.) that's a nice short one=

228. A: right

229. T: =yeah you have a go at writing that one

Having offered the aphasic person the opportunity of initiating her own unsupported choice of word (lines 223-4) the therapist actually chooses (line 227), presumably basing her choice on the likelihood of success due to the shortness of the word (line 227: "that's a nice short one").

4) Precision or clarity of task-related responses may refer to grammatical correctness or clarity of spoken or written responses. The factor of clarity or precision may well relate to the demand for a particular response content. For example in D5 (1) the therapist explicitly 'rewards' the aphasic person with praise for producing exactly the required target: "excellent that time A you you used the verb and the thing that he's doing it to (.) together".

As was mentioned above, considerable effort may be invested in achieving the 'correct' target. The notion and actual practice of repair work undertaken by therapist and person with aphasia will be discussed in more detail below (Section 6.2.6 'Response Management'). Here it is worth mentioning that requirement for precision or clarity is by no means always explicit. Therapist follow-up of the aphasic person's response may not be overtly corrective, but may indicate a 'norm' to be aspired to. This has perhaps some of the flavour of the "veiled correction" mentioned by Simmons-Mackie *et al* (1999: 224), in that there is no direct mention of error. There are numerous instances of these "veiled corrections" in the data. The following are two such examples:

46. A: wipe window

47. T: the window ( )

48. A: wipes window

D5 (1)

70. T: I know you like your shoes

71. A: cunsforfor[ble]

72. T: [comfortable] ones

D14 (1)

Reflecting back a response to the aphasic person is one feature of 'Elicitation-response – follow-up'. In D5 (1) this reflection takes the form of the sort of elaboration and expansion evident in adult-child interaction (Boyle and Peregoy 1990). These authors argue that such elaboration provides "a scaffold, unconsciously modelling linguistic and conversational patterns" (Boyle and Peregoy 1990: 195). Norris and Hoffman (1990) refer to this type of phenomenon within a framework of opportunities for language learning, where therapists may use a variety of devices, including

expansions of the client's preceding utterance, which "add new information of greater complexity" (Norris and Hoffman 1990: 79). Whether this all pervasive feature of therapist talk in these data is a result of a deep-seated routine ingrained in childhood, and then perhaps in school, is not known. However, this type of "veiled correction" has a distinctly didactic flavour. It's presence in sequences which are not overtly about 'Doing therapy tasks' – as in the example from D14 (1) in the previous paragraph above which is taken from a 'conversational' sequence – is an indication of the pervasive power exercised by therapists in their control of therapy sessions. In other words they exercise the rights of control and correction over the other's speech at any time.

Dimensions associated with task-related responses: summary

- Mode of response varies considerably across the data, but may be a matter of negotiation between therapist and aphasic person
- Response content is highly representative of the purpose of the therapy
- Responding routines are supportive routines inherent in the set-up of the task
- Precision or clarity of responses may relate to the demand for a particular response content, but the required level of precision or clarity may not be explicitly expressed by the therapist

6.2.4.iii.II Dimensions associated with stimulus items

The following dimensions will be discussed:

1) types of items – pictures, sentences, written words, spoken words
2) combinations of item types – pictures with spoken words, spoken words with written words, single words with sentences
3) numbers of different items (choice from)
4) workload – numbers of items to be dealt with in a task

5) ambiguity or clarity of items or stimuli – are the pictures clear, is the relationship between word and referent unequivocal.

1) The types of items represented in these data have essentially been enumerated and described in Chapter Four (Section 4.3.2.v Categorising and enumerating items used). Therapists make use of commercially available photographs, line drawings or sets of pictures with associated word frequency and imageability norms taken from published papers (e.g. Snodgrass and Vanderwart 1980). As was mentioned above choice of actual items may be subject to negotiation between therapist and aphasic person actually in the session. It may also have been dependent on work together and negotiations in the past, such as in the use of personal photographs and other personal picture items used in D2 and D3. Other personal items may be brought in to the session on that day, such as in D4 and D12. In D4 (3) the items are personal photographs brought in by the aphasic person. The therapist chooses the therapy items in the first instance, but then changes her mind and the following sequence ensues:

1. T: so let's let's focus on this on these two ((looks at A)) yeah/
2. A: m:: ((nods))
3. T: well er having said that which would you like to do
4. A: I don't mind
5. T: d'you want to carry on with this one ((points)) or ( )
6. A: I don't mind
7. T: you choose
8. A: oh no
9. T: well don't want to impose my
10. A: ((points to picture))
11. T: yeah ((nods)) okay (3.0) might be thinking I don't want to do that ((T and A
12. both laugh))

The therapist – not unexpectedly – exercises control over the choice of item in the first instance, and the aphasic person complies with her choice (lines 1-2). When she changes her approach to one of offering a choice, the aphasic person resists, passing up the opportunity to make the decision, and choosing to remain passive on two occasions (lines 4 and 6). The therapist perseveres, finally resorting to an imperative form (line 7: "you choose"), which receives a strongly negative reaction from the aphasic person, who puts emphatic stress on his response – "oh no" (line 8). He finally does choose once the therapist has begun an explanation of her reasoning. The awkwardness of the situation is possibly made apparent from the way in which she makes a joke out of the incident (line 11), and they share in the laughter. This sequence is perhaps an illustration of how the prevailing pattern of therapist control and aphasic person passivity makes aphasic person choice the dispreferred option.

There is clearly quite a strong tendency towards the use of personally meaningful items, presumably in an effort to make the type of impairment-based therapy characteristic of these data as relevant as possible to the aphasic person's communicative life and to act as springboard to generalisation of the therapy. In this respect therapy tasks which rely on the semantic relatedness of distracter items, for example, may require a compromise between what would be ideal sets of items (e.g. ones where posited degrees of relatedness or category membership can be strictly controlled), and those which are actually available. Thus for example in the work of D2 and some of the work of D3 items are grouped in categories as far as is possible with the given items: 'Transport': bus; train; ticket; 'Health professionals': doctor; dentist; 'Leisure': football; music; pub. While bus, train and ticket are all clearly to do with transport in some way the closeness of the association one-to-another is relatively loose. The fact that there were only two 'Health professionals' meant that there was only ever

a 50:50 choice within this category. The items under the 'Leisure' category clearly represent three very different types of sub-category.

As was mentioned above a good deal of thought and preparation may have gone into items and configuration of items before the start of sessions. For example D5T's written comment on the use of 'stick figure drawings' as one of the therapy items points out that: "Pictures focus on verb meaning rather than on the arguments i.e. stick men only". In D5 (2) therapy tasks entail use of ten groups of five nouns with two nouns semantically related and having an agent-theme relationship (see APPENDIX THREE for details of all items and tasks), a piece of work that surely required a good deal of background research and preparation. The same is true for many of the other dyads. Semantic therapy work, where the aphasic person may be required to choose from among related items can entail a great deal of forethought and preparation and it is not surprising that many therapists turn to commercially available pictures and work-sheet type exercises.

2) Combinations of item types inevitably occur in word-picture matching tasks – either written word-picture or spoken word-picture, but there are numerous other item combinations represented in these data. An impression can be gained by referring to APPENDIX THREE. Item combination also relates to the 'closeness' of distracters presented together as a choice selection – for example as a set of words or a set of pictures. Distracters appear together with target items in various modalities, from sets of pictures or written words, to pairs of spoken words. For example in D7 (1) the aphasic person is required to indicate a 'Yes/No' response as to the appropriateness of combinations of a target word – such as "ride" – with a variety of themes, such as "motorbike" or "dog". The themes selected by the therapist to be accepted or rejected vary greatly in their semantic constitution and relatedness and thus in the likelihood they have of constituting a therapeutic challenge to the aphasic person.

Item combination may also refer to the mode in which items are presented to the person with aphasia. For example, some presentation modes are seen or experienced as more problematic for particular individuals. The following is an extract from D11 (1):

229. T: okay so we'll move onto the categorising the words [which I]=

230. A: [okay]

231. T: =know were a lot more tricky

232. A: yeah

233. T: what I'll do is just give them to you (.) I won't read them out

234. A: okay

235. T: if you're really not sure then I'll read them out

The therapist (line 231) refers to previous work together with the categorisation of lexical items. Here "more tricky" is a comparison with categorisation of pictures. However despite the fact that they were "tricky" she makes a deliberate choice not to read them out (line 233) – in other words to organise the presentation in a single modality (written) – unless the aphasic person experiences difficulty (line 235: "if you're not really sure"), where she will allow for presentation in two modalities – written and spoken. Her mention of a contingency plan for presentation or re-presentation of items essentially relates to work that would be carried out in 'Response management' and this will be discussed in Section 6.2.6 below.

3) The number of items may vary from task to task. As has been mentioned in Chapter Four Section 4.3.2.v Categorising and enumerating items used, in consecutive tasks of the same type (e.g. one category sorting task followed by another), the number of items in each task varies, and there are various factors associated with these variations which have already been discussed. 'Numbers of items' also refers either to the number presented concurrently, such as in an odd-one-out or word-picture matching tasks with distracters, or to the amount of items to be addressed in any one task. The

former could be construed to relate to cognitive, linguistic or perceptual factors. The latter relates both to the factors discussed in Chapter Four Section 4.3.2.v Categorising and enumerating items used, and to the aphasic person's fatigue and the ability to maintain concentration. As was mentioned in Chapter Five therapists take responsibility for the well-being of their aphasic clients and this may be reflected in the number of items in any one piece of work as well as the overall management of tasks in the session.

In D8 (2) for example the therapist refers to the configuration of items in the previous session. She relates this configuration to that of the same task in the current session: "you were complaining they were too easy okay so so this time A you've got the same picture but you've got four words to choose from okay" (lines 77-8). The implication is that an increase in the number of items from which to choose represents a greater challenge to the aphasic person and thus perhaps a more powerful remediation tool.

A task – for example word-picture matching – may well begin with a certain number of items which are contingently reduced from time-to-time by the therapist according to current circumstances. More detailed discussion on this topic will follow in Section 6.2.6 ('Response management') but what is clear is that therapists may manipulate the number of items during the course of a task, and that the number of items which was used at the beginning of a task is not necessarily the same throughout the task. This is not necessarily just a factor to do with numbers of items but may also relate to the type of items withdrawn – for example ones which appear to be causing difficulty for the aphasic person. Therapists also pay attention to the actual physical layout of items (e.g. word or picture cards) on the table top. For example in D9 (1) the therapist starts by setting out the four picture cards in a row from left to right in front of the aphasic person. As she begins the 'Elicitation' she re-arranges the cards into a

square. Presumably the therapist's action is related to considerations of visual perceptual difficulty.

Ease or difficulty of doing a task may also be attributed by the therapist to the order of presentation of items. For example in D9 (1) the aphasic person is required to sort picture cards into two categories. At the beginning of the task the therapist mentions that: "they're not very well shuffled but it doesn't matter". However as the task proceeds, after eight items have been categorised, the therapist reaches for the stack of cards and reshuffles them, saying: "not very well shuffled at all (.) might make things slightly more difficult by...". The assumption appears to be that too many items from the same category in succession does not provide a sufficient challenge to the aphasic person, but this is not explicitly justified.

4) Ambiguity or lack of clarity of items themselves is the final factor relating to items in this section. In D5 (1), in response to a picture stimulus (stick figure) the aphasic person has (prematurely – see 6.2.4.i Introduction) named the action as "washing". As this was not one of the choices available he was asked to choose a different target from the selection, and he chose "wipe". The task continues with the aphasic person being required to say an agent and a theme, thus completing a sentence ("a man wipes the window"). After the task is complete the therapist checks whether the aphasic person considers "washing the window" to be acceptable:

62. T: do you think that's okay as well a man washing the window
63. A: no no
64. T: why not
65. A: (he's wipe) ((points))
66. T: he's wiping but couldn't he be washing as well
67. A: no yes yes
68. T: yeah

69. A: yes

70. T: it's possible remember there's not=

71. A: yes

72. T: =there's not necessarily only one verb that you could use here

It is perhaps not surprising, after all the work that has gone into constructing the sentence around "wiping" that he initially rejects "washing" (line 63). The therapist argues for flexibility around the verb in this instance (line 72) rather in contrast to the apparent rigidity of the conduct of the task in the first place. Other instances of disagreement arise in D5 (1) around the choice selection in the word-picture matching task. Again this is to do with the word the aphasic person has indicated and said ("knocking") not being among the available choices. Difficulty also arises in D5 (1) in relation to the ambiguity – or perceived ambiguity – of the picture. The picture is of a person (stick figure) holding a tennis racket and there is a ball and an indication of a court. The aphasic person actually completes the task – "John hits ball" – but the difficulties arise when the therapist asks him to tell her what game it is:

107. A: (it is) ping pong

108. T: right okay right I shall do this drawing differently next time

The therapist expresses the view that the ambiguity or misinterpretation has come about through her poor drawing. Therapists frequently refer (personal experience of the author) to their poor drawing skills, and this does arise in these data too. In D1 (2) the therapist presents a task which requires the aphasic person to describe what might be happening in a park scene: lines 560-561: "right now no laughter on this at all (.) the bare outline of a park scene". The therapist clearly anticipates laughter (and gets it) on presentation of her drawing, but there are no instances of ambiguity arising from the drawing. In D11 (1) the therapist asks the aphasic person whether they need to use drawings as well as written words: "do you need my drawings as well...just so you can

have a laugh". In D13 (3) the therapist refers to "some terrible little pictures here". One might argue that these displays by the therapist of incompetence at one level are designed to affiliate with the aphasic person's perceived linguistic 'incompetence' and therefore put them at their ease in some way.

One more type of uncertainty that arises is around the type of task discussed above in the example from D7 (1). The aphasic person is required to indicate a 'Yes/No' response as to the appropriateness of combinations of a target word – such as "ride" – with a variety of themes, such as "motorbike" or "dog". There are some instances where the combination is, or is perceived as, uncertain – for example D7 (1) "washing a horse" or in D7 (2) "painting shoes" or "buying a tree". The aphasic person in D7 not only has obvious difficulties understanding spoken language, but also has difficulties distinguishing between "Yes" and "No" in her responses, and so these ambiguities understandably lead to a degree of discussion and prolonged explanation – the example with "buying a tree" continuing for another eighteen therapist turns (with explanations to do with "buying" itself; where you would buy a tree; the aphasic person's personal experience; the differences between big trees and small trees).

Dimensions associated with stimulus items: summary

- There is a large range of item types in this study – commercially available images, sets of images/words, but also items which are personally meaningful to the aphasic person
- Items are presented in tasks in various combinations, within and across modalities. Some items or types of items are considered to be more 'tricky' than others
- Numbers of items vary both in consecutive tasks, and concurrently, where the number presented at any one time may be deliberately manipulated by the therapist
- Items may be more or less clear or unambiguous

6.2.4.iii.III Dimensions associated with enacting routines

It is not the purpose here to examine 'Enacting routines' at the level of individual functional "Acts" as in ATICS (Horton and Byng 2000) for example. At the level of "Act" ATICS describes at least forty-eight individual types of what are described as words or word groups which are "more-or-less equivalent to the notion of speech act" (Horton 1999). Hence each "Act" attempts to capture the functional impact of therapist and aphasic person talk or action in a particular context. The purpose of this section however will be to address a number of dimensions related to 'Enacting routines' which ATICS, as a categorical system, generally fails to address. The following dimensions will be discussed:

a) the content and manner of therapists' 'Elicitations' in relation to:
   1) responding routines
   2) information content and response demands
   3) the structure of tasks

b) time and timing in:
   1) 'Elicitation'
   2) 'Elicitation-response'
   3) 'Elicitation-response – follow-up'

c) 'Elicitation-response – follow-up'

d) The 'Responding process'

It has been argued in depth and at length by a number of authors that turn-taking sequences such as those entailed in 'Enacting tasks' (Table 6.1 Feature B) are actually best understood in terms of a three-part structure. This is referred to variously as a "stimulus-response-reinforcement model" (Norris and Hoffman 1990: 73); a "three-part, evaluative sequence" (Kovarsky and Duchan 1997: 298); a "triad of adjacency units" consisting of Request-Response-Evaluation (Simmons-Mackie and Damico 1999b).

This conceptual approach to instructional dialogue pioneered by Sinclair and Coulthard (1972, 1975) was the basis for the development of ATICS, where the three-part sequence consists of three "Moves" – Opening, Answering and Follow-up.

In 'Doing therapy tasks' the therapist's 'Elicitation' forms the first part of this typically three-part adjacency structure. As a first-part it fulfils a role akin to the first pair part in a Question-Answer sequence. Adjacency pairs such as Question-Answer or Greeting-Greeting are characterised by a "first pair part" which is affiliated with a "second pair part" to form a "pair type" (Schegloff and Sacks 1973: 296). For any actual sequence a first and second are "*discriminatively related*" (Sacks 1992: Vol 2, Part VIII, Lecture 1, 521) (original italics) – that is to say, given a particular first pair part only a particular type of second pair part is admissable. In other words, a 'Question' projects an 'Answer' and not a 'Greeting' for example.

In terms of the third part of these exchanges Coulthard (1985) suggests that the three-part structure is so powerful that if it does not occur then it is, in Sacks' terms, 'noticeably absent'. Lesser and Milroy (1993) point out that because an absence of feedback is often a sign that the student has not produced the answer the teacher wants, short periods of silence in certain sequential contexts may trigger powerful inferences. Simmons Mackie *et al* (1999: 222) in their paper on feedback in aphasia treatment suggest that both participants "anticipated the feedback of the evaluation phase in the RRE sequence". Mehan (1979: 54) argues that: "the three-part initiation-reply-evaluation sequence contains two coupled adjacency pairs. The initiation-reply is the first adjacency pair. When completed, this pair becomes the first part of a second adjacency pair". He goes on to argue that: "the status of the student's reply as an answer or nonanswer is not determined until the teacher contributes an evaluation" (Mehan 1979: 64). In other words the meanings of the different acts as performed by (here) teachers and (here) pupils are not known until the sequences are completed. Whether

'Elicitation-response' can be said to project an 'Elicitation-response – follow-up' in the same way as is argued for the second pair part of adjacency pairs such as Question-Answer or Greeting-Greeting is not a matter for discussion here. However there is abundant evidence in these data for this type of three-part structure.

Some of the examples in Table 6.1 (Feature B: 'Enacting tasks' 'Elicitation' 'Elicitation-response' and 'elicitation-response – follow-up') demonstrate how this structure appears in its simplest form. The following is an extract from D2 (3):

222. T: can you work out which of the words
223. goes with each picture
224. A: um ((puts word card with picture))
225. T: good yeah

The therapist's 'Elicitation' occurs in lines 222-3, the aphasic person's 'Elicitation-response' in line 224, and finally the therapist's evaluation ("good yeah") in the 'Elicitation-response – follow-up' (line 225). Similarly in D15 (1):

3. T: ((puts picture in front of A)) right (.)
4. d'you recognise that
5. A: (2.5) ((leaning forward to table)) yes er
6. erm milk
7. T: excellent (.)

The therapist in D15 initiates an 'Elicitation' in lines 3-4, to which the aphasic person responds in lines 5-6. The therapist follows-up with an evaluation of that response in line 7.

There is nothing novel in the observation that such three-part exchanges occur pervasively in formal instructional dialogue, whether it be in school classrooms (e.g. Mehan 1979; McHoul 1978) or in speech and language therapy (e.g. Lesser and Milroy 1993; Panagos 1996). There is abundant evidence from these data that this is so, and as

has been discussed in Chapter Five it can be conspicuous by its presence in sequences not necessarily related to doing tasks *per se*. The three-part exchange has become in a way almost symbolic of the therapist's control over the dialogue of therapy. It will not be the main purpose of this section to present large amounts of empirical evidence for the existence of three-part exchanges in these data. The physical subdivision of dialogue into smaller units with boundaries separating one unit from another (such as 'utterances' 'turns', 'adjacency units' or 'three-part exchanges') is applied in order to answer certain questions about "the organisation, patterns and rules guiding the sequencing of a dialogue" (Markova 1990: 6.131). In respect of understanding the process of 'Doing therapy tasks' the concept of a three-part turn-taking structure will be used to help examine the relationships between parts of the structure one to another, and to the therapy items that constitute the material substance of the task. In other words what follows will seek to make explicit certain features of the complex relationship between the content and manner of 'Elicitation', the demands made on the aphasic person in terms of 'Elicitation-response' and how this relationship may be bound up in complex sequences through therapists' 'Elicitation-response – follow-up' and any subsequent 'Elicitation'.

Many of the dimensions and features observable in these data appear to have much in common with those discussed by Duffy (1994) in relation to Schuell's Stimulation Approach to aphasia therapy. The design of that approach to intervention mentions "response demands, feedback, and the sequence of treatment steps" (Duffy 1994: 7, 150), as well as details of the semantic relationships between response choices, response latencies and uncertainty of stimuli, and the order of difficulty of presentation and error rates. More specific reference will be made to these concepts where appropriate in the sections that follow.

6.2.4.iii.IIIa Dimensions of 'Elicitation'

'Elicitation' generally consists of a move or moves (verbal or non-verbal) made by the therapist which function to – as the name suggests – elicit a response from the aphasic person. 'Elicitations' take various forms, and these will be discussed in more detail below. As Panagos *et al* (1986) point out requests which initiate and maintain clinical sequences are "a frequently occurring clinician utterance" (Panagos *et al* 1986: 220).

As has been pointed out by numerous authors there is special nature to the type of questioning in formal instructional dialogue. Coulthard (1985) argues (with reference to classroom dialogue) that the teacher does not seek information in the accepted sense, as s/he already knows the answer. As Mehan (1979: 43) points out: "an elicitation does not seek just any information, it seeks particular information", and as has been discussed above the success or otherwise of the response to an initiation is clarified in the third-part of the exchange. Evans (1992: 506) contrasts genuine questions, where the answers are unknown with "'test' questions which are asked during instructional sequences in which the teacher knows the answers". These types of questions are also known as "quiz questions" (Kovarsky and Duchan 1997), the hallmark of which is that the clinician employs requests for "known information" (Kovarsky and Duchan 1997: 298). Simmons-Mackie and Damico (1999b) suggest that these requests on the part of the clinician are in effect requests for "displays of performance" of various types, such as "labelling performance" for example.

It has been suggested above (Section 6.2.4.iii Task demands) that the overall goal or goals of therapy can be said to be achieved through the enactment of tasks. If 'Doing therapy tasks' is the tool used to achieve one or more therapeutic goals a slightly different perspective on 'Elicitation' and a slightly different gloss on the nature of 'test questions' or 'requests' might be appropriate. That is that the content and manner of

'Elicitation' enables the aphasic person to respond to the demands of a task. Although the function of 'Elicitation' is apparently straightforward – to initiate the response process – the concern here will be to examine the ways in which 'Elicitation' is constructed and how this construction interacts with the therapy items. The ways in which 'Elicitation' and therapy items interact form one aspect of the demands placed on the aphasic person in responding to the task.

It is not the main purpose here to demonstrate how the various linguistic forms of 'Elicitation' can be seen to function as requests for a response from the person with aphasia. The forms that 'Elicitation' takes range from simple directives through indirect requests, to direct questions and complex multi-element initiations, as well as non-verbal moves. The focus here is on the type of information carried by the 'Elicitation' and where the various features of 'Elicitations' are directed. Typically content and manner of 'Elicitation' engages with the various elements entailed in the responding process as discussed above (Section 6.2.4.iii.I) – for example: responding routines; the mode of the response required from the person with aphasia; the response content.

1) 'Elicitation' in relation to responding routines. Directives such as: "now try and say it to me" (D1 (2)), or "now start off with that one at the top" (D2 (3)) are relatively infrequent in these data as a form of 'Elicitation' therapists use in the first instance. In the examples here, the directives contain information about the required manner of responding ("say it to me") or about the process of responding ("start off with that one at the top"). The aphasic person may also be directed to a specific referent in the stimulus item as in the following example from D12 (2):

1. T: (what's) going on in that picture
2. A: um ( ) [( )] ((setting to write))
3. T: [go for] go for if you go for the [verb]
4. A: [yes]

The therapist's: "go for if you go for the verb" (line 3) directs the aphasic person's attention to one aspect of the picture. Jones (1998) suggests that people with aphasia, if confronted with anything other than the simplest picture "find it difficult to decide what angle on the event to communicate – they can't focus". In other words the function of a directive to concentrate on the "verb" in D12 (2) above would be to help constrain the aphasic person's choice and thus enable him to respond.

In terms of the first 'Elicitation' of a particular task or of a particular item in a task therapists certainly appear to favour other directive forms – typically "let's" + infinitive as an imperative marker. This has a less 'directive' feel and through the use of "us", as has been mentioned before, therapist and client are brought together pronominally as an established team (Simmons-Mackie and Damico 1999b). Directives such as: "look carefully" (D7 (1), may form part of the 'Eliciation' turn, but are an adjunct to the 'Elicitation' itself, and are clearly focussed on the process of responding.

Focus on the process of responding through the use of directive forms often occurs as a part of a repair initiated by the therapist. For example, when the therapist judges that the responding process is off track: (D15 (1)): "hang on a sec hang on a sec" – the therapist directs the aphasic person simply to stop. This also takes the form of non-verbal interventions. For example in D9 (1) the therapist places her hand on the pile of picture cards and stops the aphasic person picking up the next card, adding: "okay just just (.) A hold on a second".

The directive may be aimed at enabling a more efficient response, as for example in D9 (2):

1. A: ((takes pencil to draw))
2. T: just hold it slightly more upright

This is clearly a simple and explicit directive requiring a physical response by the aphasic person. However therapists' proposals for 'efficient responding' may take a less overtly directive route as in the following extract from D12 (2):

1. T: it might be worthwhile doing what I suggested to you in the first place which is
2. writing down some of the words first and you've got them available and they
3. don't keep slipping away...if you just wrote some of the key words first you
4. might find it easier 'cause your sentences are good

The therapist's proposal clearly hints at reference to process of responding suggestions that have arisen previously – line 1: "what I suggested to you in the first place". She attempts to contrast the advantages her proposal might bring with the difficulty the aphasic person is clearly experiencing: lines 3-4: "if you just wrote some of the key words first you might find it easier".

Directives to use particular responding processes may be directed at internal language or cognitive processing routines. For example in D1 (2) the therapist urges the aphasic person to: "think about (this) how many syllables and what each one starts with", directing the aphasic person to complete a series of 'internal' routines before actually responding verbally.

Finally, therapists frequently use directives about the process of responding in a type of cautionary way, as in the following examples: D8 (2) (after an error has occurred): "so listen (.) so listen first"; D9 (3): "we've not done this before have we not quite like this so listen hard"; "listen carefully and look at all the pictures". In the example from D8 (2) the suggestion appears to be that the aphasic person needs to listen before doing something else – perhaps this is going to help him respond more efficiently, and he will be more likely to achieve a correct response. In D9 (3) the caution seems to be about the potential difficulty of the task ahead – either because it is a new one, or because there may be a lot to take in.

2) 'Elicitation': information content and response demands. The information content of an 'Elicitation' is clearly related to and to some extent determines the demands that a task imposes on the aphasic person. Information in the actual 'Elicitation' is distinguished here from the sort of information the therapist might give in 'Task introductions'. For example in the following extract from D13 (3) the therapist gives verbal information about each stimulus item as it is drawn: "sip a drink"; "this one here (.) sit...sitting on a chair"; "this one here sick (.) he's got a thermometer in his mouth not feeling well"; "the sin if I just something you do wrong....we've got four words there and you can see from the way they look at the beginning and the middle are all the same...but the last sound is different in each". The stimulus items ("sip", "sit", "sick", "sin" – the ones the aphasic person will have to choose from when the therapist says the target word) are clarified in terms of their meaning and phonemic/orthographic 'shape', but this occurs before the actual 'Elicitation' takes place.

'Elicitation' serves to carry varying degrees of information not only about the process of responding as was discussed above, but also about the actual content of the response. For example, in a task that requires a verbal response: "can you think of a vegetable that you don't have to peel" (D14 (2)); in a written word-picture matching task: "can you put the right word with each of the pictures" (D2 (2)); in a spoken word-picture matching task: "can you show me who's smiling" (D7 (2)).

ATICS (Horton and Byng 2000) divides the type of 'Acts' associated with 'Elicitation' into categories according to whether they function to "elicit" or to "inform and elicit" (Horton 1999). One of the problems for ATICS (as perhaps for other such categorical systems) is the notion (and actual fact) of multiple function. Various types of question form make explicit some requirement for the content of the response. For example: "who's hitting" (D5 (1)) shows the aphasic person that the required response has to be an agent (human). Similarly "what's he doing" (D5 (1)) shows that the

required response has to be a verb. The content of the 'Elicitation' in these examples however does not explicitly give information about the target response itself, except to orient the aphasic person to a semantic (in the first example "+human") or syntactic (in the second example "verb") feature of the response.

Clearly the actual form of the 'Elicitation' relates to the nature of the task in hand and the configuration of items available to the aphasic person. Thus the question: "who's sleeping" (D7 (2)) uttered by the therapist as an 'Elicitation' in a spoken word-picture matching task (where there is a choice of a number of possible target pictures) performs a different function to: "who's hitting" (D5 (1)) discussed above in the previous paragraph. In D7 (2) not only is the focus of the 'Elicitation' on the verb ("sleeping"), but the response required is very different from that in D5 (1). In the latter the focus is on the agent as the target of the response, and the response required is a verbal one rather than one that requires a pointing response.

'Elicitation' may contain specific information which relates to various features of the target response, such as phonetic/phonemic information, semantic information, or orthographic information. The way this works depends on the type (and extent) of the information being imparted. For example, when the therapist uses phonetic/phonemic information (commonly called 'phonemic cueing') s/he may use a 'carrier' phrase or sentence followed by a fragment of the target word. The following is an example from D5 (1):

1. T: a man what's he do doing he's ((holds lips in unreleased /*w*/ while looking at
2. A))
3. A: wipe
4. T: wiping ((then holding unreleased /*w*/))
5. A: his window

The therapist gives two pieces of phonetic information – in line 1 for one target ("wipe"), and line 4 for the other ("window"). The two target words just happen to start with the same sound, but in both instances the phonetic information is supported by a 'carrier'. As can be seen from this example the nature of the information can be quite subtle – here an unreleased sound. Such phonetic/phonemic fragments are also used after other types of information (for example semantic) have failed to elicit the correct response. The following is an example from D15 (1):

1. T: ((holds up a picture)) is that a shower
2. A: no=
3. T: =no (.) it's not a shower [it's a]
4. A: [it's a] /*f*::/
5. T: it's not a shower it's a /*b*/ ((voice onset but unreleased))
6. A: bath

The therapist's direct question in line 1, which orientates the aphasic person to the semantic category of the target (bath), in combination with the 'carrier' sentence fragment in line 3 ("it's a") fails to elicit the desired response. The therapist continues in line 5 to offer phonetic information in the form of an unreleased phoneme, and the target word is successfully elicited.

In D1 (2) where the aphasic person is required to read a sentence to herself and dictate the secondary clause, the therapist uses a variety of subtle pieces of phonetic/phonemic information to support the aphasic person's responses. For example, she co-articulates the first sound of the word with the aphasic person (also nodding her head slowly with each syllable of the word); she makes the unreleased sound shape of a target word ("so I ((lips brought together unreleased and unvoiced))"); she makes the first sound fragment of the target word:

1. T: I bought the ((high and level intonation))

2. A: ((makes mouth shape as if for */nj/*))

3. T: yeah (.) */then:/*

4. A: ((nods)) new

The therapist (line 1) uses a particular intonation contour to set up the next response, but this partially fails – the aphasic person achieves a mouth shape for the target word but no more. The therapist's runs "the" into the first sound of "new" (line 3) which is enough (as acknowledged by the aphasic person in line 4: "((nods))" to support the successful response.

As has been shown information about the target offered by the therapist in order to support the responding process and outcome may be given in relative isolation or in various combinations. This may happen simultaneously (i.e. in the same 'Elicitation') or in a sequence. In the following example from D15 (1) the therapist uses orthographic information in conjunction with other types:

1. T: ((writes down letter P)) what did he used to play (.) he used to play the

2. A: piano

The aphasic person is able to see the first letter of the target word as well as hear information of a semantic nature given in two forms by the therapist. The therapist's uncompleted sentence: "he used to play the" (line 1) is a frequently used formulation by therapists. Elsewhere in these data it appears as: "the professor is" (D5 2); "you used to ride a" (D15 (1); "you fill up the watering" (D15 (2)). Norris and Hoffman (1990: 78) call this a "cloze procedure" – a type of filling in the blank, which enables the client to "share the expression of the message".

One might argue that fragments such as: "so a man" or "he's" (D5 (1)) carry little or no semantic information, and that these types of 'carriers' have a purely

syntactic function. However they also, in implicitly delineating the nature of the target (here both 'verb') surely also impart semantic information at the sentence level.

Depending on the particular type of task 'Elicitation' may be the site of opportunity for elaborating on properties of the stimulus item. For example in a task that requires the aphasic person to study and then copy 'unseen' a written word from memory, the therapist rehearses the orthographic properties of the word. The following is an extract from D3 (2): "it's got two sets of double letters ((points)) and at the end too ((points)) that might help (.) double letters there and double letters there". The aphasic person then responds to the writing task. The information provided here by the therapist is understood to be part of an 'Elicitation' rather than as a 'Task introduction'. The therapist in this session is inconsistent with providing such information in 'Elicitation' – the previous two items were initiated simply by: "have a go now"; and: "let's have a go at writing it". Provision of information about stimuli may have been dependent on something noticeable about the stimulus item which in the therapist's judgement would help the aphasic person achieve a 'better result', rather than a general 'rule' that this person benefits from additional orthography-related information.

'Elicitation' – especially in repairs of error responses – may also feature a repeat and elaboration of information about the stimuli rather than information about the response target. This can take the form of information added in a different modality. For example in D7 (1) the therapist adds 'sound effects' and mime to an 'Elicitation' that has previously failed: "who's (.) /*sni:zing*/ atschoo ((miming a sneeze))"; or: "who's crying ((gesturing tear running down cheek))".

Additional information about the stimuli may also proceed stepwise in other ways. In D6 (2) the therapist has originally initiated an odd-one-out task (odd-one-out of four) with the following 'Elicitation': "these are the categories again you've got fruit vegetables and meat right...now three of those are one particular category and one isn't

any idea what the odd-one-out is". The aphasic person successfully responds to the first set of stimulus items. With the second she makes an error response and the therapist offers the following: "...three of them are either meat vegetables or fruit three of them come from one category and one doesn't". This is more-or-less a reiteration of the original 'Elicitation'. With a subsequent error the following ensues:

1. T: what's the odd-one-out
2. A: one two three ((pointing))
3. T: what one's the odd-one-out
4. A: ( )
5. T: which category
6. A: no
7. T: does that come from is it a meat a vegetable or a fruit

In line 7 the therapist specifically (and metaphorically) holds up the aphasic person's response (line 4) to scrutiny against each of the stimulus categories, and she then proceeds to do this in turn with the other stimulus items until the aphasic person has identified the odd-one-out correctly.

Repairs of error responses often use the actual error as information carried in the therapist's 'Elicitation' to contrast with something about the stimulus. For example in D5 (1) the aphasic person has mistakenly described a picture of someone playing tennis as "ping pong". The therapist uses the following formulation: "do you play ping pong with one of those ((pointing to tennis racquet))" (a classic 'test question'). The aphasic person goes on to make a further error by calling the game "badminton". The therapist's next formulation is: "when you play badminton do you have a (ball)", contrasting the "badminton" error with semantic information ("ball") related to the target word 'tennis'. In D14 (2) the aphasic person is required to find a word (a meal) related to items (cooking utensils) described by the therapist (a 'convergent semantic task'). The aphasic

person responds with a verb: "basting". The therapist's response is as follows: "basting was what I was doing but what d'you think I'd been cooking (4.0) what d'you baste in a roasting tin". The first part of the therapist's response provides the aphasic person with information and clarification about their response. As such this is the type of "feedback" referred to by Simmons-Mackie *et al* (1999: 224) which is designed to: "provide insight regarding the accuracy or adequacy of a response in order to mediate improved communication". The therapist's: "what d'you baste in a roasting tin" uses the aphasic person's error response together with further semantic information ("roasting tin") to help achieve the desired response.

The information content contained in the 'Elicitation' may not be conveyed to the aphasic person directly by the therapist at all. Thus for example in written word-picture matching tasks the process of extracting the required information from the stimulus item may rest with the aphasic person. Put simply, the aphasic person has to read and understand the word and respond according to the conventions of the task. The following is an example from D6 (1):

1. T: choose another one
2. A: eh let's see now
3. T: any one at all
4. A: ( ) ((picks up and places word card)) no ( ) ((replaces word card))
5. T: well done good that's another type of fruit

In line 4 the aphasic person selects a card, and having read the word to herself makes a decision as to the correct category (here a choice of three). 'Elicitation', as well as obviously functioning to set tasks in motion, is also the seat of opportunity for the therapist to provide more or less support for the aphasic person in the process of responding. In some instances therapists may specifically refer to this function. For

example in D11 (1) the therapist refers to the 'Elicitation' process in introducing a new task:

1. T: what I'll do is just give them to you I won't read them out
2. A: okay
3. T: if you're really not sure then I'll read them out if that's gonna help
4. A: yeah
5. T: but I'll let you 'cause sometimes you put it in one and I [can tell]=
6. A: [yeah]
7. T: =[that you're thinking about it]
8. A: [I know I] know

The therapist makes it clear that in the first instance the aphasic person will have to rely on his own resources (line 1: "I won't read them out") to extract the required information from the word card. He will then use this information to help him complete the task, namely choose a category for the word (from one of two). In line 3 the therapist begins to make explicit the decision-making dilemma she faces in choosing whether or not to provide more support for his response. She has to gauge or check if he's "really not sure" (line 3), and she clearly states that evidence from past work is guiding her approach: "'cause sometimes you put it in one" (line 5). The observable corollary of this type of decision is one of the key features of the enactment process – namely, what therapists do and when and how they respond to perceived or real responding difficulties.

The following is an extract from D8 (2) which shows how the notion of task or response demands translates into tasks being more-or-less 'easy' or 'difficult'. The aphasic person has successfully carried out the task (written word-picture matching followed by him reading aloud the target word) with several items when the therapist says: "I'm not managing to catch you out yet am I". This formulation gives the

somewhat playful feeling of a game, but is also an implicit challenge to the aphasic person. It also implies that the job of the therapist is somehow to expose the aphasic person's failings. A few turns later the following sequence arises:

1. T: ah good well I think they should be harder Frank
2. A: ((turns page)) */kweizez/* ((pointing to word))
3. T: okay (.) so it's this one (.) 'cause that's a tricky one to say (.) so listen so listen
4. first (.) is this one a pipe or a cigarette
5. A: */splerezez/*
6. T: (sh'll we) do you want to listen again
7. A: yeah
8. T: okay (.) I'll change it this time (1.0) is it m:: is it a cigar (.) or a cigarette
9. ((looking at A))
10. A: ((looking at T)) (3.0) cigarette ((slowly))
11. T: good (.) well done
12. A: ((turns page and yawns)) ((points to word on page))
13. T: just can't catch you out
14. A: */bezinaziz/=*
15. T: =okay hang on Frank (.) so is it (0.5) a bear (.) or a monkey
16. A: a monkey
17. T: monkey good

The notion of task demands arises in the therapist's mention of "harder" (line 1) and "a tricky one to say" (line 3). In line 13 the notion of a 'challenge' arises again. The aphasic person is clearly motivated by his success and appears pleased (smiling) whenever the therapist talks about not being able to catch him out. After the aphasic person's difficulty with the word in line 2, the therapist acknowledges his difficulty (line 3) but gives no explanation on what basis it is a "tricky" word. Is it "tricky"

because he has had difficulty, or because of its syllabic, phonetic or phonemic structure? Her first formulation (line 4: "pipe or cigarette") offers him information in the form of a 'spoken alternatives choice' (or 'forced alternative' in the common speech and language therapy jargon) – target word is second, and so there is a possible recency effect to help him. When this fails the therapist chooses a different information set in the form of "a cigar (.) or a cigarette" (line 8). Again the target word is in final position, but the distracter bears greater phonemic similarity to the target this time. The aphasic person is successful. After his error in line 14 the therapist again uses spoken word choice information as a means of facilitating his response, this time using words which are semantically but not phonemically related. We have no way of knowing whether the spoken word choice offered by the therapist reflects the actual words that the aphasic person has had to choose from on the page.

3) 'Elicitation' in relation to the structure of tasks. 'Elicitation' also occurs 'as understood' as part of the sequential structure of task routines. What this means is that clinicians' utterances do not necessarily initiate an explicit task routine, such as in: "say it to me" (D1 (2), which embodies an imperative and explicitly states the response mode. Where 'Elicitation' occurs as a consequence of the structure of the session it occurs in several ways.

Firstly it may be preceded by a sometimes lengthy and precise exposition by the therapist of the items and/or the task routine. The following is an extract from D6 (2):

1. T: so I'm going to write down three words again (.) same words as last week
2. A: yeah
3. T: vegetables
4. A: vegetable
5. T: fruit
6. A: fruit

7. T: meat

8. A: meat

9. T: so let's see if you can do this

10. A: er ((places card in category))

The reference by the therapist in line 1 to the "same words as last week" obviously also serves as a shortcut to an explication of the task routine. The distinct item categories are set out as word cards as well as being verbalised one-by-one by the therapist (and acknowledged by the aphasic person). The therapist's "let's see" (line 9) is the type of directive formulation which was discussed above, but here the therapist's "do this" assumes that the task requirement and response mode are already understood.

In D9 (1) (Table 6.1 Feature A: 'Beginning doing therapy tasks' 'Task introductions') the responding routine is modelled by the therapist. She initiates the 'model' with: "so let me get you going" (line 43). The task routine is made explicit through the process of laying three cards and the actual 'Elicitation' takes place in line 53 where the therapist simply hands the next card to the aphasic person.

Where tasks require manipulation of (e.g. category sorting) or verbal responses to a series of word or picture cards 'Elicitation' quite often takes the form of the therapist simply handing over or displaying the next card. Therapist control over these items can in one sense be related to features of 'Task procedures' (see Section 6.2.4.ii above) – in other words in terms of control over the flow of stimuli in relation to language or cognitive processing factors in the aphasic person. In D9 (2) for example the therapist explicitly states this as a reason for her retaining control over the flow of items: "so we're going to do sorting but I'm going to hold onto the cards so (the important thing) */wi/* ((cut off)) you're fine if you do them one at a time but if you give (A) the pile you go too quickly ((A smiles and T chuckles)) too much of a hurry". She is referring to instances which are observable from 'Enacting tasks' in the previous

session where the aphasic person had control over the pile of picture cards. For example in D9 (1):

1. A: ((picks up card and places it immediately on one of the three piles))=
2. T: =oo::eroo:: ((looking up at A)) woa
3. A: ((picks up the last card and places it on a different pile pulling a face))
4. T: ((chuckles and smiles)) go a little bit [slower] ((downward waving hand
5. movement))
6. A: [((picks up and places next card))]

The therapist clearly relates the aphasic person's response, which is evaluated by the therapist in line 2, as being due to her going too fast (line 4: "go a little bit slower"). There is some justification in this assessment as the aphasic person is able to correct the error-response straight away on reconsideration (line 3). It has to be said however that up until this particular response, the aphasic person had carried out an immediate and correct placement of the picture cards twelve out of thirteen times. On the one exception occasion of these thirteen she hesitated for 1.5 seconds before making her (correct) response. It may be therefore that the therapist's judgement of her going too fast is actually not born out by events, and that her decision to take control of the cards is unwarranted. Control over therapy materials by the therapist may also be considered in terms of the social control exercised by the therapist as the dominant partner and professional in the therapy interaction.

As is clear from the example in D9 (1) above, 'Elicitation' may also take a more self-directed form, where the person with aphasia simply addresses their attention to the next item in their own time and, ostensibly, under their own control. However this type of 'Elicitation' does not occur as an isolated event. When considered in relation to other facets of the enacting routine it is clearly also under strict, albeit not necessarily explicit, therapist control. As was mentioned above in terms of the three-part structure of 'Doing

therapy tasks' first- and second-parts of the structure project the occurrence of an appropriate next turn. It is pervasively the case in these data that, where there is a series of items in a particular task, work on the next item does not successfully proceed until the preceding 'Elicitation-response' has been evaluated by the therapist in some way. This needs some explanation and qualification. Firstly: "successfully proceed" refers to the next 'Elicitation – Elicitation-response – Elicitation-response – follow-up' triad being followed through and brought to a close. For example in D9 (1):

1. A: ((places next card))
2. T: and: ((hand moving over to stop A placing next card)) this one (.) is that
3. [the air or the sea]
4. A: [((holds card against 'land' pile]))

Thus the aphasic person has carried out an 'Elicitation-response' in line 1 and is in the process of placing the next card when she is stopped by the therapist (line 2). In other words the therapist does not let her proceed with the following item until the previous error is addressed. The implication is that, even where the aphasic person appears to have control over the 'Elicitation' of items (simply by taking the next card), s/he does not have that control, being dependent on the therapist's 'Elicitation-response – follow-up' from the previous item. Thus the appearance of the aphasic person running through a series of 'Elicitations' is just that – an appearance. In actual fact, each 'Elicitation' in the task in D9 (1) is <u>preceded</u> by an implicit evaluation, and the routine is enacted through the structure of the task.

There is an exception to this. This occurs either where the task actually requires self-evaluation by the aphasic person, or where evaluation is only carried out by the therapist after the aphasic person has completed an item-set or task. The following are all extracts from D2 (3):

Extract one

1. T: can you have a go at writing it underneath
2. A: ((writes letter [concentrating on the page])) ((sits back))
3. T: [((nods))] that's good so far
4. A: ((considers but does not write)) (10.0)

Extract two

1. T: now start off with that one at the top maybe yeah you can do that without
2. having anything or do you want some kind of clue
3. A: ((starts and finishes writing word))
4. T: aha (.) brilliant

Extract three

1. T: you have a go at writing that one
2. A: ((writes))
3. T: are you happy with that
4. A: yes it's this I think ((points to a letter))
5. T: m:: the end is not quite right

The manner of therapist contingent responding (i.e. evaluation in the 'Elicitation-response – follow-up') may be dependent on how problematic the therapist considers an item to be. In Extract one here the therapist follows-up the first written letter with a positive evaluation (line 3: ((nods))) which is quasi-simultaneous with or almost imperceptibly follows the response. She adds weight to this with an encouraging: "that's good so far" after the aphasic person has sat back. Thus this is an example of a completed 'Elicitation – Elicitation-response – Elicitation-response – follow-up' triad, and although the aphasic person does not actually manage a further 'Elicitation-

response', the subsequent 'Elicitation' is understood and the ten second silence in line 4 is attributable to her non-response.

In contrast to the structure in the first extract, in Extract two it is not until completion of the whole word that the therapist makes her evaluation. In Extract three her request for the aphasic person's self-evaluation awaits completion of the word. In other words, in Extract two and Extract three, letter-by-letter 'Elicitation' has proceeded under the aphasic person's own control. This may seem rather too fine a distinction to make, but it does perhaps illustrate the subtle relationship between 'Elicitation' and 'Elicitation-response – follow-up' which is in the gift of the therapist to manipulate. It is significant in that the way in which the therapist manipulates this relationship impacts upon the nature of the demands placed on the aphasic person.

Self-initiated 'Elicitation' does occur in certain circumstances, although its status as 'self-initiated' is uncertain. This occurs usually after a successful 'Elicitation-response'. Thus for example in the following extract from D15 (1):

11. A: .../*si:*/ is for (2.0) can
12. T: can
13. A: can
14. T: that's it

The aphasic person's turn in line 13 could be construed as a self-initiated retry or review of the target word, after she has achieved a correct response in line 11 ("can"). However, if the therapist's turn in line 12 is seen both as reflecting her 'Elicitation-response', and as a new eliciting move (followed-up by a positive evaluation in line 14), then her retry is not self-initiated. However, these types of retries are often seen, when they do occur, after relatively long and problematic task-related sequences, and may therefore reflect the aphasic person's self-initiated rehearsal of a 'difficult' item.

Dimensions of Elicitation: summary

- The content and manner of the therapist's 'Elicitation' may direct the aphasic person to respond in a particular way or address themselves to a particular aspect of the process of responding
- The information content of the 'Elicitation' is related to and to some extent determines the information-processing demands the task places on the aphasic person
- 'Elicitation' occurs both explicitly and implicitly as part of the sequential structure of task routines

6.2.4.iii.IIIb Time and timing

1) Time and timing in 'Elicitation'. A further feature of 'Elicitation' is one that has been remarked upon by Sinclair and Coulthard (1975) among others. This is to do with the way in which the therapist – or teacher in Sinclair and Coulthard's (1975) study – may produce an utterance which has the potential to initiate an 'Elicitation', but which is followed by a further utterance which either appears to supersede or to underscore the focus of the preceding one. Sinclair and Coulthard (1975) opine that this may be to do with the teacher realising s/he could have expressed the intention in a better way. It is not possible to impute intention from these data (nor was it actually possible for Sinclair and Coulthard). In the nomenclature of Sinclair and Coulthard's (1975) approach to classroom analysis, this phenomenon causes the initial utterance to be "pushed down" and changes its status to one of "Starter". "Starters" are acts which function to provide information about, or direct attention or thought towards an area in order to make a correct response to the initiation more likely.

One of the difficulties in analysing the status of the different elements in 'Elicitation' where this phenomenon occurs is a simultaneous need to consider the time

which therapists 'allow' for responses – or rather the time that may elapse before a subsequent utterance. In other words, how does this particular feature of 'Elicitation' interact with the dimension of time, and is the passing of time to be construed in terms of 'pause' (i.e. time 'belonging to' the therapist), or 'gap' (i.e. time which is attributable to the aphasic person), or in Sacks' (1992) terms: "The question is, is it your pause or my pause?" (Sacks 1992: Vol 1, Part III, Lecture 5, 310). Doubtless there are a number of considerations here. These might include reconsideration by the professional of their own initial utterance as proposed by Sinclair and Coulthard (1975), or the therapist's degree of tolerance (planned or unplanned) for a 'response thinking time' (see also McHoul 1978).

The following are extracts from the data which demonstrate this phenomenon in various contexts. The first example is from D5 (1). The tasks here form a series or 'task-set' where the aphasic person is required to: 1) choose a written verb from a choice of four or five in response to a picture stimulus; 2) name the agent of the action; 3) name the theme. The sequence below illustrates tasks 2) and 3):

1. T: m:: okay (.) who who's hitting (0.5) who is this
2. A: (2.0) a man ((laughs))
3. T: does he have a name do you think (.) you're very good at names [((laughs))]
4. A: [((laughs))] ( ) (2.0) ((looking down at paper)) John ((looks up at T)) ((laughs
5. quietly))
6. T: ((T and A both looking down at paper)) John ((starts writing)) okay (.) John
7. (4.0) hits\ ((finishes writing and simultaneously looks up at A))
8. A: (6.0)
9. T: *what's he hit*
10. A: ((brief glance up at T then points to paper)) er a ball

Before the sequence above takes place, the aphasic person has successfully completed the first task in the set. In the first task the therapist's 'Elicitation': "which verb shall we have", is followed by a 15 second uninterrupted silence which is clearly attributable to the aphasic person as part of the phenomenon of response, following as it does the therapist's direct question. This accords with Sacks' (1992) notion of "*responsible silence*" (original italics) – silence which is attributable to someone – in this instance, "the silence of one who should speak now" (Sacks 1992: Vol 1, Part VI, Lecture 1, 631).

In the extract above various aspects of silence are apparent. In the therapist's initial turn (line 1) she restates the question: "who is hitting" in a slightly different form after a very brief (0.5 second) pause. This looks very much like an example of the type of phenomenon described by Sinclair and Coulthard (1975). One might say that the two different elements – "who's hitting" and "who is this" – are additive. The first encompasses both reference to the agent and to the verb, while the second is concentrated on the agent alone. It is worth considering this turn in the light of some work that went on earlier in the same session. In the previous set of three tasks, all with the same format as this one, the aphasic person had some difficulty with the 'step two' task – the question concerning the agent of the sentence. In response to the therapist's question: "who's wiping" his response was as follows: "(3.0) ((sighs)) er ( ) wiping (his) er" – in other words he was unable, initially to access and produce the word for the agent of the sentence. In the following turn the therapist repeated the question but with additional emphasis: "John <u>who</u> is it (1.0) who is that ((pointing to paper on desk))". In other words there is a little bit of history concerning his difficulty with accessing and producing the word for the agent of the sentence. Perhaps this is why the therapist, after a brief pause, makes the addendum to the 'Elicitation' in her first turn in line 1 above.

This therapist has already demonstrated that she is relatively tolerant of silence attributable to the 'Elicitation-response'. In lines 2 and 4 the aphasic person apparently has little trouble responding appropriately (both two second silences). Although there is no apparent question or directive to respond in the therapist's turn (lines 6-7), this turn is clearly an 'Elicitation'. This is evident from the therapist's actions. Both she and the aphasic person are attentive to the paper on the desk as she writes and says the words out loud. Even though "hits" (line 7) is delivered with a falling intonation (i.e. not apparently inviting a response), she looks up at the aphasic person immediately she has finished writing signalling the end of the turn and the moment when the response becomes due. Thus the six second silence in line 8 is attributable to the aphasic person's 'Elicitation-response'. The therapist's turn in line 9, delivered very quietly though it is, must be construed as a repair phenomenon, designed to help the aphasic person in some way to achieve the appropriate response, and thus is not part of the initial 'Elicitation'.

It appears that one can make a reasonable judgement about the attribution of silence to the current speaker or to the next. For example, again in D5 (1) in the same type of task-set as discussed above, the therapist's 'Elicitation' is thus: "a man wipes (.) what's he wiping (4.0) a man wipes"; in a picture naming task it is thus: "what's he doing (.) what what game is he playing here (3.5) what game is this". In the first example the four second silence seems to be intuitively attributable to the aphasic person. This is perhaps because evidence from elsewhere in D5 suggests that this therapist's reformulations tend to come after micro- or very brief pauses such as: "a man wipes (.) what's he wiping"; "who who's hitting (0.5) who is this", or as in the second example in this paragraph, where the three-and-a-half second silence can be contrasted with the micro-pause between: "what's he doing (.) what what game is he playing here".

This feature of 'Elicitation' appears to be associated with types of tasks which require a naming response on the part of the aphasic person. It appears to have the function of providing increasing amounts of information about the stimulus item, as in D5 (1): "so what's he playing (1.5) with a racquet↑ (3.5) it's a fairly soft ball isn't it (2.0) that bounces". Whether these silences here are attributable to the therapist or to the aphasic person is debatable – it could certainly be argued that the three-and-a-half second silence, merely by dint of its relative length, is attributable to the aphasic person. But what about one-and-a-half or two seconds?

The contrast between 'pause' and 'gap' is more apparent in the following examples from D14 (2). Firstly the task itself involves the therapist verbally listing a number of features of the stimulus item that are (presumably) designed for the aphasic person to use in finding and formulating the required object name (here the aphasic person cannot see the picture). For example: "um this is very fattening (.) er:: sometimes has raisins or chocolate in er might have coconut in you bake them in the oven...". The aphasic person however is having some difficulty naming the item, and the following ensues: "they're sweet you bake them in the oven (and) and they have got sugar in them (2.0) they're very easy to make (.) sugar (.) flour (1.0) butter and eggs (5.0) you can buy them in a packet". There is some degree of variability in the pauses in this 'Elicitation'. This would be expected where the therapist is having to 'think on her feet', and perhaps having decided that there should be some additional information, needs time to think of it. Alternatively, she feels, as is opined by Sinclair and Coulthard (1975), that the formulation just completed, on reflection (after one second and two seconds in the example from D14 (2) above) needs addition or adjustment. However, it seems clear that, in contrast to these admittedly variable silences, the five second silence is attributable to the 'Elicitation-response' and thus to the aphasic person.

What does it actually mean when there is a pause within an 'Elicitation' or a gap between 'Elicitation' and 'Elicitation-response'? Therapists are clearly at pains to ensure that there is an appropriate amount of information in an 'Elicitation'. This may mean reformulating the 'Elicitation' until they judge that the demands on the aphasic person are properly adjusted. Into that balance also goes a judgement about the right amount of time to allow for a response to come from the aphasic person.

Therapists not only make additive or reformulative contributions to 'Elicitations', they also adjust the delivery of the 'Elicitation' as a whole in ways that they think is proper, whether the 'Elicitation' consists of one word or many. The following examples illustrate how time and timing within 'Elicitations' may be adjusted by therapists in subtle ways. These examples also illustrate that one cannot easily separate the dimension of 'time and timing' from that of 'information content' (see Section 6.2.4.iii.IIIa Dimensions of Elicitation above). In all the following examples subtle changes to time and timing within 'Elicitation' could be said to add to the information content of the 'Elicitation' relative to the response demands as discussed above.

In all the extracts below therapist adjustments to the time or timing of 'Elicitations' appear to be designed to improve the likelihood of a correct response. The following is an extract from D3 (2). The therapist has just introduced the task, explaining that the aphasic person will be asked to have a look at a picture and say the word, before doing some written naming work:

1. T: and this is Oxford ((looks up from the picture to A))
2. A: (2.0) yeah ((looks at picture and then up at T nodding))
3. T: Oxford ((holding /o/ mouth shape unreleased for a split second)) (1.0) (can you
4. say that)
5. A: ((looks up at T))

6. T: ((holds /o/ mouth shape for 0.5 seconds))

7. A: Oxford

The aphasic person's "yeah" (line 2) appears to be an acknowledgement of the therapist's naming of the picture. She does not appear to have taken the therapist's (line 1) turn as an 'Elicitation' at all, and perhaps this is why the therapist holds the /o/ mouth shape (line 3) before explicitly requesting an 'Elicitation-response' (lines 3-4: "can you say that"). The therapist's 'Elicitation' in line 6 is very much akin to the type of target related (phonetic) information discussed above in 'Elicitation': information content and response demands in the previous section (Section 6.2.4.iii.IIIa Dimensions of Elicitation). Later in the same session and in the same task-related context, the therapist carries out a comparable series of time related adjustments to the stimulus item in 'Elicitation', beginning with "music", continuing with "*/m::/*" ((unreleased)) and finally eliciting the required target with: "*/m:jusik/*".

These time-adjusted 'Elicitations' may also carry subtle changes in emphatic stress. For example in D7 (2), where the task requires the aphasic person to decide which theme legitimately goes with a particular verb, the therapist occasionally places additional stress on part of the verb, as in: "*/plei:/* (.) football". Here the /p/ is also heavily aspirated. Interestingly this contrasts with other 'Elicitations' in this task set which are delivered in a quite normal conversational pattern, such as: "play bingo" or "play chess", and there appears to be no obvious reason for the therapist to make this particular adjustment.

The brief pause between "play" and "football" apparent in the above example can be seen elsewhere in the work of D7. In D7 (1) in a task that requires the aphasic person to choose a picture to match a spoken word, the therapist frequently inserts a micro pause thus: "can you show me who's (.) smiling". The "who's" is delivered with high level intonation as if to signal the impending utterance of the target word. The

aphasic person is then perhaps further prepared for the actual stimulus by the micro pause, and this is frequently further underscored by prolongation of the target word, thus: "who's ((high level intonation)) (.) */sni:zing/*".

2) Time and timing in 'Elicitation-response'. Mention has already been made of therapists' 'tolerance' of silences attributable to the aphasic person as they respond to an 'Elicitation'. As was discussed in the review of the literature (Chapter Two) additional time for 'lexical search' has been found to be an effective method of aiding word-finding in speech production for people with aphasia. Time – 'thinking time' or 'processing time' – is therefore not a trivial matter, but potentially a valuable resource for the person with aphasia. Time allowed for the response to emerge, or before the therapist intervenes does vary greatly across the data, and is clearly related to a variety of factors – the type and severity of the aphasic impairment, the task type and extent of the demands placed by the task on the aphasic person, and of course the therapist's own judgement (or tolerance) of 'processing' on behalf of the aphasic person.

While silences attributable to the aphasic person have been described as 'tolerated' by the therapist, there is a phenomenon observable in these data where the aphasic person takes an active role in 'claiming' silence as their own. There is evidence in data already discussed above in D5 (1):

3. T: does he have a name do you think (.) you're very good at names [((laughs))]
4. A: [((laughs))] ( ) (2.0) ((looking down at paper)) John ((looks up at T)) ((laughs
5. quietly))

In line 4, after the shared laughter, the aphasic person says something which is not clearly heard. This has the effect of "seizing the floor" (Sacks 1992: Vol II, Part VII, Lecture 13, 497), which Sacks goes on to argue allows a subsequent silence (in their utterance and therefore a 'pause') for preparation of the ensuing utterance. The sequence then in terms of 'Doing therapy tasks' (rather than casual conversation) would

be: 'Elicitation' 'Floor seizure' 'Silence' (= 'pause') 'Elicitation-response'. Thus the two second silence in line 4 above would be interpreted as a 'pause' rather than a 'gap'. There is other evidence in these data for this type of sequence. The following is another extract from D5 (1):

1 T: Jim sorry sorry Jim (1.0) Jim hits

2. A: (3.5)

3. T: what's he hitting

4. A: hits (7.0) hits a (3.5)

5. T: what's he hitting

Here the three-and-a-half second silence (line 2) has been construed as being attributable to the aphasic person, due to its relative length. One might ask why the phenomenon that occurs in line 3 did not occur here. In line 3 the aphasic person uses "hits" to acknowledge that he has registered the 'Elicitation' and this allows him the seven seconds he gets before making an 'Elicitation-response' attempt ("hits a"). This has been construed as an 'Elicitation-response' attempt because the inclusion of "a" is taken as an attempt to formulate the verb phrase that is required. This phenomenon is also noted by McHoul (1978) in observations of classroom interaction, where a pupil uses "well" as a device to show that he has embarked upon an answer and that he can therefore go on to take his time to produce that answer (McHoul 1978: 195).

Elsewhere in the data this phenomenon is represented in various ways. The following is an extract from D1 (3):

1. T: okay so what's happening there

2. A: um (12.0) ((in which A looks up and away tapping her finger on the table))

The aphasic person's "um" (line 2) buys her thinking time, but it could also be said that her non-verbal behaviour also sends out 'I'm thinking about this' signals, even

though the time space does not enable her to achieve the response here. A few turns later she signals that she is preparing to give a response before making the utterance:

1. T: where does it start
2. A: ((opens mouth as to speak holding for (2.0))) (the) (7.0)
3. T: right

In line 2 the aphasic person shows readiness to make the verbal response, even though it takes two seconds before she does so. The actual response ("(the)") is the start of a sentence and so this buys more time (seven seconds) before the therapist intervenes again (line 3).

The ways in which aphasic people lay claim to the 'processing floor' depends very much on the nature of the task at hand and the nature of their aphasic impairment. The aphasic person's speech in D1 for example is characterised by physical struggle. The therapist at the beginning of the second session (D1 (2)) reiterates advice about going about responding: "so take your time...um think carefully plan it...and then take your time". The aphasic person, having read a sentence to herself, is required to dictate a secondary clause to the therapist.:

1. T: okay so you dictate it to me (.) so/
2. A: (10.0) ((starts making baton-like hand gestures)) (2.0)
3. T: so/
4. A: er (3.5) she
5. T: good girl so she/
6. A: (3.0) ((lifts hand and starts making baton gesture)) ahh ((drops hand, smiles
7. and tilts head))
8. T: what helps your verb

There are ten seconds of silence at the start of the aphasic person's turn in line 2 which remain 'unmarked' by the aphasic person and uninterrupted by the therapist. The

'take your time' advice has obviously been allowed to occur by the therapist. The aphasic person's hand gesture appears to signal a recognisable start to the onset of word production – after 2 further seconds of silence the therapist repeats her 'Elicitation' of line 1 in line 2 ("so/"), and this time the aphasic person signals acknowledgement by use of "er" (line 4), buying herself the space to complete preparation for the articulation of "she". The association between hand gesture and 'processing' or the onset of articulation is confirmed by actions in the aphasic person's turn of lines 6-7. Here she makes as to articulate the next word (line 6: "((lifts hand and starts making baton gesture))"), but her "ahh" and the dropping of her hand signals that she has given up the attempt, and this is confirmed by the therapist's check in line 8.

In tasks that do not require the spoken or written production of a word, the onset of the aphasic person's 'Elicitation-response' turn is often signalled by the handing over of a card or uncovering of a set of pictures. This has already been discussed above ('Elicitation' in relation to the structure of tasks in Section 6.2.4.iii.IIIa Dimensions of Elicitation), and here mention will only be made regarding the relationship between the initiation of the 'Elicitation' and the 'claim' that the aphasic person makes upon time taken to respond In the majority of sessions where this type of task takes place, the moment the picture or word card is under the aphasic person's control (whether it is uncovered, handed to them or picked up by them) they are considered to be committed to a response. The following is an extract from D6 (3), where the task requires the aphasic person to pick the odd-one-out from three pictures:

1. T: [((uncovers next row of pictures)) what d'you think's the odd-one-out there]
2. A: [(((3.0) while looking down at the pictures))] (2.0) m:: (2.0) I think that
3. ((pointing)) no it's not ((finger remains resting on page)) (5.0) that ((pointing))

The aphasic person's gaze is directed at the pictures from the moment they are uncovered, rather than from the moment when the therapist's utterance (line 1) is

completed. After the therapist's utterance is completed two more seconds pass before the aphasic person's "m::" (line 2) which serves to preserve her command over the turn. Once she has responded, but amended her response, her finger remains on the page, continuing to lay claim to the response space for a further five seconds, until her final pointing response (line 3).

In a not dissimilar way the aphasic person may physically take the card and hold it up against the potential categories to test the relationship. In a way this is an observable demonstration that 'I'm still thinking about it'. This occurs in category sorting tasks in many different sessions – for example D6 (1) and D6 (2); D8 (3); D9 (1) and (2); D10; D11 (1) (2) and (3), as well as in written word-picture matching tasks – for example: D2; D3; D10; D11 (1) (2).

In spoken word-picture matching tasks the aphasic person may demonstrate that they are occupied with the process of responding by their bodily posture – leaning forward over the pictures on the table, often with a hand or finger passing over the choice in front of them. In this way long periods may elapse before a response falls without the therapist intervening. The following are extracts from D7 (1) (... indicates that part of the sequence has been omitted):

1. T: ...who's sneezing
2. A: (sneezing) (23.0) ((points))
3. T: no it's not him...
6. T: the one that's got a cold (.) achoo ((mimes a sneeze))
7. A: aha (16.0) ((looking for target))...
12. T: ...achoo ((mimes a sneeze)) sneezing
13. A: (20.0) m:↓ ((continues to look at paper for ten more seconds)) ((points))

'Elicitations' occurring in lines 1, 6 and 12 are all targeted at the same item within the same task. The aphasic person in lines 2 and 7 appears to acknowledge the

therapist's 'Elicitation' ("(sneezing)" and "aha" respectively) allowing herself time to consider the response. In line 13 her "m:↓" indicates she is still 'on the job' while clearly still having difficulties targeting the response. The therapist does not appear to become any less tolerant of silent thinking time with each ensuing 'Elicitation', using additional stimulus information with the subsequent 'Elicitation' in line 6, which is repeated in line 12.

Duffy (1994: 164) argues that the: "temporal relationship between stimulus and response should be considered". He goes on to discuss the amount of delay appropriate between presentation of the stimulus and the response, reporting on various studies in terms of output and comprehension tasks. In terms of output tasks he concludes that: "delays allowed for processing rarely should have to exceed thirty seconds" (Duffy 1994: 164), and that in terms of comprehension tasks the therapist may actually impose delays before allowing the aphasic person to respond. The notion of the aphasic person 'going too quickly' has already been discussed in relation to data from D9 (1). The phenomenon of an imposed delay is also observable in the extract from D8 (1) which follows below. Preceding this extract has been a task-set following the same procedures – the aphasic person chooses one of two written words to match a picture, the therapist presents two spoken words as alternative names for the target, and the aphasic person is required to choose (implicitly) and say the correct word. In the first task-set the therapist has instructed the aphasic person to: "wait (1.0) just for a couple of seconds and then you'll try and say it". The fact of the imposed pause is referred to by the therapist several items into the first task-set, and she proposes that they drop this particular part of the routine: "it's a bit harder now we're having this gap (.) between it (.) yeah/ (.) okay let's just (.) this time if you say it straight after me...". After completion of this set the following ensues:

1. T: okay now to make it harder then

2. A: yeah

3. T: yeah 'cause I think it's getting a bit easy for you

4. A: yeah

5. T: so we definitely have to have this break now before you say it

6. A: yes

7. T: okay I'm going to count to three like I did yesterday okay and you're not to say

8. it until I have counted to three (.) is that all right

9. A: yes

10. T: yeah okay so can you point to the word to start with

11. A: ((points))

12. T: aha so vest or pants ((T counts by extending thumb and two fingers over 3

13. seconds, hand held mid shoulder height)

14. A: (pantses)

15. T: *okay* (1.0) you're almost ((hand making 'so-so' gesture)) there with that one

16. try it again vest or pants ((T counts by extending thumb and two fingers over

17. 1.5 seconds, hand held at table level))

18. A: pants

19. T: good well done Frank okay

The imposition of a delay is associated with making the task harder (lines 1 and 3). Mention has been made above (Section 6.2.2 'Task Introductions'; Section 6.2.4.iii.IIIa Dimensions of Elicitation 'Elicitation': information content and response demands) of therapists referring to tasks (and items) being 'easier' or 'harder' and there is a sense that if the task is too 'easy', it may not be effective, and that a balance of challenges should be struck. In line 5 the therapist is clear that there "definitely" has to be a break, and she outlines how that will be established i.e. through her 'counting down'. Thus in lines 12-13 she 'counts down' holding up her thumb and two fingers for

each second. Her hand is held halfway between table top and shoulder just to the aphasic person's left His response in line 14 is acknowledged by the therapist but is adjudged to be unacceptable, and she repeats the 'Elicitation'. However this time her hand has dropped to table level (line 17), her thumb and fingers are barely extended and the count is reduced to 1.5 seconds. The impression is that she is reluctant to impose this degree of control over the aphasic person. Her commitment to the countdown continues but in a rather desultory way – this impression is gained through her hand movement and position (hand held low and very little extension of thumb and fingers) and the fact that the time delay to response continues to vary between 1.5 and 2 seconds. She occasionally raises the level of her hand for the count, and also often reaches across towards the aphasic person to try and attract his attention to the count, a move which he generally ignores. At one point the therapist explicitly returns to the matter of the time delay: "you didn't wait though (.) alright this time I'm going to be really strict okay not until I've counted to three do I want to hear you okay", and the task-set continues with reference and re-reference to the time delay.

One final observation regarding time and timing in relation to 'Elicitation-response' is that the pace of task sequences may accelerate as well as being slowed down. In the following extract from D15 (2) the interaction between therapist and aphasic person becomes more and more intense and the pace increases as the desired object name becomes more and more apparent:

1. T: what's that letter ((points))
2. A: a (mad) a (mad) [um:]
3. T: [what's] that letter
4. ((A and T both point, both leaning forward now towards the paper on the table))
5. A: oh: matter paterin
6. T: what's that first letter

7. A: pan ((looks at T))

8. T: what's the first letter (.) it's the letter */s:/*

9. A: */si:/*

10. T: */si:/* is for=

11. A: =*/si:/* is for (2.0) can

12. T: can

13. A: can

14. T: that's it

15. A: oh I got it ((sits back in the chair))

The task requires the aphasic person to name pictures of objects or people. She has failed to get the whole name of this particular item ("watering can"), and the sequence above traces the interaction as they work towards the required word. The therapist has written the first letter, and both participants lean forward over the table, focussed on the letter (line 4). The therapist's repeated 'Elicitations' (lines 3, 6 and 8) are delivered quickly and without hesitation – the beginning of the 'Elicitation' in line 3 overlapping with the aphasic person's turn in line 2. In a similar way the aphasic person's turn in line 11 latches immediately on to the 'Elicitation' in line 10, maintaining the pace and intensity of the interaction. The therapist's acknowledgement/evaluation (line 12) and aphasic person's re-try (line 13) follow quickly, and the relief and satisfaction of achieving the target word is evident in the aphasic person's: "oh I got it" (line 15) and the way that she sits back in her chair, moving back from the intensity and concentration of the preceding work.

3) Timing in relation to 'Elicitation-response – follow-up'. This section will consider timing in relation to therapist follow-up of the aphasic person's 'Elicitation-response'. Some mention has already been made of the relationship between 'Elicitation-response' and 'Elicitation-response – follow-up' above in 'Elicitation' in

relation to the structure of tasks (in Section 6.2.4.iii.IIIa Dimensions of Elicitation). Here it was pointed out that in tasks that appear to be 'self-administered' there is an implicit relationship between 'Elicitation' and evaluation in the preceding 'Elicitation-response – follow-up'. For the task to continue smoothly and without uncorrected errors the preceding 'Elicitation-response' generally requires immediate evaluation. Exceptions were mentioned with regard to tasks which require self-evaluation by the aphasic person, or where evaluation is only carried out by the therapist after the aphasic person has completed an item-set or task. The therapist may choose to calibrate their contingent response to items which are completed as a series of discrete responses (such as spelling a word letter by letter, or saying a sentence word by word). Such series of discrete responses have the status of "installment presentations" (Clark and Schaefer 1987: 25) and therapists respond contingently according to a variety of potential factors – for example item difficulty, cognitive load, or prompted by signals from the aphasic person. For example, as discussed above in 'Elicitation' in relation to the structure of tasks (in Section 6.2.4.iii.IIIa Dimensions of Elicitation) the therapist may choose to evaluate immediately, as in the example from D2 (3) where the therapist's positive evaluation of a first written letter is quasi-simultaneous with or almost imperceptibly follows the response. The following examples will examine the timing of therapist contingent responses not in terms of absolute time, but rather in terms of relative timing.

The following extracts from D11 (1) illustrates task sequences where the aphasic person is required to place a written word card in one of two categories – "parts of the body" or "clothing". The therapist has prefaced the task thus: "I won't say whether it's right or wrong until you say yep definitely I'm going to (keep) it in that pile". In the following set of extracts ... indicates that part of the sequence has been omitted:

1. T: okay the first one where does that go
2. A: (drill) ((places card and looks up at T))

3. T: okay\ (.) it's a dress

13. T: ((hands next item to A))

14. A: ((places item))

15. T: ((immediate response)) good a [back]

16. A: [yeah]

17. T: is part of the body ((hands next item to A))

18. A: ((places item and looks up at T))

19. T: car[digan]

20. A: [(cardin)] ((changes response and laughs))

25. T: ((hands next item to A))

26. A: ((places item)) yep ((looks up at T)) [no (no's)]

27. T: [gloves]

28. A: yes

29. T: you can tell by my face can't you

30. A: ((laughing)) oh no

The therapist's stated tactic of waiting until the aphasic person has made a final decision about his choice of category appears to be undermined immediately. The aphasic person, instead of taking time on the placement of items (i.e. in his turns in lines 2, 18 and 26) looks to the therapist for feedback as soon as he has placed them. As she clearly perceives in line 29, he can tell at once from her expression that he has got it wrong. There is another probable reason for this. When he does get it right her follow-up response in the form of positive evaluation is immediate – she does not allow space for him to consider the rightness or wrongness of his choice. His seeking feedback as in lines 2, 18 and 26 in one way reflects his uncertainty about the choice, just as the fact

that he does not actively seek feedback in line 14 reflects his certainty. Thus a combination of therapist timing, and control exercised by the aphasic person over the therapist serve to make this a rather inconsistent 're-learning' sequence.

The following sequence continues the D11 (1) session. The therapist has decided that she will now read out the word on each card as she passes it to the aphasic person to categorise:

1. T: ((gives card)) foot now foot is that something you wear or is it a part of your
2. body
3. A: ((places card))
4. T: ((immediate response)) good (.) body part
5. A: yeah
6. T: leg ((giving card))
7. A: (leg) ((places card)) [yes]
8. T: [good] ((nodding)) hat ((giving card))
9. A: yeah ((places card))
10. T: ((immediate response)) *well done* (.) jumper ((giving card))
11. A: (6.0) ((places card)) (0.5) no ((changes response)) yes ((A and T both looking
12. down at the table))
13. T: jumper (.) it's a bit like a cardigan

The therapist's evaluations in following-up (lines 4, 8 and 10) all immediately follow the aphasic person's responses in the preceding turns. Her response in line 8 even overlaps with the aphasic person's self-confirmatory "yes" (line 7) just after he has placed the card. In contrast to this there is no immediate feedback after his first response to "jumper" (line 11). The suggestion is that even the evidence of a split-second absence of a therapist response signals to the aphasic person that there is a problem with the response. The six second silence before he makes his first response here suggests that he

is uncertain about it anyway, but the pattern of therapist follow-up that has been already established confirms the error, and he then corrects.

In the above example the suggestion was that therapist follow-up patterns become quickly established and that the aphasic person is quickly attuned and very sensitive to changes in the pattern. While it is not possible to explore the therapist's purpose in her stated intention of withholding feedback until the aphasic person had thoroughly explored the category choice, the implication is that he should try and bring all his language and cognitive processing capacities to bear on the decision-making process. Seeking or receiving feedback before he has been through this work is to be avoided. The next examples explore rather different aspects of the timing of therapist contingent responses.

The following is an extract from D6 (1):

1. T: ((gives next card))
2. A: eh that one ((places card))
3. T: ((immediately)) well done so ( ) you sorting the words out
4. A: uh huh
5. T: so that they're not all jumbled ((giving next card))
6. A: right ((places card))=
7. T: =excellent onion's a vegetable ((gives next card))
8. A: ( ) (4.0) ((starts to place card, gaze down at table))=
9. T: =((starts to nod))
10. A: ((withdraws card)) (2.0) ((starts to place card, still gazing at table))=
11. T: =((starts to shake her head))
12. A: ((withdraws card)) (2.0) ((places card in third category, still gazing at table))
13. T: (1.0) bacon
14. A: oh bacon no no

The extract is taken from some way into the task. The task again involves placing word cards, here into one of three categories. The pattern of therapist follow-up being established here is one of an ever decreasing time interval between aphasic person response and therapist feedback – in the form of verbal and non-verbal action. Thus the therapist's follow-up is immediate in line 3, almost simultaneous with the aphasic person finishing laying down the card (line 7), and then in the sequence from lines 8-11 the therapist's actions actually pre-empt the completed response. Thus, as the aphasic person moves to place the card in one category in line 8, the therapist is already starting to nod, though this is not apparently seen. A very similar action occurs as the aphasic person makes a move to lay the card in the next category (line 10) – this time the therapist's action is one of negative evaluation. After the aphasic person places the card in the final category there is a silence (negative evaluation by implication) and the therapist offers additional stimulus related information in line 13 ("bacon"). The pattern of very brisk positive evaluation for correct responses continues to the end of the task. The implication here is that the therapist, in a way that is almost diametrically opposed to the example in D11 (1) above, is, through her follow-up actions, ruling out uncertainty for the aphasic person. Thus even if her response is only tentatively moving towards the correct category the therapist is in a position to ensure, through the timing of her follow-up, that she actually does makes that choice.

The dimension of time in therapists' 'Elicitation-response–follow-up' is one that is available to the therapist to manipulate in order to vary the demands on language or cognitive processing, Therapists have to balance the degree of certainty/uncertainty that an aphasic person might experience when doing therapy tasks with what might be considered to be a 're-learning' opportunity – in other words the opportunity to make a judgement for themselves about the status of their response, and to correct if necessary. The problem presents itself of course in different ways for people with different aphasic

impairments (and according to the nature of the task). For example, in D8 (1) the therapist points out: "the good thing is that you can hear that it's not quite right". This is clear from the aphasic person's self-evaluative actions as soon as he has made response attempts. Thus the status of time as a follow-up dimension in that particular session is very different from, for example, one where the aphasic person has less certainty about their responses. In these instances the therapist must judge when to respond. As has been shown, the therapist may (as in D6 above) try and eliminate uncertainty as far as is possible within the limitations of the task itself.

In the following section some aspects of the actual content and function of 'Elicitation-response – follow-up' will be considered in relation to 'Elicitation-response' and subsequent 'Elicitation' within the task.

Time and timing: summary

- Therapists' 'Elicitations' are sometimes characterised by pauses and reformulations, as well as adjustments to the timing of information delivery
- Time that elapses before a response emerges is a valuable resource for the aphasic person, which therapists tolerate or manipulate to varying degrees, and upon which the aphasic person may lay active claim
- The timing of therapists' 'Elicitation-response – follow-up' may be considered as a therapeutic resource to be manipulated by therapists in order to vary the task demands

6.2.4.iii.IIIc Dimensions of 'Elicitation-response – follow-up'

'Elicitation-response – follow-up' is generally taken here to occupy the third position in the triadic sequence that has been referred to in a number of places above. In the sequential position after 'Elicitation-response', 'Elicitation-response – follow-up' is also taken to encompass a follow-up to the 'Elicitation-response – follow-up'. This

occasionally takes place as the aphasic person reflects in some way on the therapist's contingent response. For example in D14 (2):

1. A: (3.0) biscuits
2. T: biscuits↓ (.) yeah
3. A: oh↓ ((smiles))

The therapist's turn in line 2 is a follow-up contingent upon the aphasic person's 'Elicitation-response' in line 1. The aphasic person's turn in line 3 is a further follow-up (to the therapist's follow-up).

The status of 'Elicitation-response – follow-up' could be said – very roughly speaking – to fall within the general domain of 'feedback'. 'Feedback' has been defined in many and various ways. For example: "any response, made by the clinician, based on the patient's response..." (Kinsey 1990: 282). Kinsey (1990) points out that the literature shows evidence of many feedback types according to the different ways in which they have been classified, ranging from "judgemental", to "corrective", "congratulatory" or "intrinsic" (Kinsey 1990: 282). Brookshire (1973) delineates two main categories of clinician consequences which are delivered contingent on given client responses. These are divided into those serving an incentive function and those serving a feedback function. The latter provide information – for example regarding appropriateness or correctness – about the preceding response, and as Brookshire (1973) points out consequences may serve both incentive and feedback functions simultaneously. Simmons-Mackie *et al* (1999) point out that not only do clients receive feedback from therapists, but also that: "the feedback that we receive from our clients influences how we monitor our own performance and modify our treatment efforts" (Simmons-Mackie *et al* 1999: 218). In their qualitative study of feedback in aphasia treatment sessions they found that, among other things, feedback served multiple purposes, not only providing information about client's responses but also contributing

to the establishment of discourse routines, and fulfilling important treatment goals. As has been demonstrated and discussed above ('Elicitation' in relation to the structure of tasks in Section 6.2.4.iii.IIIa Dimensions of Elicitation) the structuring nature of therapists' 'Elicitation-response – follow-up' is to be found in these data also. Other features identified by Simmons-Mackie *et al* (1999) – such as "continuer latchings", "affiliative feedback", and "veiled correction" – are to be found pervasively in these data. The types of summary statement about the client's performance referred to by Simmons-Mackie *et al* (1999) which appear at the starts and ends of sessions have already been addressed and discussed in this thesis in the sections on 'Opening up the business' and the 'Closing down period'. Other types of summarising work carried out by therapist and aphasic person will be addressed in Section 6.2.4.iv 'Summary' below. It will become clear that this examination of therapy data differentiates between summarising as a process which occurs in 'Elicitation-response – follow-up', and which refers to the preceding response or responding process, and other occasions of summarising.

1) 'Elicitation-response – follow-up' is demonstrably multifunctional in a variety of ways in these data. It may function to signal evaluation, metre out praise and encouragement, acknowledge the difficulty of the task or particular item. As such both therapist and aphasic person contribute to the process of 'Follow-up'.

2) Explicit statements about evaluative routines. It is highly unusual in these data for therapists to make explicit statements about their evaluative routines. However, in the following extract from D11 (1), the therapist does just that: "so I won't say whether it's right or wrong until you say yep definitely I'm gonna (keep) it in that pile". Generally speaking however, evaluation routines are not spelled out by therapists.

3) Negative evaluations are often implicit, and function in a variety of ways. The negative evaluation may be understood through the structure of recurring task routines, such as the following from D7 (1):

1. T: do you write with a pen
2. A: ((moves paper to NO position looks up at T and nods)) ((points to paper
3. again)) (that)
4. T: okay listen again

Here, the therapist's directive to listen again (line 4) as a preparation for another 'Elicitation' also functions as an implicit negative evaluation of the aphasic person's response in lines 2-3. Elsewhere in the work of this dyad, a correct (or acceptable) response by the aphasic person is met by immediate and explicit positive evaluation.

Implicit negative evaluation may take other forms. For example in the following extract from D6 (1):

15. A: ((withdraws card)) (2.0) ((places card in third category, still gazing at table))
16. T: (1.0) bacon
17. A: oh bacon no no

The established routine is that the aphasic person places the word card in the appropriate category without therapist intervention. If the aphasic person gets it right then appropriate positive evaluation ensues. The fact that here (line 16) the therapist reads out the word on the card is indicative to the aphasic person that she is wrong. Her realisation is signalled through the "oh" (line 17) and her own self-evaluation ("no no"). Furthermore, the therapist's additional piece of information about the stimulus item (the spoken name of the written word) serves simultaneously as a fresh 'Elicitation', functioning to enable the aphasic person to correct her error and make a correct response.

Similarly in D11 (1):

4. T: okay the first one where does that go
5. A: (drill) ((places card and looks up at T))
6. T: okay\ (.) it's a dress

The therapist's low falling tone on "okay" (line 6) acknowledges the aphasic person's response in line 5, and this in contrast to explicit positive evaluation he normally receives after a correct response is enough to signal negative evaluation. Again the therapist gives additional information about the stimulus item (spoken word) which enables the aphasic person to correct his error.

In the following example from D12 (1) the therapist's follow-up is an 'Elicitation':

1. T: okay you wrote that
2. A: (yes)
3. T: now what what letters which letter is wrong there do you know (.) if I say it out
4. if I read it to you as you've written it and then I I'll write I'll read it again the
5. way it should be see if you can pick up (which) is the wrong letter (.) eltest ( )
6. eltest
7. A: oh yes
8. T: listen again (.) eldest

The first part of the therapist's turn in line 3 has used the negative evaluation (which is more-or-less explicit and more-or-less specific) as an 'Elicitation'. However, she increases the specificity of the evaluation (or conversely increase the information value of the 'Elicitation') by contrasting the spoken form of the word as written ("eltest") with the target form. This is designed to increase the likelihood of the aphasic person picking out the rogue letter.

Therapists' follow-ups often simply reflect the aphasic person's response in the preceding turn. For example in D14 (2):

1. T: you can get them in tins (3.0) Fox's and McVities
2. A: (3.0) biscuits
3. T: biscuits↓ (.) yeah
4. A: oh↓ ((smiles))

The therapist reflects back the aphasic person's (correct) response, but the high falling intonation, and stressed first syllable (line 3) have special significance here. These features simultaneously indicate strong positive evaluation after what has been a relatively lengthy search for the word, hence the aphasic person's ensuing high falling intonation (line 4: "oh↓") and subsequent smile in the 'follow-up to the follow-up'. Here therapist and aphasic person share the pleasure of success through the function of the 'Elicitation-response – follow-up' as the aphasic person follows-up the therapist's 'Response follow-up'. Simmons-Mackie *et al* (1999) point out that, in their study, client acknowledgement and agreement with therapist feedback was often required before treatment continued.

Therapist reflecting back the preceding 'Elicitation-response' also includes non-verbal actions. The following is an extract from D5 (1):

1. T: you tap your fingers on (there)
2. A: ((knocks))
3. T: right okay you're knocking though ((imitates A's knocking))

In line 3 the therapist reflects back verbally the aphasic person's response in line 2, which is non-verbal. The therapist also continues by reflecting back non-verbally, giving additional information. Again this functions not only to inform the aphasic person about their error response, but is also looking ahead to increasing the likelihood of enabling a correct response, but without actually giving 'the answer'. There are of

course many instances where the therapist does follow-up a wrong response with 'the answer'. This occurs either after a lot of work to achieve the correct response (both in terms of time and repair work), or due to the fact that the configuration of the task means that negative evaluation of the error also, inevitably, points to the correct response. This occurs for example in tasks which require sorting into two categories, or word-picture matching tasks (two words one picture or vice-versa).

4) Explicit negative evaluation. Therapists do follow-up with explicitly negative evaluations, but may also provide information about the error response as in the following example D14 (2):

1. A: no ((shakes her head pursing her lips)) um (6.0) yorkshire pud
2. T: (no) it's not not savoury it's a sweet thing with lot's of sugar in...

Here (line 2) the therapist's reflects back not the actual response (i.e. "yorkshire pud") but a feature of the response (i.e. "savoury"), which is also emphasised. This is then combined to contrast with 'positive' information about the intended target ("it's a sweet thing...").

5) Directing a particular course of action. As has been discussed above, the aphasic person's response (or series of responses) may stimulate therapists to direct a particular course of action – for example to slow down. For example, therapists often comment on the process of responding, and not just the response itself (D12 (2): "okay you had a bit of a struggle with this one but you got it right in the end". Follow-up routines may therefore not be directed at responses per se, but at the manner of responding, as has been discussed above ('Elicitation' in relation to responding routines in Section 6.2.4.iii.IIIa Dimensions of Elicitation). Thus this type of feature of 'Elicitation-response – follow-up' is concerned with the process of responding rather than the response itself. It is essentially directed at future responses, in a way that attempts to

help increase the likelihood of correct responses (or perhaps reduce the number of errors).

6) Specificity in 'Elicitation-response – follow-up'. The therapist's 'Elicitation-response follow-up' may be very specific. The following is an example from D12 (1). Here the therapist is reading back to the aphasic person what he has written:

1. T: now what it actually says there is my friend got the fishing tackl/*de*/ for us
2. A: oh yeah
3. T: what do you need to change there
4. A: ((writes))

The information the therapist provides in line 1 about the preceding response, emphasising the superfluous letter, is used to support the 'Elicitation' which subsequently occurs (line 3).

There are many variations on the theme of specificity. Further examples come from the following extract from D12 (2):

1. T: right now you've started off that word really well okay you've got you've
2. written decor there
3. A: right
4. T: and that's the beginning of the word you want
5. A: ((writes))
6. T: you've you've just you've only missed out one letter

Thus in line 2 the therapist informs the aphasic person about the content of his 'Elicitation-response' (simultaneously giving negative evaluation). This she follows-up with further information about the status of that response (line 4: "that's the beginning...") and this functions to elicit a further (written) response in line 5. The therapist's follow-up in line 6 is specific, referring to one missing letter, but calibrated in such a way as to allow for the possibility of further work by the aphasic person. In

other words she is not so specific that she gives information about where the missing letter might be.

Therapists are also nonspecific in following-up responses. This may be a direct function of the 'Response follow-up' itself, as in: "not quite there" (D15 (1)). This type of follow-up has the flavour of vagueness mentioned by Simmons-Mackie *et al* (1999), and is a means of implying negative evaluation while conforming to the politeness rules of interaction which "allow both parties to preserve their identities" (Simmons-Mackie *et al* 1999: 225).

The nonspecific nature of 'Elicitation-response – follow-up' may also be a function of the equivocal nature of the stimulus item. The following is an example from D14 (2):

1. T: ...and they've got a single stone in each one
2. A: plums victoria
3. T: it could be (.) these are a smaller you're on the right lines ( )

The therapist's 'Elicitation' in line 1 is one in a series that has been giving increasing amounts of information about the intended target. The therapist has a 'hidden' picture which she is defining, and thus the referent is specific, but her definitions have not specifically defined it. Thus the therapist's "it could be" (line 3) reflects not only on the aphasic person's response but also on her own 'Elicitation' attempts. The aphasic person's 'error' in fact gives the therapist the information she needs in order to make adjustments to the subsequent 'Elicitation' in line 3, also keeping the aphasic person encouraged with "you're on the right lines".

Even where the stimulus is 'shared' it may still be equivocal (as has also been discussed above (Section 6.2.4.iii.II Dimensions associated with stimulus items). The following is an extract from D5 (1), where the aphasic person is required to choose a word from a number of written words to match a 'stick man' action picture:

1. T: okay right ((presents picture plus word choice))

2. A: build

3. T: m:: that's the best one I think isn't it

4. A: yes

5. T: yeah is there another one that would be possible

The therapist's "m::" (line 3) is thoughtful, both indicating agreement and acknowledging the work entailed in the choice the aphasic person has made. This is reinforced through her ensuing: "that's the best one I think..." (line 3). However it turns out that there is another possible 'right' choice, which the therapist encourages the aphasic person to find through her turn in line 5. Thus we are not sure if "the best one" is referring to the 'best' given the choice of other words in relation to the picture, or the 'best' to suit this particular task, which entails further work on sentence construction.

7) Calibration in 'Elicitation-response – follow-up'. Mention has already been made of the way a therapist might calibrate 'Elicitation-response – follow-up' to suit his/her aim in ensuing turns. There are many examples in these data which show evidence of therapists calibrating their 'Elicitation-response – follow-up' in a variety of ways. This may function to accept a 'not quite right' response as in the following example from D8 (1):

1. T: okay so tulip or daffodil

2. A: ((immediate mouth movements before vocalisation)) gladfostil

3. T: (that's a) good try (.) daffodil

4. A: glad (.) gladfosdil

5. T: okay good...so slug or snail

6. A: */bleu/ /bleu/*

7. T: is: yeah ((nodding vigorously)) yes I can tell which one you're saying A

8. snail (.) yeah/

9. A: yeah

10. T: excellent

The therapist's "good try" (line 3) functions to encourage the aphasic person as well as indicating that his response is a reasonable approximation. Her "daffodil", whether it was intended merely as a summarising statement about the stimulus item, a veiled correction or as further 'Elicitation' relating to that item, it does appear to function as the latter, although the aphasic person's turn in line 4 could be a self-initiated retry. The aphasic person's second attempt (line 4) is acknowledged with a final acceptance: "okay good" (line 5). This functions not only to indicate that the response is adequate (they both know that it is not correct), but also to curtail further efforts on the part of the aphasic person. In this sense it functions as part of the system of control exercised by the therapist over the initiatives of the aphasic person.

After the aphasic person's attempt at the second item (snail) the therapist's vigorous nod (line 7) is encouraging, and she confirms the positive nature of her follow-up by explaining that his response has been, in a way, communicatively adequate, or adequate for this purpose now: "I can tell which one you're saying" (line 7). Her rising intonation on "yeah/" (line 8) checks with him, and he confirms. There appears to be mutual agreement that this try has been adequate – "excellent" in the therapist's terms. It would seem, and there is a good deal of evidence for this in these data, that therapists are not merely concerned with the adequacy or accuracy of a response in absolute terms, but that positive evaluation in terms of the strength of their 'praise' often relates to a judgement (usually based on empirical evidence) of the relative difficulty of an item for the aphasic person there and then. The empirical evidence consists of, for example, the number of attempts made, the length of deliberation before a response, or, as will be discussed below, the aphasic person's own stance towards the responding process or response itself.

Another example of the therapist calibrating their follow-up comes from D5 (1):

1. T: ..so a man
2. A: (man) wash wash wipe
3. T: a man wipes (.) what's he wiping

Here the therapist chooses not to comment on or make any correction to the aphasic person's error responses in line 2, The target is clearly "wipe", and, possibly because the aphasic person has already self-corrected, the therapist merely confirms "wipe" as being the correct response. She does this, as has been discussed above, by reflecting back the aphasic person's response, but at the same time she embeds it in the noun phrase which is one of the targets of the task. She also provides a veiled correction of the aphasic person's "wipe" (line 2), providing the correctly inflected ending: "wipes" . Together these amount to the type of "expansions" occurring in consequential feedback mentioned by Norris and Hoffman (1990).

Some of the examples above have shown evidence of the therapist accepting as 'good' or 'right' a less-than-perfect response, and the posited reasons for this have been discussed. There are also a few instances where the therapist appears to make a positive evaluation, but ensuing events seem to contradict the original evidence. The following is an example from D5 (1):

1. A: (make a bed)
2. T: lovely ((gestures with an open hand stretched out)) (4.0) right what's missing
3. A: make
4. T: what do we need

The therapist's positive evaluation in line 2 is clear and seemingly unequivocal. However it turns out that the response as it stands is not adequate. After the four second pause the therapist's turn continues with an 'Elicitation' which makes explicit reference to the shortcomings of the preceding response. It could be argued that the therapist's

evaluation in line 2 referred specifically and only to what was actually said by the aphasic person. In other words, "lovely" (line 2) tells him that what he said was 'good' and 'right' (with the hand gesture suggesting: 'there, you can do it' encouragement). The ensuing 'Elicitation' on the other hand is an addendum which only looks ahead to completing the task rather than being a commentary on what has happened. The manner of the 'Elicitation' (in line 2) however does not function to enable the aphasic person to achieve the targeted response – presumably the agent of the sentence.

8) Therapists may also make their attitude to a response apparent. This does not happen in terms of negative attitude at all in these data. In task-related data therapists are almost exclusively encouraging. However the following example serves to illustrate that therapists do allow their attitude to 'leak' in some circumstances. The following example is from D9 (1). The interaction certainly has features which make it appear task-like, such as evaluative follow-up in third turn position. However, the fact that the response content is not shared means that the therapist's 'Elicitations' are not test questions. The set-up follows on from a category sorting task, uses some of the same items and uses the same sort of procedure to engage the aphasic person in questions about her own personal experience:

1. T: how many of these have you been on
2. A: (3.0) ( ) ((points to a card))
3. T: you been on this one ((touches card))
4. A: *yes* ((points to and touches another card)) ( )
5. T: that↓ one
6. A: yes
7. T: yes↓
8. A: (well) ((touches and looks at card again))
9. T: well you might have been (2.0) that's a submarine that goes under ((gestures

10. one hand under the other))

11. A: oh (.) no no ((shaking head))

The therapist's follow-up with high falling intonation and emphatic stress in lines 5 and 7 shows her incredulity at the aphasic person's response to her inquiry (about forms of transport she has personally been on). This reaction clearly makes the aphasic person doubt herself as she re-examines the picture (line 8). The therapist again makes clear how unlikely the aphasic person's response is (line 9: "you might have been"), and the therapist's verbal and gestured information about the picture further underlines the aphasic person's lack of competence. The 'error' response is negotiated between therapist and aphasic person in the turns from lines 5-11, and the therapist's turn in line 5 appears to imply that the therapist is in a position to know something better about the aphasic person's life than the aphasic person herself.

Dimensions of 'Elicitation-response – follow-up': summary

- 'Elicitation-response – follow-up' is multifunctional, and may be the occasion of praise and encouragement, evaluation, or talk about the task or item
- Therapists do not usually make explicit statements about evaluative routines
- Negative evaluation is often implicit
- Explicit negative evaluation may be accompanied by further information which is crafted to improve the chances of a correct response
- Follow-up may be directed at the process of responding
- 'Elicitation-response – follow-up' is very variable in terms of specificity, but specificity or lack of it is a resource in terms of the responding process, and in terms of maintaining the relationship between therapist and aphasic person
- Therapists may calibrate their 'Elicitation-response – follow-up' in ways that demonstrate acceptance or imply correction of a 'not-quite-right' response

- Therapists' attitudes to responses may be 'leaked' in following-up an aphasic person's response

6.2.4.iii.IIId Dimensions of the 'Responding process'

The 'Responding process' encompasses observable actions and behaviours on the part of the person with aphasia that take place during 'Elicitation-response'. This includes the type of "trouble-indicating behaviors" (Simmons-Mackie *et al* 1999: 222) on the part of the aphasic person, which actually precede the response, as well as spontaneous self-evaluations of various sorts that may follow the 'Elicitation-response'.

As Simmons-Mackie *et al* (1999) point out, the fact that the aphasic person indicates trouble with the response (or responding process) may provide an opportunity for the therapist to make an appropriate intervention. It also provides an opportunity for the therapist to demonstrate support and affiliation. The following is an example from D8 (1):

1. T: ...platform or signal
2. A: */ligu/* ((purses lips and shakes head))
3. T: okay
4. A: cleagal ((shakes head))
5. T: alright I know that's difficult isn't it yeah
6. A: cleagal
7. T: A the good thing is that you can hear that it's not quite right

The aphasic person's dissatisfaction with his responses is clear (lines 2 and 4), and the therapist begins to acknowledge this in line 3 ("okay"), completing the acknowledgement of the difficulty he is experiencing in her turn in line 5. She is not specific about what is difficult, nor does she use his difficulty here as a platform to launch a fresh 'Elicitation', but chooses to reflect on his feelings and his stance to his

response, rather than return to the response itself. Interestingly the aphasic person himself initiates a further 'Elicitation' (understood) in line 6, when he retries the target. The therapist does not respond to this retry with an 'Elicitation-response – follow-up', thus its status remains in a sense equivocal.

Therapists often acknowledge the aphasic person's difficulty with the process of responding. Difficulties are often expressed though sighs or marked intakes of breath. In the following extract from D7 (1) the therapist readily affiliates with the aphasic person's difficulty:

1. T: ...can you ride a motorbike
2. A: (6.0)
3. T: do people ride motorbikes
4. A: (6.0) ((deep intake of breath as she concentrates at pictures)) */hju::/=*
5. T: =m::

The therapist's "m::" in line 5 is latched on to the aphasic person's deep sigh in a supportive and affiliative manner, acknowledging the aphasic person's efforts and that 'this is a hard one'.

As has been mentioned above indication of trouble on the part of the aphasic person in the process of responding is often the occasion of special praise from the therapist. The following is an extract from D9 (1):

1 A: ((picks up next card moves to put it on one pile, pulls a face shaking her head
2. slightly. T glances up at A's face. A then places card on the other pile))
3. T: good (.) well done

The therapist (line 2) demonstrably notices the aphasic person's trouble. The fact that she makes a correct response after expressing doubt and indecision is an occasion for positive evaluation (line 3). Although the praise does not appear very fulsome, the tenor of this evaluation is in marked contrast to the pattern of preceding

positive evaluations. In the sequences that precede this example, positive evaluation has taken place through the structure of the task – the therapist simply 'allowing' the aphasic person to lay the next card.

It is by no means always possible to be sure of the meaning of an aphasic person's follow-up to their own response. The following extract from D7 (1) is an example:

1. T: do you write with a toothbrush
2. A: (oh) ((moves paper away to NO position)) yes aha
3. T: that's it ( ) well done

In this case the aphasic person is using a two-position option to indicate 'Yes' or 'No'. One might hazard that the aphasic person's "yes" (line 2) is her own evaluation of her response. On the other hand, she may have difficulties differentiating between "yes" or "no", and the "yes" in line 2 is a perseverative utterance. In this case the therapist has calibrated her follow-up to ignore the "yes" and accept the non-verbally positioned "no" as the correct response. It is quite likely that the latter is the case – the responding procedure having been put in place just for this type of eventuality.

The aphasic person's self-evaluation may take the form of doubt, expressed through intonation – for example in D14 (2):

1. T: they're yellow
2. A: aubergines/

The response in line 2 is marked by rising intonation (a 'try marker') casting doubt on the certainty of the response. Doubt is also expressed explicitly, as in: "cooking is it" (D14 (1)), and finally the aphasic person may frankly express their inability to think of the right response, as in: "I can't think" (D14 (2)), or as in the following extract from D12 (2):

1. T: what are these two doing they're obviously

2. A: ((spreads hands in 'don't know' gesture))

The aphasic person may also give an explicit evaluation of their own 'Elicitation-response'. For example in the following extract from D11 (1):

6. T: leg ((giving card))

7. A: (leg) ((places card)) [yes]

8. T: [good]

The aphasic person clearly demonstrates his certainty with his response in the follow-up ("yes") in line 7. This is an example of a positive self-evaluation, but as has already been seen, the aphasic person may 'correct' him/herself with a negative self-evaluation – for example in the process of responding as in: A: "( ) ((picks up and places word card)) no ( ) ((replaces word card))" (D6 (1)). The brief "no" signals an evaluation which then subsequently results in a renewed response attempt.

The process of task-related work may arouse strong emotions in the aphasic person, especially when responding poses an almost physical challenge to them. However, sessions are not without humour, and people have the capacity to laugh at themselves as in the following extract from D12 (1):

1. T: ...I arise quite early

2. A: ((laughs and shakes his head))

The therapist is reading the aphasic person's sentence back to him out loud, much to his amusement in this case – at the pomposity of his formulation.

However in most cases it is anger and frustration that are expressed. This expression sometimes takes physical form, such as balling up of fists, or banging the table. It also finds expression in vocal non-verbal outlets, such as in this extract from D15 (1):

1. T: okay what's that one ((presenting picture))

2. A: yeah that's the cow (.) that's the (2.0) ah:: for it that's the (1.0) yes

The combination of knowing what the picture is, but being unable to access and express the right word is a thoroughly frustrating experience. Here the aphasic person's emphatically voiced and aspirated "ah::" sums up her feelings.

Finally, as in this example from D12 (1), frustration may get the better of the aphasic person. The following extract is however the only example of this type of occurrence:

1. T: is it is it North or South
2. A: er erm douse
3. T: South
4. A: yeah er ((nods)) */rau/* oh sh: ((shaking his head)) */fu?/ /fu?/ /fu?/ /fu?/*
5. ((grinning and then laughing and looking straight at the camera))
6. T: ((laughing))

The aphasic person's series of expletives are deliberately addressed to the video camera in what appears to be a cathartic episode ending in gales of laughter, with which the therapist joins in.

Dimensions of the 'Responding process': summary

- The 'Responding process' encompasses observable actions and behaviours on the part of the person with aphasia that take place during 'Elicitation-response'
- The aphasic person may indicate 'trouble' in various ways, as well as offering self-evaluations of various sorts
- The aphasic person may show strong emotions during task-related activity, including frustration and anger, but laughter is also shared between aphasic person and therapist

6.2.4.iv 'Summary'

As was mentioned above this study has differentiated between what is classically know as 'feedback' (i.e. therapists' contingent responses), and other types of summarising processes. The data appear to warrant such a distinction. Although as will be seen below, some of the therapists' (and aphasic persons') actions and offerings do in actual fact 'feed back', their subject matter often makes it problematic to include these actions and offerings within the feature of 'Elicitation-response – follow-up'. As will be seen it is occasionally also problematic to differentiate between summarising and clarifying offerings.

The process of summarising is retrospective, but as has been mentioned above therapists are free to refer back across the session as a whole or to previous work together. They often use current 'performance' to create comparisons with previous 'performance' enabling them to highlight progress in a generally encouraging way. The following is an extract from D12 (1):

1. T: (these er these are) perfect sentences (1.0) 'cause when you first started doing
2. this you were you were looking for single words
3. A: yes
4. T: and literally within a few months you've started to turn it into sentences

This extract follows the completion of a piece of task-based work. As can be seen in line 1 the therapist refers to the immediately preceding task, giving positive evaluation, encouraging in its superlative nature ("perfect sentences"). The therapist goes on to relate previous ability or performance (situated in specific terms in line 2: "looking for single words") to the present. She gives a general feel for the time span of improvement ("within a few months"), and finally the yardstick of improvement (line 3: "turn it into sentences"). It is interesting to note the measure of time that the therapist uses here – "literally within a few months" – as being a positive measure of

improvement. The aphasic person makes no comment as to the time span here. Personal experience of the author highlights two main points about the way time is problematic for therapists and people with aphasia in ways that may arise in 'Summary'. Firstly therapists appear to like to keep reference to time-span quite vague – here as in "a few months", elsewhere as: "a little while ago" (D6 1) – when it comes to discussion of progress. For people with aphasia progress can (rather obviously) never be fast enough. It appears that therapists are well aware of this, and deliberately keep reference to time as vague as possible in this context, firstly in order to mitigate the loss (of language, of communication), and secondly because they find it very hard to confront the very slow progress that is often made.

'Summary', again 'spring-boarded' through reference to immediately preceding task-related work, may be much more specific than in the example above. The following is an extract from D1 (1):

1. T: ...I don't think you have decided on this verb because you are approaching it
2. from two different angles
3. A: m:: m:: m::
4. T: this is your biggest problem isn't it going from thought into language because
5. you keep changing and finally scrabbling away

The therapist in line 1 refers to "this verb" meaning the one currently the subject of the task in hand. Reference continues to be specifically about the current task and the immediately preceding failure on the part of the aphasic person to access the verb (lines 1-2: "you are approaching it from two different angles". This then becomes a reference point for a remark about the aphasic person's problem generally (in line 4): "going from thought into language". Thus the therapist uses current performance as a way of illustrating a general point about the aphasic person's language processing difficulties.

It should be noted that the 'Summaries' in the two examples above have not shown any evidence of collaborative summarising work between therapist and aphasic person. Although it is generally the therapist who initiates the 'Summary' and who has the power to control the topic content, collaborative 'Summary' work does occasionally take place. In the following extract from D12 (1) therapist and aphasic person share the discussion:

1. A: I ( ) erm I (tur)ned it out home ((leans back and makes hand gesture))
2. T: d'you want a ( ) ((arranges paper and pen for A)) you did something at home I
3. didn't get the word [( )]
4. A: [er] and (I) er um oh (I tried at home)
5. T: I I I'm getting (you) at home but I'm not getting the word in between=
6. A: er
7. T: =could you write it for me (.) write it on here

The aphasic person in this (rare) case initiates further 'Summary' talk through his turn in line 1. This extract follows on from the first extract from D12 (1) above where the therapist was referring to progress made "within a few months". In line 1 here the aphasic person appears to be referring to work he has been doing at home: "I (tur)ned it out home...". The therapist (line 2) indicates her state of understanding, and clarification of the point ensues (lines 4-7). Further clarification work follows as they work together to establish the point, and it transpires that, a few turns later in D12 (1):

1. T: you practised [it]
2. A: [(is)]
3. T: did you keep writing it until it looked right
4. A: yes it's
5. T: mhm (1.0) on another bit of paper
6. A: yes

7. T: (well) you're very wicked

8. A: ((laughs))

9. T: ((laughs)) don't you remember I said to you I want all your mistakes here

Having established that the aphasic person has practised the word (or words) he's been writing at home, the therapist goes on to quiz him more exactly about what he did and how he did it – line 3: "did you keep writing it until it looked right"; line 5: "on another bit of paper". This extract finishes with a light hearted rebuke by the therapist (line 7), but the point is a more serious one. She wants to see his mistakes – presumably to establish some sort of pattern of errors for possible diagnostic purposes – and she goes on to remind him why she wants to see what the words are that he chooses in the first instance. The 'Summary' continues with talk together about the aphasic person reading the paper, and ends thus:

1. T: so reading the paper every day=

2. A: yes

3. T: =now is actually helping you do your writing

Although it is the therapist who in actual fact summarises (lines 1 and 3) it is through joint work that they establish that reading is helping him with his writing.

Elsewhere, the therapist's 'Summary' initiation is the impetus for inquiry by the aphasic person. The following is an example from D6 (1):

1. T: ...now a little while ago you would never have been able to do that

2. A: uh

3. T: so that means that you're listening to words and that you're able to sort them

4 out and it's very important for you to get the words out

5. A: d'you think I'm I'm alright getting

6. T: I think you I think there's an improvement

7. A: uhh yes

8. T: slowly but surely

The therapist summarises the immediately preceding performance by relating it to the aphasic person's previous ability (presumably on a similar task). In a way this is reassuring for the therapist, as well as potentially for the aphasic person. Thus this type of comparative 'Summary' could be said to perform a function for both parties. The aphasic person in line 5 asks the question that could be construed as a key concern – basically: 'am I getting better'. The therapist's response is cautious (line 8: "slowly but surely") but positive. The therapist is being asked to perform as the expert here, and as such she appeals to empirical evidence to substantiate her opinion. She goes on to talk about the aphasic person's progress in terms of the exercises contributing to: "stimulate that part ... of the brain". However, she then appears to conclude her 'expert evidence' in the following way:

1. T: okay but no I think you are better I think you seem brighter in yourself as well
2. A: yes I I feel (as) good ((sits back)) you know I really do

The therapist's "okay" in line 1 marks the end of the particular 'technical' presentation mentioned above and the beginning of a phase of collaborative work around the aphasic person's feeling of being better, the tone being set by the therapist's reference to "better" and "brighter", which seem to enable the aphasic person to expand on her own feelings.

The extracts above represent lengthy pieces of work together – lengthy in part due to the aphasic person's language and expressive difficulties of course. There is evidence of other, briefer 'Summary' work together, as in the this extract from D8 (1):

1. T: yeah and I know it's still hard
2. A: no no no ((nods))
3. T: to change it isn't it
4. A: no no ((nods))

The therapist initiates the proposition (lines 1 and 3) on the basis of immediately preceding work on one particular therapy item which has caused some difficulty. The aphasic person has demonstrably struggled with the item, and the therapist has picked up on one aspect of the struggle to self-correct an articulation error. Here the therapist becomes the means through which the aphasic person expresses feelings or opinions about the therapy (or other aspects of his/her experience of aphasia). In this respect this is 'Summary' work together, even though the aphasic person appears to make little contribution. In a very similar way this process occurs some turns later in the same session:

1. A: smoke ((clicks tongue, looks upwards, smiles broadly and laughs))
2. T: ((laughs)) good okay
3. A: no no no no
4. T: they're coming out much more easily (right) now aren't they (.) you can't stop
5. yourself

The aphasic person follows-up his response ("smoke") in line 1 with a positive self-evaluation, evidenced non-verbally. The therapist, while reflecting his positive evaluation with her own confirming statement in line 2 ("good okay"), also reflects his obvious pleasure about having responded correctly so easily, in the 'Summary' which follows in lines 4-5.

'Summary' may also simply be about confirming the item or some aspect of the item in the preceding task. For example this may occur where the task requires the aphasic person to respond with a "Yes" or a "No" in relation to a semantic congruence or anomaly. The following is an extract from D7 (2):

1. A: [yes]
2. T: [you] do↓
3. A: aha

4. T: yeah you would say he's riding a motorbike wouldn't you

5. A: aha

6. T: he's riding (.) you drive a car but you ride a motorbike

The aphasic person has responded (correctly) in line 1 and this is positively evaluated by the therapist in line 2 in the 'Elicitation-response – follow-up'. The therapist then provides 'Summary' information about the item in line 4, followed-up by what is probably best construed as 'Information and clarification': "you drive a car but you ride a motorbike" in line 6 (see Section 6.2.4.v).

'Summary' work about the item may take the form of a simple repetition of the target item or items. This for example in D8 (3):

1. A: (g case)

2. T: good try A [gate]

3. A: [gate]

The therapist's "gate" in line 2 could be construed here as a veiled correction of the aphasic person's error in line 1, and indeed he makes another self-initiated attempt to say the word simultaneously with the therapist.

Elsewhere similar phenomena occur. In D7 (1):

1. T: this is more difficult today

2. A: aha yes

3. T: yeah he's [crying]

4. A: [crying]

5. T: really sad

6. A: aha

7. T: yeah okay

The extract begins with the therapist's 'Summary' statement about the general level of difficulty (presumably *vis à vis* the aphasic person's ability to 'perform' today).

The therapist then gives a brief 'Summary' about the item in line 3 (simply saying the word "crying"), which the aphasic person echoes. The therapist proceeds from the 'Summary' to give further information about the item (line 5: "really sad"). Additional information in the 'Summary' about an item may also come in the form of information in an additional modality, such as that used by the therapist in D7 (2) where she adds gesture: "good (1.0) so sewing ((large sewing gesture)).

'Summary' may also come after work on a series of items. This often happens quite simply as an enumeration of items that have been the subject of a particular task – in D7 (1) for example the therapist simply points to each picture of a spoken word-picture matching task in turn, saying the word as she does so. In the following extract from D2 (2) the process is apparently very similar:

1. T: good okay so we've had football (.) pub
2. A: pub
3. T: and music
4. A: (mu)
5. T: music
6. A: music
7. T: that's it that's it good good

While the therapist sets out with a simple enumeration of the items, structuring this particular 'Summary' sequence with the discourse markers ("good okay") in line 1, the aphasic person clearly also wishes to co-summarise. She acknowledges "pub" in line 2, but has some difficulty with "music" as evidenced by her contribution in line 4. This suggests that the therapist's turn in line 5 actually has the hallmarks of an 'Elicitation' and this is confirmed through the therapist's use of an evaluative follow-up in line 7: "that's it that's it good good". Thus what starts out as a 'Summary' concludes with an 'Elicitation – Elicitation-response – Elicitation-response – follow-up' sequence. This

example tentatively suggests that therapists find it very difficult to avoid 'Elicitation', unless they are very careful in structuring their non-task talk. The following extract from D5 (1) is a further illustration of this phenomenon:

1. T: ...just like you did on that other
2. A: yes
3. T: what was he making a */reu?/*
4. A: road
5. T: road wasn't it building a road or making a road

The therapist is referring back to previous work together in line 1 ("just like you did on that other"). Instead of simply referring to the item herself she turns the reference into an 'Elicitation' which includes a phonemic cue (line 3: "what was he making (.) a */reu?/*", to which the aphasic person responds. The response is duly followed-up (line 5: "road wasn't it") and the summary reference to previous work is complete, but in a way the aphasic person has been coerced into a co-operative 'Summary' by the therapist's use of 'Elicitation'.

Therapists have the power to refer back across the immediately preceding work to work that took place earlier in the session, and this includes reference to the target item, as in the following extract from D5 (1):

1. T: ...but yeah he he's playing
2. A: tennis
3. T: tennis but you chose the best verb and you you made a sentence out=
4. A: yes
5. T: =of it John hit the ball
6. A: yes

The extract begins with an 'Elicitation' and subsequent response and confirmatory positive evaluation by the therapist (lines 1-3 ending in line 3: "tennis").

She continues by referring back across the session to earlier work on this item (a stick figure action drawing of someone with a racquet and ball) and summarises with a simple statement recapping the sentence that the aphasic person actually produced (line 5): "John hit the ball".

'Summary' may refer back to the process of completing the task. This generally takes the form of reference to whether it has been easy or hard – for example: "that was an easy one" (D14 (2)), or: "okay now to make it harder then... 'cause I think it's getting a bit easy for you" (D8 (1)), or: "it's a bit harder isn't it now we're having this gap (.) between it (.) yeah↑" (D8 (1)), or by implication: "you have to really concentrate actually don't you". 'Summary' may simply be a general statement of encouraging evaluation, which appears to have general reference to a whole sequence of task-related work, such as "okay that's brilliant" (D8 (1)).

Generally speaking 'Summary', as opposed to 'Elicitation-response – follow-up' refers to overall performance on a task or performance on a number of items rather than a specific item, as in the following extract from D9 (1):

1. T: hey: (.) best yet (('excellent' hand gesture'))
2. A: ((slight smile))
3. T: only once ((holds up one finger)) did you go wrong (1.0) ( ) and that's 'cause
4. you were going too quickly

The therapist's "best yet" (line 1) clearly refers to the aphasic person's work on all the items in this particular task. In line 3 she specifies how often the aphasic person made an error in the task as a whole, relating the error here to a particular aspect of the aphasic person's approach to doing the task (Line 4: "going too quickly").

Reference to the process of going about the task is often characteristic of 'Summary'. The following is an extract from D12 (1):

1. T: ...absolutely perfect that's very good (.) I mean the the odd mistakes that you
2. made um I think it's something to do with the sound [of language]
3. A: [m:: m::]
4. T: because when I read it out to you
5. A: yes
6. T: you're immediately able to correct it aren't you

The extract starts (characteristically) with an evaluation of performance, here couched in positively encouraging terms (line 1: "absolutely perfect that's very good"). The therapist continues with reference to a possible relationship between errors the aphasic person has made and a linguistic feature (line 2: "the sound of language"). She goes on to clarify this observation by relating one aspect of the process of enacting therapy to the aphasic person's performance – in other words, reading out loud in relation to self-correction. Elsewhere in the same session the therapist makes a similar 'Summary' statement: "it helps when you hear it out loud doesn't it". This type of observation based on empirical evidence is perhaps an example of the process of clinical decision making therapists engage in. They observe an aspect of the aphasic person's performance. This observation or these observations are clearly related to a particular task or set of tasks and an item or set of items. The next step is then taken to draw inferences which relate their observations to some aspect of the task or item and which may shed light on the aphasic person's abilities or difficulties. In turn this may lead to changes in the way therapy is enacted or to decisions about future therapy work together. This is further illustrated in another extract from D12 (1) where the therapist makes specific reference to an error on a particular item: "so that's a sound error...you're you're saying */eltest/* in your head and the one you need is eldest". She relates the error ("*/eltest/*") to the target ("eldest") in a way that is illustrative of the type of error ("a sound error"), and she uses this point to demonstrate with the aphasic

person the physical (voice/voiceless) distinction between */te/* and */de/*. This particular passage ends in a general observation about the aphasic person's abilities: "because you're good at spelling you're you're writing what you're hearing". This is an attempt to explicate and make sense of the often confusing experience of aphasia.

'Summary' may be the occasion of specific explanation around the linguistic type represented by a particular stimulus item. In the following extract from D5 (1) several issues are apparent:

1. T: aha that is a bit more complicated that verb 'cause you've chosen that verb
2. A: slips
3. T: you you don't slip something you have to slip on something so I'm not (wo)
4. too worried about that um the woman slips on the floor yeah
5. A: yes
6. T: she slipped over on the floor because she stood on a banana

The therapist begins by talking about the difficulty of a particular stimulus item ("slip"), relating the difficulty to the nature of some verbs – by implication transitive as opposed to intransitive verbs (line 3: "you don't slip something you have to slip on something"). Her statement about being "not (wo) too worried about that" (lines 3-4) appears to refer to not wanting to get too involved in discussion and explanation of these distinctions right now. She moves on quickly to summarise the aphasic person's actual performance, reflecting back his finished work on the particular item (line 4: "the woman slips on the floor yeah"). She goes on to add a brief summarising statement of work which they also carried out together to establish the causality of the event (line 6: "she slipped over on the floor because she stood on a banana").

As has been demonstrated above 'Summary' may be the opportunity for connections to be made. In the extracts that follow, there is further evidence of the way

that 'Summary' is a connecting point for various issues, observations and reference to work to come as it relates to past work. The following is an extract from D5 (1):

1. T: okay because what we're going to do now you've chosen the word you've
2. chosen the verb the middle the middle of the sentence
3. A: ( )
4. T: the main word that describes what's happening and now we want to make a
5. whole sentence with it
6. A: yes
7. T: like we've been doing
8. A: yes
9. T: just like you've been doing before

The extract begins as a 'Task introduction' (line 1: "what we're going to do now you've chosen the word"), but continues with reference to what the aphasic person has just been working on (lines 2-4: "you've chosen the verb the middle the middle of the sentence...the main word that describes what's happening"). This also includes a brief explanatory statement about verbs, positioning this statement as a springboard to what is about to happen. Thus – 'this is what you've been doing and it related to this particular item which has these particular characteristics which are now going to fall into place when you do the next piece of work'. Finally the therapist refers to previous work together in a way that serves both as a reminder of the routine at a cognitive level, and as the type of alignment strategy referred to by Simmons-Mackie and Damico (1999b: 317), where the aphasic person is reminded of their joint past "as an established team". Later in the same session (D5 (1)) the therapist refers back to an error the aphasic person made 18 turns before: "you said you said bricks didn't you" as a starting point to go over the nature of the verb "building" and the aphasic person's tendency to focus on the object rather than the verb ("instead of the verb you focused on the objects again").

She then uses this summarising work as a point of reference to work to come ("we're going to do more of this later when we come on to doing more complicated sentences"), either in this or in future sessions.

In the following extract from D12 (3) 'Summary' is the point at which reference to performance and process come together in a way that looks to future work:

1. T: right you you you wrote some very good sentences for me and that was lovely
2. A: yes
3. T: but you didn't actually do what I asked you to do (.) did you realise that
4. A: ((looks at T))
5. T: or did you just not feel like it
6. A: no ((points to words on the page))
7. T: (m::) you you went on and ( ) about the [sentence]
8. A: [yes]
9. T: that's okay I don't mind um it's just that I think you are trying to write
10. something that important and it makes it much easier for you to get some of
11. that vocabulary down first
12. A: ( )
13. T: (well) do you find it easier just to write the sentence
14. A: (oh) yes

The sequence begins with a summarising statement about the aphasic person's performance on a set of items (line 1), and then in line 3 the therapist relates the process of how the aphasic person has gone about the work to discussions that have gone on between them at some previous point. Line 3: "you didn't actually do what I asked you to do" refers to some process which the aphasic person has not adhered to. The therapist's question in line 3: "did you realise that" marks the start of a sequence of clarification, where the aphasic person appears to be asserting his right to control the

means of production (line 6: "no ((points to words on the page))") while the therapist is clarifying her reasoning (lines 9-11). The sequence ends in a way that appears to point to how future work might be tackled as it is established that the aphasic person feels most comfortable with the way he is going about the work rather than how the therapist has proposed he go about the work. As such this sequence, as well as some others in extracts above, illustrates the difficulty in clearly differentiating between the processes entailed in 'Summary' and those evident in 'Information and clarification'. The latter will be illustrated in the next section.

'Summary': summary

- 'Summary' involves a retrospective process, referring back to a previous item, task, 'Response process', series of items, earlier work in the session or work in previous sessions
- Therapists almost exclusively control summarising work, although they occasionally invite the aphasic person to participate in 'Summary'
- 'Elicitation' sequences may be found in 'Summary'
- 'Summary' may represent opportunities for connections to be made between observations, issues, or for reference to work to come as it relates to past issues

6.2.4.v 'Information and clarification'

There have been clear instances of simple informing entailed in some of the 'Summary' sequences above – the therapist making statements about the nature of therapy items for example. There has also been evidence of clarification sequences as in the final example in the 'Summary' section from D12 (3). It is clear, as has often been mentioned, that it is not possible always to make clear cut distinctions between the types of features entailed in therapy sessions which are being put forward as evidence of this particular structure of therapy. The features of 'Information and clarification' also suffer from some of the problems of lack of exclusivity. Thus 'Information and clarification'

is taken to include both (unsolicited) offers of information, requests for information and checks to establish states of understanding, almost exclusively by the therapist checking their own understanding or that of the aphasic person. The purpose of delineating such features of the domain of 'Doing therapy tasks' is not to create a set of categorical coding criteria but to orient the reader to distinguishing features of the interaction.

One of the key features of 'Information and clarification' is therapist statements about various features of therapy items. Such statements cannot reasonably be understood as 'feedback' because they do not reflect information back to the aphasic person about their performance or about the therapy process. The following are some examples from D9 (1) which look back to items just completed in a particular task:

1. T: okay just just (.) A can you see why (it was wrong)
2. A: ((nods))
3. T: ('cause it's) on the [water]
4. A: [((nodding and picking up next card))]

This extract illustrates two features of 'Information and clarification'. Firstly, that there is a close connection between informing statements by the therapist such as that in line 3 ("('cause it's) on the water"), and information about performance – essentially feedback. Here the therapist links the negative evaluation in line 1 with clarification and information about the nature of the item. Secondly the aphasic person indicates her understanding of the information – here in line 4 as she nods. Thus 'Information and clarification' is an opportunity to provide, discuss and understand the reasoning behind evaluative information in 'Elicitation-response – follow-up'. Thus, in a further example from D9 (1): "it's in the air isn't it", the therapist's contribution is not evaluative *per se* but clarifies the reasoning behind the evaluation which has preceded. A further example from D9 (1) illustrates how this type of informative statement may arise around items which have proved problematic: "but this one ((points to remaining

card)) is in the air". The therapist emphasises the key feature of the item using emphatic stress, and goes on to try and further clarify features of the item: "might be a bit difficult...supposed to be um (.) er (1.0) ( ) space" which are to be considered relevant to the category of 'in the air' – here "space" (the particular item here being a 'space rocket').

Informing about therapy items does not only take place retrospectively. The following is an extract from D7 (1):

7. T: ...we're going to look at some of those=
8. A: aha
9. T: =words now
10. A: yes
11. T: (the) verbs words that talk about what people are doing

The therapist's first turn has the general function of a 'Task introduction', and of course 'Task introductions' are generally informing and clarifying prospectively. The additional feature here is the clarifying statement about verbs by the therapist in line 5: "words that talk about what people are doing". These types of statements occur frequently throughout the data, and typify the challenge which therapists face when trying to clarify linguistic features in meaningful ways.

Clarification is quite often a shared process, but it is generally the therapist who checks something with the aphasic person This may be about the aphasic person's performance on a particular item as in the following from D12 (2):

1. T: now you you've you've got a good sentence there but you're not happy with it
2. A: no

The therapist checks back with the aphasic person, here on the basis of some evidence of his dissatisfaction, and this is often the case. This can be shown in an extract from D12 (1):

1. T: ...I (arise) quite early
2. A: ((laughs and shakes his head))
3. T: not right/
4. A: (no)
5. T: right what else would you say
6. A: er
7. T: it's a perfectly good word but [um]=
8. A: [(um)]
9. T: =it's a bit old fashioned

In line 1 the therapist has read back the aphasic person's written sentence, and in line 2 the aphasic person shows his stance to what he has written by laughing and shaking his head. The therapist checks with him in line 3, and goes on to talk about the "word" (although neither of them has specifically referred to which word) and what might be unusual about the choice of word. These types of checks differ from the type self-evaluations which may be required of the aphasic person as part of some task-related responding routine.

The clarification check may also relate to the process of enactment as in a further example from the D12 (2):

1. T: would it be a help if I just stacked them up and you did one at a time rather
2. than having them all spread out
3. A: ((shrugs))

This type of instance, where the therapist asks what might be a helpful way of going about doing the task can be contrasted with the way therapists usually make the decision themselves. One has to be cautious however about interpretation of surface meaning – here an inquiry into how the cards should be configured – because, in the personal experience of the author, such inquiries are often polite ways of disguising a

proposal to do the task in a certain way, and the check is merely a politeness device. Due to the prevailing power and control conditions of therapy sessions such inquiries are a subtle means of apparently empowering the aphasic person while actually undermining their ability to exercise the right of choice.

A further example from D12 (2) illustrates collaborative work between therapist and aphasic person as they establish the basis for the current problem. The therapist has set a task in motion which requires the aphasic person to write the verb depicted in a picture stimulus item:

1. T: ...go for if you go for the [verb]=
2. A: [yes]
3. T: =for me
4. A: (I'll write)
5. T: fair enough [okay]
6. A: [(er yes)] er er ( ) er
7. T: yeah
8. A: er oh oh ((hits down on table))
9. T: alright so he's um
10. A: [( )]
11. T: [what word] were you trying to make get there
12. A: er ( ) um
13. T: is it that you can't spell it
14. A: (yes yes) er oh
15. T: I know what you're trying to say [go on]
16. A: [yes]
17. T: go for that then what what which word would you look up
18. A: ( )

19. T: something beginning with */em/*

20. A: er um

21. T: d'you know what the word is you're looking up A

22. A: [yes]

23. T: [okay] [fair enough]

24. A: [( )]

25. T: you've got it in your head

26. A: yes

27. T: yeah

In lines 1-5 there is a clarification sequence about the process of going about the task – the therapist makes a proposal about the aphasic person going for the verb, while the aphasic person apparently chooses to start writing the sentence from the beginning (although this is not entirely clear from the transcription or the video). In line 6 the aphasic person sets about the task of writing but runs into difficulties and becomes clearly frustrated, banging the table (line 8). In the following turn (line 9) the therapist attempts to repair the situation through a further 'Elicitation' attempt in a type of sentence framing move: "so he's...". Her contribution in line 11, while framed as a check, actually functions as a further 'Elicitation' because she is asking for information which is co-incidentally the same as the task item the aphasic person cannot achieve. Thus she changes her strategy and checks about the root of the problem, establishing with the aphasic person that a spelling rather than a word-finding difficulty is at the heart of the problem. Thus they manage to move forward to establish the word he is to look up (without it actually yet being stated explicitly).

Rarely the aphasic person will explicitly initiate a check about an item. It has been shown in previous sections how the aphasic person more-or-less implicitly demonstrates their stance towards a response – for example though intonation (try

marker) or other non-verbal or verbal means. However in the following extract from D14 (2) the aphasic person explicitly asks about the semantic category of the item:

4. T: you can buy them in a packet

5. A: is that a vegetable

6. T: no it's not a vegetable

Thus in line 2 the aphasic person initiates a clarification check about the item and the information she receives from the therapist enables her to move her field of inquiry in the right direction. Of course there are instances where, despite prolonged efforts on behalf of therapist and aphasic person, the required response is not achieved. In these instances the therapist simply 'gives' the right answer, such as in D9 (1): "this one goes here". Naturally the 'right' answer will take many different forms, from the placement of a card as in D9 (1) here, to written or spoken words, depending on the type of therapy task.

In the previous section we have seen how the therapist's 'Summary' may be the occasion of the aphasic person asking about their progress. Later in the same session (D6 (1)) the aphasic person again requests information:

1. A: ( ) how does you you ( ) people the people eh like me eh how do they go

2. T: how do they get on

3. A: aye ( ) like me how is it

This time the request for information seems to be about her progress in comparison with other people with aphasia – "the people eh like me" (line 1). The initiation comes, not in a 'Summary' but in the middle of a task, and thus perhaps reflects her preoccupation and concern with her situation. The therapist follows up this initiation by talking about other people with aphasia ("everyone's different"), the "quality of life", being able to "go out and about", and then more specifically about

stroke and aphasia. The sequence is lengthy – about sixty eight major turns – and concludes, after talk about the impact of aphasia on everyday communication, thus:

1. T: and also it affects your writing
2. A: aye I can thingmy you know
3. T: because you can't think how to write the word
4. A: I know
5. T: you can write but you can't=
6. A: true
7. T: =think how to get the word out
8. A: true so it is oh
9. T: so that's why we're doing lots of words
10. A: aye
11. T: exercises
12. A: that's right aye
13. T: to try and stimulate=
14. A: aye true
15. T: =that part of the brain

The therapist's turn in line 1 touches on one of the ways in which aphasia impacts on her communication in day-to-day life ("writing"), and she uses the 'explanation' of this phenomenon (lines 5 and 7: "you can write but you can't think how to get the word out"), as a way of justifying the task-related work in which they are engaged in the therapy sessions – "to try and stimulate that part of the brain" (lines 13 and 15).

'Information and clarification' may happen over one or two turns, but as was clear from the previous example, informing sequences may be lengthy. There are also instances in the data where sequences of clarification are extremely prolonged. In D5

(1) a lengthy clarification sequence arises after the aphasic person has had to choose a verb (in a written word-picture matching task) which might not normally be expected:

1. T: what would you say I just want you to forget about those words for a minute
2. because the word that you were expecting to see isn't there (.) I think the verb
3. (1.0) what (.) what am I doing
4. A: knocking
5. T: knocking yeah that's what you'd normally say isn't it
6. A: yes
7. T: knocking and that word isn't among these

In line 2-3 it looks as though the therapist is about to explicitly state which verb she thinks the aphasic person has in mind: "I think the verb (1.0)". The one second pause suggests that she has changed her mind. She chooses to elicit the verb in a task-based sequence, thus establishing the object of the clarification and the puzzle surrounding it's absence from the word choice. This sequence leads to a complex unravelling of verb meaning through a series of 'Elicitations' (e.g. "would you say I'm hitting", combined with further 'Elicitation' of agent and theme: "what's he hitting"). The therapist continues with the clarification, saying: "I think what's throwing you here A is it's not a verb that we would normally associate with...and you would prefer to probably say Jim knocks on the door...". Further action ensues, with the therapist asking the aphasic person to carry out the various types of action associated with different verbs (e.g. 'hitting'; 'tapping'). Finally, they establish, through mutual work together, the verb that the aphasic person would prefer to use, given the choice before him:

1. T: ...I think you would
2. A: knocking
3. T: prefer to use the verb

4. A: tap yes

5. T: tap on the door...

From the initial follow-up of the 'Elicitation-response' at the beginning of the task, to the end of the clarification there are one hundred and fifty major turns of talk. Much of this sequence is taken up with 'Elicitation' sequencesThe contention here is that therapist uses these to help establish the objects of discussion and clarification, rather than as a means of getting the aphasic person to perform a task per se. In other words 'Elicitation' (in the form of 'test questions') functions as a means to achieving a particular purpose – in this instance one of clarification.

'Information and clarification': summary

- 'Information and clarification' is taken to include offers of information, requests for information and checks to establish states of understanding
- Informing about therapy items takes place retrospectively and prospectively
- The therapist is usually in control of offers of information, and usually initiates clarification checks
- Collaborative work may take place between therapist and aphasic person to establish the basis of a current problem
- Clarification sequences may take place over a number of turns, and involve 'Elicitation' sequences where these are used to establish the objects of discussion

6.2.5 'Inserted conversation'

Just as conversations are 'inserted' into other phases of the session so too are they a feature of 'Doing therapy tasks'. In the process of 'Doing therapy tasks' 'Inserted conversation' arises in a variety of circumstances, and may be initiated by therapist or aphasic person, although, not surprisingly, people with severe expressive difficulties make very few initiations.

Therapists quite frequently make conversational initiations on the basis of a current therapy item. There are many instances of this feature throughout the data. The following are some examples, the first from D15 (1):

1. T: ((taps A on the arm)) did I ever tell you how I get to work
2. A: no
3. T: ((gestures holding handle bars))
4. A: on your bike oh:↓ do you:

The sequence above has many of the key features of a 'normal' conversation, with a pre-sequence inquiry by the therapist in line 1 as a topic initiation, which is then topicalised by the aphasic person (line 4), who makes appropriate expressions of surprise and approval. However, it should also be pointed out that the therapist's use of gesture in line 3 mirrors the use of gesture which has taken place during the completion of the task related to this particular item.

In D6 (1) the therapist initiates a conversational sequence with a question about one of the items:

1. A: cauliflower
2. T: would you would you have that with a cheese sauce
3. A: ay I like that
4. T: I like that as well

The therapist's question in line 2 differs from the sort of 'test' question found in task-related work, in that it seeks 'unknown' information, and has the flavour of a casual inquiry. The aphasic person's offer of personal information in her response (line 3) is reciprocated by the therapist's self-disclosure (line 4).

A particular item may be the stimulus for questions initiated by the therapist around the experiences or current activity of the aphasic person, as in the following extract from D7 (2):

1. T: ...when you used to sew

2. A: aha

3. T: did you sew clothes or things for the house

4. A: um yes ((hand flipping from side-to-side gesture)) ( ) yes

5. T: did you like hand sewing ((gestures))

It is apparent that, while the aphasic person can participate in conversation – clear through her contribution in line 4 – she is enabled by therapist turns which allow her to make substantive contributions. Here the therapist changes from a form which demands a response that can identify one of the alternatives (line 3), to a series of questions requiring a polar alternative, which she initiates in line 5. This change in approach enables both parties to contribute to the conversation.

The therapist may use an item as a stimulus for 'Inserted conversation' which appears to act as a 'breathing space' between sequences of task-related work. For example in D2 (2) the name of a football player is one of the stimulus items. Just after completion of a 'Summary' sequence relating to work on spelling a group of names, the therapist singles out the football player's name to initiate a conversation about the fortunes of the local football team – "that's what you get for being a ((football team's name)) player". The 'Inserted conversation' which ensues has the hallmarks of casual conversation – initiations coming from both parties, neither obviously in control of turn taking or type of turn – but it is the therapist who brings it to a close: "...I'm leaving ((football team's name)) supporting in your capable hands (.) aha right good (.) so we had three people there". The transition to 'business' is briskly managed after what has the appearance of an 'intermission'.

In D6 (3) conversation arises in a 'Summary' which ensues after the completion of an odd-one-out task. In the 'Summary' that immediately follows the task the therapist has pointed out the name of the items that the aphasic person has struggled to find.

Immediately following this the aphasic person becomes evidently distressed and angry raising both hands into fists and saying: "I know...what I think to myself" making clear that she knows but cannot say the word. The therapist re-commences a brief 'Summary' stressing the positive aspects of the aphasic person's performance, and then moves into an 'Inserted conversation', initiating with: "what's your favourite there", and the aphasic person duly engages in the conversation. Here it feels as though the therapist is using conversation around a relatively trivial topic to lighten up the mood and to distract the aphasic person away from her distress, but it also functions to avoid the issue of her distress.

Aphasic participants do initiate conversation around particular items, but rarely. In D14 (1) for example the aphasic person initiates a short story about a holiday on the basis of a particular item. She responds thus to the therapist's comment about a particular item: "I know I hate going in dungeons in anywhere (under) ground..." and then begins to tell her story. It is the therapist who takes control of the therapy work again by simply initiating the next 'Elicitation'.

In D15 (1), just after the completion of work on an item the aphasic person initiates conversation in reference to that item:

1. A: (1.0) yes I've had I've just been er ((leans back in chair)) give the milk ( ) to
2. tell him not to (.) to give any milk for next fortnight=
3. T: =oh you=
4. A: =no (.) because there's too all much in the house

The aphasic person has control of the topic here and is in a position to rebut the therapist's assertion started in line 3. The aphasic person's physical position (line 1: "((leans back in chair))") shows how she has disengaged from the task (where she was bent over the table) and is now attending to a different mode of interaction altogether, where she is (temporarily) in control.

Brief asides from therapists are a frequent feature of the data, and they occur in a variety of different contexts. In D14 (2) the therapist is in the process of 'Elicitation', which begins thus:

1. T: what day of the week (.) I I only do it once a week what day of the week
2. d'you reckon that was my washing up (1.0) that I'd been roasting something

The aphasic person is required to name a feature of something in the kitchen given the verbal definition stimulus by the therapist. Here the therapist throws in the briefest of asides – "I I only do it once a week" (line 1) – in the process of the 'Elicitation'. Perhaps this is designed to add information to the 'Elicitation', perhaps to lighten and personalise the task.

Another means therapists use to personalise tasks is to ask for 'peripheral' contributions to therapy items. For example in D5 (1) the therapist asks the aphasic person to think of a name for the protagonist in the sentence processing work ("does he have a name"). She later comments on the name in relation to the action taking place in the task item: "oh right so Jim is your domestic help". This type of light-hearted banter is frequently to be found in the data, and is presumably a way for therapists to distract from the often tough (and repetitive) work that they are asking people with aphasia to undergo.

Asides by therapists quite often refer to some sort of operational hitch, such as in two light-hearted asides by the therapist in D5 (1): "I shall do this drawing differently next time"; "and between my drawing and your word-finding difficulties (sorry) we get very confused between us don't we". In D7 (1) the therapist comments: "the trouble with me sitting here is sometimes I I don't know whether they're upside down (or not)" referring to her view of the pictures.

It has often been pointed out in the course of this thesis that a task-based sequential structure may 'leak into' phases which are ostensibly not concerned with

doing task-based work. The concern that a genuine inquiry might be misconstrued as a 'test' is evident in the following extract from D12 (3): "what sort of plane is that I genuinely can't remember (please tell me)". Here the therapist is at pains to point out that hers is a genuine question asking for information rather than a 'test' requiring a performance.

Humour too is characteristic of 'Inserted conversation'. In the following extract from D14 (2) the aphasic person initiates a joke inspired by the therapy item:

1. T: mushrooms that's right
2. A: they're not mush room ((much room)) ((points to the page))
3. T: (o:h) no I haven't got mush room left have I

The therapist responds to the aphasic person's initiation with her own echo of the pun (line 3), and they share brief laughter, before the therapist moves the work on with a new 'Elicitation'.

In the following extract from D12 (1), after the aphasic person has placed a picture in a card sequence, the therapist asks:

1. T: okay so when (do you normally) see your wife
2. A: no ((shakes his head and laughs))
3. T: ((laughs)) ( ) always out yeah
4. A: er
5. T: if you were a working man when would you be seeing your wife

The aphasic person's response to the 'Elicitation' is a joke which the therapist responds to with laughter, reflecting back the implied meaning. However she quickly reverts to the therapy work in hand, making her meaning more explicit so as to avoid any further ambiguity.

'Inserted conversation': summary

- Therapists usually initiate 'Inserted conversation', although aphasic people occasionally do so
- The aphasic person may be a competent co-conversationalist despite speech and language difficulties
- Particular items often inspire 'Inserted conversation'
- 'Inserted conversation' often takes the form of brief asides from the therapist
- Therapists control the ways in which 'Inserted conversation' is brought to an end

6.2.6 'Response management'

The final section in this chapter on 'Doing therapy tasks' does not put forward any features in addition to the ones already outlined in the various sections above. 'Response management' is a way of conceptualising the process through which aphasic people's responses in therapy tasks are anticipated and contingently managed. This work entails an almost infinite number of combinations of the features of 'Doing therapy tasks' which have already been outlined and discussed above. It is a way of gathering, under one conceptual umbrella, the features and related dimensions entailed in 'Enacting tasks' and 'Overall task management'. 'Response management' is intended as a concept aimed at sensitising the observer to the various features, combinations of features and dimensions which therapists and people with aphasia use in the process of responding to the challenges represented by therapy tasks.

The manner in which responses are managed ranges from basic evaluative feedback in 'Elicitation-response – follow-up', to extremely complex and lengthy sequences of interaction. These sequences of interaction may entail, for example: a series of 'Elicitations' where task demands are manipulated in relation to the various dimensions of enacting routines; adjustment to the configuration of stimulus items; or

'Information and clarification' and 'Summary', which may be used to guide and inform the aphasic person's responses.

The concept of 'Response management' will be illustrated using three contrasting extracts from the data corpus. The features and dimensions of 'Response management' associated with each extract will be summarised in a table at the beginning of each extract.

1) The first example illustrates an ostensibly simple task from D7 (1) – spoken word-picture matching. The following features and dimensions of 'Response management' will be discussed:

FEATURES	DIMENSIONS
Time and timing	Elicitation-response
Elicitation	Information content and response demands
Elicitation-response – follow-up	Multiple function
Stimulus items	Numbers of items
Information and clarification	Offer

Table 6.4 Response management: features and dimensions for D7 (1)

The aphasic person is required to choose the target from a choice of ten black and white drawings of people doing things. These are on a single sheet of paper on the table. The aphasic person has just successfully completed the first item:

97. T: yeah listen hard with this one ((finger held up to ear)) (1.0) who's sneezing
98. A: (sneezing) (23.0) ((points))
99. T: no it's not him he's doing something else (what) sneezing's when you go achoo
100. ((mimes a sneeze)) he's got a cold
101. A: aha
102. T: the one that's got a cold (.) achoo ((mimes a sneeze))
103. A: aha them ((looking for the target)) (16.0)
104. T: they all sound quite similar don't they these=
105. A: aha

106. T: =these words (.) that one's sleeping ((points))

107. A: yes

108. T: but I'm looking for (2.0) snee:zing (.) achoo ((mimes a sneeze)) sneezing

109. A: (20.0) m:↓ ((all the while looking down at paper on table top)) (10.0) ((points))

110. T: (no) that one's singing

111. A: aha

112. T: ((places blank sheet of paper over bottom half of the page of pictures)) ( ) the

113. top four (5.0) see who's sneezing

114. A: ((points))

115. T: okay↓ yeah

116. A: ah

117. T: that one's swimming ((mimes))

118. A: aha

119. T: so ((pointing)) it's this one that's sneezing it's hard=

120. A: ah ah

121. T: =to [see] can you see=

122. A: [yes]

123. T: =he's got a tissue

124. A: aha

125. T: he's got a tissue in his hand

126. A: aha

127. T: achoo ((mimes a sneeze)) (.) he's sneezing

128. A: aha

129. T: he's got a cold

Time and timing. The first characteristic feature of this particular sequence is the time the therapist allows for responses. In line 98 it is 23 seconds, in line 103 it is 16

seconds, and in line 109 a total of 30 seconds. In this sense, the manipulation of time is in anticipation of an 'Elicitation-response'. In other words, by allowing a certain time to elapse before the response occurs (or does not as the case may be) the therapist is manipulating the conditions which might make a response more likely. One could conjecture (rather obviously) that if this particular aphasic person were put under strict time constraints then no responses at all would ensue

Elicitation. After the aphasic person's initial error response, the therapist's subsequent 'Elicitations' all contain additional information. In lines 99-100 the information clarifies the meaning of sneezing ("when you go achoo"; "he's got a cold") and the therapist adds supporting gestures ("((mimes a sneeze))"). This is repeated in line 102, which initiates the 'Elicitation'. In line 108 the therapist repeats the gestural information and in addition draws out the pronunciation of the target word: "snee:zing", adding additional phonetic information. This phonetic information is contrasts with the information the therapist has given in the previous turn – information about the nature of the stimuli as a whole: "they all sound quite similar don't they" (line 104), giving specific information about one of the stimuli ("that one's sleeping ((points))") (line 106), and the specificity of the target is highlighted through the use of "but" (line 108) and the aphasic person is prepared for the presentation by the two second pause before "snee:zing" (line 108).

'Elicitation-response – follow-up' by the therapist includes simple negative evaluation (line 99: "no it's not him he's doing something else"), but also with the addition of information about the error response (line 110: "(no) that one's singing"; line 117: "that one's swimming"). She finally offers the target to the aphasic person in line 119: "it's this one that's sneezing".

Before this the therapist has also manipulated the configuration of the stimuli by cutting down the number of choices to four (lines 112-113). This type of manipulation

of stimuli is a common feature of 'Response management' in these data and relates both to reduction in numbers of stimuli as well as manipulation of the types of co-occurring stimuli (i.e. ones that might be considered to be too similar in sound or meaning are replaced by ones that are more 'distant').

Having given the target in line 119, the therapist 'softens' the impact of the failure by emphasising the problematic nature of the stimulus ("it's hard to see"). She offers information by going on to point out the features of the picture which relate to the meaning of the stimulus word, i.e. line 123: "he's got a tissue"; line 125: "he's got a tissue in his hand", backing this information up with repeated gestural (line 127: "achoo ((mimes a sneeze))") and semantic (line 129: "he's got a cold") information.

2) The second example is from D12 (2). The task is more complex than in the previous example, and is a 'production' rather than a 'listening' task. The aphasic person is required to write a sentence in response to a picture stimulus. The therapist initiates the 'Elicitation' by asking: "what is he actually doing for this woman". The aphasic person's response in the first instance is to write "nothing". The ensuing sequence, which is too long to include as a transcription, includes the following features of 'Response management':

FEATURES	DIMENSIONS
Stimulus items	Clarity of items
Overall task management	Introduction of different sub-tasks
	Extemporised tasks
Elicitation-response – follow-up	Specificity
	Calibration
Elicitation	Information content and response demands
	Responding routine
Summary	
Task-related response	Response content
Responding process	Indication of trouble
Information and clarification	Offer

Table 6.5 Response management: features and dimensions for D12 (2)

The nature of the stimulus means that there is not necessarily one correct response. With this in mind it can be seen how the therapist tries to work the aphasic person towards a response which relates appropriately to the picture by introducing a series of sub-tasks which contingently follow one another. He is first asked to write a "vocabulary", which he is unable to do. Then, he is asked about the man's purpose in being there, to which he is unable to respond. He begins to respond after the therapist fashions the 'Elicitation' into a question asking what the man does for a living.

In her 'Elicitation-response – follow-up' to his incomplete response the therapist works to repair the half-completed word. This includes specific information about the response and verbatim repetition of the response ("decorting"). Thus a complex series of embedded repair routines arises.

The therapist uses his (corrected) response as the basis for a brief 'Summary': "so he's doing some decorating for her". She then continues with a new 'Elicitation' where he is required to give the name of the trade (of the man in the picture): "so what's his job (3.0) what does he call himself if he had to write what he did for a living". The therapist proves not to be satisfied with the response "decorator" and attempts another 'Elicit': "sometimes they call themselves something beginning with */pe/* ((gestures painting)) (4.0) painter/". As can be seen she finally offers the word ("painter"), the rising intonation denoting the offer which the aphasic person must confirm or disconfirm.

After another brief 'Summary' on the part of the therapist ("so he's he's decorating he's a decorator or painter by trade isn't he"), a further 'Elicitation' occurs: "what's he actually doing there in that picture". It takes several turns to establish the target, which the therapist finally elicits through a gesture (a 'talking' gesture).

The aphasic person first attempts to say the word (which sounds like "gabbling" but it is difficult to hear). He starts to write but gives up and the therapist now proposes

a responding routine in the form of a synonym dictionary. He searches and finds the word "yapping". While this could be considered to be an appropriate colloquial expression for what the participants are doing (talking) the therapist is not satisfied with the content of his response and steers him towards this particular target (i.e. 'talking').

He has difficulties with the spelling and the therapist offers general information about the target ("it doesn't spell the way it sounds") as well as more specific information about his error response ("and you've written TA"), until offering the final letters of the word ("and what you need is LK").

Having established "talk" the therapist then asks him to look for "a better word for what they're doing" using the synonym dictionary. The therapist reads out the possible alternatives before proposing "discuss". She returns to his previous response via a 'Summary': "think if you come up with a word like yak um it's very hard to look it up", which continues with advice about the use of the synonym dictionary to pinpoint an appropriate word.

A further 'Elicitation' ensues: "just try and write a sentence about what what's going on in that picture there". The aphasic person begins to write but cannot progress, indicating his frustration by throwing up his hands and looking up at the therapist. She makes a proposal about how he should go about starting the sentence, and he gets going. While he is writing, the therapist makes a correction on the page without explicitly drawing his attention to it. She then makes a brief 'Summary' of what he has written so far: "the decorator is having a discussion". This forms the starting point for further work on the sentence, but the aphasic person is unable to continue, pointing to the side of his head and shaking his hands in evident frustration. The therapist here reflects back her understanding of his frustration.

They continue with the work on the sentence, again using the synonym dictionary to help locate an appropriate way to continue the sentence. The therapist also

proposes use of a preposition ("about") as a means of helping the work forward, and the aphasic person completes the sentence ("the decorator is having a discussion about the wall").

The therapist initiates a 'Summary' which relates the previous and evident frustration expressed by the aphasic person to the possible advantages of using a "key words" strategy: "you write the sentences very well when you've got the right words available...you you you slot them together beautifully...but it's just that frustration you're starting to write a sentence and then you're losing a key word".

3) The third example used to illustrate 'Response management' again concerns a relatively simple task – providing the spoken name for an object picture in D15 (1). The main instruments used by the therapist are so-called test questions (see Section 6.2.4.iii.IIIa Dimensions of Elicitation) and 'Information and clarification':

FEATURES	DIMENSIONS
Elicitation	Information content and response demands
Elicitation-response – follow-up	Evaluation: implicit/explicit
Task-related response	Response content
Time and timing	Elicitation-response – follow-up
Information and clarification	Offer

Table 6.6 Response management: features and dimensions for D15 (1)

The stimulus is a black-and-white line drawing of a bicycle. The aphasic person has been unable to name the picture, but begins a brief account of rides and picnics in her childhood. The word 'bicycle' is not mentioned, but she does mention the word "handlebar" as she points to the picture:

1. T: how d'you make it go along
2. A: well you go on there you've got your bars (.) you've got your (.) wheels
3. T: and what d'you have to do

4. A: and you've got to put on your hand to make sure it make goes

5. T: that's right and how d'you make it go along (.) what d'you have to do

6. A: (well) stop it ((pointing to the picture))

7. T: (1.0) (ah) now (.) how d'you make it go along what do you have to do to make

8. it go along (.) can you remember

9. A: (3.0)

10. T: it involves your legs

11. A: (1.0) ( ) oh↓ you've got your you've got your two pedals

12. T: A

13. A: you've got your two pedals

14. T: you sit on the saddle ( ) [you]

15. A: [yeah]

16. T: and what d'you have to do with your legs (.) you have to ((taps A's arm))

17. A: ((looks up))

18. T: ((gestures pedalling with both hands))

19. A: you've got to ( ) on your pedal=

20. T: =you'd have to [pedal]

21. A: [pedal] pedal [paddle]

22. T: [you have to] pedal yeah you have to pedal quite hard as well don't you

Here there is a brief sequence of 'Inserted conversation', which is initiated by the aphasic person saying: "those days have gone". The therapist brings the 'Inserted conversation' to an end with an 'Elicitation':

23. T: nowadays if you go about you have to go about in a ((gestures steering wheel))

24. A: car

25. T: in a car (.) when you were little you used to

26. A: my grandson

27. T: (wait) ((taps A on the arm)) when you were little you used to ride a ((holds up
28. the stimulus picture))
29. A: on a bicycle ((pointing to the picture))

The aphasic person has already indicated in the conversational account that precedes this extract that she has access to semantic knowledge about the stimulus item. She talks appropriately about it, and is also able to access a word ("handlebar") which is part of the object. The therapist's first 'Elicitations' are all test questions (i.e. ones to which he knows the answer). Thus questions in line 1: "how d'you make it go along"; line 3: "and what d'you have to do" and essentially repeated in lines 5 and 7-8, are constructed to elicit a response to do with action associated with the target item. The aphasic person's response in line 2 is an enumeration of parts of the bicycle and is followed-up by an 'Elicitation' which emphasises the actor's role (i.e. implicit negative evaluation of the preceding response). The aphasic person's response in line 4 is rewarded with positive evaluation – possibly because the response content refers to some sort of action – and is followed-up with the repeated questions about the action in line 5. The aphasic person's response in line 6 is also action oriented, although now at an almost opposite pole to the correct response. Perhaps this is the reason for the therapist's one second silence in line 7, as he thinks how to set the course right again. He simply reiterates the same type of questions, and this time there is no response.

Now the therapist adds information about the item. In line 10 reference is to the means of propulsion and this information actually elicits another object-related response – "two pedals" (line 11). More information is added in line 14, which appears to be increasingly oriented to giving a visual picture of a scene, followed in line 16 with another test question and sentence frame ("you have to"), which is structured to elicit a verb rather than a noun. To this is added further visualising information in the form of gesture (line 18).

It looks as though the aphasic person's response, although it contains the appropriate word – "pedal" – is not structured so that "pedal" can possibly be a verb, as has been targeted by the therapist. The therapist continues by offering the target sentence in line 20 ("you'd have to pedal"), although the actual target item has still not been achieved.

The aphasic person initiates a sequence about the past, which the therapist quickly curtails with an 'Elicitation' about a completely different form of transport ("car"). This turns out to contrast with the ensuing question which appears to tap into the aphasic person's own account (line 25: "when you were little"), but the therapist ends up using a sentence frame with a verb phrase collocation device in conjunction with the stimulus item (line 27: "you used to ride a").

'Response management': summary

These three extracts from the data have been used to illustrate the concept of 'Response management', and in doing so, demonstrating the variety of features and dimensions which are applied by therapists (and people with aphasia) in the process of tackling the challenges of 'Doing therapy tasks'. 'Response management' as a concept aims to reflect, through the flexible application to therapy data of a broad range of features and dimensions, the fluidity and complexity inherent in the enactment of therapy routines. While acknowledging the complexity of the therapy process, 'Response management' also aims to make the intricacies of therapeutic interaction available to the observer in a form that allows structured and coherent observation and analysis.

6.3 Data analysis 3: summary

This chapter has examined the domain of 'Doing therapy tasks' in terms of its key features – principally, 'Task introductions' and 'Task management', which is divided into the 'Overall management of tasks' and the 'Enactment of tasks'. The latter is further subdivided into various sub-features and these have a number of dimensions associated with them. In other words, the description and analysis of task-related work has ranged from a globally oriented perspective, to one which takes the detailed processes of moment-by-moment interaction into account. In addition, features which are intimately associated with and entailed in the enactment of tasks, namely 'Summary' and 'Information and clarification' have been described and analysed.

'Inserted conversation', a characteristic feature of therapy sessions which has already been discussed in Chapter Five, has also been examined here in relation to 'Doing therapy tasks'.

Finally, 'Response management' as a conceptual cover term for the processes entailed in 'Task management' was introduced and exemplified through the analysis of three sequences of therapy interaction.

In the following chapter the descriptive-analytic framework which has been proposed in the course of Chapters Five and Six will be put into practice in the analysis of a single therapy session. The process of analysis will be used to test and demonstrate the utility of this framework in furthering an understanding of therapy for language impairment in aphasia.

CHAPTER SEVEN

ILLUSTRATIVE ANALYSIS

7.1 Introduction

As has been pointedly noted by Byrne and Long (1984) in their study of the verbal behaviour of general practitioners, information gleaned from the study of health service interactions "might be interesting as the subject of an esoteric PhD, but as such it is of no practical value" (Byrne and Long 1984: 126). Taking to heart the spirit of their advice this chapter sets out to illustrate the potential utility of the approach to description and analysis of aphasia therapy sessions which has been outlined in the previous chapters. This approach has been derived from observation of data from a wide-ranging and relatively large number of therapy sessions. The analysis has generated a framework for observation and description which has not used relative frequency of observations as a criterion for including or excluding features. Single instances of observed behaviour have been considered just as valuable in crafting the framework as multiple instances. The point is, can such a framework, effective perhaps in describing a large body of data, be at all useful as a means of description and analysis at the level of a single session of therapy?

In order to explore this question a single session was selected for illustrative analysis from all the available sessions by a simple random method. Sessions from each dyad were typed on separate slips of paper (i.e. D1 (1), D1 (2), D1 (3), D2 (1), D2 (2) and so on), jumbled up and drawn blind. The session thus selected was D8 (2), and the following sections illustrate how description and analysis have been applied to this session. The analysis is not intended to be comprehensive or exhaustive, but rather to illustrate the potential of this approach to further the understanding of 'what is going on' in therapy sessions for aphasic language impairment.

7.2 The session: structure

7.2.1 Therapist's outline

As was described in Chapter Four therapists who participated in this study were asked to submit data on the sessions they recorded. The therapist's record of D8 (2) (under the given headings of 'Tasks' and 'Items') is as follows:

'Tasks'

1. Written word-picture matching with three close semantic distracters
2. Production of target in response to forced alternatives from the therapist
3. Categorisation of written words into 6 categories
4. Written word choice from definition (same words as in previous task)
5 Conversation and homework

'Items'

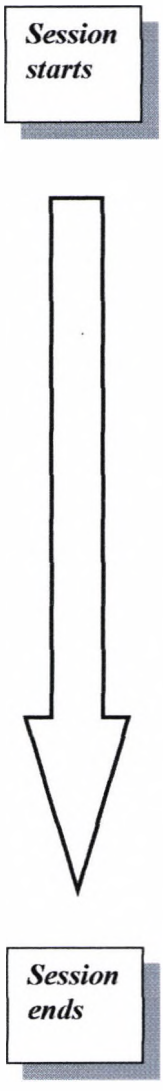
1. A set of 26 high and low frequency object pictures with written label and three close semantic distracters
2. Written word list made up of words belonging to six semantic categories

Outlines for previous and subsequent sessions for this dyad can be found under D8 in APPENDIX THREE. No other data or artefacts were submitted by the therapist.

The session was recorded on video- and audiotape simultaneously. The videotape starts some moments before the audiotape – just enough to show the therapist switching on the tape recorder and going to take her place at the table. The aphasic person is already sitting at the table, working at some papers. The therapist sits to his left around the corner of the table. The centre of the video picture is approximately mid-way between the therapist and the aphasic person. The audiotape and videotape end almost simultaneously after thirty-one minutes.

7.2.2 Session outline

While the purpose of this chapter is not to comment particularly on the impact of the data collection methods on the interaction, it should be noted that – apart from perhaps one of the therapist's opening turns (which will be discussed below in Section 7.3.1) and one fleeting comment by the therapist at the end of the session, neither participant demonstrably notices the recording process. At the end of the session the therapist says "wave bye bye", which is followed by the aphasic person's laughter as the camera is switched off. The sequence of the session structure may be broadly outlined as follows:



DOMAINS and FEATURES	OUTLINE
Doing therapy tasks (1): *Enacting tasks*	A is required to read out words he has previously written (to picture stimulus). 5 items written while waiting for the therapist, 6 new items completed with therapist (say word only, no written naming)
Summary; Information and clarification	T invites A's comments on how he did and ease/difficulty of task; checks whether this task could be used as homework in the future
Opening up the business	T makes general introduction to next task; refers back to doing them previously, mentioning ease/difficulty
Doing therapy tasks (2): *Task introduction*	Specific task instructions – configuration of items in the task are clarified
Enacting tasks	A required to choose a written word to match a picture – target word + three distracters; A then required to say word (25 items)
Inserted conversation	
Summary; Information and clarification	T invites A to comment on how he did; asks A about whether easier/harder (uses 1-10 'pointing to' scale)
Inserted conversation	T comments on computer work A has done elsewhere
Opening up the business	T opens next business
Doing therapy tasks (3): *Task introduction*	T introduces specifics of next task, including delineation of categories
Enacting tasks	A is required to choose and write a word to fit one of six categories; A required to say chosen/written word (18 items)
Doing therapy tasks (4): *Enacting tasks*	A is required to choose a written word from T's spoken definition (6 items)
Inserted conversation	
Closing down period	Homework introduced and briefly tested; cursory plan for future meeting

Figure 7.1 Sequence of session structure: D8 (2)

Figure 7.1 gives a broad indication of the chronological sequence of domains and features that make up the session. The bulk of the session consists of 'Doing therapy tasks', with entailed and associated features, as well as a relatively protracted 'Closing down period'. As can be deduced from the arrows leading from two of the 'Inserted conversation' boxes, these occurred during the course of 'Doing therapy tasks' (2) and (4). Conversation also continued after the completion of 'Doing therapy tasks' (4), hence the arrow split in two directions. The information contained in Figure 7.1 is designed to orientate the reader in the first instance to the most general features of the session in rough chronological sequence and to prepare the ground for more detailed analysis. The following section will very briefly set out and discuss the ways in which the domains and major features of the session will be analysed.

7.2.3 Plan for the analysis

The following table gives an outline of the way the analysis will be carried out:

DOMAIN	FEATURES	REMARKS
1) 'Opening up the business' and 'Doing therapy tasks'	• Previous therapy work • 'Task introductions'	• One domain, and one feature of another addressed in one section • Only two instances occur
2) 'Doing therapy tasks'	• 'Overall management of tasks'	• Addressed across the session as a whole
	• 'Enacting tasks' ➢ 'Task procedures' ➢ 'Task-related responses' ➢ 'Stimulus items' ➢ 'Response management'	• Across the whole session • Dimensions across task-sets • Examines: ➢ task structure ➢ error and repair ➢ summarising and informing across and within task-sets
3) 'Inserted conversation'		• Addressed across the session as a whole
4) The 'Closing down period'	• 'Homework' introduced • 'Arrangements for other meetings'	

Table 7.1 Plan for the whole session analysis of D8 (2)

The analysis of this session will follow the general plan of examining the major domains, and features of those domains, across the session as a whole, rather than analysing the session as a consecutive sequence of events. The order of the analysis, however, will follow the numbered outline in Table 7.1.

As can be seen from row 1) in Table 7.1, 'Opening up the business' and 'Task introductions' (a feature of 'Doing therapy tasks') are addressed in one section. The reason for this is that, as was discussed in Chapters Five and Six, there is often little to differentiate between the two, and here this is also the case

'Doing therapy tasks' is examined in relation to the features outlined, and these are addressed both across the task-sets as a whole, and, in the case of 'Response management', also within a single task-set in depth.

'Inserted conversation' is addressed across the session as a whole, and the final section examines the 'Closing down period'.

The analysis will follow the advice of Seale (1999: 121) by "counting the countable". Events that can be well-defined and illustrated will be counted, and percentages or means calculated where this is deemed to add to the power and credibility of the analysis.

7.3 The session: domains and features

This section with its sub-sections will examine the major features of the session, the purpose being to provide a detailed analysis in terms of the framework that has been outlined and discussed in this thesis. While the outline in Figure 7.1 shows (an approximation of) the chronological sequence of events, this section will generally proceed by examining the major domains and features across the session as a whole. As was mentioned above, 'Doing therapy tasks' occupies most of the session. Associated with 'Doing therapy tasks' is 'Opening up the business'; entailed within 'Doing therapy

tasks' are 'Task introductions', 'Task management', and 'Enacting tasks', which in turn entails 'Summary' and 'Information and clarification'. Conversations are inserted from time-to-time and in various contexts, and the session ends with the 'Closing down period'.

7.3.1 'Opening up the business' and 'Task introductions'

As is clear from the structure outlined in Figure 7.1 there is no discernible 'Settling down period' in this session. We may presume that this has occurred off-camera. The first task-set is already in progress when the video starts, and thus the first instance of 'Opening up the business' and 'Task introductions' precedes task-set two:

1. T: ...now I've got your pictures here
2. A: yeah
3. T: but seeing as you did so well=
4. A: (yes)
5. T: =yesterday I've made them a bit harder
6. A: ((grimaces))
7. T: no faces please
8. A: *no no no no*
9. T: you were complaining they were too easy (.) okay so so this time A you've got
10. the same picture (.) but you've got four (.) words to choose from
11. A: ((turns over top sheet of pictures))
12. T: ((turns top sheet back again))
13. A: (no no no)
14. T: ((draws chair up closer to table)) okay so it's the pictures you've seen before
15. you've got to choose the right word to [go with the picture]
16. A: [((points to word))]

17. T: brilliant

The therapist links past work with work to come by referring back to "yesterday" (line 5) and to the aphasic person's performance yesterday in relation to the difficulty of the work ahead of them today (line 5: "I've made them a bit harder"). There is a light hearted exchange, which the aphasic person initiates in line 6 by pulling a face. The therapist aligns herself with this gentle humour through her comment in line 7. Her justification in line 9 ("you were complaining they were too easy") – light-hearted though it is – surely represents a preoccupation with adjusting the level of task difficulty in order to maintain a 'challenging' level of information processing demands.

This particular instance of 'Opening up the business' merges imperceptibly into 'Task introduction' as the specifics of the task are cursorily introduced (lines 9-10: "you've got the same picture (.) but you've got four (.) words to choose from"). The aphasic person is clearly eager to start (line 11), but the therapist demonstrates her control over the proceedings by taking charge of the picture sheets (line 12). The aphasic person starts the task while the therapist is still finishing off her 'Task introduction' (lines 15-16), thus perhaps offering a mild challenge to her authority. The task-related procedure is clearly familiar to both of them, and the task-related sequences swing into motion without further ado.

The only other substantive instance of 'Opening up the business' precedes task-set three:

1. T: okay let's put that one away ((moves folder of papers across table)) (3.0) now
2. A this is similar to what you were doing yesterday
3. A: yes
4. T: yeah (.) d'you remember there's some words at the top here (.) that all fit into
5. different categories
6. A: yeah

7. T: yeah/ (.) and you have to try and put them in the right place (1.) when you've
8. finished yawning (3.0) (but) you only need to see one at a time (I think)
9. A: yes
10. T: so it's different to yesterday we've got different things here...

The impending phase of 'business' is very briefly introduced by the therapist with reference to "what you were doing yesterday" (line 2). The 'Task introduction' emerges from this prologue in terms of a brief reference to the task procedure in lines 4-5 and 7: "there's some words at the top here (.) that all fit into different categories...and you have to try and put them in the right place". The reference to the task procedure is relatively vague and the therapist appears to rely on its familiarity in order to short-cut any lengthy explanation. However, as the categories are different, the therapist introduces them one-by-one in a sequence which follows on from the one illustrated above – "we've got different types of professions (.) okay...we've got things to do with banks...". The aphasic person acknowledges each in turn before the actual task is initiated by the therapist's 'Elicitation'.

The impending fourth task-set is actually signalled in an aside during task-set three: "okay (.) two more (.) and then I'm gonna ask you some questions about this", and the actual introduction to the task is limited to a sort of transitional statement of intent: "okay (.) then you have a look at these (.) okay I'm gonna ask you some questions about them". Again there is a point about the familiarity of the two participants and the work they have doubtless carried out frequently together perhaps not necessitating very elaborate explanations. This is also born out in the reference to "your pictures" in the first instance of 'Opening up the business' – a personal set which clearly need no further explanation.

The following section will examine the process of 'Doing therapy tasks' in detail as set out in Section 7.2.3 and Table 7.1 above.

7.3.2 'Doing therapy tasks'

The therapist's opening remarks at the outset of the video imply that the aphasic person has been doing some therapy work while she has been delayed in some way:

1. T: good (2.0) you've got (1.0) two more of those (.) were those difficult ones
2. A: ((shakes his head slightly)) *no*
3. T: yeah okay we'll have a look at those ones together (.) so A while I was keeping
4. you waiting (.) I'm sorry about that
5. A: yes
6. T: (you're) just having a look at these for me
7. A: yes

The therapist refers in a summarising manner to work that the aphasic person has already completed, and adds a query about difficulty (line 1). Her statement of intent (line 3: "we'll have a look at those ones") is a mark of her control over the proceedings. This is underlined by her use of "for me" (line 6) – the implication being that the aphasic person is fulfilling the requirement of the therapist's purpose, the phrase also carrying a strong sense of obligation. There is a sense that the therapist's remark: "while I was keeping you waiting...(you're) just having a look at these" (lines 3-6) may be directed at the camera as an explanatory aside to the researcher, but this is only a tentative conclusion.

Thus the session starts almost immediately with 'Doing therapy tasks'. While the first task-set does not feature any preamble in the form of 'Opening up the business' or 'Task introduction' – we assume that the first task-set has already been introduced or explained in some way – 'Opening up the business' and 'Task introductions' clearly feature elsewhere, as has been illustrated and discussed above. In the following sections 'Doing therapy tasks' will be discussed in terms of both the 'Overall management of tasks' and 'Enacting tasks', with its sub-features and dimensions related to these.

7.3.2.i 'Overall management of tasks'

There are four main task-sets in this session. There is some task-related work in the 'Closing down period' associated with discussion of homework and that will also be discussed in this and subsequent sections. All tasks and items used in the tasks are pre-prepared by the therapist. There is no discussion or negotiation between therapist and aphasic person leading to choice of task or items used in the task, and therefore no preparation of materials during the session. The shaded boxes in Figure 7.1 indicate the four task-sets across the session. 'Homework' (in the 'Closing down period') is also highlighted, and will be examined from a task-related perspective.

The opening task-set is in one sense not pre-prepared, in that it came about as a contingency – the aphasic person was asked to do some work while the therapist was delayed. It is not entirely clear what the task was, except that the aphasic person has already written a series of words by the start of the session. He is then required to read or say the words. There are a number of items (six) which he is asked to say aloud for which he has not yet written the words. That there are picture stimuli involved, although this cannot be clearly seen on the video, is clear from the therapist's query: "did you have a look at the pictures as well", and subsequent implied reference to visual images.

The second task-set follows soon after. In this the aphasic person is required to choose a written word (from a set of four) to match a picture, and then to say the word. In a sense these two tasks, while obviously completely different (being 'judgement' and 'production' tasks respectively) could be said to compliment one another. The first requires the selection of a written word on the basis of its meaning – discriminating the target from a set of distracters and doing 'semantic work'. The second 'uses' the selected word as a basis for doing phonological or articulatory work. This type of sequence is also applied in task-set three, but the aphasic person is also required to write target words. In task-set four, the words from task-set three are used as the basis for a

different type of judgement task – choosing a written word to match a spoken definition. Thus there is a certain sense of continuity about the management of tasks over the course of the session. The general emphasis is on semantic judgements using a variety of different approaches, but word-production work, both written and spoken also features strongly. The relative emphasis on interactive work between therapist and person with aphasia in relation to 'judgement' and 'production' tasks will also be discussed in the sections that follow.

Homework for the next meeting is discussed in the 'Closing down period'. The content and purpose are presented by the therapist, but the aphasic person is also required to complete work on some of the items in the task, presumably by way of demonstration. The therapist states her intention: "...okay (.) so we'll do the first couple together now", and the aphasic person complies by starting to enact the task routine. The task entails choosing and then writing a word to complete a short phrase – for example: "a cup of _____". We do not know from the video- or audiotape the number of word choices there are to choose from. Presumably the type of task has been chosen by the therapist as one which the aphasic person can complete on his own ("you can do that one on your own if you want"). This task therefore also entails elements of 'judgement' and 'production'.

7.3.2.ii 'Enacting tasks': 'Task procedures'

'Task procedures' addresses issues to do with the planned management of tasks as they are put into practice. Thus for example, the therapist's submission as outlined in Section 7.2.1 gives an indication of the sort of procedures that are entailed in the tasks – for example, selecting a word from a choice of written words, or use of "forced alternatives" by the therapist to elicit word production. 'Task procedures' are often clarified in 'Task introductions'. We are not privy to any clarification of the procedures

for the first task-set, but procedures are outlined by the therapist for task-sets two and three, implied for task-set four, and clarified in the presentation of homework in the 'Closing down period'.

In task-set two, which has twenty-five items, the procedure relating to the second task as outlined by the therapist in her submission – entailing the production of the target in response to the presentation of "forced alternatives" – does not take place consistently. In fact the production of the spoken word is not elicited in the first instance at all in this way. "Forced alternatives" are used by the therapist eight times out of twenty-five, but only in the context of contingent 'Response management', when the aphasic person has somehow failed to achieve the target response.

There is an indication in task-set three that the aphasic person is going about the task in an unanticipated way. The therapist has not explicitly stated the procedure, but after the aphasic person has chosen and written the first item, the therapist says: "okay oh you're doing it that way round that's okay good that's okay good". The suggestion is – as evidenced through the therapist's "oh" – that there is something about the way the aphasic person is going about the task that is unusual or surprising. However, we are not privy to what that may be, but it is an indication of the (unspoken) presence of a procedure.

7.3.2.iii 'Enacting tasks': 'Task-related responses'

Mode of response clearly varies across tasks – for example, choice of written word requires the aphasic person to *point* to the target, whereas production tasks require either the *spoken* or *written* word. In task-set three, where the aphasic person is required to choose one of six categories to fit a set of stimulus words, the response mode appears to be writing – the aphasic person must not only choose the word but also write it in. After each category in this task-set the therapist and aphasic person review the items

associated with that category – always three words. At the beginning of the task-set, the therapist reads out two of the words, and requires the aphasic person to say the third one. For example:

1. T: so what let's look at the other ones we've got we've got dentist ((pointing))
2. A: yes
3. T: teacher ((pointing))
4. A: yes
5. T: and what's the one you've just done (2.0) */do?/*
6. A: (2.0) */bwokter/*
7. T: doctor (.) good

Thus the therapist appears to be doing informing/summarising work related to the items within the category (lines 1 and 3: "dentist" and "teacher"), followed by an 'Elicitation' – 'Elicitation-response' – 'Elicitation-response – follow-up' three-part sequence targeted at the spoken production of the word the aphasic person has written. The same pattern ensues with the next item and the three words associated with it. However in the next set of words the therapist appears to require the aphasic person to actually say all three words:

1. T: ...so what we've had already we had a ((pointing to her own watch))
2. a */w[o?/]*
3. A: [watch]
4. T: watch good (.) something you keep your money in we had a ((points to paper
5. on the table)) */per/*
6. A: purse
7. T: purse (.) and then you wrote down */gl:/* ((points to paper))
8. A: glasses
9. T: glasses

Thus in lines 2 and 5 she uses target-related phonemic/phonetic information in her 'Elicitations'. Spoken word production ensues in each case, as well as in the case of the word the aphasic person has actually written down (line 8: "glasses"). This pattern is now generally the one that continues throughout the rest of the task-set, although there is no explanation for the change, and the aphasic person complies without hesitation.

There is generally no doubt about the intended content of target-related responses. This is probably due to the fact that, firstly, target words to be chosen in relation to a picture, category or spoken definition are already pre-ordained. Secondly, production of spoken words is constrained by the word already having been delineated, so that alternatives are ruled out. There are only two instances of uncertainty – one about the lexical label for one stimulus picture, and another to do with choosing the most appropriate of two possible responses. These instances will be discussed in relation to 'Stimulus items' in the following section.

Responding routines – which refer to any type of supportive routine that may be inherent in the task set-up or proposed by the therapist as a type of self-help routine– are not apparent in any of the task-sets in. None are invoked by the therapist or aphasic person, nor are any implied by the interaction.

Precision or clarity of target-related responses is clearly specified in relation to certain tasks. Judgement tasks require a single and particular response, and only that response will do. For example, in task-set two, in the judgement task, the aphasic person makes two errors in his initial choice of target word, and in both instances the therapist does contingent work to pinpoint the correct response. In task-set three, the aphasic person makes no errors in the judgement task, while in task-set four, where he is required to make a choice of written word from a spoken definition, he makes two errors in his initial choice, both of which are corrected through contingent work.

Standards of precision or clarity in relation to spoken and written production tasks are by no means clear, and they are not explicitly referred to by the therapist. These types of standards relate to the level of demand that can be made on the aphasic person's ability to say or write words. There are no clear instances of difficulties with written words. In one instance (task-set one), after the aphasic person's first attempt at saying a word he has written, the therapist remarks:

1. T: okay have another look at this one ((writing)) (1.0) you've got the first (1.0)
2. two there alright (1.0) ((makes a mark on the paper)) that's the third sound
3. that's a (1.0) */bo?/*

It is not clear whether the "you've got the first two there alright" (lines 1-2) refers to a correction she is making on the "third sound", or whether she is using the orthographic structure of the word as an aid to subsequent spoken word production, which ensues after her 'Elicitation' (line 3: "that's a (1.0) */bo?/*").

In another instance the therapist comments that: "it's difficult to write so small" referring to the aphasic person's writing of a target word, but there is no suggestion of error or correction.

The standards of clarity or precision required for spoken word production appear to arise and be decided on a case-by-case basis. The sequence of events is usually as follows. The aphasic person says the target word, or attempts to do so, and there is then some indication of its acceptance or rejection as it stands, usually by the therapist. Thus, for example:

1. T: ...you've got a picture of a
2. A: */kreit/*
3. T: cat (.) good

Here the aphasic person's target-related attempt (line 2) – while unlikely to be intelligible out of context – is accepted by the therapist without further work, except that

she follows-up with a model of the 'norm' for the target, or veiled correction (Simmons-Mackie *et al* 1999). These types of instances – where the aphasic person's not-quite-right attempt is accepted with an ensuing veiled correction – occur once in task-set one (9%); seven times in task-set two (28%); twice in task-set three (15%).

There are also a large number of cases of spoken word production where the therapist makes an intervention to rectify a less-than-accurate response. For example:

1. T: what about this one we've got a
2. A: */maks/* ((looks up to T))
3. T: m::
4. A: mate
5. T: man
6. A: oh↓ ( )
7. T: man (.) yep

In this case the negative evaluation of the aphasic person's task-related response in line 2 is implicit in the therapist's renewed 'Elicitation' (line 3). This fails to elicit the correct response and the therapist offers and confirms the target in lines 5 and 7. Further discussion of the therapist's contingent management of the aphasic person's task-related responses follows in Section 7.3.1.v below ('Enacting tasks': 'Response management').

The aphasic person also exhibits his own standards of spoken word production. He does this in two main ways. Firstly by repeated attempts at the target word, which are not mediated by the therapist. These instances are actually rare – for two apparent reasons. Firstly, the therapist usually intervenes quickly after the aphasic person's 'failed' attempts, thus not allowing him time to retry. This may be because his retry attempts usually do not get him any closer to the target. For example:

1. A: ((turns page)) (2.0) ((points to word)) (1.0) */khriuz/* ((looks up to T))
2. T: ((nods)) it's the right one

3. A: */kwigls/*

4. T: okay good try you've gone for the right word

The aphasic person's attempt in line 3 is a rough approximation of his first attempt (line 1). The therapist's "it's the right one" (line 2) refers to his choice of the target word in the first part of the task-set, and her "good try" (line 4) clearly refers to his spoken word attempt.

A clue to the evidence for the second way in which the aphasic person exhibits his own standards of spoken word production, and to the reason for the small number of self-initiated retry attempts also lies in the extract just discussed. This is related to the way in which he looks up to the therapist immediately after he has said a word which he is not sure about (see line 1 above). The implication is that he has adjudged his production to be inadequate, that he needs confirmation of this, and is eliciting help to make the necessary correction. However this action on the part of the aphasic person is not consistently present even when his spoken word production is very discrepant from the target word.

7.3.2.iv 'Enacting tasks': 'Stimulus items'

There are various types of items in this session, according to the task-set and task. There are pictures as stimulus items in task-set one; pictures and written words in task-set two; written words in task-set three; spoken and written words in task-set four; and written words and phrases in the homework. All these items were pre-prepared by the therapist on sheets of paper, generally clipped together as a set. It is not possible to see the pictures or written words, but of course spoken words can be verified, and also give clues to the content of pictures or written words.

Combinations of item types and numbers of different items are various – again relative to the type of task. Thus, for example, written word-picture matching has

written words and pictures. In the case of task-set two, there are four written words (including the target) to choose from. In this task-set the nature of the relationship between target and distracter words is only evident where the aphasic person makes a choice error – for example, we know that one set includes: "axe" and "hammer" (where "axe" is the target); another set includes: "blouse", "dress" and "skirt", where "skirt" is the target. Otherwise we have no way of knowing. We do know however that the therapist equates an increase in the number of items to choose from at any one time with the task becoming "harder": "...you were complaining they were too easy (.) okay so this time A you've got the same picture (.) but you've got four words to choose from".

In task-set three the six categories are enumerated by the therapist, and it becomes clear that there are three words associated with each category. However, what is not clear is the relationship between target category and the number of written word choices available at any one time, or vice versa. It is difficult to infer how the task procedure is constructed. For example, at one stage the therapist says: "you have to try and put them in the right place...(but) you only need to see one at a time". Whether "one at a time" refers to the six categories or to groups of word choices is not known. Later in the same task-set the therapist says: "...okay so food (3.0) it's easier now 'cause you've only got two to choose from". The implication is that after the aphasic person has completed the 'set' of choices related to each category, they are set aside. Thus, as the therapist suggests ("it's easier now"), the demands on the aphasic person at the very least have changed over the course of the task-set.

In task-set four the choice for the aphasic person is of a written word from a spoken definition. We do know that, at least in some instances, the choice is from within a single category (e.g. "jobs"), and that it is usually a choice from three items (e.g. "which one of those three"; "out of these three").

There are no general obvious difficulties with lack of clarity or ambiguity of the stimuli. There are two exceptions to this however. The first is where the aphasic person appears not to have the necessary knowledge of words referring to types of women's clothing to make a successful choice. As has been pointed out he only makes two categorisation errors in task-set two, and one of these is this particular episode. His error choice, in the first instance is "blouse" instead of "skirt". He then chooses "dress", and finally "skirt" (obviously having narrowed down the possibilities). This series of errors is unusual enough to warrant the conclusion that he was not familiar with the lexical item and its referent, rather than it being solely due to a semantic deficit.

The second exception is where the aphasic person is required to choose a written word on the basis of a spoken definition:

1. T: ...which one would you live next door to
2. A: (4.0) ((points)) friend
3. T: you might↓ live next door to your friends

The word we assume the therapist is targeting is "neighbour", which she elicits a few turns later. The difficulty has arisen, arguably, not necessarily because of a mis-selection by the aphasic person, but because of ambiguity introduced by the particular phrasing of the therapist's 'Elicitation' taken in conjunction with the available word choice. Given the content of the 'Elicitation' ("would" having the possible implication of: 'if you had a choice'), "friend" is a not unreasonable response. In the end she elicits the required word using a collocative strategy (a cloze procedure) in conjunction with target-related phonetic information – "you've got your next door /*n:*/".

7.3.2.v 'Enacting tasks: 'Response management'

As was discussed in Chapter Six (Section 6.2.6) the concept of 'Response management' is a way of gathering, under one conceptual umbrella, the features and related dimensions entailed in 'Enacting tasks'. Features and dimensions entailed in 'Response management' will be used here to examine the ways in which tasks are enacted through the anticipatory or contingent work carried out by therapist and aphasic person. The following features and dimensions will be examined here:

FEATURES	DIMENSIONS
Elicitation	Responding routines
	Information content and response demands
	The structure of tasks
Time and timing	Elicitation-response
Elicitation-response – follow-up	Multiple function
	Evaluation: explicit/implicit
	Specificity – lack of specificity
	Calibration
Responding process	Indication of trouble
	Self-evaluation
Summary	
Information and clarification	

Table 7.2 Response management: features and dimensions for D8 (2)

'Response management' may also include manipulation of the various dimensions associated with stimulus items (see Chapter Six Section 6.2.6), but there are no instances in this session of this type of work by the therapist. This section will examine 'Doing therapy tasks', analysing 'Response management' both across and within tasks. The features delineated within 'Response management' in Table 7.1 above will not be discussed one-by-one as isolated phenomena, but will be drawn on as necessary under the headings that follow: 1) Task structure: 'Elicitation' and 'Elicitation-response – follow-up'; 2) Error and repair; 3) Summarising and informing.

Task structure: 'Elicitation' and 'Elicitation-response – follow-up'

All task-sets and tasks within them are characterised by an 'Elicitation – Elicitation-response – Elicitation-response – follow-up' three-part structure. 'Elicitation' begins the cycle, but successful 'Elicitation' is dependent on the completion of a previous 'Elicitation-response – follow-up'. This means that, for example, the absence of a third-part cannot be construed as having a neutral value. In fact in this session, absence of any 'Elicitation-response – follow-up' in third position always implies negative evaluation. For example, in task-set one, out of seven error responses, implicit negative evaluation occurs on six occasions in this way (the odd-one-out is a self-correction) – i.e. 86% of the time. This takes place as the therapist moves to make a new 'Elicitation' after an unacceptable response. In contrast, in task-set two, implicit negative evaluation takes place in this way four times out of thirteen error responses – 31% of the time. The reason for the difference probably lies in the nature of the task-sets. In task-set one, there is only a single task – to give the spoken name of a word/picture. In task-set two, the aphasic person first has to choose a word to match the picture (first task), and then say the word (second task). The change in evaluation routine probably lies in the fact that the aphasic person often almost runs the two tasks together. This happens as follows.

While the three-part structure is pervasively present in this session, 'Elicitation' is not necessarily initiated by the therapist. In task-set one it is exclusively so, but in task-set two it is the aphasic person who initiates 'Elicitations'. This is signalled by him, in the first instance, turning over the page of the work folder, then pointing to the written word choice. In 64% of instances his 'Elicitation-response' to the first task requirement occurs simultaneously with the 'Elicitation-response' associated with the second task requirement – i.e. he points to a word and says it at the same time. Sometimes both his choice response and the spoken word are accepted as correct.

However on some occasions the response to the first task is correct, but the response to the second task is considered unacceptable. Therefore the therapist must differentiate her evaluation of the two separate task requirements, and this very likely precludes the use of implicit negative evaluation. The following is an extract from task-set two to illustrate the point:

1. A: ((turns the page)) (3.0) ((starts to point but withdraws his finger)) (3.0)
2. ((points)) (1.0) */pas/* ((looks up to T))
3. T: (2.0) *okay* you [pointed]
4. A: [*/pos/*]
5. T: all right A you're pointing to the right one (.) so that's excellent okay but it
6. didn't come out qu:ite probably the way you mean it to so can you do you want
7. to listen and and see which one you think it is do you think it's (.) a river or a
8. mountain
9. A: mountain
10. T: good

While the aphasic person's first response to the second task – "*/pas/*" (line 2) – is not simultaneous with the pointing response in this instance, it clearly occurs soon enough after that response for the therapist to have to differentiate her follow-up evaluation to the two responses. This she does through: 1) positive evaluation of the choice response – line 5: "you're pointing to the right one (.) so that's excellent", where she makes it clear that she is evaluating that particular response through her use of "pointing"; and 2) a very guarded and politely framed negative evaluation of the spoken responses – lines 5-6: "it didn't come out qu:ite probably the way you mean it to". The drawn-out "qu:ite" is vague, and while clearly intended to conform to standards of politeness, it seems almost to have a note of irony, given that the aphasic person's attempt is so far off-target. The repair is set in motion by the therapist's 'Elicitation'

(lines 7-8: "d'you think it's (.) a river or a mountain") and resolved in line 10 with her final evaluation.

Error and repair

The aphasic person's differential error rates will be examined across different tasks, across comparable tasks in different task-sets, and within one particular task-set in detail. Mention has been made of differential error rates between different types of tasks – for example, the aphasic person only makes two categorisation errors on task-set two (out of twenty-five items), but twelve errors of self-initiated spoken word production; he makes no categorisation errors on task-set three (six category sets), and only two sound production errors (out of fourteen items). The following table sets these figures out in relation to task-set and task type:

Task-set	Task type	
	Categorisation	Spoken word production
Task-set two	8%	48%
Task-set three	0%	14.3%

Table 7.3 Error rate in relation to task type and task-set

The differential error rates between the two different types of task are perhaps not surprising. However the differential error rates on spoken word production between the two task-sets are perhaps more surprising. As was mentioned above, the nature of error and the standards of 'acceptability' are by no means clear cut when it comes to spoken word production, but this may not be the only reason for the differential rate of error.

Firstly one has to take into account the way the therapist calibrates her evaluation of the aphasic person's responses (against which criteria we do not know). Thus the 'fact' of an 'error' is an uncertain fact indeed. Secondly, production of the spoken word takes place in a context of variable demands placed on the aphasic person's ability to produce accurate spoken responses. Various dimensions have to be

taken into consideration here: 1) time and timing; 2) information content of 'Elicitation'; 3) linguistic factors – for example, phonetics, phonology and semantics. While the third set of factors no doubt have a significant impact on the aphasic person's ability to say words, we are not able to make observations of these, and can only surmise – as the therapist does here from time-to-time – that certain words are "tricky to say". The other two dimensions however will be examined in relation to 'error', as will the nature of 'Elicitation-response – follow-ups' which ensue.

As was mentioned above, in task-set two the aphasic person 'controls' 'Elicitation' initially. He turns the page, points to the chosen word, and then initiates production of the spoken word. Once he has chosen the target word, very crudely speaking, he is dependent on his own resources for the production of the spoken word – the therapist makes no moves to initiate 'Elicitations' in the first instance (apart from the very first item). At the aphasic person's disposal is the orthographic form of the word he has chosen – hopefully correctly – and the lexical semantic representation which this and the picture help him form in order to produce the correct articulatory sequence for the pronunciation of the word. His approach to this challenge will be analysed in the first instance in relation to time and timing of 'Elicitation-responses' in task-set two.

Taking the onset of 'Elicitation' from when he turns the page (apart from the very first item where the page is already open – this item has been excluded from the analysis), the time taken to make a first response was measured using the video display. This is a relatively crude measure, but gives some indication of how he manages his responses. Over the course of twenty-four items the quickest pointing response (final decision on the target word) is one second, while the slowest is fifteen seconds. The following figure gives an overview of the time budget in relation to his responses:

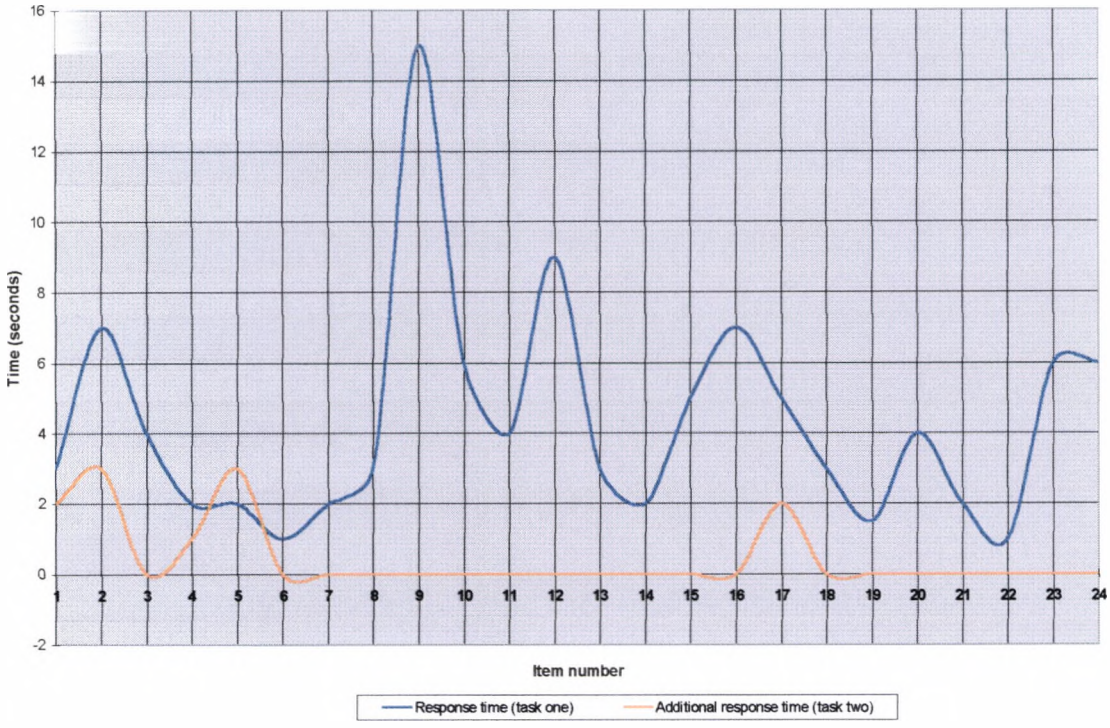


Figure 7.2 Response time in task-set two: D8 (2)

As can be seen from Figure 7.2 there is a large variation in response times across the items. The dark line represents time taken to final response in the first task (the judgement task). Any additional time taken after the pointing choice, but before the spoken word production is shown by the red line. Thus for five of the items he took additional time before saying the word for the first time. Otherwise, he pointed and said the word simultaneously. This information on its own is of little value except to point out that, generally, the therapist 'allowed' the aphasic person this time – before the choice response and/or before the spoken word response – uninterrupted by any move to re-elicit or intervene. There were some exceptions, which will be discussed below.

The following table sets out time budget, outcome and therapist follow-up on an item-by-item basis for decision making (choice) and spoken word production in task-set two:

Item no.	Target	Time 1 (choice)	Time 2 (say word)	Total time	Self-initiated responses		Therapist follow-up
					Correct	Error	
1	radio	3	2	5	*/reido/*		+ve evaluation + model
2	kettle	7	3	10		*/weidel/*	*/k'/ /ke/*
3	window	4	0	4	windows		+ve evaluation
4	squirrel	2	1	3		*/khriuz/ /kwigls/*	spoken alternatives choice
5	stable	2	3	5		ables	*/s:/*
6	cigar-ette	1	0	1		*/kweizez/*	spoken alternatives choice x 2 + */s:/*
7	monkey	2	0	2		*/bezinaziz/*	spoken alternatives choice
8	saxo-phone	3	0	3	*/vagsafeun/*		+ve evaluation + model
9	triangle	15	0	15		( )	spoken alternative choice x 2
10	butter	6	0	6	butter		+ve evaluation
11	ticket	4	0	4	ticket		+ve evaluation
12	skirt	9	0	9		*/wei/ /wens/*	choice error: therapist contingent work
13	vege-table	3	0	3		*/vegaval/*	spoken alternative choice
14	horse	2	0	2	horse		+ve evaluation
15	carrot	5	0	5	carrot		+ve evaluation
16	tongue	7	0	7		*/lump/*	spoken alternative choice
17	axe	5	2	7		*/rebammer/*	choice error: therapist contingent work
18	tree	3	0	3		*/spwi:z/*	spoken alternative choice
19	envel-ope	1.5	0	1.5	*/envelow/*		+ve evaluation + model
20	medal	4	0	4	medal		+ve evaluation
21	crown	2	0	2	*/aun/*		model + acknowledgement
22	fox	1	0	1	fox		reflect
23	moun-tain	6	0	6		*/pas/ /pos/*	spoken alternative choice
24	fence	6	0	6	fence		+ve evaluation
Total time					43.5 secs	71 secs	
Mean time					3.625 secs [range 1-6]	5.92 secs [range 1-15]	

Table 7.4 Time budget, outcome and therapist follow-up on an item-by-item basis for task-set two (spoken word production) D8 (2)

The purpose of Table 7.4 is to give an overview of the relationship between 'Elicitation', 'Elicitation-response' and 'Elicitation-response – follow-up', taking timing and outcome (in terms of 'correct' and 'error') into account. What might be useful would be to see whether there is any relationship between time spent on the responding

process, and the outcome of the task, item by item and as a whole, and how this relates in turn to therapist follow-up. As has been pointed out above the aphasic person has been 'allowed' to control the timing of his responses in this task-set. The timing of his responses cannot therefore be attributed to any active intervention on the part of the therapist. As can be seen from Table 7.4 the mean length of time to spoken response for errors is 5.92 seconds, and for correct responses 3.625 seconds. While the difference is not statistically significant ($t = 1.824$, $p = 0.10$ [two-tailed], $df = 22$)[1], the difference between the mean times makes some intuitive sense in that perhaps if he is going to achieve the correct response he will do so more quickly, because he has 'got it'. Although the tendency towards shorter response times for correct responses does run counter to research discussed in the review of the literature (Chapter Two) which suggested that extra time given for naming might be the most effective 'treatment', the situation with these data is not clear cut, and the results are not necessarily comparable with results from the literature.

A closer look at the total time taken for 'error' responses shows that a little over 87% of that time was taken up with the search for the target word choice, the additional time being attributable to preparation before producing the spoken word. This suggests that the time given to searching for the target is a reflection of his lexical-semantic uncertainty. The following extract shows the course of the aphasic person's search for one of the targets:

1. A: ((turns the page)) (7.0) *m:↓* (3.0) ((intake of breath)) ((starts to point and
2. then stops))
3. T: ah I've got you thinking have I
4. A: *m:* (5.0) ((points))
5. T: ((nods))

[1] "the *t* distribution" from Miller, S (1984: 174) Experimental Design and Statistics. (2nd Edition). London: Methuen.

6. A: ( )

7. T: well done so is it a circle or a triangle

8. A: triangle

9. T: good well done (.) at least I've got you thinking a bit

The aphasic person's uncertainty is not only reflected in the length of time taken but is also observable in the reflective use of "m:" (lines 1 and 4), the intake of breath (line 1) and the change of mind in his choice selection (lines 1-2). The therapist appears to construe this as a positive occurrence. She remarks twice that "I've got you thinking" (lines 3 and 9). Her "at least" (line 9) suggests that despite the aphasic person's failure here to say the word correctly, he has had to work hard at the judgement task, and that this is in some way a positive occurrence. However, despite what she says, it actually looks as though the challenge associated with this particular item (and the other items where there is an extended search followed by a production 'error') is a reflection of the aphasic person's uncertainty The extra time devoted to the search does not lead to a profitable outcome in terms of spoken word production, even though it may be beneficial in terms of lexical semantics, although this cannot be proven. That being said, there is considerable variability in time taken before responding where the result is an 'error', and some error responses come after a relatively short consideration time (e.g. items 4, 6, 7, 18, Table 7.4).

Mention has been made of the differential error rates between task-set two and task-set three in terms of spoken word production. Discussion so far has focussed on the way that, in task-set two, the aphasic person initiated his own 'Elicitations' and how this related to the distribution of time in preparation for responding and the association with 'error'. In task-set three the error rate for spoken word production is 14.3%, compared with 48% for task-set two (see Table 7.3). However, this is perhaps not surprising as 'Elicitations' in task-set three are all therapist initiated, and what is more, six out of the

fourteen 'Elicitations' lead with phonemic/phonetic information about the target word. Thus for example:

1. T: something you keep your money in we had a /per/
2. A: purse
3. T: purse (.) and then you wrote down /*gl:*/ ((points to paper on desk))
4. A: glasses
5. T: glasses

As can be seen from the example, 'Elicitations' may contain semantic and phonetic/phonemic information about the target (line 1), or simply phonetic/phonemic information (line 3). Presumably in the latter case, as probably in all cases in this task, the orthographic form of the word is also available to the aphasic person. That being said, the aphasic person was also able to achieve a correct response on five occasions given 'Elicitations' with no additional phonetic/phonemic or semantic information, although the two errors did occur in response to these types of 'Elicitation'.

In task-set two the therapist generally applies her stated plan of using "forced alternatives" (called 'spoken alternatives choice' in Table 7.4), but only as contingent management of the aphasic person's spoken word errors. The 'Elicitation' which ensues after the error contains whole-word information about the target word plus a distracter. The aphasic person must be able to choose, remember and say the target. She sometimes prefaces repair 'Elicitations' with remarks that seem designed to be encouraging, such as: "that was a good try", or "that was a brilliant try". She has to repeat the "forced alternative" on two occasions to achieve the correct response, once with the addition of word-initial phonetic information ("/*s:*/"). On other spoken word 'repair' occasions she uses 'Elicitations' with target-related phonetic/phonemic information.

As has been mentioned above, a number of spoken word attempts are accepted as correct (33%), despite being less than accurate. These are followed-up with positive evaluation or acknowledgement in conjunction with a 'veiled correction' (called 'model' in Table 7.2).

Contingent work by the therapist after a 'choice' error is of course very different from that which follows a spoken word production error. One instance has already been discussed in relation to possible lack of clarity or ambiguity of the stimuli (Section 7.3.2.iv). The other occasion (in task-set two) involves her initiating a new 'Elicitation' with semantic information about the target: "...this one's actually what you would use (.) to chop up wood", and the aphasic person responds immediately with the correct spoken response.

The aphasic person attempts self-repair occasionally – this has been discussed above in relation to his own standards of spoken word production (Section 7.3.2.iii) – and this type of self-repair attempt occurs chiefly in task-set two. Examples are given in Table 7.4 (items 4, 12 and 23). While he does not often express obvious satisfaction when having successfully produced a spoken word, there is one occasion when he seems to savour the moment:

1. T: ...it's (.) a river or a mountain
2. A: mountain
3. T: good that's better
4. A: ((looks up and makes a little downward movement of his head)) *mountain*
5. T: ((nods and smiles))

The target word is repeated *sotto voce* but with a deliberate posture of the head. The therapist seems to appreciate the significance of the moment and joins in with an affiliative nod and a smile, but no more is said.

'Response management' in relation to error and repair: a brief summary

- The prevalence of choice errors, and errors of spoken word production have been contrasted within and across sessions
- The status of a spoken word response as an 'error' has been examined
- The different sequential contexts of spoken word production errors have been examined in depth. This has entailed attention to
    - the time lapse between 'Elicitation' and 'Elicitation-response' in relation to error
    - the information content of 'Elicitations'
- The total responding time for errors was found to be higher than for correct responses (but not significantly so), with a likelihood of indications of uncertainty on the part of the aphasic person. This was thought to reflect uncertainty in terms of lexical semantics
- The therapist's implied assertion that additional search time is a positive attribute of the therapy task is only supposition on her part
- Different types of 'Elicitations' appear to be related to different 'Elicitation-response' outcomes
- The type of 'Elicitation-response – follow-up' is highly reflective of the type of 'Elicitation-response' and the degree of 'correctness', but the criteria for accepting a spoken word as 'correct' are not clear

A considerable amount of discussion has been devoted to 'Error and repair'. This perhaps reflects not only the actual time devoted to addressing 'Elicitation-response' by both therapist and aphasic person in this session, but also the more general preoccupation with such matters as is reflected in the subject matter of this thesis.

Two final features of 'Response management will now be discussed in relation to this session.

Summarising and informing

In the course of the session the therapist often adopts an approach of inviting the aphasic person to form his own summary of work that has taken place. After task-set one the following exchange takes place:

1. T: okay how did you find that
2. A: (no no)
3. T: it was alright was it
4. A: ( )
5. T: would you like to do more of that sort of thing for for homework ( )
6. A: (no no no no)
7. T: yeah wasn't too easy
8. A: (no no no)
9. T: okay excellent

The aphasic person's perseverative "no no no" appears to be interpreted by the therapist in the context of imperceptible non-verbal signals as being largely affirmative, whatever the design of her question – i.e. expecting a "yes" (line 3), or expecting a "no" (line 7). Her turn in line 9 could be construed as a 'Summary' of the 'Summary', or as a positive evaluation of the impact of the task.

Her approach after the second task-set comprises a more thorough exploration of the impact of the task, especially in relation to how hard or easy he perceived it to be compared with "before":

1. T: ((writes word s on a piece of paper)) was it harder or easier than before
2. A: ((points to paper))
3. T: it was easier (.) well I tried to make it harder A (.)=
4. A: mhm
5. T: =d'you know what the problem is

6. A: no

7. T: you've got better=

8. A: ((laughs))

9. T: =and as it as it you've got better at it

10. A: (yeah)

11. T: it becomes easier even though I'm trying to make it harder okay (.) d'you agree

12. with me

13. A: (yes)

This interaction, using supportive means for the aphasic person to express himself, is, unsurprisingly, initiated by the therapist, and she uses the occasion to air her views on his progress. His laughter (line 8) appears almost self-deprecating. We are not able to confirm any improvement through his performance in this session, but the therapist is clearly at pains to verify her opinion that the task-related work is becoming easier for him – despite her trying "to make it harder" (line 3) – although she gives no reason for trying to do this. After the sequence above she gets him to use his communication folder to indicate on a 1-10 scale how hard or easy the work was today. When he points to "quite hard", she says, in a relatively jocular tone: "don't believe you A", and then changes the subject. Although she is clearly keen to prove (to him/to herself?) that he has made progress, she does not attempt to win over his opinion by recourse to any concrete evidence from the previous task.

The therapist also summarises with the briefest of asides during the course of tasks – for example, after work on three category sets in task-set three: "okay (.) good (.) so far (1.0) so good". The therapist's "okay (.) good" functions as a discourse marker, separating the previous set of items from the upcoming set, and thus marking "so far (1.0) so good" as a 'Summary' rather than an evaluative follow-up of the preceding item.

7.3.3 'Inserted conversation'

"Conversation" is actually one the features of the therapy session which the therapist noted (see Section 7.2.1 above) in her submission. There is a lengthy 'conversation' towards the end of the session, which will be discussed at the end of this section. 'Inserted conversation' also arises during task-related work in the form of therapist asides. In task-sets two and four these instances are related to the current therapy item. The first extract is from task-set two:

1. A: ((turns page)) (7.0) ((pointing to different words in turn))
2. T: how are you on women's clothing ((T and A chuckle))
3. A: ((pointing)) (2.0) /wei/ /*wens*/

---

24. T: a skirt (.) a little bit of guess work there A I think
25. A: no no no
26. T: do you not take an interest in ((wife's name))'s clothes [then]
27. A: [no no] no no no

There is no doubting the informality of the therapist's comments in lines 2 and 26. In line 2 the aside follows an obvious problem for the aphasic person in choosing the target word, and they share the joke. In line 26 the comment is equally light-hearted, as she pokes a little 'gender war' fun at the aphasic person, and he rises to the jibe with some 'indignant' denial.

These two scraps have a much more informal and off-the-cuff flavour than the 'Inserted conversation' which occurs between task-sets two and three. This is a slightly longer exchange, which the therapist initiates, having noticed some typed work in the aphasic person's folder. The sequence – which takes the form of the therapist posing yes/no questions and the aphasic person answering – is brought to a close with the following statement:

1. T: yeah (and) I hear you quite like (.) you're doing quite well in that
2. A: (no no no)
3. T: okay let's put that one away now ((moves folder of papers across table))

The therapy is taking place in an in-patient rehabilitation unit, and the therapist is clearly reporting back to the aphasic person something that has been said to her by one of the other staff (line 1). This invocation of a third party report gives a powerful flavour of 'institution', where people in control (therapists; other staff) are privileged to talk about the people in their control (patients). The therapist ends the 'Inserted conversation' briskly by directing attention back to task-related work – both verbally (line 3) and physically, by moving the folder to one side (line 3).

The final 'conversation' (and quite possibly the one the therapist was referring to in her submission as "conversation") is initiated by the therapist, who uses the last item of task-set four to pose a question:

1. T: d'you get on well with your neighbours
2. A: (no) ( )
3. T: ((opens communication folder)) is that a yes or a no
4. A: ((points to something in the communication book))
5. T: is a yes

As has been evident in other extracts from the data the aphasic person often uses a perseverative "no no no" to respond and comment. Here the therapist initiates the use of the communication folder in order to disambiguate 'yes' and 'no'. In this final 'Inserted conversation' the therapist almost exclusively controls the choice of topics, which include: 'who has been to visit you' (with much use of the communication folder); 'the bank holiday weekend'. It appears as if the 'conversation' is an opportunity for the therapist to try and get the aphasic person to practice using the communication folder:

1. T: .. do you know if anybody is coming to visit you this weekend (3.5) ((points
2. with circular finger motion to the communication folder)) anyone that you
3. know might be coming
4. A: ((scratches his head)) ( )
5. T: there's one person I <u>know</u> who'll be coming (.) 'cause she comes every day
6. A: ((chuckles and points to communication folder))
7. T: yeah ((nods))

When the aphasic person fails to respond to the therapist's question in line 1 – signalled by the 3.5 second silence (line 1) – she gestures towards the communication folder as a means for the aphasic person to impart the information (lines 1-2). When he does not respond by using the folder, the therapist sets up a quasi-demonstration with her statement of prior knowledge (line 5). This turns into a test of the use of the folder – the therapist's turn in line 5 initiates the 'Elicitation', to which the aphasic person responds in line 6, and the therapist confirms and evaluates in line 7.

The aphasic person does use the folder to initiate a topic – about who might or might not visit – which the therapist chooses to topicalise, and a lengthy exchange ensues. The therapist and aphasic person go through a long sequence of 'hint and guess' (searching for information which is not in the communication folder), with the therapist finally going out of the room to find a map in order for the aphasic person to be able to pinpoint the place name he is trying to locate.

This phase is brought to a close in business-like fashion:

1. T: oh↓ how <u>lovely</u> (.) but ((wife's name)) is going to be here (.) okay (.) right A
2. last thing

After the briefest of pauses the therapist passes from the topic of visitors at the weekend to the business of homework, signalling the "last thing" with a discourse marker. The 'Closing down period' ensues.

7.3.4 The 'Closing down period'

As has been shown above the 'Closing down period' is signalled by the therapist briskly announcing: "okay (.) right A last thing". Most of the period is taken up with introducing and demonstrating homework ("first of all I want you to do one of these"). Her "I want you to..." sounds rather like a doctor's preface to a prescription. The use of "I want..." places the aphasic person in a position of being obliged to follow professional direction. Two pieces of homework are introduced, the second being a "new one". The therapist proposes: "so we'll do the first couple together now (.) and then we're done okay". The therapist is brisk, efficient and in control – the homework is tried and a number of task-related sequences ensue.

The therapist remains in strict control of the session until the end. At one point in the 'Closing down period', when she thinks that the aphasic person is about to pack up, she becomes overtly authoritative:

1. T: do you want to borrow the felt tip pen (.) if it's easier to write with
2. A: no ((pushes glasses up his nose and lifts folder looking underneath))
3. T: no hang on ((puts hand up)) don't take your glasses off just yet (.) I don't know
4. where it is

The aphasic person's movement in line 2 (pushing his glasses up his nose) is interpreted by the therapist as a movement to take off his glasses, presumably with the implication that he is going to pack up and finish the session of his own accord. Her imperative (line 3) is supported by a firm gesture to indicate 'stop', the "don't take your glasses off just yet" (line 3) being an indication of work still to come. She realises her misinterpretation of his movements (lines 3-4: "I don't know where it is") and joins in the search (for a missing pen).

The session is business-like to the end, and the therapist's statement of her intention to meet up with the aphasic person's wife is delivered and designed with an

added "is that okay" tag – expecting "yes" – which extends her control to his impending response.

7.4 Illustrative analysis: summary

This chapter has applied the framework developed through the course of this thesis to the analysis of a single therapy session. The framework has been used to clarify the ways in which different phases of the session were devoted to different activities, how these activities may be related one-to-another, and how comparable activities were enacted across the course of the session. Within this framework the relationship between therapist and aphasic person was examined, both in terms of their roles a social actors, and as participants in doing therapy business.

The following summaries are offered under the analytic headings:

'Opening up the business' and 'Task introductions'

- Links between past work and work to come in this session were briefly made in the process of 'Opening up the business'
- The aphasic person's recent performance is highlighted relative to the new level of information processing demands in the impending tasks
- 'Opening up the business' and 'Task introductions' are relatively vague and cursory, and the therapist appears to rely on familiarity in order to short-cut lengthy explanations. However, new items are carefully introduced
- The therapist exercises control over the introduction of tasks, but the aphasic person offers a mild challenge to her authority on one occasion

'Doing therapy tasks'

- The four main task-sets across the session (plus homework) are outlined and contrasted in terms of items and procedures, and there is a certain sense of continuity about the management of tasks over the course of the session

- Mode of response required is not always explicitly stated, but the content of responses is almost always made clear through the way items are presented and 'Elicitations' constructed by the therapist
- Standards of precision or clarity for responses required in spoken and written production tasks are not made clear, and they are not explicitly referred to by the therapist
- The aphasic person demonstrably exhibits his own standards of clarity in spoken word production
- The therapist equates an increase in the number of items to choose from at any one time with the task becoming harder
- Certain items are considered to be more difficult than others by the therapist, but no reasoning is given
- The general pattern of the aphasic person's responses is an indicator of some quality about the item or therapist's 'Elicitation', when errors arise in choice tasks
- The three-part structure of task-related work is pervasively present in 'Doing therapy tasks', but 'Elicitation' is not necessarily initiated by the therapist
- The structure and content of 'Elicitation-response – follow-up' is partly determined by the process of the aphasic person's responding
- The therapist's implied assertion that additional search time is a positive attribute of the therapy task is only supposition on her part
- Different types of 'Elicitations' appear to be related to different 'Elicitation-response' outcomes
- The type of 'Elicitation-response – follow-up' is highly reflective of the 'Elicitation-response' and the degree of 'correctness'
- The therapist tries to promote shared summarising work, is keen to stress progress, but does not provide concrete evidence of progress

'Inserted conversation'

- There is a good deal of variation in the spontaneity and interactive characteristics of 'Inserted conversation' across the session
- It appears that some 'conversations' are an opportunity for the therapist to initiate practice in using the communication folder

The 'Closing down period'

- The 'Closing down period' is primarily used to introduce and demonstrate homework
- The therapist maintains strict control over the topic agenda in the 'Closing down period'
- There is no discussion about the session or the relevance of tasks used in the session to communication outside the therapy room

The following chapter will turn to a discussion of the description and analysis of the data which has taken place in the preceding chapters. The scope of the descriptive-analytic framework will be summarised and the question of whether the study has fulfilled the methodological criteria will be addressed. The discussion will also examine whether the analysis has adequately addressed and answered the research questions. Finally, the discussion will examine the analysis in relation to previous research.

CHAPTER EIGHT

DISCUSSION

8.1 Introduction

This chapter will set out by summarising the framework, with its domains, features and dimensions, which has been proposed in the course of the preceding chapters. The chapter will then continue by examining whether this particular approach to the study of therapy for aphasic language impairment has fulfilled the methodological criteria outlined in Chapter Three – for example in relation to the sense of relevance of the data or transferability of the findings – and how far it has gone in answering the research questions posed at the beginning of the thesis (Chapters One and Three). While the process of analysis in the preceding chapters has been relatively discursive on a point-by-point basis, the implications of the findings in terms of the wider literature, and their impact on furthering the understanding of the process of aphasia therapy has not yet received consideration. The chapter will therefore conclude with a discussion of the study in relation to previous research, and examine the relevance and potential impact of the study and its findings.

8.2 The description and analysis of aphasia therapy sessions

8.2.1 Therapy domains

The proposed framework begins with a very broad outline, which essentially delineates a 'phase structure' for sessions (see Heritage 1997). This structure proposes, very simply, the following set of general domains: 1) The 'Settling down period'; 2) 'Opening up the business'; 3) 'Doing therapy tasks'; 4) The 'Closing down period'.

There are some advantages and disadvantages inherent in this approach. Its scope is tied – in part – to chronology. This seems partly inevitable, in that, for example, there is no doubt that sessions do begin and end, and that there is a middle

period. However, the domain 'Doing therapy tasks' does not straightforwardly sit in a middle period – it may be preceded by 'Opening up the business' or it may not, and the two may occur recursively. 'Doing therapy tasks' in the form of homework may actually precede 'Opening up the business' (as was seen in Chapter Seven) at the beginning of the session. Thus the chronology of sessions is not straightforwardly linked to this framework, and this begs the question, why then this framework, and not one, which for example, targets and examines other themes across the breadth of the session?

Firstly, the sense of chronology of sessions does appear to be oriented to by the participants. As has been demonstrated the link to past (and future) sessions is an important one to the therapist and to the aphasic person for various reasons – making sense of what therapy is being done today in terms of what happened before, and what may happen in the future; comparing what happened previously with what is happening now in terms of progress; how this next thing we are doing links with the preceding one, and so on. The links within sessions also appear to be important and 'Summary' – as one of the sub-features of 'Doing therapy tasks' – and the process of summarising are salient features. Summarising work is retrospective both in terms of the immediately preceding task or tasks, and the session as a whole, but also provides a point of reference and departure for discussion of the relevance of future work.

It is this sense of the session as a whole which this approach to the description and analysis of therapy strives to capture. The participants in this process do not just go through therapy routines, or have conversations, or give feedback – they are doing all of these things all the time in a sequential process which ebbs and flows through a whole session, involving "...changing participant roles, and different speaking styles or codes..." (Damico *et al* 1995: 86) as they go.

The process of description and analysis has followed a route where domains were described and analysed, not only in terms of their sequential placement, but also in terms of how they actually function as part of a sequence in the therapy session as a whole. Domains are described in terms of set of general features, each of which is exemplified in various ways, and which have certain characteristics. It has to be remembered that this study did not set out to offer an in-depth analysis of each and every session in the data corpus. However, the ways in which the descriptive-analytic framework might be applied to a single session have been explored in Chapter Seven.

A more detailed discussion of the framework in terms of domains, features and functions now follows.

8.2.2 Therapy domains: features and functions

This section will give an overview of the features and functions of the therapy domains outlined in the previous section, discussing common and divergent themes that appear to run through the various phases of the session. The following table gives a summary overview of the therapy domains, their associated features and dimensions:

Domain	**Features**						
The Settling down period	Organ-ising talk	Organ-ising talk and action	Settling talk	Topical talk	Action	Ending the Settling down period	
As part of the structure of sessions • 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							
Functions • 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'							

Domain	Features						
Opening up the business	Beginning Opening up the business	Reference to previous meetings	Progress	Planning	Reference to aphasia	Ending Opening up the business	

As part of the structure of sessions

- '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

Functions

- '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

Domain	Features and sub-features					
Doing therapy tasks	Beginning Doing therapy tasks	Task management				
	Task intro-ductions	Overall task manage-ment	Enacting tasks			
			Task proced-ures	Task demands Dimensions associated with: • responses • stimulus items • enacting routines	Summary	Infor-mation & clarific-ation
		◄—— Response management ——►				

As part of the structure of sessions

- 'Doing therapy tasks' usually occupies the middle phase of the session
- Sequences typical of 'Doing therapy tasks' (e.g. task-related 'testing' sequences) are to be observed in other phases of the session

Function

- 'Doing therapy tasks' is demonstrably the 'main business' of the session for the participants
- 'Doing therapy tasks' is the occasion of enacting the tasks which realise the aims of therapy
- 'Enacting tasks' is the process whereby the therapist initiates, the aphasic person responds and the therapist makes a contingent response, and these processes entail a complex set of dimensions

Domain	Features						
The Closing down period	Starting the Closing down period	Organ-ising talk	Topical talk	Ending the Closing down period	Parting talk		

As part of the structure of sessions

- 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

Functions

- 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

Table 8.1 Overview of therapy domains: features and functions

Table 8.1 gives a summary overview of the features and functions of the therapy domains, but does not include 'Inserted conversation', which is a feature of therapy sessions across nearly all domains. 'Stimulus items' receive only a brief mention in the table above (under 'Doing therapy tasks': 'Task demands'). However as is apparent from the analysis of items (and tasks) in Chapters Four and Six items used as stimuli play a significant role in the type of task-related work that is demonstrably oriented to as the main business of sessions.

It is apparent from the layout in Table 8.1 that some domains have features in common. Unsurprisingly, for example, the 'Settling down period' and the 'Closing down period' both have features to do with organising – 'Organising talk' and 'Organising talk and action' in the 'Settling down period', and 'Organising talk' in the 'Closing down period'. These features are obviously concerned with the 'mechanics' of greeting and preparing the session, or conversely closing the session and making preparations for the next meeting. The subject matter of topical talk is also reflected in the respective positions of these two domains – again this is unsurprising.

'Doing therapy tasks', not surprisingly, has a distinct set of features which relate almost entirely to the enactment of therapy tasks. These features and sub-features are employed in any number of ways along a series of dimensions, under the conceptual umbrella of 'Response management'. However, despite the temptation to isolate 'Doing therapy tasks' as the 'main business' of the session, and thus treat it as a 'technical' entity in itself, the approach to description and analysis which is being pursued in this study attempts to reflect the ways in which 'Doing therapy tasks' can be shown to be 'situated work'. This essentially means two things. Firstly, in a rather obvious way, 'Doing therapy tasks' is one of several phases in the session, and as such it is clearly linked with the other phases. Reference is made forward and back to 'Doing therapy tasks' from elsewhere in the session, and occasions arise in 'Doing therapy tasks' where

reference is made beyond the current business of task-related work. Secondly, for all the features, sub-features and dimensions of 'Doing therapy tasks' which are essentially 'technical', it remains a social encounter. Technical and social processes run intertwined and inextricably linked in the course of 'Doing therapy tasks'.

An important aspect of this descriptive-analytic framework is that it offers the observer/analyst a viewing window onto how the links between impairment-based therapy and its potential relevance to the communicative abilities of people with aphasia may be forged (or not). This happens – where it does – in ways that are often distributed around the different phases of the session. For example, mention of task-related work in connection with communication in a more general sense arises in 'Topical talk' in both the 'Settling down period' (Table 5.1 Feature C 'Your/my communication) and the 'Closing down period' (Table 5.4 Feature C 'Your/my communication'). It also arises in 'Summary' and 'Information and clarification' in the course of 'Doing therapy tasks'. This was observed in the example from D12 (1) (Section 6.2.4.iv 'Summary'), where discussion about the process of task-related work carried out at home is linked to everyday reading practices. In the example from D6 (1) (Section 6.2.4.v 'Information and clarification') discussion of the impact of aphasia on all communication modalities is linked to task-related work in the therapy sessions. 'Inserted conversation' also provides an opportunity to observe behaviour which illustrates the implicit links (and conflicts) between the process of task-related work and the process of communication between therapist and aphasic person.

The way that phases of the session may follow on from each other can be observed – setting aside the observation that there is not necessarily a fixed order of phases – as the features, and the functions of those features within domains, presage the advent of a following phase. For example 'Opening up the business' does not happen without 'Doing therapy tasks' in some form following it; on the other hand, where task-

related work is implicit or covert, there is no 'Opening up the business'; where 'Task introductions' are cursory or fleeting, familiarity with the task can be assumed. The 'Settling down period', for example, may function for the therapist to broach the topic of how aphasia impacts on the communicative life of an individual, to test the aphasic person's communicative abilities or use of communication strategies, perhaps demonstrating the aims and objectives of therapy. These themes may be elaborated in 'Opening up the business', as the focus moves to the business of the day and its links with therapy in previous sessions, and what is to come. Opportunities are made available to establish links between themes emerging around the impact of aphasia on communicative life and the therapy which will take place today. The nature of the therapy items and the reasoning behind the implementation of those items may be introduced and clarified before being put into operation in 'Doing therapy tasks'. This domain in itself has a complex structure of interrelated features and sub-features, each with its own dimensions, which are available to the therapist and aphasic person – consciously or otherwise – to be manipulated in various ways according to circumstances. The work of the session may be reviewed, and the relationship between the therapy and the aphasic person's communication disability re-examined as has been discussed above in relation to 'Topical talk' in the 'Closing down period'.

The structure of inter-linking domains, with features, sub-features and dimensions allows the session to be examined in a variety of ways. It may be examined as has been broadly discussed above, as a whole entity of inter-linked phases and features. This approach has been demonstrated through the illustrative analysis in Chapter Seven. Conversely, individual domains may be singled out for examination. This has been demonstrated to some extent through the examination of the utility of 'Response management' as a tool for describing and analysing episodes of 'Doing therapy tasks' in Chapter Six.

The framework has been proposed as a way of describing and analysing therapy sessions. As has been mentioned from time-to-time during the course of the analysis, it is not a proposal for the way 'ideal' sessions should be conducted, nor has it always been possible to make clear cut distinctions between the types of features which are being put forward as evidence of this particular structure. Various discrepancies have emerged and been discussed, but it could be argued that, for example, processes such as 'summarising' or 'transition' could have been put forward as key features. However, these types of process have been subsumed and situated within the various features of the domains that make up the phases of the session, and are thus tied into the chronology of sessions as it is represented through the framework.

It becomes clear from the way that therapists choose to topicalise certain subjects, introduce certain topics themselves, test the aphasic person or demonstrate the aims and objectives of therapy – for example in the 'Settling down period' – that it is predominantly to the aphasic person as a person with aphasia that they are relating from the outset of the session. This study has clearly demonstrated the ways in which therapists choose which topics to promote, and how they control the structure of sessions. However, it has not examined in any systematic way how individual therapist's 'styles' find expression in observable behaviour within or across the different phases of the session. Thus, for example, features such as affiliation, power masking (as in 'veiled correction') or humour, while they may have been invoked from time-to-time in the analysis, have not been pursued systematically as features in themselves.

This brings the discussion to whether the scope and depth of the study has been sufficient to achieve the sense of relevance of the data or transferability of the findings suggested in the discussion of methodology.

8.3 Relevance and transferability of the findings

While the background to this study lay in a proposal to investigate therapy for 'semantic impairment', it has been demonstrated that by no means all the therapy that took place can necessarily be construed as 'semantic therapy'. A considerable number of tasks (and the therapy items associated with them) certainly fall within a common understanding of what constitutes 'semantic therapy', however a number certainly fall outside that understanding – for example 'Listening and answering questions'; 'Repeating words'; 'Drawing'; 'Written word copy'; and some 'Written word-finding' tasks (see Table 4.6). In other words there is certainly a sense that while the proposed framework for description and analysis of therapy sessions is based largely on a study of 'semantic therapy', a sufficiently diverse range of therapy tasks is included in the study for there to be a strong claim – all other things being equal – for this framework to be applicable across various language impairment based therapy approaches. The tasks and items as submitted by the therapists are available for scrutiny. The tasks as they were enacted by therapists and people with aphasia are described and analysed generally rather than on a dyad-by-dyad basis, except in the case of D8 (2), where a single session has been subject to close scrutiny as an entity in itself. While information on assessments was submitted by participating therapists, neither the process of formal assessment nor 'case history' taking have been addressed.

The sense of relevance and transferability of the study and its findings is also underpinned by the detailed descriptions of the characteristics of the participants and the location of the work. The characteristics of participants were described in terms of a range of features – for example therapist experience of working with people with aphasia, or the aphasic person's linguistic and communicative strengths and weaknesses. These characteristics were outlined and tabulated in Chapter Four, but have also been referred to from time-to-time in the detailed analysis of interactions in

Chapters Five and Six. This study has not examined particular types of aphasia (e.g. 'fluent' or 'non-fluent') in any way as 'factors' to correlate with particular types of interaction. However, specific aspects of the aphasic person's communication disability have been invoked occasionally where it was thought relevant – for example, where a struggle to articulate was manifest, or word finding difficulties were relevant to collaborative work between therapist and the person with aphasia. Aphasic people's task-related responses have also not been described and analysed in the way that they might in a study of aphasia therapy 'treatment'. Reference has been made to the nature of such responses where it was appropriate to understanding the interactive process.

As was mentioned in the previous section features of individual therapist's 'styles' have not been examined consistently across the data. The lack of consistency in examining therapist 'style' to some extent undermines the sense of relevance and transferability of the study findings. However, features of the interaction between therapist and person with aphasia which relate to 'style' have been described and discussed throughout the analysis, and this does give some sense of relevance and transferability. The descriptive-analytic process has been anchored to objective methods of analysis and a comprehensive consideration of the domains and features of therapy interaction. Speculation by the author has been kept to a minimum, and where it has occurred it has been explicitly declared as such.

It is argued that the status of the author as a therapist and a participant in the study has not undermined the objectivity of the analytic process. Being a therapist and a participant has provided some insights into the relevance of findings in the study. These instances have been made clear as they have been addressed and discussed in the course of the analysis. The self-critical mindset necessary to develop a true sense of relevance has been enhanced by an informal process of presentations and discussions with colleagues during the course of the study. During this process the author's

interpretations of the data have been exposed to scrutiny, as they have through the process of supervision of the thesis.

The way in which the study has been conducted in terms of recording data from therapy sessions should be born in mind in the interpretation of findings. The recording process has had a demonstrable impact on the data. This has been discussed in relation to how it revealed the participants' perceptions of the 'main business' of sessions. What this also suggests, however, is that perhaps the type of 'main business' which predominated, did so because the participating therapists thought the researcher/s wanted that type of data. The question of whether the presence of the camera meant that therapists, for example, chose not to follow up certain topics which were initiated by the aphasic person participants should also be born in mind. They may have considered certain topics too sensitive to be aired in the presence of the camera (and hence researcher). They may also have considered certain topics not germane to (what they considered to be) the researcher's interest. We have no real way of knowing whether this has been the case generally or in particular instances. The question of 'respondent validation' or 'member checking' has been discussed, and whether interviews with the therapist participants would have entirely clarified this point is debatable.

The issue of how far this study has gone in answering the research questions posed at the beginning of the thesis is addressed in the following section.

8.4 The research questions

The overall aim of the study – to examine what therapists and people with aphasia do in the course of therapy sessions for aphasic language impairments in day-to-day practice – was addressed through five main questions:

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?

Sessions are clearly structured and organised in various phases. The process of organisation has been revealed through attention to a variety of interactional features. Participants have exhibited different patterns of turn-taking according to the business in hand – for example, task-related interactions in 'Elicitation' sequences always have a formal three part structure, although positive or negative evaluations in third position (Elicitation-Response – Follow-up) are by no means always explicitly stated. Other phases of the session may have a question-answer pattern, or, rarely, even less formal turn-taking routines as in some instances of 'Inserted conversation'. It has been shown too that formal instructional turn-taking routines may 'leak' into other phases of the session, revealing implicit goal orientations on the part of the therapist.

Sequences of interaction have been shown to typify certain phases of the session. In these sequences – 'Opening up the business' or the 'Settling down period' for example – the participants demonstrably orient to certain topics. Sequences may also be typified by an asymmetric organisation of turn taking or topic management.

Therapists' control of the business in hand, and the overall conduct of the session, is revealed through the ways in which they structure turn taking, design their own turns, introduce, manage and end topics. The aphasic person contributes to the organisation of phases in the session by generally being an active and willing participant in the interactional processes outlined.

The organisation of the session is also revealed in the use of and reference to therapy items, and the use of other supporting materials and objects, such as communication folders or pencil and paper used to support communicative efforts.

2. What are the characteristic features of the interaction between therapist and aphasic person during the course of the session?

The overall characteristic feature has been shown to be an almost universal control of the proceedings by the therapist throughout all phases of the session. As was pointed out above this is achieved in a variety of ways, both by the therapist and interactionally. Features characteristic of the various phases in the session have been demonstrated and their functions discussed, but exceptional cases have also been examined. These features are summarised in Table 8.1 and as has been discussed above in Section 8.2.2 processes such as 'summarising' or 'transition' have been subsumed and situated within the various features of the domains that make up the phases of the session.

Features of the interaction which may be considered characteristic of therapist 'style', such as affiliation, power masking (as in 'veiled correction') or humour, have been invoked from time-to-time in the analysis, but have not been systematically explored as features in themselves.

3. Can a 'main business' of the session be identified and how do the participants orient to the 'main business' of the session?

The orientation of the participants to a 'main business' has been demonstrated. The participants both oriented to 'Doing therapy tasks' as the main business of the session. This was revealed in a variety of ways – for example through the actual process of producing the data in the course of recording sessions, and through the ways in which participants talked and acted. Some caution has been expressed in Section 8.3 above in relation to such interpretations in the light of the methods used to produce therapy interaction data.

4. What is the relationship between the 'main business' and other aspects of the session?

Sessions are described broadly in terms of a structure of phases – the domains outlined in Section 8.2.1. As has been discussed in Section 8.2.2 above, 'Doing therapy tasks' can be shown to be linked to other domains, either directly, as in the relationship to 'Opening up the business', or more indirectly, as in the relationship between 'Topical talk' in the 'Closing down period' and task-related business occurring in 'Doing therapy tasks' for example. Reference is made forward and back to 'Doing therapy tasks' from other phases in the session, such as the 'Settling down' and 'Closing down' periods, and, as was pointed out in Section 8.2.2 occasions arise in 'Doing therapy tasks' where reference is made beyond the current business of task-related work.

Characteristic features of interactions arising in 'Doing therapy tasks', such as three part instructional sequences or the therapist's turn design, can also be observed to arise – whether wittingly or unwittingly – in other phases of the session.

Other business was also shown to arise throughout the session. That business may have been explicitly initiated by the therapist or the person with aphasia, or it may have been implied through a particular orientation to the current topic, the way in which turn taking was structured, or the design of a turn.

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'?

Evidence has been found and demonstrated, which provides a principled and systematic way of describing and analysing these processes. The descriptive-analytic framework proposed in this study allows the breadth and depth of these types of therapy techniques to be explored and analysed. The scope of the definitions of these therapy

techniques outlined in the research question has been expanded by: 1) investigating the relationship between therapist-aphasic person interactions and the items used in therapy; 2) investigating in depth the design of turns, and the relationship between turns in different positions in task-related routines; 3) conceptualising the relationship between three part instructional sequences, summarising/informing work by the participants, and the management of tasks in the session as a whole under the umbrella of 'Response management'.

Therapists' preparation for the tasks they will present clearly includes decisions about how 'Elicitation' is managed and the burden that different routines place on the aphasic person. This is clearly demonstrated in the way therapists talk about the relative difficulty of tasks, for example in relation to the number of items presented simultaneously, or the control the therapist chooses to exercise over the presentation of items. However on-line decision-making presents the therapist with numerous choices and possibilities. Their responses to these choices and possibilities in many ways seem to echo the precepts of the sensory stimulation approach to therapy, which "employs the manipulation and control of stimulus dimensions to aid the patient in making maximal responses" (Duffy 1994: 148). It becomes clear through the detailed and systematic study of how therapy tasks are enacted that discrepancies may arise between the demands that the task as planned place on the person with aphasia, and those that actually pertain as the various dimensions of 'Enacting tasks' are contingently manipulated by therapist (and aphasic person) during the course of the task.

The question of the consistency with which therapists employ therapeutic techniques has not been central to this study. However it has become clear that therapists do not always employ techniques consistently, and that therefore the demands that are placed on the person with aphasia as tasks are enacted may also be inconsistent, and possibly incompatible with the goals of therapy as they were envisaged.

This then begs the question of how these observations of therapy in day-to-day practice, and the descriptive-analytic framework which has been developed relate to or inform the ways in which therapy has been reported in the literature.

8.5 The study in relation to previous research

This section will examine the findings of the study in relation to the literature which was reviewed in Chapter Two. Other research will also be examined from time-to-time as issues arise. As was pointed out in the introduction to this chapter, some of the literature has already been examined on a point-by-point basis in the course of the data analysis. This section will concentrate on the implications of the findings and their impact on furthering the understanding of the process of aphasia therapy in relation to the literature in general.

8.5.1 Therapy process

The processes of aphasia therapy as delineated by Byng *et al* (1994) and Byng and Black (1995) – 1) therapy procedures; 2) control over the properties of the stimuli used; 3) types of facilitators; 4) strategies for modifying tasks; 5) the timing and pacing of tasks, and the ways in which tasks are introduced and explained (Byng and Black 1995) – have received detailed attention in this study. All of the above have been examined in terms of the interaction between therapy participants, and, it is argued, in enough detail to satisfy Avent's (1997) requirement that tasks and materials involved in treatment can be explained in enough detail to allow replication of therapies. This also includes relatively extensive consideration of instructions to clients in the form of 'Task introductions'. The point to be made here is that while the descriptive-analytic framework does not propose a specific set of categories for introducing tasks or giving instructions, a set of considerations have certainly been outlined. These have referred to

specificity, links with previous work together, being explicit and relating the current activity to the wider impact of communication disability. This type of approach has also been adopted by Llewellyn (1999), who uses concepts related to task explanations – whether they are explicit or well justified for example – as one of the areas in her training study of student speech and language therapists.

While this study has proposed a detailed descriptive-analytic framework for therapy sessions, it could certainly be argued that, in its current form it is too detailed and unwieldy to be of practical use in the context of therapy replications. It is of course possible that many of the dimensions associated with features of 'Enacting tasks' have no bearing on the actual 'outcome' of therapy (leaving aside discussion of what is entailed in 'outcome'). The study has not systematically examined whether the manner in which features or dimensions have been applied actually impacts on the therapy. There is therefore scope for further investigating which features and dimensions might influence the outcomes of therapy. For example, the interactive work between therapist and aphasic person in relation to the task and resource demands alluded to by Schwartz *et al* (1994), might be a profitable area for further inquiry. The nature of 'error' has also received some consideration, and findings from this study suggest that the status of 'error' (for example in Marshall *et al* 1990) should be carefully scrutinised and made explicit.

Insights gained through this study of aphasia therapy sessions may be used to shed light on or compare with some of the recent literature on aphasia therapy and associated areas. For example, Best *et al* (2002) point out that phonological cues, as opposed to semantic ones, are provided very simply. As has been seen in this study, therapists may use phonological cues almost as a last resort in semantic therapy, where semantic cues have somehow 'failed'. The phonological cues used in Best *et al*'s (2002) study were whole word, rime (vowel and final consonant of the target), and first

consonant and vowel of the target word. In this study, therapists were occasionally observed to use much smaller fragments of target words which elicited responses from the person with aphasia. Best *et al* (2002) found that extra time (as has been discussed in the review of the literature and in Chapter Seven) did not facilitate naming, and there is a tentative suggestion in the illustrative analysis of D8 (2) that this may also be the case in this study.

In a single case study of treatment for anomia Francis *et al* (2002: 252) claim that "circumlocution induced naming", where the aphasic person was required to talk around the topic of words she could not express, led to her accessing the name herself. They give an example of this therapy, which ends with the following sequence:

THERAPIST "You've told me you'd hang it on the wall if you'd achieve something – just imagine now, you've done something you're proud of – what would you hang on the wall?"

(Provides summary of information given by MB and continues to encourage name retrieval)

MB "A certificate"

(from Francis *et al* 2002: 253) (original italics).

The therapist's turn looks very much like a test question in a 'Response management' sequence from this study – the point being that it is hard to see how the authors can claim that the aphasic person accessed the word herself. She surely accessed the word through the interactive work carried out by herself and the therapist, whose final turn is designed in such a way as to enable the production of the word. The authors do point out that circumlocution is a technique frequently used by therapists as a strategy for clients to use, but that they used it as a treatment technique in their study. It would seem essential however, in the light of findings from this study, to know more about the type of information content in client and therapist turns, and about the

sequence of interactions, in order to be able to make more sense of their claims. The process they describe is reminiscent of the "continued subtle adjustments in type and amount of cueing ... by which the therapist adjusts the antecedent events and contingent responses to communication attempts" (Ferguson 1999: 129) – indeed the type of work carried out by "an experienced therapist" (Visch-Brink 1997: 1108). This study provides the analytic-descriptive tools to go beyond these broad, conventional descriptions, and tie a deeper understanding of the interactive work between therapist and aphasic person to the demands of the task.

Ridley *et al* (2002) in a study of teacher talk point out how initiations in what are essentially 'Elicitations' by the teacher can predict different responses in the ensuing turns, and that the various turn-design strategies can keep a topic going or close it down. The differential impact of different turn-design strategies is certainly born out in this study. Therapists have available to them at any one moment a great deal of information about the aphasic person's linguistic and communicative strengths and weaknesses, as well as information from the immediate context of the interactive sequence. This should enable them to make decisions about facilitative strategies – for example, control over the work that the aphasic person is being asked to do in the repair of task-related errors. The therapist should be in a position, as expert, to apply their expertise to decisions about the apportionment of the repair burden. The value of the "ultimate plum" of the correct response cited by Kovarsky and Duchan (1997: 298) may well not depend on the fact that it is achieved, but rather how it is achieved. Understanding the process of how this may take place is enabled by the descriptive-analytic framework proposed in this study.

8.5.2 Describing and analysing therapy sessions

8.5.2.i The structure of sessions and lessons

A comprehensive structure for the description and analysis of therapy sessions has been proposed, although it differs somewhat from others (e.g. Panagos *et al* 1986) in its very detailed analysis of 'Doing therapy tasks'. The purpose has been to situate task-related work of a particular nature within the session as a whole. In this respect it differs from the work of some other authors, who have concentrated on specific segments of the session (e.g. Ripich *et al* 1985), or on particular types of interaction within the session (e.g. Silvast 1991).

While other authors have explored 'instructional sequences' to a certain level of detail, this study has examined task-related work minutely. The approach is in principle not very different from various other studies of therapy techniques (e.g. Norris and Hoffman 1990), or studies of teacher talk (e.g. McHoul 1978), but it does present a detailed analysis of task-related work in a highly interactive way and within the context of a more global framework.

Multiple function – one of the major problems associated with categorical systems for the analysis of therapy lessons or sessions – has been embraced in this study. Thus one of the problems associated with the use of ATICS (Horton and Byng 2000) for example, has been avoided. Therapist and aphasic person contributions to the enactment of therapy sessions are demonstrably and diversely multifunctional. The approach to description and analysis in this study has examined how contributions function in particular sequential contexts, and the content of those contributions. This again is in contrast to ATICS, where only function is taken into consideration.

This study has demonstrated the value of a detailed analysis of, for example, turn design and lexical choice, in particular sequential contexts. For example, in common with other studies (e.g. Stoicheff 1960) a lack of comment or follow-up was

not found to be 'neutral'. The aphasic person – or any learner in an instructional context for that matter – strives to find meaning in the structure of the sequence and the design of the 'teacher's' turn. The influence of the aphasic person's contribution on the therapist has been pointed out by Simmons-Mackie *et al* (1999) and is confirmed in this study in a number of ways – for example through the contingent management of task-related routines in the enactment of 'Response management'.

The process suggested by Stech *et al* (1973), where some clinicians tend to hear more responses as appropriate or correct than actually occur, can certainly be observed in these data. There is a strong argument that in certain circumstances the clinician's professional and personal needs influence the ways in which they react to or interpret the aphasic person's responses. This may entail a liberal interpretation of 'error' for example, or a positive gloss on progress in therapy where none is actually demonstrable.

The final section of this chapter goes on to explore in more detail the interaction between the technical and social processes that has been revealed in this study

8.5.2.ii Aphasia therapy as a technical and social process

The purpose of developing a comprehensive structure for the description and analysis of therapy sessions has been to enable a deeper understanding not only of the processes entailed in 'Doing therapy tasks', but also to enable an understanding of this 'business' as part of the process of sessions as a whole. Understanding the process of sessions as a whole entails understanding 'technical' work – 'Doing therapy tasks' and associated business – as well as the social processes of therapy, and the ways in which they may be understood to interact with or impact upon each other. For example, the fact that a therapist chooses to topicalise certain issues raised by the person with aphasia and not others may be related to the therapist's preoccupation with demonstrating the relevance or effectiveness of a particular therapy to that person (and/or to themselves).

Therapists may seek to maintain their expert status by not displaying evidence of their own thinking or reasoning processes. This is apparent in the course of 'Doing therapy tasks' in a lack of specific or explicit reasoning as to why a word or a task routine might be 'tricky' (see ten Have 1991 for a discussion of professional reasoning processes).

As has been pointed out, generally speaking, therapists tended to relate to the aphasic person as a person with aphasia, suggesting that, at least in this type of therapy, there is a danger that therapists may fail to appreciate the potential communicative competence of the person with aphasia (Simmons-Mackie and Damico 1999b). It may be that therapists are so preoccupied with the complexities of 'Enacting tasks' and associated work that they tend to reinforce the values associated with 'improving language' rather than those of competent communication (see West and Frankel 1991 for a discussion of the values of medicine in comparison with life-world experiences of patients). For example, if in the noticing of communicative competence, therapists remark upon it, or if they indulge in artificial demonstrations of the aphasic person's competence, such as requesting displays of information they already know (but not in task-related sequences), or the use of task-related elicitation strategies in the context of 'Inserted conversation' their relationship with the aphasic person will inevitably remain one of 'helper'-'helpee'.

The strong tendency of both participants in language impairment therapy to maintain established therapeutic identities has been discussed by Simmons-Mackie and Damico (1999b). The question then arises, are these identities an inevitable consequence of language impairment therapy? Quite clearly the competence of the aphasic person as a communicator (and by extension as a human actor) is in danger of being confused with the competencies being addressed in language impairment therapy. The practices which are integral to some parts of 'Doing therapy tasks' – for example turn taking patterns and turn design in 'Elicitation' sequences – have a very different

impact if they are applied elsewhere in the session. However the interactional asymmetries inherent in 'Elicitation' sequences do not perforce have to be applied elsewhere.

In this study the issue of control in the therapeutic encounter has been a constant theme. Therapists take obvious control over the phase structure of sessions, initiating and terminating the different phases as they see fit. They exercise rather less obvious control over the management of topical talk, and can also be seen to resist the aphasic person's attempts to take control of aspects of 'Doing therapy tasks', such as choice of vocabulary used or the way task-related strategies are implemented. Therapist control as the 'default' status was also observed in the aphasic person's reluctance to take an active role in the choice of therapy items. The asymmetry of control to be observed in therapy sessions may be in part related to the practice of healthcare in general, where participants produce asymmetry in various ways (ten Have 1991). However, passivity on the part of the person with aphasia (see Bobkoff Katz 1990 for a discussion of 'passive learning' in trainer-oriented vs child-centred therapy) is a potential consequence of language impairment therapy, rather than a requirement.

Understanding and recognising where control resides and through which mechanisms it operates is of potential benefit to therapists and people with aphasia alike. This understanding should enable therapy for language impairments to be enacted by therapists and people with aphasia as collaborators. The challenge for therapists, as Holland (1998) argues – and for people with aphasia for that matter – is to be able to shift roles appropriately and act as equals in the enterprise of therapy.

8.6 Discussion: summary

In this chapter discussion of the study has been addressed in four main ways. In terms of the descriptive-analytic framework itself; in terms of methodological issues; in terms of the research questions; and in terms of the literature.

The descriptive-analytic framework was summarised and discussed in terms of its broad outline as well as in terms of the features and functions of the therapy domains. The discussion continued with a consideration of 'Doing therapy tasks' as 'situated work'. The fact that discrepancies have emerged and been examined was discussed, as well as the ways in which processes such as 'summarising' or 'transition' have been incorporated in the framework. The fact that features such as affiliation, power masking or humour were not pursued systematically as key features in themselves was also discussed.

The sense of relevance of the data and transferability of the findings was discussed in terms of the way in which they were underpinned through detailed description of therapy tasks, of participants' characteristics and the location of the work. The status of the author as therapist and participant was also addressed, as were the possible implications of the recording process.

The issue of whether and how the thesis has addressed the aims of the study was discussed in relation to the five main research questions.

The final sections of this chapter addressed the study in relation to previous and current research, and examined the relevance and potential impact of the study and its findings in relation to the description and analysis of therapy sessions, the structure of sessions and lessons, and aphasia therapy as a technical and social process.

CHAPTER NINE

CONCLUSIONS

9.1 Aphasia therapy in day-to-day practice

This study has addressed the ways in which 'clinical intuition', or 'traditional practices' are evidenced in therapy for language impairment in aphasia. Through the systematic and comprehensive observation of therapy in day-to-day practice a descriptive-analytic framework has been developed. The process of developing this framework has revealed features of the session as a whole, detailed features and dimensions of the ways in which task-related work is enacted, and the way that this may be understood as 'situated work'. The techniques of skilled and experienced therapists have been examined as interactive phenomena, rather than ones taken out of the context of collaborative work with the person with aphasia.

This study has been broad in scope, describing sessions as whole entities, but has also examined the process of therapy in depth and detail. The main object of study – task-related work and its associated features and dimensions – has dominated the thesis. The ways in which experienced therapists and people with aphasia enact tasks in day-to-day practice has been the resource on which this study has based all its findings, and therefore, in one sense, there is nothing new. These are the practices – learned, acquired, developed – which are the stuff of therapy for aphasic language impairment. No new therapy methods, skills or techniques are being proposed.

What is proposed however, is a means of describing and analysing therapy sessions in ways that are, hopefully, meaningful and revelatory. Depth of description and detail of analysis have been necessary to reveal the subtle moment-by-moment work carried out by therapist and person with aphasia alike. Application of CA-derived methods to the study of task-related interactions has enabled a descriptive-analytic framework to be developed, and developed within the context of the session as a whole.

9.2 Considerations and future questions

Interactional dimensions of task-related work have been revealed through the process of developing a descriptive-analytic framework. This framework has the potential to enable therapists to develop a greater understanding of their practice in the enactment of therapy. Through such an understanding therapists would be enabled to develop their awareness of how they are enacting tasks both in terms of the skilful application of technique, and also in terms of their relationship with the person with aphasia as a collaborator in the enterprise.

Firstly, therapists would be able to examine therapy at a technical level, as 'technique-in-interaction'. In order to develop more effective therapy they could, for example, examine the consistency and timing of their follow-up moves or pay close attention to turn design. Secondly, they would also be able to consider how their values as therapists find expression in the actual manner of enacting therapy. The expression of values, such as respect for the client, have been shown to reside in aspects of the interaction which are ostensibly 'technical'. Explicitness and specificity in follow-up moves or in the summarising process for example, can be considered as a mark of respect for the client as an equal and competent partner in the therapy process. More obviously, values reveal themselves in other phases of the session, through the ways in which therapists exert – or share – control over the interaction. Therapists who understand the ways in which the status of the aphasic person as an equal partner can be undermined through their own actions as therapists are potentially in a position to change their own practice. This type of awareness may allow therapists to facilitate client choice and involvement in therapy decisions, and at the same time facilitate their ability to retain their own professional identity (see Atwell *et al* 2001).

In all these respects this study provides the potential for experienced therapists and students alike to develop their understanding of therapy process. It also provides

tools for more consistent and explicit descriptions of the ways tasks are enacted in the reporting of therapy studies. As has been discussed in the previous chapter it is probably true to say that this framework as it stands is too detailed and unwieldy to be used without adaptation. However, future work could be carried out which might reveal the dimensions of enacting tasks which had the greatest impact on outcomes.

A deeper understanding of the process of therapy interaction is not enough however. Therapists need to be able to explore – and this thesis has not addressed this issue directly – why they are doing what they are doing. In one sense, answers to this question can be revealed through the application of this framework. For example, therapists might provide a justification for a particular type of follow-up move on the basis of knowing a particular strength of the aphasic person. However, in the broader sense of 'why you are doing what you are doing' this study has to find its place within a more comprehensive conceptual framework, and one which is able to incorporate an understanding of 'why this is being done', with a principled and systematic description of what is being done.

Therapy for aphasic language impairment has been shown to entail a complex set of processes. The appearance of simplicity referred to in the introduction to this thesis is just that – an appearance. This study has gone some way to demonstrating and describing not only the complexities of aphasia therapy as a means of 'improving' language, but also the complex and related social processes entailed in this enterprise.

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APPENDIX ONE

FORMS USED BY PARTICIPATING THERAPISTS TO SUBMIT INFORMATION

Form 'A': Information about the therapist

INFORMATION ABOUT THE THERAPIST

NAME: Date:

Where did you train as a Speech and Language Therapist?	
When did you qualify as a Speech and Language Therapist?	
Roughly how many years have you been working as a Speech and Language Therapist?	
Roughly how many years have you been working with clients who have dysphasia?	
How would you describe your current caseload?	
Are you a member of the British Aphasiology Society?	
Are you a registered member of the Royal College of Speech and Language Therapists?	
In what setting/s are you working with clients with dysphasia? (e.g. Acute hospital out-patients; domicillary; rehab. centre etc)	

Signed .....

All information which you give us about yourself in connection with this project will be treated in strictest confidence. Any published accounts of the project will keep the identities of the participants - both therapists and people with dysphasia - completely anonymous.

Form 'B': Information about the person with aphasia

INFORMATION ABOUT THE APHASIC PERSON

Therapist's name: Date:

1. Aphasic person's initials:
2. Age:
3. Sex:
4. Time since onset of dysphasia:
5. Type and site of stroke:
6. Other relevant brain damage or injury:

7. Brief SLT history to this date

   How long has this person being having therapy:

   How long have you been working with this aphasic person:

   How frequently do you work together (approximate times per week/month):

8. Assessment data summary

   What assessments have been carried out (formal and informal):

   Assessment results (significant strengths and weaknesses):

   Thumbnail sketch of this person's dysphasia:

Form 'C': Information about therapy sessions

INFORMATION ABOUT THERAPY SESSIONS

This is background information about the *content* of the therapy sessions. We need this information for each therapy session that you record for this project.
In this context *content* means: the items used in the therapy session (e.g. a set of ten object pictures; five written SVO sentences); the tasks or types of tasks used in the therapy session (e.g. word-to-picture matching with distracters; word choice from definition). The information does not have to be very detailed. Do not worry if there was no specific plan of therapy, just write down broadly what type of things you did, and what type of items you used.

Therapist's name:

Aphasic person's initials:

Date of session:

ITEMS	
TASKS	

APPENDIX TWO

APHASIC PERSON PARTICIPANTS: SUMMARIES OF ASSESSMENTS, AND COMMUNICATIVE ABILITIES SUBMITTED BY PARTICIPATING THERAPISTS

[1] Worked with two different therapists

Person with aphasia			History of stroke and aphasia		Assessments (+ date of test where available)			
Study code	**Sex**	**Age**	**Type and site of stroke**	**Time since onset of aphasia**	**PALPA[2]**	**TROG[3]**	**Pyramids and Palm Trees[4]**	**Other**
D1A	F	53	(L) MCA[5] infarct	5 years	• Written and spoken naming = 0 [1994]	• 12/20 blocks [1994]	• 40/52 (version unknown) [1994]	• Kay's (auditory selection from pictures) test[6] = 30/40 (with semantic errors) [1994]
SUMMARY	Assessment summary: Severe aphasia – some input problems but copes using pragmatic knowledge with conversation. No spoken or gestural output. Severe apraxia. ++ emotional upset. Now: Excellent input of auditory material, written less stable, but able to read most of newspaper. Output – has had very severe problems accessing lexical/sentence semantics leading to poor phonological access + problems in organising articulation. Sentence syntax good at positional level now. Just beginning to use sentence structure in spoken output now.							

[2] Psycholinguistic Assessments of Language Processing in Aphasia (Kay et al 1996)
[3] Test for Reception of Grammar (Bishop 1982)
[4] The Pyramids and Palm Trees Test (Howard and Patterson 1992)
[5] MCA = Middle cerebral artery
[6] Kay's Test (Kay: unpublished)

Person with aphasia			History of stroke and aphasia		Assessments (+ date of test where available)		
Study code	**Sex**	**Age**	**Type and site of stroke**	**Time since onset of aphasia**	**PALPA**	**Pyramids and Palm Trees**	**Other**
D2/3A	F	50	Large (L) PCA[7] infarct	2 years	• Spoken word-picture match = 11/40 (17 semantic errors) • Written word-picture match = 0/40 [19/12/97] • Spoken word-picture match = 13/40 (9 close semantic errors) • Written word-picture match = 6/40 (12 close semantic errors) [8/5/98]	Three pictures: 24/52 [12/5/98]	• Word repetition = 13/15 • Object naming = 0/20 [19/12/97]
SUMMARY	Assessment summary: Semantic deficit on PALPA w-p match + visual errors. Word repetition much better than confrontation spoken naming. Unable to complete written w-p match. No functional writing at 19/12/97. Informal comparison of oral word-picture vs. sent-picture match shows improvement in the latter condition. She has severe jargon aphasia characterised by neologisms and extended English jargon in conversational speech. Her jargon is interspersed with correct and appropriate (syntax and meaning) English phrases and sentences. Jargon is at its worse when she is trying to make direct reference to something. She is (30/4/99) beginning to use written messages to convey conversational meaning. She uses words and numbers, and some drawing.						

[7] PCA = Posterior cerebral artery

Person with aphasia			History of stroke and aphasia		Assessments (+ date of test where available)			
Study code	**Sex**	**Age**	**Type and site of stroke**	**Time since onset of aphasia**	**PALPA**	**TROG**	**Pyramids and Palm Trees**	**Other**
D4A	M	59	(L) MCA infarct	2 years	• Same-different judgement; 3, 15 (auditory and written versions) = no results given [1/5/98 and 5/5/98]		• 3 pictures = 35/52 • 3 written words = 44/52 [14/11/97]	
SUMMARY			Assessment summary: 17/9/97 Severe dyspraxia, mod/severe aphasia affecting reading and writing. Using facial expression, vocalisation, writing and drawing + some gesture. Currently: moderate/severe dyspraxia, and moderate/severe aphasia. More accurate spoken output in conversation.					

Person with aphasia			History of stroke and aphasia		Assessments (+ date of test where available)		
Study code	**Sex**	**Age**	**Type and site of stroke**	**Time since onset of aphasia**	**PALPA**	**TROG**	**Other**
D5A	M	64	(L) CVA	19 months	• Spoken word-picture match = 39/40 • Naming = 11/16	• 11/20	• Informal verb judgement test = 25/30 • Odd-one-out (moderate level) = 10/10 • Odd-one-out (advanced level) = 6/10 • Verb naming = 3/12 • Boston[8] cookie theft subtest = 1 noun, 1 verb, no phrase/sentence structure
SUMMARY			Assessment summary: Moderate auditory and visual receptive difficulties. Severe word finding difficulties, especially verb retrieval and propositional information. In addition problems exacerbated by dyspraxia.				

[8] Boston Diagnostic Aphasia Examination (Goodglass and Kaplan 1983)

Person with aphasia			History of stroke and aphasia		Assessments (+ date of test where available)		
Study code	**Sex**	**Age**	**Type and site of stroke**	**Time since onset of aphasia**	**PALPA**	**Pyramids and Palm Trees**	**Other**
D6A	F	67	Large (L) MCA infarct	8 months	• Spoken word-picture match = 33/40 • Written word-picture match = 26/40 (3 close, 6 distant and 4 visual distracters) • Picture naming (unknown modality) = 0/20 • Word repetition = 30/60	• Three pictures = 46/52	
SUMMARY			Assessment summary: Auditory comprehension appears relatively good in conversation. Occasionally will require repetition and generally needs slower rate and emphasis. Written comprehension of functional material is not good. Breakdown of central semantic system causing lack of specificity when accessing Phonological Output Lexicon.				

Person with aphasia			History of stroke and aphasia		Assessments (+ date of test where available)
Study code	**Sex**	**Age**	**Type and site of stroke**	**Time since onset of aphasia**	**PALPA**
D7A	F	60	2 x CVA over a ten day period	18 months	• Spoken word-picture match = 12/40 [16/11/98] = 28/40 [10/5/99] • Written word-picture match = 15/40 [9/11/98] • Lexical decision = 26/30 • Naming = 1/10 [November 1998]
SUMMARY			Assessment summary: Central semantic and phonological output problems. Unable to write or gesture. "Dyspraxic". Increased ability to repeat and respond to phonemic cues. Reading modality seems better than auditory, and appears to support comprehension. Concentration and alertness vary, but generally: good auditory comprehension now of concrete high-frequency nouns – more variable with verbs, with less common vocabulary, and with two spoken words. Reading is a little more reliable functionally. Good repetition and response to phonemic cues, but little spontaneously, apart from some automatic responses. Can used forced alternatives functionally to an extent. Prior to D7T involvement D7A did well on tasks involving sorting and selection of items within category. In recent sessions with D7T, D7A did well using closely related items within category. Now D7T is looking at verb comprehension, and reading of verb-noun combinations. Uses word lists functionally in groups. Has many interests and a supportive partner and carer, with whom she has good relationships.		

Person with aphasia			History of stroke and aphasia		Assessments (+ date of test where available)		
Study code	**Sex**	**Age**	**Type and site of stroke**	**Time since onset of aphasia**	**PALPA**	**Pyramids and Palm Trees**	**Other**
D8A	M	63	(L) MCA infarct	7 months	• Spoken word-picture match = 32/40 • Written word-picture match = 2/40 (NB: Therapist notes much more reliable functional single word reading) • Subtest 51 = 8/15 (High imageability); 3/15 (Low imageability) • Picture naming = unable to carry out any oral or written naming, read aloud or repeat names (produced perseverative neologistic output)	• Three picture version = 43/52	
SUMMARY	Assessment summary: Severe non-fluent aphasia with mild comprehension difficulties in conversation. Reads single words and short phrases. Significant impairment of writing. Uses picture communication book and some speech + gesture/facial expression to communicate. Semantic errors in input and output tasks (mainly close semantic errors). Suspect reduced semantic drive to Phonological Output Lexicon + Orthographic Output Lexicon (as well as some central semantic impairment).						

Person with aphasia			History of stroke and aphasia		Assessments (+ date of test where available)		
Study code	**Sex**	**Age**	**Type and site of stroke**	**Time since onset of aphasia**	**PALPA**	**Pyramids and Palm Trees**	**Other**
D9A	F	63	(L) CVA	9 months	• Spoken word-picture match = 15/40 • Written word-picture match = 15/40 (Therapist comments on 'bizarre error patterns') • Picture naming (unknown modality) = 15/40	• 32/52 (version not given)	
SUMMARY			Assessment summary: Profound semantic impairment plus reduced attention leading to inability to access not only spoken/written word forms but also inability to access drawing/gesture or use pictures (i.e. non-verbal communication strategies) Unable to read aloud or name (written/spoken). Unable to assemble Consonant-Vowel-Consonant (CVC) anagrams to picture stimulus. Output usually perseverative utterances, but now increasingly: "I don't know". Unable to communicate even basic daily needs as unable to use pointing and gestures. She does not spontaneously use drawing despite her ability to draw.				

Person with aphasia			History of stroke and aphasia		Assessments (+ date of test where available)		
Study code	**Sex**	**Age**	**Type and site of stroke**	**Time since onset of aphasia**	**PALPA**	**TROG**	**Pyramids and Palm Trees**
D10/11A	M	40	(L) parietal infarct resulting from extracranial carotid dissection after RTA (road traffic accident)	5 months	• Spoken word-picture matching = 28/40 • Written word-picture matching = 19/40	• 27/40	• 38/52 (version not known)
SUMMARY			Assessment summary: Difficulties within semantic system. Able to make distinctions between unrelated categories but has increasing difficulties with closer semantic relations (for pictures, written and spoken words). Naming only with significant phonemic cueing. Able to follow verbal information in context but inconsistent at two word level on testing. Communicates by yes/no + facial expression. Moderate receptive and severe expressive aphasia				

Person with aphasia			History of stroke and aphasia		Assessments (+ date of test where available)			
Study code	**Sex**	**Age**	**Type and site of stroke**	**Time since onset of aphasia**	**PALPA**	**TROG**	**Pyramids and Palm Trees**	**Other**
D12A	M	75	(L) CVA	28 months	• Spoken word-picture match = 24/40 [17/2/97] • Spoken word-picture match = 39/40 [17/4/97] • Subtest 39 = 23/24 • Subtest 45 = 6/24 [January 1998]	• 5 blocks passed [26/2/97] • 13 blocks passed [12/5/97] • 14 blocks passed [January 1998]	• 36/40 (not completed: version not known) [26/2/97]	
SUMMARY			Assessment summary: Good auditory comprehension and excellent pantomime skills. Severely dyspraxic spoken output. unintelligible out of context. Emerging sentence level written output.					

Person with aphasia			History of stroke and aphasia		Assessments (+ date of test where available)		
Study code	**Sex**	**Age**	**Type and site of stroke**	**Time since onset of aphasia**	**PALPA**	**Pyramids and Palm Trees**	**Other**
D13A	F	59	(L) tempero-parietal infarct	8	• Spoken word-picture match = 21/40 (5 close & 5 distant distracters) [1/2/99] = 33/40 (4 close distracters) [26/3/99] = 33/40 (5 close distracters) [10/6/99] • Spoken picture naming = 1/16 [10/2/99] = 0/12 [29/3/99] • Written picture naming = 4/32 [24/4/99] • Auditory word repetition: High Imageability = 26/40; Low Imageability = 22/40; High Frequency = 25/40; Low Frequency = 23/40 [4/2/99]	• Three picture version = 39/52 [4/2/99] = 40/52 [10/6/99]	
SUMMARY			Assessment summary: Fluent neologistic jargon aphasia. Significant strength that has emerged is writing to dictation and use of writing, when prompted in a conversational setting.				

Person with aphasia			History of stroke and aphasia		Assessments (+ date of test where available)			
Study code	**Sex**	**Age**	**Type and site of stroke**	**Time since onset of aphasia**	**PALPA**	**TROG**	**Pyramids and Palm Trees**	**Other**
D14A	F	83	CT scan showed no abnormality	2 years			• (Version unknown) = 47/52 [13/4/99]	• Mount Wilga Test[9]: (among others) Spoken naming from description = 3/6; Category naming = 1/4; Logico-Semantic Relationships = 3/4 [16/2/99]
SUMMARY		Assessment summary: Unimpaired semantic access, some word-finding difficulties. Slow, stilted expressive output. Difficulties with inferential material. Sometimes requires repetition or slowed rate of speech.						

[9] Mount Wilga Test – a non-standardised, unpublished test of high level language, from Australia

Person with aphasia			History of stroke and aphasia		Assessments (+ date of test where available)	
Study code	**Sex**	**Age**	**Type and site of stroke**	**Time since onset of aphasia**	**PALPA**	**Other**
D15A	F	85	(L)	3 months	• Spoken picture naming = 16/40 [21/7/99 = 25/40 [13/10/99	• Informal verb comprehension test = 29/40 (9 semantic distracters) [18/10/99]
SUMMARY			Assessment summary: Fluent aphasia with mixture of jargon and formal paraphasias. Auditory comprehension reasonable in conversation.			

APPENDIX THREE

SESSION SUMMARIES SUBMITTED BY PARTICIPATING THERAPISTS: ITEMS AND TASKS IN EACH SESSION

Therapy dyad	Session	Date	TASKS	ITEMS	CONSIDERATIONS NOTED BY THERAPIST
D1	1	18/2/99	1. A[1] to listen to read sentence and then dictate a suitable follow-on clause with full structure 2. Read orally her own output	20 written sentences read orally to A. Each sentence either begins or ends with a secondary clause	• A has big problems deciding on what to put across & changes mind frequently if word-finding problems occur • Needs to plan sentence internally • To concentrate on word processing at that point – rushes in without planning • To concentrate on articulation of multisyllabic words • Gesture not positively encouraged
	2	23/2/99	1. A to read silently & then dictate final clause 2. A to listen to paragraph read back to her – A to answer questions about information in paragraph 3. A to listen to verb definitions and provide verb	1. 8 short written paragraphs – last sentence demanding a secondary clause 2. 15 verb definitions read orally	1. A to read in order to 'slow her down' and force better planning 2. In answering questions on paragraph A to concentrate on articulation
	3	25/2/99	A asked to think of things happening in a park which T[2] would then draw	Bare outline drawing of a park	• A to produce sentences without being cued • A reminded of verb definitions from previous session and it was suggested she could use many for this task • Emphasis on breaking up ideas into information pieces to formulate sentences

[1] Refers to person with aphasia
[2] Refers to therapist

Therapy dyad	Session	Date	TASKS	ITEMS	CONSIDERATIONS NOTED BY THERAPIST
D2	1	10/3/99	1. Written word-to-picture match within group (all words, all pictures) 2. Written naming of each item: i) A to choose one of two written words for single target item (picture) ii) copy target word iii) A to enter anagrammed letters into target grid iv) [optional] A to write word from memory 3. A to read word aloud 4. Items in each set reviewed as set completed	Ten items (from a set of personal vocabulary items) in four groups of semantically related items: 1. i) bus, ii) train, iii) ticket 2. i) Eva, ii) Michelle, iii) Eadie 3. i) doctor, ii) dentist 4. i) Yarmouth, ii) Oxford	
	2	24/3/99	1. Written word-to-picture match within group (one word, all pictures) 2. Written naming of each item: i) A to choose one of two written words for single target item (picture) ii) copy target word iii) A to enter anagrammed letters into target grid iv) [optional] A to write word from memory 3. A to read word aloud 4. Items in each set reviewed as set completed – degraded word forms provided for all items	Ten items (from a set of personal vocabulary items) in four groups of semantically related items 1. i) football, ii) music, iii) pub 2. i) doctor, ii) dentist 3. i)Steve, ii) Gill, iii) Eadie 4. i) Hurd Road, ii) Jarrolds	• At start of session A keen to show she could write Gill, Eva spontaneously, and egg and bus with support • Task 2i) not completed for all Items where A confident of target identity • Spoken word seemed difficult today and not emphasised

Therapy dyad	Session	Date	TASKS	ITEMS	CONSIDERATIONS NOTED BY THERAPIST
D2 (cont.)	3	21/4/99	1. Written word-to-picture match within group (one word, all pics) 2. Written naming of each item: i) A to choose one of two written words for single target item (picture) ii) copy target word iii) A to enter anagrammed letters into target grid iv) [optional] A to write word from memory 3. A to read word aloud 4. Items in each set reviewed as set completed – degraded word forms provided for all items	Ten items (from a set of personal vocabulary items) in four groups of semantically related items 1. i) pub, ii) football, iii) music 2. i) Michelle, ii) Paddy, iii) Steve, iv) Eadie 3. i) dentist, ii) doctor 4. i) Hurd Road	• Messages using writing in the preliminary conversation

Therapy dyad	Session	Date	TASKS	ITEMS	CONSIDERATIONS NOTED BY THERAPIST
D3	1	2/3/99	1. A to repeat each word 2. Written naming of each item: i) A to choose one of two or three written words for single target item (picture) ii) A to enter anagrammed letters into target grid iii) A to write word from memory 3. A to read word aloud	Nine items at random (from a set of personal vocabulary items): i) eggs, ii) dentist, iii) bus, iv) Michelle, v) Eadie, vi) Jarrolds, vii) Eva, viii) flour, ix) Steve	
	2	5/3/99	1. A to repeat each word 2. Written naming of each item: i) A to choose one of two or three written words for single target item (picture) ii) A to enter anagrammed letters into target grid iii) A to write word from memory 3. A to read word aloud	Eleven items at random (from a set of personal vocabulary items): i) Oxford, ii) music , iii) football, iv) pub, v) ticket, vi) Gill, vii) doctor, viii) Yarmouth, ix) milk, x) train, xi) Hurd Road	

Therapy dyad	Session	Date	TASKS	ITEMS	CONSIDERATIONS NOTED BY THERAPIST
D3 (cont.)	3	16/7/99	1. A to match a sentence (containing a message) to a choice of two first letters (one of which represents the target item) 2. A to write appropriate word for each message	Complete set of personal vocabulary items: i) Steve, ii) milk, iii) music, iv) Michelle, v) train, vi) Oxford, vii) doctor, viii) ticket, ix) Yarmouth, x) eggs, xi) Paddy, xii) football, xiii) pub, xiv) Hurd Road, xv) bus, xvi) Jarrolds, xvii) Gill, xviii) Eadie, xix) Eva, xx) dentist	

Therapy dyad	Session	Date	TASKS	ITEMS	CONSIDERATIONS NOTED BY THERAPIST
D4	1	27/7/99	1. Spontaneous conversation (total communication approach), highlighting verbs/SVO structures used 2. Written sentences with verb choice taken from spontaneous conversation – verb choice /4	Personal photos chosen by A	
	2	30/7/99	1. Spontaneous conversation (total communication approach), highlighting verbs/SVO structures used 2. Written sentences with verb choice taken from spontaneous conversation – verb choice /4	Personal photos chosen by A	
	3	6/8/99	1. Planned tasks as before, but general conversation not linked to photos per se. 2. Generated some verbs/SVO type structures which were then used as format for verb choice /4 in written format	Personal photos (but not used very much)	

Therapy dyad	Session	Date	TASKS	ITEMS	CONSIDERATIONS NOTED BY THERAPIST
D5	1	18/2/99	1. Study picture and select appropriate action verb (targets meant to be transitive verb types) 2. To identify arguments of verb (agent and theme) and to position appropriately in relation to verb. 3. To produce sentence verbally if possible.	Nine pictures depicting an action verb. Each picture accompanied by a choice of five semantically related verbs (pictures focus on the verb meaning rather than on the arguments i.e. stick men only)	
	2	2/3/99	1. To read words silently and to isolate the semantically linked agent and theme 2. To order the two targets correctly (i.e. agent first) – therapist as scribe 3. To find a verb to describe the relationship between the two targets 4. To read back or judge the sentence created (SVO)	10 groups of five nouns. Two nouns are semantically related and have an 'agent-theme' relationship. The remaining three nouns may be semantically linked to either of the target items but not closely enough or not in this relationship e.g. jockey/table/suitcase/dog/horse	
	3	9/3/99	1. To read words silently and select verb that relates to all three nouns 2. To judge whether own responses are accurate 3. To read the sentence silently and to locate one source of semantic anomaly (either the V or N) e.g. 'the chihuahua threw the ball' 4. To provide a more semantically appropriate verb to describe a possible action between 'chihuahua' and 'ball' etc	Three nouns written, then four verbs written. Nouns are semantically related to one another (e.g. car, bike, bus). Verbs are semantically related to one another (e.g. drive, steer, pedal, race). Only one verb relates to all three nouns. 12 semantically anomalous sentences, where either V or N must be changed to 'correct' the meaning.	

Therapy dyad	Session	Date	TASKS	ITEMS	CONSIDERATIONS NOTED BY THERAPIST
D6	1	17/5/99	1. A asked to select pictures of food she would commonly use. Therapist wrote name of each picture 2. A sorted written words into 3 categories. Category name given in written form by therapist 3. A asked to point to written category name when presented with each word auditorily 4. A asked to select unrelated distracter from choice of /4 written words	1. One set of food pictures 2. Set of 25 written words relating to food from three different categories 3. Above words presented in auditory form 4. 4 written words presented (3 related, 1 unrelated)	Tasks were all input - however as A is keen to work on speech, expression of most words is facilitated by repetition. No other cueing technique has been successful.
	2	22/5/99	1. A asked to place written words under correct category headings 2. Choice of 4 pictures/words – asked to select odd-one-out (OOO) 3. Asked to select OOO from written words only 4. Asked to categorise written words in (2) above into higher order semantic categories 5. Introduce auditory stimulus in the same way as (4)	1. Selection of written words from 3 related categories (vegetables/fruit/meat) 2. Set of vegetables/fruit/meat pictures with written words 3. Set of four written words 4. 4 written categories with increased semantic relatedness	
	3	27/5/99	1. A asked to indicate OOO, and if possible reason why 2. As in (1) above but with items of increased semantic relatedness 3. A to indicate OOO (categories given auditorily by therapist if difficult) 4. A to read words and then select associated word from written choice of three	1. 8 x set of 3 semantically related pictures 2. 8 x set of 4 pictures with increased semantic relatedness 3. 8 x set of 4 written words as used in 2 above 4. 4 x set of 3 written words for word association	

Therapy dyad	Session	Date	TASKS	ITEMS	CONSIDERATIONS NOTED BY THERAPIST
D7	1	5/5/99	1. Informal assessment/probe 2. Semantic circles – inclusion/exclusion task. Using drawing, written and spoken stimulus 3. Verb choice for associated picture (written)	1. Line drawings of intransitive verbs. 2. Semantically related photos; composite picture depicting semantically related line drawings. 3. Semantic circles (published materials) 4. Worksheet – two related written verbs for selection to match with object picture	
	2	11/5/99	1. Semantic links for verbs (sew, drive, wash, paint, fly, read, buy, play) 2. Inclusion/exclusion tasks	Semantic links drawings with written word & spoken input.	
	3	14/5/99	1. Select group of objects associated with a spoken verb 2. Select verb from spoken choice to match picture. Related e.g. trot/jump. Racing theme. Moving to more abstract verbs e.g. win/lose 3. Semantic links, spoken verb – spoken and/or pictured object. More abstract. 4. Functional postcard reading – answer questions	1. Line drawings of objects related to a verb 2. Selection of magazine cuttings, photographic materials and hand drawings. Paper and pencil – horse racing theme 3. Semantic links drawings with written word and spoken output. Other more abstract ones without picture (visit, change)	

Therapy dyad	Session	Date	TASKS	ITEMS	CONSIDERATIONS NOTED BY THERAPIST
D8	1	12/5/99	1. Written word-picture matching with one close semantic distracter 2. Production of target in response to closed question/forced choice from therapist (e.g. is it a train or a bus?) 3. Discussion re forthcoming trip to betting shop	A set of 26 high and low frequency object pictures with written label and 1 close semantic distracter	
	2	25/5/99	1. Written word-picture matching with three close semantic distracters 2. Production of target in response to forced alternatives from the therapist 3. Categorisation of written words into 6 categories 4. Written word choice from definition (same words as in previous task) 5. Conversation and homework	1. A set of 26 high and low frequency object pictures with written label and three close semantic distracters 2. Written word list made up of words belonging to six semantic categories	
	3	11/6/99	1. Written word-picture matching with three close semantic distracters 2. Production of target in response to forced alternatives from the therapist 3. Non-verbal sorting task – kitchen vs living room objects 4. Spoken word-picture matching (6 closely related choices) 5. Written word-picture matching (1 picture + three written words) 6. Homework – written categorisation.	1. A set of 26 high and low frequency object pictures with written label + three close semantic distracters 2. Category specific object pictures (Household items)	

Therapy dyad	Session	Date	TASKS	ITEMS	CONSIDERATIONS NOTED BY THERAPIST
D9	1	24/5/99	1. Sort animals from transport 2. Sort transport into sea, land, air 3. Sort land into private vs commercial 4. Draw private vehicles, turn-taking with therapist 5. Sort birds from animals 6. Questions re bird semantics 7. Draw bird, turn-taking with therapist 8. Sort animals into zoo (foreign) and farm/domestic (UK) 9. Draw preferred pet	1. Animal and transport pictures (animals: zoo, domestic, farm; transport: air, land, sea)	1. Establish non-language leisure pursuits 2. Establish personal portfolio to aid social communication 3. Trial semantic (non-verbal) programme with a view to consolidating semantic features of objects within categories with a view to establishing distinctive features for drawing. 4. Collaborative drawing with SLT in community 5. No emphasis on any spoken language, although sometimes necessary to use in order to clarify/emphasise. Aim for near errorless performance
	2	1/6/99	1. Sorting fruit and vegetables (given one at a time) 2. Sorting fruit, vegetables and other foods 3. Use of drawing food, and fruit and vegetables to communicate (NB session begun with conversation which successfully elicited drawing as a mode of communication)	1. Fruit and vegetable pictures 2. Fruit, vegetable and food pictures	

Therapy dyad	Session	Date	TASKS	ITEMS	CONSIDERATIONS NOTED BY THERAPIST
D10	1	26/5/99	1. Homework – odd-one-out (feedback) 2. Semantic sorting 3. Colour of fruit – selecting pens 4. Written word-picture match: 5 pic-1 word 5. Forced alternative name of same five items with written word present. Cued to produce written word in presence of picture 6. Colour of foreign fruit 7. As in (4) for foreign fruit 8. As in (5): pointing response for forced alternatives 9. As in (4) 10. Colour 11. Forced alternatives questions re picture name (pointing yes/no response) 12. As in (4) 13. Same procedure for sorting but with vegetables 14. Drawing: in pairs, emphasis on similarities and differences, chooses appropriate colour, ++ feature emphasis	1. 4 related items 2. Fruit and vegetables	

Therapy dyad	Session	Date	TASKS	ITEMS	CONSIDERATIONS NOTED BY THERAPIST
D11	1	7/5/99	1. Sorting pictures into categories – clothing and body parts 2. Sorting written words as above 3. Written word to picture matching (one word with up to four pictures) 4. Spoken word to picture matching (one picture, two words)	1. 18 clothing pictures + 18 corresponding written words 2. 18 body part pictures + 18 corresponding written words	
	2	13/5/99	1. Sorting pictures into categories (fruit and vegetables) 2. Sorting written words as above 3. Odd-one-out with written words (three fruit, one vegetable) 4. Spoken word-picture match (one word, 4 pictures) 5. Spoken-written word matching (one spoken, two or three written) 6. Spoken word – picture matching (one picture & two words e.g. apple or pear)	1. 16 fruit pictures and written names 2. 16 vegetable pictures and written names	
	3	18/5/99	1. Sorting pictures and words according to: a) electrical Yes/No b) furniture Yes/No c) in the kitchen Yes/No 2. Written word – picture match (four words, four pictures)	27 pictures of household objects + corresponding written names	

Therapy dyad	Session	Date	TASKS	ITEMS	CONSIDERATIONS NOTED BY THERAPIST
D12	1	1/6/99	Homework review: 1. To write a description of the story which unfolds when the pictures are laid out in sequence	1. 8 sequence cards (Camping: Winslow Press 1991) 2. Synonym/antonym dictionary	• A just out of hospital but insisted on taking part • "I always suggest that he write a vocabulary first, but he is not keen to do this! He prefers free flow!"
	2	3/6/99	1. Sequencing pictures and determining the course of the story 2. Written description using predetermined strategies	1. 8 sequence cards – a day in the life of a painter and decorator (Winslow Press 1991)	
	3	28/6/99	1. To describe holiday in Ireland with help of photographs and written sentences using previously thought-out vocabulary and written sentences	1. Holiday pictures 2. Prior instructions (written) 3. Synonym/antonym dictionary	• He does not follow my instructions and produces his own sentences • I am interested to know what classes of word are difficult to find – I suspect that his verb range is quite restricted, from ongoing evidence

Therapy dyad	Session	Date	TASKS	ITEMS	CONSIDERATIONS NOTED BY THERAPIST
D13	1	24/2/99	1. Odd-one-out +/- spoken cues	Sets of four pictures: 1. 3 members of semantic field, 1 unrelated 2. 3 members of semantic field, 1 related	
	2	12/5/99	1. Choosing between spoken forced alternatives: altering target position, altering semantic relatedness 2. Writing target: after forced alternative choice, +/- to dictation.	1. Object pictures	
	3	15/7/99	Spoken word – written word matching +/- lip shape cues, +/- drawing	Sets of four written words differing by final phoneme/grapheme	

Therapy dyad	Session	Date	TASKS	ITEMS	CONSIDERATIONS NOTED BY THERAPIST
D14	1	11/5/99	No written information	No written information	
	2	25/5/99	No written information	No written information	
	3	8/6/99	No written information	No written information	

Therapy dyad	Session	Date	TASKS	ITEMS	CONSIDERATIONS NOTED BY THERAPIST
D15	1	28/7/99	To provide semantic information about the pictured objects in response to my questions	23 object pictures: milk, bicycle, purse, piano, washing machine, egg, fish, shoe, cow, bath, pen, towel, bed, comb, postman, book, ring, wine, church, TV, hat, key, doctor	
	2	4/8/99	To provide semantic information about the pictured objects in response to my questions	21 object pictures: glass of beer, waste bin, box of tissues, postbox, fish, cake, hairdresser, man washing dishes, suitcase, nurse, lipstick, pregnant woman, woman singing, umbrella, fridge, car, loaf of bread, pot and cup of tea, moon, phone, watering can	
	3	13/8/99	To provide semantic information about the pictured objects in response to my questions	15 object pictures: phone, fish, bed, sparrow, box of eggs, pen, kettle, lemon, sailing boat, banana, chair, horse, potato, jar of jam, cornflakes.	