

# Management of Discourse in Group Therapy for Aphasia

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A qualitative study of group therapy for aphasia was undertaken in order to discover interaction patterns and discourse management strategies that help define “social” or “conversation” group therapy for aphasia. Specifically, an analysis of the discourse of clients and therapists was conducted to identify patterns across therapists and settings. Six group communication therapy sessions involving individuals with aphasia were videotaped and analyzed. Within the well-managed social group therapy sessions studied, a variety of discourse management features were identified, including establishing the feel of discourse equality, focusing on everyday communicative events and genres, employing multiple communication modes, mediating communication, calibrating corrections, aiding turn allocation, and judiciously employing teachable moments. The discourse patterns identified in these social conversation groups differ from discourse patterns associated with traditional impairment-focused therapy described in the aphasia literature. **Key words:** *aphasia, conversation, discourse, group therapy, qualitative research, social model, treatment*

**I**N the past decade, group therapy for adults with aphasia has gained increasing attention (Avent, 1997; Elman, 2007a; Kearns & Elman, 2001; Marshall, 1999). The efficacy of group aphasia therapy has been demonstrated, and master clinicians have anecdotally reported positive benefits of this intervention (e.g., Beeson & Holland, 2007; Bollinger, Musson, & Holland, 1993; Elman & Bernstein-Ellis, 1999a, 1999b; Holland, 2007; Kagan & Cohen-Schneider, 1999; Pachalska, 1991; Penman & de Mare, 2003; Ross, Winslow, Marchant, & Brumfitt, 2006; Wertz et al., 1981). If group therapy is to be efficient and efficacious, then the behaviors that contribute to effective group management must

be understood. Therefore, a project was initiated to describe clinical discourse associated with group therapy for aphasia. Specifically, this project focused on groups conforming to “social approaches” to aphasia intervention (Elman, 2005; LPAA Project Group, 2000, 2001; Pound, Parr, Lindsay, & Woolf, 2000; Simmons-Mackie, 2000, 2001).

## **BACKGROUND OF GROUP THERAPY FOR APHASIA**

During the mid-20th century, group therapy for aphasia was accepted as a practical method of improving communication for war veterans who had sustained brain injuries (Kearns & Elman, 2001). However, group aphasia therapy lost favor as more specialized individual therapy methods were introduced. Recently, clinicians have recognized that group therapy offers opportunities that differ substantially from the communicative experiences of individual aphasia therapy (e.g., Elman, 2007b; Holland, 2004). The “mechanics” of group therapy for aphasia have been detailed. For example, session structure and length, client selection,

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communicative activities, and client goals have been described (e.g., Avent, 1997; Beeson & Holland, 1994, 2007; Bernstein-Ellis & Elman, 2007; Elman, 2000, 2007b; Garrett, Stalteri, & Moir, 2007; Kearns & Elman, 2001; Marshall, 1999; Pound et al., 2000; Worrall, Davidson, Howe, & Rose, 2007).

Case studies and theoretical descriptions have contrasted traditional didactic or "impairment-focused" therapy with interactive "social" group therapy (Elman, 2000; Pound et al., 2000; Simmons-Mackie, 2000, 2001). Descriptions of discourse characteristics associated with typical individual impairment-focused therapy for aphasia have been offered (e.g., Damico, Simmons-Mackie, Oelschlaeger, & Tetnowski, 2000; Ferguson & Armstrong, 2004; Ferguson & Elliot, 2001; Horton, 2003, 2004; Horton & Byng, 2000; Silvast, 1991; Simmons-Mackie & Damico, 1999; Simmons-Mackie, Damico, & Damico, 1999), and there is evidence that similar characteristics are present in impairment-focused group therapy (Kovarsky, Kimbarow, & Kastner, 1999; Kovarsky, Shaw, & Adingono-Smith, in press; Simmons-Mackie, 2006). The most obvious characteristic of traditional impairment therapy is the explicit focus on implementing activities associated with individual cognitive or linguistic impairments. For example, tasks might focus on picture naming to improve word finding or on producing accurate grammatical structures to counteract agrammatism. Thus, sessions tend to be relatively structured and didactic, with clinician discourse crafted to maintain a controlled focus on particular deficits. In order to achieve the structured focus on impairments, sessions are characterized by control asymmetry, with the therapist clearly in charge (Damico et al., 2000; Horton, 2003; Simmons-Mackie & Damico, 1999; Simmons-Mackie et al., 1999; Simmons-Mackie & Schultz, 2003). The therapist tends to plan the sessions, administer the activities, and control the tempo and discourse structures of therapy. A pervasive discourse structure is the Request—Response—Evaluation (RRE) sequence in which therapists make a request

for performance ("What is the name of this?"), clients respond ("pencil"), and therapists evaluate the response ("good"). Errors by clients and error correction by therapists are expected elements of this approach. Because of the relatively rigid structure of therapy and predominance of teaching discourse (i.e., RRE structures, corrections), the variety of speech acts performed by aphasic clients is limited, and communicative choices are constrained (Silvast, 1991; Wilkinson, 2004). Such sessions have been described as "therapist-centered" (Simmons-Mackie & Damico, 1999) or in the child intervention literature this asymmetrical structure is called "adult-centered" therapy (Kovarsky & Duchan, 1997).

Related research examining interactions within 20 group therapy sessions for adults with traumatic brain injury (TBI) concur with the above findings regarding impairment-focused therapy (Kovarsky et al., in press). In these group therapy sessions, tasks were designed to focus on specific deficits, such as attention and memory impairments. That is, tasks were not typical of everyday peer social interaction. The therapists enacted structured games in which each client took a turn and the therapist provided feedback, evaluated client utterances, or corrected errors. Kovarsky and colleagues (1999) noted that these rule-bound "quiz" sequences created a rigid structure that focused explicitly on the deficits of participants.

In contrast to therapist-centered approaches, socially oriented aphasia groups have been described in the literature as less structured and more client-centered, with the intent of promoting communicative experiences that more closely resemble natural peer communication (Bernstein-Ellis & Elman, 2007; Graham & Avent, 2004; Holland, 2004; Kagan & Gailey, 1993; Pound et al., 2000; Simmons-Mackie, 2000, 2001). Principles drawn from social model philosophy help form a foundation for socially focused groups (e.g., Byng & Duchan, 2005; LPAA Project Group, 2000, 2001; Pound et al., 2000; Simmons-Mackie, 2000, 2001;

Worrall, 2000). Such groups *explicitly* focus on communicating in everyday social life, empowering group members, and enhancing communicative confidence and self-esteem. A controlled research study has supported the efficacy of social group therapy for aphasia (Elman & Bernstein-Ellis, 1999a, 1999b).

Holland (2004) and Bernstein-Ellis and Elman (2007) have described methods of promoting successful social aphasia groups based on their experiences. For example, the clinician should serve as a resource rather than an authority figure. Interactions within group therapy should approximate natural discourse patterns typical of peer conversation and other familiar social genres (Simmons-Mackie, 2000). Elman (2000) has suggested that the interaction and interrelationships within the group are the key to successful group therapy. Thus, the emphasis must shift from thinking about the defined tasks to be implemented by clinicians, to thinking about the complex interaction among group members as the basis of therapeutic outcomes. The group process literature in psychology and sociology provides information concerning group dynamics and guidelines for group therapy (e.g., Ewing, 2007). Although concepts regarding group dynamics have aided the design of aphasia group therapy, it is not clear if the specific discourse techniques available to these group leaders apply readily to groups of people with pervasive difficulty understanding and producing language. In fact, there are no data describing how discourse management behaviors are actually realized in social therapy groups for aphasia. How does one go about creating an “interactive social group” for people with aphasia—that is, facilitating successful conversation among individuals with pervasive communication deficits? In order to address this question, a qualitative study of group therapy for aphasia was undertaken. The research was designed to discover interaction patterns and discourse management strategies that help define “social group therapy” for aphasia.

## METHODS

### Participants and settings

Six group communication therapy sessions involving individuals with aphasia served as the data source. The settings included two university clinics and one outpatient community program for people with aphasia. Participants included speech-language pathologists (SLPs), student clinicians, and individuals with aphasia. Student clinicians were supervised by SLPs with more than 15 years of experience. The number of participants in therapy groups ranged from 4 to 10. All client participants were diagnosed with aphasia without complicating communication conditions such as significant dementia, dysarthria, or hearing loss. All participants with aphasia were more than 10 months postonset of aphasia. All groups were considered “long term,” in that they had existed for more than a year. Although the experienced clinicians and supervisors had been associated with the groups for over a year, student clinicians changed each school term.

Group #1 was conducted in a community outpatient program for people with aphasia located in the western United States. It comprised 10 members, including an experienced SLP (>20 years), a student clinician, and eight people with aphasia ranging from moderately severe to mild. The group involved discussion of various topics, including favorite restaurants and recent events. Group #2 was conducted in a university clinic in the southwestern United States. It comprised four members, including an experienced SLP (>20 years), a student clinician, and two people with aphasia, one with mild aphasia and the other with moderate aphasia. Group conversation covered a variety of topics, such as types of stroke, positive things about life, and strategies for dealing with daily communication. Groups #3, #5, and #6 comprised three student clinicians and three people with aphasia, and Group #4 comprised three student clinicians and four people with aphasia. Groups #3 through #6 were conducted in a university clinic in the southern United States.

Topics of conversation included a member's trip to Africa and strategies for reading (Group #3), summer activities and pets (Group #4), favorite hobbies (Group #5), and a presidential election (Group #6). All groups shared the common goal of improving conversational skill and confidence.

## PROCEDURES

### Data collection

The group sessions that served as the data source were routine, ongoing therapy sessions. No alterations in participants, procedures, or activities were undertaken for the purposes of the study. No criteria for designation as a social communication group was specified a priori because it was the purpose of the study to discover patterns that define this type of group. Rather, highly experienced clinicians who adhere to a social or functional philosophy were asked to contribute samples of group therapy. Such sessions have been labeled "social group therapy," "social model therapy," "functional therapy," or "conversation therapy." In addition, examples of poorly managed social group therapy were solicited for contrastive analysis to ensure that the findings were not simply general group behaviors.

Two independent experienced SLPs judged the pool of videotapes to select well-managed and poorly managed conversation groups. These judges made global judgments of good versus poor groups based on their intuitions as therapists; they were not asked to determine the type of group or discourse strategies. Groups #1 through #4 were considered well-managed groups. Groups #5 and #6 were judged as poorly managed groups. Thus, data for a total of 6 sessions comprising over 5 hours and 52 minutes of therapy were collected, including the 4 well-managed sessions and 2 poorly managed sessions.

Length of sessions ranged from 30 minutes to 2 hours. All sessions were videotaped using a stationary camera that captured all participants. Video segments of interest were transcribed using transcription notations adapted from Sacks, Schegloff, and

Jefferson (1974) (see Appendix). In addition to videotapes of therapy sessions, feedback on sessions was elicited from selected clinicians. Thus, clinicians were able to provide their perspectives on aspects of group therapy or on specific segments of videotaped group interactions to add an additional layer of analysis.

### Data analysis

Qualitative analysis was used to (a) identify, categorize, and describe discourse sequences of these sessions; (b) determine how discourse was achieved within the groups; and (c) arrive at categories of discourse management behaviors typical of social group therapy for aphasia (Spradley, 1980). Discourse management was defined vaguely as any behavior that "stood out" as helping in some way to engage group members or otherwise contribute to conversation management. This open-ended approach to data analysis is consistent with qualitative research in which unusual and/or patterned events or behaviors provide a focal point for investigation (Agar, 1986). Specifically, the primary investigator cycled through video and associated transcripts in order to identify repeated and/or patterned events or behaviors to provide a focal point for investigation.

Microanalysis of discourse was completed to determine the function(s) and organization of the behavior across samples of group therapy, and categories of discourse behaviors were identified and defined. After a pool of behaviors was identified, the investigator recycled through the videotapes and transcripts to verify or refute that categories existed across contexts. Group participants did not participate in the identification of categories; however, interviews with clinicians helped determine that the identified categories and functions concurred with their authentic experience.

Finally, clinicians read the initial draft of the manuscript to verify or refute the descriptions and findings. Thus, a description of clinician discourse management behaviors (typical of videotapes representing social group therapy

for aphasia), functions of discourse behaviors, and their effects on group interaction were discovered.

## RESULTS

Although clinician style and personalities varied across sessions, analysis of the sessions suggested several features of discourse that were shared by the well-managed sessions. These categories of clinical discourse included establishing the “feel” of discourse equality, focusing on everyday communicative events, using multimodal communication, mediating group communication, calibrating the use of corrections, aiding turn allocation, and employing teachable moments.

### Establishing the feel of discourse “equality”

The well-managed social groups involved relatively symmetrical conversation among the participants, including both clinicians and members with aphasia. Symmetry refers to the right of group members to be valued and respected within interactions and to agree or disagree and participate as preferred; symmetry does not imply that each person had equal turn length or equal contributions. According to Goffman (1981) conversation accords “everyone the right to talk or listen without reference to a fixed schedule; everyone is accorded the status of someone whose overall evaluation of the subject matter at hand . . . is to be encouraged and treated with respect; and no final agreement or synthesis is demanded. . .” (p. 14).

The well-managed social aphasia groups were consistent with this definition. Explicit judgments of communication by therapists were rare (e.g., “good talking”). Frequent evaluation of group member utterances would set the clinician apart as the judge or “boss” of group interaction. Because clinicians did not enact the role of judge, clients were not forced into the role of “patients” or incompetent parties within the interaction. Rather, all parties had the opportunity to contribute, to agree, to disagree, or to evaluate. Exceptions occurred when clinicians identified useful communica-

tion strategies during group interactions (as in teachable moments described later) or when clinicians solicited evaluations from group members. When clients asked for help or asked questions, clinicians tended to open the discussion to the group and seek the opinions of others as well as provide information. Thus, clinicians avoided the appearance of being the only source of suggestions or the only one who might instruct.

In the following example from Group #4, the clinicians and clients carried on a conversation about different types of pets.

#### Example 1

1. Laura: You can uh uh uh find parrots do uh ((points to Clinician 1)) like uh uh you talking about.
2. Clinician 1: I think it must just depend on, you know
3. Clinician 2 [at least with a bird you can put a sheet over and =
4. Laura: =Yea you right!
5. Joe: He has a big uh uh cage? ((hands wide apart))
6. Clinician 1: He has a big cage outside, but when he comes in I put him in a little cage.
7. He likes that cage. . . it’s a big one. ((gestures hands wide apart))
8. Joe: It’s a big one, yeah yeah.
9. Clinician 1: You sold all different kinds of animals? ((looking at Joe))
10. Joe: I’ve got a cat and uh uh uh fishes at the moment but I mean uh. . .
11. Sandy: Where?
12. Joe: ((shrugs with hand out)) I usually usually find it on a doorstep.
13. Clinician 1: You find them?
14. Joe: Yes I take it in ((laughing)).
15. Clinician 3: ((laughing)) That’s how my mom got all those dogs.
16. Joe: ((laughing and nodding yes)) Yes, yes
17. Laura: What place she have that many dogs?

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Without the speaker labels, the clinicians and clients would probably be indistinguishable in this example. Symmetrical interaction is evident as both clients and clinicians took turns and contributed to the conversation when and if they had something to say without clinician evaluation or overt control.

### Focusing on everyday communicative events

An obvious but important element of these interactions was the focus on communication events and genres typical of peer interactions rather than discourse patterns associated with teaching or artificial tasks such as picture naming. Thus, a pervasive characteristic of clinician discourse within the sessions was the *avoidance of rigidly structured discourse*. The aphasia literature has described traditional aphasia therapy as rigidly controlled with clinicians enacting planned tasks, allocating turns, and eliciting responses (Horton, 2003; Simmons-Mackie et al., 1999). The sessions identified as well-managed social therapy did not conform to this description. There was a notable absence of "test questions" (questions to which the clinician already knows the answer); RRE sequences typical of teaching discourse; predetermined response sequences, such as preselected turns (e.g., turns shifting automatically around the table); or programmed response types (e.g., "is verbing" sentences).

The following example from Group #3 demonstrates characteristics of natural peer conversation. In this segment, Joe, a man with aphasia, was showing photos of his trip to Africa. The student clinicians' written goals included having the clients work on word finding in natural conversation by encouraging them to identify exotic animals in the pictures.

#### Example 2

1. Joe: ((looking at a snapshot)) Gori - gorilla
2. ((hands the picture to Patty))

3. Patty: [((laughs while looking at the picture))
4. Joe [((smiling and leaning forward to look at picture with Patty))
5. Clinician 3 [Sandy, would you like to have a pet gorilla?
6. Sandy: NO! ((shaking her head))
7. Clinician 3 ((laughing))
8. Sandy: [No::: ((looking at Clinician 3))
9. Clinician 2 You don't need anything else to take care of, huh?
10. [((group members laughing))
11. Sandy: [No ((looking at clinician 2)) - horses
12. Patty: [((looking at Joe)) Oh, I used to have a
13. eh eh, (xxx) monkey
14. [and they could be trained.
15. Clinician 3: You have horses? ((to Sandy))
16. Sandy: [((nodding yes)) yea, horses - cows - dogs
17. Patty: [Up to sevens, like a a seven year old ((looking at Joe)).
18. Joe: Yeah ((looking at Patty))
19. Clinician 1: Which ones? ((looking at Patty))
20. Joe: [The, the gorilla.
21. Patty: [When I had a pet shop people were buying 'em and, honey, they kept 'em, uh uh
22. [dressed and - uh
23. [dressed and - uh
24. Clinician 1: [You had a pet shop, too?

This segment was fast paced and involved two overlapping conversations during which clients offered new information about their lives. The clinicians oriented to the information with interest even though the talk digressed from African animals. The discourse structure was typical of peer conversation in which participants overlap, break into subgroups, and follow various topic lines. Interestingly, in spite of the loose structure the clinicians provided a context in which clients

produced a variety of animal names. This contrasts markedly with an impairment-oriented group described by Kovarsky and colleagues (1999) in which each member took a turn naming an object to take to the moon. In the “going to the moon” game, sequential naming performances were followed by clinician evaluations. Deviation from the prescribed response types resulted in corrections or cues. By contrast, word finding was embedded within natural conversation in Example 2. The student clinicians created a natural structure and oriented to client offerings as interesting, rather than as “performances to be evaluated.” Rather than using test questions, clinicians used comments (line 9: “You don’t need anything else to take care of, huh?”) and questions regarding new information (line 15 “You have horses?”) to further the talk.

In keeping with the emphasis on natural communicative activities and the avoidance of overt discourse control, clinicians often followed up on client discourse offerings. For example, in line 24 the clinician followed-up on Patty’s statement that she owned a pet shop even though this deviated from the planned African animal discussion. Thus, clients were allowed to make creative discourse choices, negotiate meanings, and share control of topics. Clinicians did not adhere to preplanned agendas or expectations. The reinforcement of client initiations helped to create a context in which group members shared responsibility for initiating and advancing topics. The result was a wide variety of speech acts and discourse sequences.

### Using multimodal communication

In the well-managed social groups, clinicians tended to use a variety of communicative modes such as speaking, gesturing, pointing to objects or pictures, writing key words, and drawing. Although multimodal communication is characteristic of standard conversation, the use of various modalities within the groups was expanded to support conversation. These layers of communication were

employed seamlessly by clinicians within the conversational interactions and provided a model for group members. When members encountered trouble communicating, clinicians tended to model alternative modes and strategies or directly suggest particular strategies (“Is it something you can draw?”). Thus, multimodal communication was an integral part of conversations and activities, and was employed by clinicians as well as group members.

Example 3: Group #1 was discussing restaurants to fulfill the group goal of improving conversational skill and confidence. Paul had been trying to communicate something related to restaurants, cooking, and his stroke.

1. Clinician So does it make it hard to cook? ((gestures stirring with right arm))
2. Paul Oh yea ((gestures cooking with left arm))
3. Clinician Is that why you go to restaurants?
4. Paul Yea yea ((vigorously gestures cooking with left arm)) because
5. ((points to paralyzed right arm))
15. Clinician .....  
[ ((looks at Paul)) Are you worried about burning yourself?
16. Jeff [ ((pointing to Paul)) yea yea
17. Paul No no no no ((hand to chin))
18. It’s uh - don’t know how to say it.
19. Clinician Draw something else that will help us,  
20. or write a word.
21. Dan. . . . [ ((reaches across for the pad in front of Paul))
22. Paul. . . . [ PIZZA uh uh
23. Dan. . . . CHEESEBURGER ((draws on pad))
24. Paul. . . . Cheeseburger ((nodding and pointing toward Dan)).

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25. It's everything. ((sweeping gesture))  
 26. Clinician Fast food?  
 27. Paul.... Yes ((points around the table))  
 28. Clinician You eat a lot of that.  
 29. Paul.... Right! Right!

The use of gesture, drawing, and pointing in this repair sequence helped to ultimately clarify Paul's intent—that he eats at fast food restaurants because of difficulty cooking. The clinician modeled augmentative modes and group members employed various modes. For example, the clinician's clarification question in line 1 was accompanied by a right-handed gesture for cooking. Paul followed with confirmation and an elaboration by gesturing cooking with his left hand. Thus, he built upon the clinician's gesture to further focus his line of talk on the issue of right versus left hands. In lines 4 and 5, Paul elaborated on why he used his left hand to cook by pointing to his paralyzed right arm. When Paul expressed difficulty on attempting to elaborate ("don't know how to say it"), the clinician offered a suggestion ("Draw something else that will help us, or write a word"). It is interesting that another group member, Dan, responded to the clinician's suggestion and began to draw in order to assist Paul in the repair. This suggests that this group accepted the use of multimodal communication and shared responsibility for resolving communicative breakdowns of members.

The use of multimodal communication was more prevalent in groups involving members with more severe aphasia. However, even among less involved group members, additional modalities were employed. For example, during a discussion about medications for people who have suffered stroke, one client in Group #2 (Allen) began an explanation of the derivation of heparin from a chemical used to kill rats. The experienced clinician used backchannels (head nods, "yes") that encouraged the group member to continue, but also wrote out RAT POISON. The written referent was introduced discretely and did not divert

attention from Allen's description. However, it helped clarify the key point for the other group member and provided a written referent as a starting point for further discussion.

### Mediating group communication

Another characteristic of clinician discourse was the mediation of interpersonal communication. Since group members sometimes struggled to understand each other's intents, clinicians served as unobtrusive "translators" who repeated or expanded messages clearly to the group and/or supplemented messages with information in additional modes (e.g., written key words). The written "rat poison" example above serves as a written mediation of meaning between the speaker (Allen) and his aphasic listener. Therapists typically presented messages in a matter-of-fact manner without drawing attention away from the primary speaker. The manner of production and use of gaze and body language made it clear that the primary author of the message was the speaker with aphasia. Thus, mediation was achieved without raising the disability of aphasia to the surface of communication, without exerting authority as the expert, and without taking credit for the message. The following example demonstrates multimodal mediation of a client description.

Example 4: Group #1 has been discussing restaurants. Jeff, who has moderate to severe aphasia, has been describing a favorite restaurant. This segment followed Jeff's production of a broad, sweeping gesture with his hand.

1. Clinician ((Writing COUNTER))
2. ((Holds up pad)) Is it a counter?  
 [((showing pad around table))
3. Jeff ]yep yep
4. Clinician So the one Jeff's talking about in Alameda has a counter!
5. Jeff Yep yep
6. Clinician So you can sit and have breakfast.



7. and its CHEAP!  
 8. Jeff yea ((takes pad))  
 9. ((gestures to pad)) hey hey  
 people ((drags finger down  
 page))  
 10. Clinician People line up waiting to  
 go to this place ((writes and  
 holds up))  
 11. Jeff Yea yea  
 12. Clinician Awright, well, you need to  
 go there and bring us back a  
 card.  
 13. Dan Where's this? where's this?  
 14. Jeff Olie Olie::: ((points to name  
 on pad))  
 15. Dan I seen that but where abouts  
 is it?  
 16. Jeff Park ((pen to paper))  
 17. Clinician Park Boulevard - in what city?  
 18. Jeff A:::lo:::me:::da:::  
 19. Clinician In Alameda ((writes name))

In line 2, the clinician asked a clarification question ("Is it a counter") following upon Jeff's gesture. This question ensured that the "counter" interpretation was consistent with Jeff's intended message and ratified his control as the message author. The clinician then repeated the "counter" description within a summary statement ("So the one Jeff's talking about in Alameda has a counter") with her gaze directed toward the group members in a manner similar to a translator. Similarly, in line 10, the clinician translated Jeff's gesture into a spoken description ("People line up waiting to go to this place"). In line 17, the clinician expanded Jeff's one word into a complete street name ("Park Boulevard"). These repeats and elaborations served to mediate the talk between the speaker (Jeff) and the listeners, as well as to model more complete utterances and multimodal presentation.

Echoing group member contributions and elaborating on offerings could be annoying or give the impression that the clinician is correcting the group member's production. By doing so the group interaction could shift toward a teaching style and promote an impression that accurate form or content is the primary goal. In the above example, the clinician

used several interesting devices that helped her avoid sounding like she was "fixing" Jeff's utterances or engaging in overt repair.

First, her utterances appeared to serve two purposes—as a translation or expansion of a prior offering(s) and also as a marker of interest and attention. For example, in line 4, the intonation imparted a "wow" factor—a level of surprise and pleasure that the restaurant had a special feature, a counter. In line 17, the clinician's expansion of "Park" into "Park Boulevard" could have sounded like a correction (which technically it is), but the intonation made it sound like "interest" rather than correcting. Also, the clinician's question ("in what city") built a discourse bridge back to Dan's question in Line 15 ("where abouts is it?"). This carried the conversation forward and deflected emphasis from the translation of "Park" into "Park Boulevard." In line 19, the clinician repeated "Alameda" while writing out the word, creating an impression similar to a secretary taking notes on an important point. In fact, the clinician's mediation of Jeff's utterances served to ratify his discourse contributions in a manner similar to that described by Tannen (1989), who noted that certain conversational repetitions can link speaker to speaker and ratify the first speaker's offering. By recasting mediations into markers of interest and conversational facilitators, the clinician helped move the conversation forward with the understanding and interest of the entire group.

### **Calibrating the use of corrections**

Clinicians in group therapy for aphasia are frequently faced with vague utterances, breakdowns, or errors produced by members with aphasia. When communicative breakdowns or errors occur in conversation, the person who made the error runs the risk of "losing face" or of appearing less competent, particularly if the error is "exposed" to others. Management of errors in traditional aphasia therapy is accomplished by exposing the errors and working on corrections. In the well-managed social group sessions studied, clinicians used few explicit corrections.

Rather, strategies such as mediated talk or implicit corrections (e.g., repeating with corrected utterance) were combined with shows of interest to deflect attention from errors. When the meaning was unclear, natural clarification sequences resulted (e.g., Example 4, line 2, "Is it a counter?"). When clients sought help or openly acknowledged errors, therapists sometimes introduced a side sequence discussion of repair strategies, enlisting the group to help solve shared problems. However, when the conversation was moving forward successfully and the error did not derail the interaction, therapists tended to allow the talk to advance. Thus, therapists focused on the goal of successful social interaction and opted for face saving, rather than managing an error within the group. That is, management of errors was calibrated to the context of the moment. This seems consistent with the goal of building confidence and self-image along with communicative skill—important goals within social approaches.

### **Aiding turn allocation**

Clinicians employed various strategies to promote participation and ensure involvement of all group members. One method of promoting participation involved discrete aids to turn taking. Allocation of turns by the therapist is a delicate operation. Overt control of turn allocation places the clinician in a position of authority. In so doing, group members tend to look to the leader to initiate and manage the discourse, and the session shifts to an asymmetrical leader-centered interaction with communicatively dependent members. Several discourse strategies aided in the allocation of turns while maintaining the egalitarian feel of peer interaction. These included solicitation questions and requests, gaze and silence, and minimal turn lengths.

*Solicitation questions or requests* shifted turn responsibility to particular group members. Solicitation questions and requests are typical of both socially oriented therapy and impairment-focused therapy. Turns during traditional therapist-centered therapy are often

elicited within predictable, planned discourse structures such as requests or test questions. For example, in a description of impairment-focused group therapy, Kovarsky and colleagues (in press, p. 17) provided a brief example of an RRE exchange from a game requiring group members to name something they would take on a hypothetical trip to the moon:

#### **Example 5**

1. SLP: What did I say I was taking?
2. Mr. H: You was taking an apple.
3. SLP: Good.

The test question in line 1 was designed to allocate a turn to Mr. H. for the purpose of practicing remembering names. The therapist was in charge of who spoke next, and she allocated turns to complete the therapy task and focus on the goal of remembering a list of items.

Solicitation questions typical of the social groups were qualitatively different from test questions and controlled sequences (e.g., RRE). That is, solicitation questions or requests were "slipped" into the ongoing talk and did not give an overt appearance of controlling the interaction. In such circumstances, clinicians did not require specific or expected responses or known information. For example, one clinician asked the group "Who else do we need to hear from?" This form of solicitation allowed group members to either self-select or share responsibility for turn allocation to other members. In Example 2, clinician 3 (in line 5) drew a group member into the discussion with a humorous question: "Sandy, would you like to have a pet Gorilla?" This question was a request for new information that effectively opened a new topic line (pets). Since Sandy had not been participating in the discussion of African animals, the introduction of "pets" helped her to enter the conversation.

Solicitation questions or requests were used to draw reticent members into ongoing activities or create "turn slots" during a fast-paced interaction to help a member join the talk. For example, during a relatively fast-paced discussion of driving in Group #4, a

clinician noted that a member was having difficulty entering the talk; the clinician interjected a solicitation question for new information to create an entry opening for the client (e.g., "Laura, do you have a car?"). Solicitation was also used when an ongoing topic of conversation stalled or paused. When conditions indicated that a topic had been exhausted, clinicians often introduced open-ended solicitation questions (e.g., "So what else is new?"). In fact, these strategies are familiar methods of furthering peer conversation in general. Contrast these questions with "performance"-oriented solicitation questions or requests typical of therapist-focused interactions (e.g., "Tell me the name of this"; "Jim, describe your picture"; "Lil, you go next").

*Silence and gaze solicitation* were also used to offer turns. For example, gaze was sometimes directed at a particular member to shift the turn to him/her, or the therapist moved her gaze around the group to signal a "next turn" opening. Silent pauses combined with gaze solicitation provided slots for group members to enter the talk. To encourage continuation of a turn by a member, clinicians used gaze and at times backchannels (nodding, *mbm*) to indicate continued interest in longer turns. The following example demonstrates the use of silence and gaze to shift a speaking turn in Group #2.

Example 6: The group was discussing workout routines as part of the group goal to improve communication and problem solve "living successfully" with aphasia. Betty had not been participating in this segment of the discussion.

1. Allen: Yea, yea, treadmill and then I - after - that he - I do uh
2. Oh uh - the wader or something like that.
3. But every every time I come - I do treadmill
4. or or bicycle. ((Pause))
5. Clinician: ((Looks at Betty)) ((pause continues))
6. Betty: ((leans forward)) I don't do one thing!

7. Clinician: ((laughing)) Nobody else is going to say that, Betty.

8. Betty: ((laughing)) I know it.

When Allen finished his workout description, he paused to signal his turn ending. Rather than picking up the turn, the experienced clinician looked at Betty. This solicitation gaze succeeded in shifting the turn to Betty and a humorous exchange ensued.

Clinicians also contributed *minimal turn lengths* in the well-managed sessions. Although the clinicians talked often, their turns were usually relatively short and focused on moving the talk forward. This might be described as "other-focused" leadership in which the thoughts and expertise of the aphasic participants were the priority, rather than having the leader show off his or her own expertise and opinions. For example, notice in Example 4 that the clinician repeated and briefly expanded on the group member's restaurant description, but she did not launch into additional discourse, offer her opinions, or otherwise shift the talk to her own propositional offerings. Clinicians contributed to a discourse structure in which group members with aphasia practiced and experienced successful communication. In the following example, one of the poorly managed sessions serves as a contrast to the use of minimal turns.

Example 7: Group #6 was discussing the 2000 Presidential election with the goal of improving conversational participation of participants.

Clinician: It was exactly like (name) was talking about with the uh electoral votes not officially passed until November eighteenth, but - presumption that each state, depending on who won that state by popular vote, that person gets the electoral votes for that state and the representative for the electoral college for that uh state will pass the votes in that way. But they could actually go in and vote the other way--(continues talking on the subject for a total of 8 minutes))

The clinician talked rapidly about a very complex and confusing topic—the process for electing the US President. She did not allocate turns to others, nor did she ensure comprehension of aphasic members or use multimodal resources (e.g., written words, pictures). Two of the group members with aphasia were excluded from participation by virtue of rate of presentation, linguistic complexity, and possibly interest in the topic. Both were noticeably disengaged (e.g., yawning, looking away). The clinician set herself apart from the group as an expert through her lecturing style and her use of facts (e.g., “not officially passed until November eighteenth”) and jargon (e.g., “electoral college”). In short, the clinician failed to engage members or provide experience in successful conversation. This is a good example of conversation that is not therapy. Although this example suggests that extended turns often exclude participants, at times more lengthy turns are appropriate to ensure that clinicians are “part” of the group and willing to share. However, such expanded turns must be crafted to promote further participation by group members with aphasia.

In summary, behaviors that aided turn allocation during social group sessions included solicitation questions and requests, gaze and silence, and minimal turns. During the social group sessions it appeared that clinicians adjusted these turn allocation behaviors based on a variety of factors present in the ongoing context. For example, clinicians tended to adhere to conversational norms for politeness. Thus, they avoided potentially embarrassing situations such as requesting performance likely to elicit significant errors or openly correcting client offerings. Clinicians varied turn requirements based on the skill and confidence of the targeted participant. For example, significantly impaired clients were sometimes offered simple response choices (e.g., yes/no; pointing) and communicative supports (e.g., physical referents, written prompts). When therapists judged that a member could offer a more sub-

stantial contribution and was not contributing to the group, then turn shifting strategies tended to be more direct. In the following example from Group #1, the clinician is forceful in allocating conversational responsibility to a group member with mild aphasia who has consistently contributed little to the discussion.

#### Example 8

1. Clinician: Alright, well, what else is new and exciting?
2. ((looks around group then at Mel))
3. Mel: Here ((pushes a collection of menus along the table to clinician))
4. Clinician: Well, don't just throw them at me ((pushes menus back toward Mel))
5. You talk about this - with the group.
6. ((sits back in her chair and puts pen down))
7. Tell the group about it, Mel.
8. Mel: Uh I always, you know, (name) and I go to Annie's Café or Hidden city,
9. And uh we always have breakfast.

In this example, the client, Mel, attempted to turn responsibility for describing his favorite restaurants over to the therapist (line 3). The clinician boldly deflected the turn back to Mel to reinforce the implicit rule that all members contribute to the conversation. Interestingly, the therapist's admonishment of Mel suggested that communicative support did not extend to being so helpful as to allow participants to avoid taking communicative risks and joining the talk. When leaders are too helpful, it is likely that members will depend on the leader to take responsibility for the talk and move the talk forward. Such dependency does not build ability or confidence to enter conversations outside of the clinic situation. Thus, turn responsibility was varied to suit the context and the skill and confidence of group members.

### Employing teachable moments

In the well-managed social group sessions there were exceptions to the minimal turn strategy. Although the overall interactive style was relatively egalitarian conversation, clinicians employed "teachable moments" to discuss particular strategies, engage in problem solving, or educate group members regarding stroke, aphasia, or related issues. Clinicians have useful information and significant expertise that could aid group members. However, providing information or assuming a teacher role has the potential to change the dynamics of the session and disempower clients. Clinicians used a variety of strategies that helped to avoid altering the interpersonal pattern of sessions. For example, during a discussion of types of stroke, the therapist in Group #2 overtly acknowledged her own expertise regarding medical aspects of stroke, but equalized the status of group members by acknowledging their expertise regarding aphasia and life after stroke. Her questions about their experiences conveyed a sense that all members of the group were valued partners in solving problems and improving communication.

In the next example, a teachable moment occurred when an aphasic group member introduced the topic of her difficulty reading. Members of Group #3 had been discussing a trip to Africa. One of the clinicians produced several books about Africa to support the conversation. As they looked at the books, Patty remarked that she had trouble with reading. One of the student clinicians remarked that she found larger print size to be helpful and the discussion diverged to strategies for reading.

#### Example 9:

1. Clinician 1: They - that's a little bit big print. ((pointing to Joe's book))
2. Patty, the print you have is smaller.
3. ((points to the book Patty is holding))

4. Patty: Yeah, yeah ((leans forward to compare books))
5. Joe: ((points to another book))  
Oh, this one =
6. Clinician 1: [yeah!
7. Joe: [=is as well. That's that's about right for me.
8. Clinician 1: This one looks a little bigger ((pointing to a large print book)).
9. Clinician 2: I've found that hard-back books are easier.
10. The print is usually a little bigger =
11. Patty: [ I can see this alright]
12. Clinician 2: =in the hardbound books rather than the paperbacks.
13. Joe: Yes.
14. Patty: [But if the, if the sentences gets too long =
15. Joe: ]yes
16. Patty: =I forget what the first part was.
17. Clinician 3: [ I do that too.
18. Clinician 1 ((nodding agreement))
19. Sandy: ((nodding agreement))
20. Joe: Yes
21. Clinician 1: That's when I need one of those little pads. ((gestures writing a note))
22. Clinician 3: I was reading a book last night and I had to read it THREE TIMES.

In this example, the group was evaluating the print size of books to determine which were easier to read. Thus, the group members were enlisted to solve a problem, rather than having the clinician dictate the preferred solution to group members. Also, clinicians shared strategies in a way that suggested they encountered difficulty reading some material themselves. For example, after Patty and Joe expressed difficulty with long sentences, Clinician 1 introduced note taking as her own strategy (line 21). According to the clinician, this was a sincere statement referring to reading graduate school texts. By engaging

in joint problem solving and assuming a “we’ve all got problems” stance, the teachable moments became less threatening to group symmetry.

Humor was also used to equalize status within the groups. In the following example, the clinician uses self-deprecating humor; this counteracts her image as an expert.

Example 10: A member of Group #1 has raised an issue about hemiplegia.

1. Clinician Okay. So some of you have trouble with one arm.
2. ((points to her own left arm then right arm with arm hanging))
3. Paul Right
4. Clinician Okay. Alright. So I might draw a picture ((drawing))
5. °Well - ((looking up)) don’t laugh at my picture.°
6. Group [(laughing)]
7. Dan [Watch out for her. ((laughing))]

The clinician started to explain that hemiplegia is a potential consequence of stroke as part of the group goal of enhancing knowledge about stroke and aphasia. By so doing, she risked setting herself apart from the group as the expert. While she is, in fact, an expert, foregrounding the expert role within the group could shift the interactive dynamics into an asymmetric expert-patient relationship. Therefore, she jokingly reduces her status by implicating her “poor drawing ability” (i.e., I have problems too). The self-deprecating humor brings her status more in line with other group members and deflects a potential shift in group dynamics.

## CONCLUSIONS AND DISCUSSION

Within the well-managed social group therapy sessions studied, a variety of discourse management features were identified, including establishing the feel of discourse equality, focusing on everyday communicative events and genres, employing multiple communi-

cation modes, mediating communication, calibrating corrections, aiding turn allocation, and judiciously employing teachable moments. The results confirm that group members participated in interactions that appeared similar to everyday peer communicative events even though therapists were subtly managing the discourse structure. The management of discourse was a dynamic, evolving process that worked toward the dual goals of improving communicative skills and enhancing communicative confidence. Although this study was not designed to address issues of therapy effectiveness, it was apparent from the analysis that clients gained experience in implementing a range of communicative strategies, dealing with natural contingencies during conversation, and practicing online communicative problem solving. In addition, group members had opportunities to feel valued and respected—feelings important for building the confidence to participate in communicative interactions.

Interactional symmetry was identified as a category of discourse structure in the well-managed group therapy sessions. Interestingly, the concept of creating interactional equality within a therapy session seems paradoxical. Therapists are trained and employed to “treat” people with communication disabilities. By definition this means that the therapist must create a situation that is “therapeutic.” Thus, a level of therapist control and leadership is required to ensure that participants obtain benefit from sessions. The key to social group therapy seems to be skill in “walking the discourse line” between a totally spontaneous and unrestrained social interaction and a rigidly structured, authoritarian interaction. In other words, therapeutic goals and objectives were nested inside of the relatively symmetrical group interactions. Perhaps this skillful and discrete management of therapeutic goals below the surface of relatively natural social interaction is what separates conversation therapy from conversation. Therapists employed a range of strategies to promote

the feel of discourse equality and spontaneity, while ensuring that the interaction was therapeutic. Tactics such as modeling multimodal communication, mediating utterances, aiding turn allocation, and employing teachable moments were managed with sensitivity to rules of politeness and the human drive for autonomy and positive image. For example, therapists did not create a double standard by having group members with aphasia employ drawing, writing, and other modes without therapists doing this themselves. Other techniques such as following the discourse lead of group members or using ordinary forms in conversation ("so what else is new") helped interactions approximate peer social interaction. Questions and comments used to initiate topics sounded sincere and genuine.

In fact, an overriding feature that the therapists in the well-managed groups shared was a respectful orientation to group members. This was projected through body language, attention, and interest as well as various management strategies. In addition, these therapists appeared to trust that group members could and would participate given an opportunity. By contrast, clinicians in the poorly managed groups created an impression of authority or superiority (as in Example 7), were overly helpful or patronizing, or appeared unaware of how to support and facilitate conversational interaction.

The identified discourse structures and therapist strategies within the well-managed social groups contrast with the literature describing traditional didactic therapy sessions and provide data-based evidence of differences between traditional, therapist-centered and social, client-centered therapy for aphasia. Some of the explicit communicative characteristics of traditional therapy were made *implicit* within the social sessions. For example, turn allocation in traditional didactic therapy is typically explicit and rigid. In contrast, turn allocation in the social therapy sessions was dictated by the members or, when therapist intervention occurred, turn shifting assists were subtle and appeared to be spontaneous conversational moves. As Jefferson

(1987) noted, actions and goals during communication "can be done explicitly or can be accomplished without emerging to the conversational surface" (p. 86). During the social group sessions, clinicians accomplished much of the "control" below the surface without appearing to be in control.

Furthermore, the results confirm that the social group sessions and traditional didactic therapy have different therapy targets. Traditional impairment-focused therapy is designed to focus on particular cognitive/linguistic processes or linguistic forms resulting in a specific and concentrated agenda. Intervention within social group sessions focused on communicative interaction as a whole with the goal of building communicative generativity, creativity, and confidence through guided experience. The social group approach attempted to address and prepare clients directly for the consequences encountered in everyday communicative life.

This approach is based in part on research that suggests that behaviors acquired in structured therapy might not generalize outside of the clinic context. For example, Ferguson (1994) suggested that self-repair and self-correction (a typical element of traditional aphasia therapy) might disrupt the natural flow of conversation and further "disable" the person with aphasia within everyday interactions. Similarly, the requirement to produce accurate grammatical forms might get in the way of the rapid give and take of natural conversation, which is often replete with sentence fragments, ellipsis, and inaccurate forms. By engaging in communication events that map more closely onto everyday communicative life, clients are more likely to generalize skills and confidence outside of the therapy situation.

The contrast between client-centered, social group therapy and therapist-centered impairment therapy is based on sessions clearly representative of these orientations (in this study and in the literature). For example, our well-managed group therapy sessions were selected to be representative of social group therapy. However, it is likely that a range

of group interaction styles exist, forming a continuum from rigid, didactic, therapist-centered groups to egalitarian, client-centered social groups. The groups studied in this project represent the "social" end of the continuum. Further research might be directed at studying a range of group interaction styles including "hybrid" groups that combine elements of different approaches (Kovarsky & Duchan, 1997). Also, although this research has focused on the behaviors and strategies of therapists, we recognize that communicative interaction evolves out of collaboration among group participants. Future research might focus more broadly on the co-construction of therapy discourse by clients and therapists. Contextual factors related to aphasia severity, culture, gender, shared information, group size, experience, or other characteristics of sessions might affect the enactment of therapy. Therefore, future research to replicate and expand this study is needed.

Finally, we offer a caveat regarding generalizing the specific results of this study. As other researchers have cautioned, all communication is locally situated and dynamic; it evolves within the context and the participants of the moment (Sacks et al., 1974). Although this

study provides general themes that help alert clinicians to important therapy issues, the enactment of therapy is a highly complex phenomenon. The strategies described are not to be considered a checklist of "necessary" therapist behaviors. Rather, the therapist behaviors represent examples of optional strategies for enacting social group therapy.

Therapist behaviors are the instantiation of a set of values and beliefs that drive management choices. It is likely that the identified therapist management strategies within this study evolved out of values consistent with social or functional philosophies of aphasia intervention.

Perhaps the most effective method of teaching therapy skills to students or others is to instill an understanding of natural discourse, introduce a range of optional clinical discourse behaviors (such as those identified herein), and teach the underlying values and principles that help clinicians make online choices during the enactment of therapy. Because studies of clinical discourse provide an understanding of optional clinical discourse behaviors, research that helps us articulate clinical know-how and match this knowledge to clinical values is essential for ensuring effective therapy for people with aphasia.

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## Appendix

### Transcription Notations

- [ Overlapping utterances or turns
- = Contiguous utterances with no interval between utterances
- A short untimed pause within the flow of talk
- : A prolongation or stretching out of a sound as in “bo::y”
- . Falling or stopping inflection
- , Continuing inflection
- ? Rising inflection (not necessarily a question)
- ! Animated tone
- CAPS Capital letters indicate that an utterance is much louder than surrounding talk.
- oo An utterance enclosed in degree signs is quieter than surrounding talk.
- (( )) Double parentheses enclose a description of the setting or some phenomenon