LSHSS

Clinical Forum

Therapy Talk: Analyzing Therapeutic Discourse

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1. *P* ok. now what's been happening
2. *C* nothing much really
3. *P* nothing much? not busy at school?
4. *C* yeah. I hate school
5. *P* mmm you got lots to do?
6. *C* yeah lots to do

The familiar discourse in this casual exchange looks ordinary, and although brief, it reveals a lot more information than one might think at first glance. The exchange is part of the opening sequence of a fluency therapy session between a 13-year-old girl who stutters (client, *C*) and a speech-language pathologist (SLP, designated as *P*). The discourse structure is similar to the kinds of conversations that typically take place between an adult and a child, where the adult (e.g., a teacher or SLP) takes the leading role in engaging the child by asking a question, the child responds, and the adult in turn follows up with a comment (or evaluation) and a further question. Along with being the person asking questions, *P* has indicated her authority role in the discourse with "ok" and "now," markers that are typically used by the speaker directing the interaction (Kovarsky, 1990; Panagos & Bliss, 1990; Simmons-Mackie & Damico, 1999). At this stage, *C* is not particularly forthcoming, perhaps indicating a slight reluctance to be engaged, and responds (2) by providing limited information. *P* repeats the limited information with rising intonation, as if to question it, which indeed she does with the following question (3). *C*'s response is a little more forthcoming, with a personal comment, "I hate school" (4), that *P* acknowledges with the back channeling "mmm" in typical authoritative fashion (Fisher, 1984). *P* then poses a further question, interpreting the comment about school, and *C* agrees. The asymmetry in this brief extract of discourse serves to establish the relationship between *P* and *C,* with the authoritative role of *P* contrasting with the more subordinate, responsive role of *C*.

ABSTRACT: Therapeutic discourse is the talk-in-interaction that represents the social practice between clinician and client. This article invites speech-language pathologists to apply their knowledge of language to analyzing therapy talk and to learn how talking practices shape clinical roles and identities. A range of qualitative research approaches, including ethnography of communication, conversation analysis, and frame theory, provides a background for the case presentation of a 13-year-old girl who stutters. Asymmetry is a feature of the therapeutic discourse presented, with evidence of recognition of the client's communicative competence emerging. Applications of analyzing therapy talk are discussed, illustrating the relevance of this approach for clinicians.

KEY WORDS: therapeutic discourse analysis, qualitative methodology, child stuttering therapy

The exchanges between *P* and *C* are further described in the analysis of therapeutic discourse that is presented in the case study that follows, focusing on important elements, providing evidence of changes that occur, and discussing these in light of research findings in the literature. First, however, a brief introduction to discourse, and to discourse analysis in communication disorders, is presented, followed by the rationale for analyzing therapeutic discourse in particular.

DISCOURSE ANALYSIS IN COMMUNICATION DISORDERS

Discourse is defined in terms of language use relative to social, political, and cultural formations (Jaworski &

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Coupland, 1999). Use of language reflects and shapes social order and the individual's interaction in society. The term *discourse analysis* covers a wide range of meanings and activities, with common threads related to describing layers of meaning in interaction but differing methodologies within social sciences, drawing from a wide range of disciplines. In any conversation, discourse is constructed between the participants, with each taking a turn and responding to what the other has said. This is done naturally, without preplanning precisely what will or will not be said. If some planning has occurred, participants still will not be able to anticipate precisely what they will say, or how exactly events will unfold. Speakers also have to deal with the unpredictability influenced by contextual events: the participants' attentiveness and motivation, what has been said, and how that has been heard and interpreted. During the interaction, participants are aware of what is going on, and they use a variety of resources from the cultural and linguistic practices of the community to decide how to participate: when to speak; when not; and what to talk about with whom, when, where, and in what manner (Hymes, 1972).

The focus on discourse and discourse analysis in the field of speech and language pathology derives from a number of different sources: attention given to language use or pragmatics in therapy for communication problems (e.g., Prutting & Kirchner, 1987), the development of interest in ethnography in the clinic (e.g., Kovarsky & Maxwell, 1992), and collaborative work between clinicians and linguistics (e.g., Hamilton, 1993; Lesser & Milroy, 1993). Clinical application of discourse analysis has been developing in recent years, with conversation analysis (CA) exploited as a means of understanding and analyzing conversational competence (e.g., in aphasia, Lesser & Milroy, 1993; in Alzheimer's disease, Hamilton, 1994; and in chronic schizophrenia, Walsh, 2002).

Therapeutic discourse has been a focus of attention in a wide range of clinical settings, including psychotherapy (e.g., Labov & Fanchel, 1977) and medicine (e.g., Byrne & Long, 1976; Morris & Chenail, 1995). Some of the earliest studies of therapeutic discourse in the speech-language pathology setting are those instigated by the late Carol Prutting and her colleagues in the context of child language therapy (Prutting, Bagshaw, Goldstein, Justowitz, & Umen, 1978). Kovarsky, Duchan, and Maxwell's (1999) text, *Constructing (In)Competence,* is a major contribution to the analysis of meaning in therapeutic discourse and in other contexts. For present purposes, therapeutic discourse analysis refers to the analysis of talk-in-interaction as a social practice in the speech clinic.

WHY ANALYZE THERAPEUTIC DISCOURSE?

The SLP's professional expertise includes knowledge and skills about language, linguistic analysis, and pragmatics or language use. In many instances, such knowledge is largely restricted in the clinical setting to applying analytical skills to consider clients' language structure and content, with a view to influencing appropriate changes in client performance. The invitation presented here is for SLPs to step outside the role of focusing on client performance and to use their knowledge of language to look at the conversational interaction in the familiar setting of the clinic. The discourse between client and clinician is arguably the strongest element of the working relationship through which the therapeutic healing or restorative process occurs. Analyzing therapeutic discourse provides the opportunity to learn how ordinary clinical encounters are constructed, to develop awareness of one's personal discourse style, and to consider how talking practices shape and influence clinical roles and identities in the interaction. In the first instance, role establishment is demonstrated in the opening extract, indicating an asymmetrical relationship, the SLP's authority role contrasting with the client's subordinate role. Asymmetry is natural where levels of expertise differ, and where one is being consulted with regard to expertise. However, it is reasonable to question whether an asymmetrical relationship is the most conducive means of facilitating change, especially when, ultimately, communication competence is the goal of the interaction. Second, knowing more about how discourse strategies influence participation has implications for decision-making in therapy; for example, when the client provides an opportunity to talk about a personal matter that may be a source of concern (as in *C*'s *I hate school* comment above), the clinician has a clear opportunity to show understanding and willingness to talk about this, perhaps in preference to getting on with therapy tasks such as technique development. Clients report that success in therapy is dependent on an understanding and supportive relationship (Corcoran & Stewart, 1998), and that the extent to which they value the feeling and attitudes of their clinician is a significant factor in facilitating change (Cooper, 1997). Turning attention away from a therapy task and giving attention to the client's concerns can be a more important element in therapy than achieving a task-related goal. The analysis of therapeutic discourse also allows the clinician to observe the ease with which clients who stutter can engage in conversations and how the client's expertise in adapting to conversational changes reflects competence. This is essentially an opportunity to move away from the analyst's traditional preoccupation with evaluating and monitoring the client's problems with communication (e.g., Simmons-Mackie & Damico, 1999) and to value the expertise of the client—something that can often be overshadowed in the clinic in favor of other therapy options, such as developing techniques. By developing awareness of different discourse strategies and styles, the clinician can learn how to provide opportunities for improving therapy interaction, thereby enhancing treatment.

Analysis of Therapeutic Discourse in the SLP Context

A client attends therapy because of a perceived deficit in communicative competence, and the SLP's expertise is to provide the appropriate diagnosis and treatment. Simmons-Mackie and Damico (1999, p. 313) referred to the "inherent

paradox" in speech and language therapy, as both clinician and client assume their roles with a presupposition of the client's deficit as the focus of attention. The orderliness of therapeutic discourse is achieved through high levels of the participants' adherence to these roles, which can be illustrated with the use of a dominant exchange structure as already outlined above: The SLP initiates the conversation, the client responds accordingly, and the response is followed up with a comment by the SLP, often evaluating the client's response. This three-part sequence of events, request-response-evaluation (RRE), is familiar to clinicians, and it occurs in many other types of adult–child conversation, notably, for example, in teacher–pupil interaction (Sinclair & Coulthard, 1975, 1992).

In the clinical context, participants' use of particular types of discourse structures and their awareness of the asymmetrical roles are established early in the interaction, as demonstrated previously. The stability of the respective roles in the therapy dyad is instilled and reinforced through such dimensions as clinical settings and professional codes of dress (Simmons-Mackie & Damico, 1999). Such elements of a hierarchical structure in health care are generally indicative of the asymmetry between the professional helper and the client.

The discourse analyst's role is to consider more than surface structures of the discourse. Using a microanalytic approach enables one to focus on the meaningfulness of the underlying structures in order to interpret the implications of moves that are taken by participants. Microanalysis aims to increase awareness of those aspects of discourse features that establish, define, maintain, and influence therapy roles. This awareness in turn provides insights into the therapy relationship. So although a quantitative analysis provides a surface view of the interaction, the use of qualitative methods is necessary to gain an understanding of the therapeutic conversation.

Qualitative Research Methods in Stuttering

In a broad sense, the issue of the relevance of understanding or using microanalytic approaches is related to the relevance of qualitative research methodologies in general, in contrast to quantitative approaches. Qualitative research seeks to investigate people and events in natural settings, taking account of sociocultural–historical aspects of context (Llewellyn, 1996).

Tetnowski and Damico (2001) described the advantages of qualitative methods in the field of stuttering, highlighting their objective to address and understand the *how* of sociocultural phenomena, not the fact that they happen. In their article, they succinctly outline the characteristics that serve to contrast the broader focus of quantitative research with the finer detail derived from qualitative methodologies. Quantitative analyses tend to work with many cases, with predetermined dependent and independent variables. On the other hand, qualitative analyses tend to work with individual data, or a few participants, and more variables that represent complexity in social action. The objectives of qualitative approaches include the collection of *rich descriptive data* from within natural or *authentic settings.* In focusing on the participants, the researcher must be aware of detail contributing to how the behaviors and context interact to produce the phenomena being described. Most importantly, qualitative methodology enables the incorporation of the participants' perspective—a feature that is often missing in quantitative perspectives.

In the field of stuttering research, studies using quantitative methodologies have produced findings that provide the basis of our understanding of stuttering from a wide range of perspectives, including the study of therapeutic discourse. Using a system for classifying counselor responses, Blood and colleagues (Blood, Blood, McCarthy, Tellis, & Gabel, 2001) categorized Charles Van Riper's verbal response patterns during stuttering modification therapy and found that his therapy relied to a high degree on instructional, informational, and educational verbal responses as opposed to confrontation and self-disclosure verbal responses. However, the advent of qualitative methodologies provides a source for investigating aspects of clinical interaction that are not accessible through quantitative research designs, and for expanding the scope of our knowledge about working with clients who stutter.

Recent qualitative studies in stuttering include that of Corcoran and Stewart (1998), who presented an analysis of interview narratives to provide rich detail concerning personal experiences of stuttering. The views of persons who stutter (PWS) regarding communicating by telephone were the subject of a qualitative investigation by James, Brumfitt, and Cudd (1999). Studies such as those by Logan and Conture (1997) on the characteristics of conversational utterances of children, and by Yairi, Ambrose, and Niermann (1993) on early development of stuttering, provide qualitative insights that demonstrate a wealth of data that is not accessible using a quantitative approach alone. Tetnowski and Damico (2001) provided a strong case for employing qualitative methods through the application of CA to stuttering. Their study focused on how gaze shifting in stuttering was used as an interactional strategy in sustaining one PWS's turn-at-talk, and presented detail concerning the collaboration between coparticipants of continuer latchings—the acts that occur at the end of the speaker's utterance, that are signals of continuing the turn-at-talk.

In a qualitative study of therapeutic discourse analysis of group fluency therapy, the predictable asymmetry in the relationship between clinician and clients was accompanied by elements of symmetry as the discourse developed (Leahy & Watanabe, 1997; Watanabe & Leahy, 2001). Although the structural analysis indicated an asymmetrical relationship, its content analysis revealed how the approach being used encouraged empowerment of clients. Findings are discussed in greater detail below.

Methodologies for using a qualitative approach to analyzing therapeutic discourse tend to center around Hymes's (1972) ethnography of communication and CA (Sacks, Schegloff, & Jefferson, 1974). Elements of these approaches, along with Goffman's (1974, 1981) concept of *framing* in discourse, will be illustrated in the present case study. These three approaches are outlined here.

The ethnography of communication. When Dell Hymes (1972) developed the notion of *communicative competence,*

he broadened the focus of attention in linguistics beyond the structural analysis of sentences and, along with grammaticality, considered three other elements to be of importance: social appropriateness, psycholinguistic limitations, and observing actual language use. Studying the rules of speaking within a community or culture is the focus of Hymes's ethnography of communication, which has the objective of describing communicative patterns, norms, and expectancies regarding social rules for participation within particular interaction contexts or communities. Hymes defined a speech community in terms of "sharing rules for the conduct and interpretation of speech, and rules for the interpretation of at least one linguistic variety" (p. 34). Such rules provide a means of continuing to reinforce the cultural practices; thus, the practices are continually sustained in their realization. *Speech events* are considered as essential to the management and interpretation of communication within a community and are the focus of attention in using ethnography. Applying an ethnographic approach to studying therapy discourse provides the opportunity to describe multiple meanings of therapy events, with the clinician's social experiences incorporated into the microanalysis of therapy. Hymes suggests that by making sense of experience through participant observation, ethnographers can analyze cultural practices of communication and thus follow traditional anthropological methods. The therapy context offers an opportunity to explore the communicative norms and expectancies for participation of client and clinician in their respective roles. The clinical ethnographer, however, is in a difficult position as observer–participant, and when observing, will inevitably bring a professional perspective as opposed to an objective one. This in itself is not necessarily a problem, as a professional perspective can contribute greatly to interpretation of observations, but it is clearly a risk of objectivity being compromised to an extent.

Conversation analysis. Conversations work in an orderly way, and this order reflects a particular culture and language in interaction. The objective of CA is "to explicate the ways in which the materials [natural conversations] are produced by members [of a society] in orderly ways that exhibit their orderliness and have their orderliness appreciated and used" (Schegloff & Sacks, 1973, p. 290). An underlying assumption of CA is that language creates, and is created by, social context. Through ordinary human knowledge, participants engage in an enterprise that constructs solutions to problematic issues in conversation, such as understanding what is said, who should speak, and when they should speak. Knowledge and action are linked, and participants' understanding provides for the organization of their social activities. There is continual interpretation and negotiation of social roles and functions in conversation: "Social action not only displays knowledge, it is also critical to the creation of knowledge: one's own actions produce and reproduce the knowledge through which individual conduct and social circumstance are intelligible" (Schiffrin, 1994, p. 233).

In CA, great detail is excavated from small samples of naturally occurring conversation in order to develop and interpret emerging categories insofar as they can be justified in the data. Rather than relying on intuitive knowledge of what is happening in conversations, analysts are dependent on the evidence demonstrated by the behavior of coparticipants (listeners) in conversations, who show by their response that they have analyzed the speaker's turn. Lesser and Milroy (1993) suggested that it is methodologically important to attempt to maintain this stance because it provides the means of achieving reliability and validity in the data.

CA has underlying theoretical assumptions, discussed in detail by Heritage (1989) and Goodwin and Heritage (1990). The assumption that conversations are *structurally organized* according to *social conventions* (in that they present organized patterns of stable, identifiable structures) implies that conversations can be studied independently of the psychological or other attributes of participants. There is an assumption that utterances are understood *primarily* according to their *sequential placement*; this means that the basic units of analysis are sequences, not single utterances, recognizing that interaction is created by at least two participants. Conversation contributions are *context-shaped*, in that contributions can be interpreted only with reference to the immediate context in which they occur; they are also context renewing in the sense that each contribution creates a context for the following contribution. As in qualitative methodology generally, an important requirement in CA is for the data to be grounded *within the analytic methodology* (that the regularities described in the observable conduct of the participants are the central resource from which the analysis develops).

Framing in discourse. The concept of *framing* in interaction was developed by Goffman (1974, 1981), based on Bateson's (1972) observation that no communication could be understood without reference to the sense of the activity being engaged in (the interpretation of the metamessage about what was going on). (Bateson had observed that monkeys at play could only interpret whether moves from other monkeys were hostile or playful if they understood the frame of interpretation of the move.)

Goffman (1974, 1981) demonstrated how frames emerge and are constructed in verbal and nonverbal interaction. As well as assuming social roles within a frame (e.g., SLP, client), the speaker also assumes more basic speaking roles, which Goffman described in terms of *footing,* which speakers use to negotiate interpersonal relationships or alignments in interaction. Goffman (1981, p. 128) described footing as "a change in the alignment we take up to ourselves and the others present as expressed in the way we manage the production or reception of an utterance."

Tannen and Wallat (1993, p. 60) drew on the work of Goffman (1974, 1981). In their study, they used frame analysis to elucidate the layers and types of shifts in alignment or footing in interaction in a pediatric interview/examination. The pediatrician was examining an 8-year-old child, Jody, who has cerebral palsy, and consulting with Jody's mother during the examination. As well as examining and consulting, the doctor was reporting her findings to a video audience of medical students. The doctor's interactive frames, her ways of establishing and expressing footing, reflect the operation of multiple frames, which are

juggled deftly as she uses different linguistic cues to signal the shifting frames. Tannen and Wallat (p. 73) referred to the "exceedingly complex, indeed burdensome nature" of the doctor's task. They proposed that frames and schemas (the patterns of knowledge, expectations, and assumptions about the world) operate in similar complex ways in all face-to-face interaction, naturally influenced by differing settings. These notions of framing and footing are important for interpreting aspects of interaction, as will be evident in the case study presented next.

THERAPY ROLES AND INTERACTION: RESEARCH FINDINGS IN THERAPEUTIC DISCOURSE

In the child language therapy context, Prutting and colleagues (Prutting et al., 1978) studied the interaction patterns between SLPs and children in a number of different sessions and determined a range of similarities in therapeutic discourse patterns. The major type of interaction structure used was RRE, as described above, with the clinician requesting the child to respond by imitating selected stimuli, the child responding, and the SLP then evaluating and/or rewarding the responses. As well as showing how the therapy relationship is constructed, such studies reveal similarities to other asymmetrical face-to-face instructional interactions where participants of unequal status (e.g., adult–child) have the dominant participant controlling the distribution of information and the kinds of activities to be engaged in. In the therapy context, the SLP's ideas about her role determine that she "pursue her lesson relentlessly"; she does this by minimizing what she considers to be disruptive behaviors and "keeping the child 'on task' at all costs" (Panagos & Bliss, 1990, p. 25). These authors illustrate the point with transcripts of interaction between clinicians and child clients, demonstrating what they refer to as "the force of precriptionist attitudes" (which have been learned as professional skills) as the major determinant of decisions made by the SLP.

Kovarsky (1990) studied the interaction in two child therapy sessions and described the clinician's use of discourse markers ("right," "well," "good," "ok," "now") at different phases in the interaction as indicating transitions between tasks or actions in therapy. The clinician's use of markers was distinctive in regulating the distribution of information and its evaluation and in controlling the session. On the other hand, the child's use of such markers indicated compliance ("ok") and a tendency for self-regulation ("ok," "now," "so"), as well as a willingness to supply the information sought by the clinician ("well") and to indicate knowledge received that the clinician already had. Compliance markers are typical of discourse in institutional settings (e.g., in classrooms and in health care). Child awareness of discourse markers is reported by Ripich and Panagos (1985), where children presented clear models of the clinician and child roles in role play. The clinician's role was demonstrated through instructions, selecting materials, pointing to pictures, requesting responses, and commenting on errors. The child's role (as client) revealed the child acquiescing to the demands of the child who was acting-as-clinician.

Therapeutic discourse in fluency therapy was the subject of a study presented by Leahy and Watanabe (1997), some elements of which are worthy of note here. The exchanges analyzed took place between a clinician and clients attending group fluency therapy for adults, which was based on a personal constructivist model (Kelly, 1955, 1969). The structure of the discourse predictably followed the sequence representative of therapy interaction generally, that of RRE, indicative of the authoritative role of the clinician in the interaction. However, some subtle elements of difference emerged. For instance, instead of evaluating the client's response, the clinician frequently commented on it, summarizing what the client had said. In the following extract, the clinician *P* is asking client *C* his impressions of clinicians' working knowledge of stuttering:

P OK. Do you say the same *C,* or how do you think we deal with it?
C well first of all I think you see it as something that em (..) can be eh overcome eh and that's why we're here
P Hhmm? (4 more exchange turns, where *P*'s turn is represented by 'Mhmm?)
C and then (unintell) like for us it's there all the time.
P OK so we can understand aspects of it we can understand the technical aspects of it very well.

The SLP's responses to the client over several turns are back-channeled ("Hhmm"), which as indicated already, represents the person in authority (Fisher, 1984) rather than, for example, students or clients. The final act of *P* is to provide a summary of what she understood *C* to have said. Referring to the RRE sequence, Fisher suggested that the act of evaluating has a greater degree of authority than that of commenting. The SLP's act of summarizing as a follow-up comment on the client's response is a more subtle practice than evaluating in terms of power, as summarizing does not necessarily represent the SLP's own opinion or expertise. This point can be further developed, drawing on Goffman's (1981) idea of *footing*, to describe how a person assumes various fundamental roles when speaking. Along with the social roles that a person plays (such as mother, clinician, doctor), the speaker also adopts the roles of animator, author, and principal. Goffman explains these roles as follows: The role of *animator* is the talking machine, the *author* is the person who has selected both the sentiments that are being expressed and the words chosen to express them, and the *principal* is someone whose position is established by the words spoken, the person active in some particular social identity or role. In summarizing, the clinician is acting as animator and principal, but not as author; the author in this instance is the client, whose sentiments and words are used by the clinician, clearly acknowledging his contribution.

Other studies of therapy discourse describe some communicating expectancies, highlighting adult-centered

aspects of clinical discourse, with the expectancy of the child (attending for therapy) as "error-maker" and the child awareness of and adaptation to that role (Kovarsky & Maxwell, 1992). This role is elucidated in an interview reported by Ripich and Panagos (1985), where the child is emphatic about his role as error-maker, thus:

Ripich: What do you usually do in therapy?
Child: Well, I'm supposed to make the bad *r* sounds, and Mrs. Smith is supposed to make the good *r* sounds.
Ripich: Don't you ever make the good *r* sounds?
Child: No! I'm supposed to make the bad *r*s.

Similarly, Ripich (1989, p. 136) reported on interviews with children who provide insight into their more passive role vis-à-vis the clinician's controlling role (including, e.g., "she picks the work and you don't," "she tells me what she wants and I do it," "she chooses the words"). Construing the child as error-maker sets expectations regarding incompetence in the child, with roles defined accordingly. However, therapy would not be necessary if there were no perceived problems, and part of the SLP's brief is to make judgements and evaluations of competence–incompetence in the client's communication ability. The important emphasis is on balancing the child's awareness of his or her difficulty that contributes to the role of error-maker with the other roles of the child, especially that of successful communicator. If therapy provision is sensitive—as is frequently the case—the child will develop communication skills appropriately, resolving the paradox between a role as error-maker and the objective of engendering confidence in the child's ability to communicate.

The language that clinicians use in therapy has been criticized by Crystal (1995), who questioned the pragmatic validity of so-called "postilion sentences," that is, grammatically well-formed sentences typical of the examples given in teaching English as a foreign language (*The postilion was hit by lightning*) that are not useful in real life because of their limited applicability. Although his article was not presenting an analysis of discourse, Crystal suggested that clinicians frequently model sentence types that are unlikely to be used (e.g., "that table has four legs"; "on the cup") that are "true postilions" in Crystal's terminology; form-restricted sentences where the model sentence could be used, but only with a change of form (e.g., "What's happening in the picture?" "What's the man doing?"); and context-restricted sentences (e.g., "How old are you?" used for the purpose of checking age restriction or for the purpose of indirectly checking behavior [as in "act your age"] or at a birthday party, where age is already known). Crystal likens use of such sentences to "providing keys without indicating the doors they can open." He suggests the use of more naturally occurring structures with a pragmatic perspective that are more likely to be generalized in real life.

SLPs have defended their use of language in therapy as a learned professional skill that is different in nature to mother–child interaction (Panagos & Bliss, 1990). Justification for the use of model sentences, or "complete sentences," is made in terms of "correctness" in the first instance, where the client's attention is drawn to the form or grammatical structure of utterances, without reference to communicative function, with the idea that reference can be made thereafter to contextual applicability. These levels of language use contrast the academic knowledge of language, which is useful for some kinds of formal situations, and the social knowledge or pragmatic functions of language. However, a case can be made for the benefit of children being made aware of appropriate academic language as well as learning about the use of more informal language use.

CASE PRESENTATION

The analysis of discourse that is presented here aims to highlight significant aspects of the ordinary talk-in-interaction between SLP and client *C* in a fluency therapy session in order to provide evidence of relationship development and changes, and to demonstrate how analyzing therapy talk is relevant for application in the fluency clinic.

In discussions with colleagues who work in the field of stuttering, the author requested audio recordings of sessions for the purposes of analysis. One SLP who frequently records sessions with clients for the purpose of quality reviews, research, and service development provided a tape recording of a session with a 13-year-old girl, *C,* who stutters.[1] The session had been randomly selected for recording, and the SLP commented that there was "nothing extraordinary" about the session in her view.

Participants

P is an experienced SLP whose clinical speciality area is stuttering. She works with both children and adults who stutter. *P* has higher degrees, including a PhD, and, in addition to managing a therapy service in a metropolitan area, she engages in research and publication in stuttering. The client, *C,* is a 13-year-old girl who had originally been assessed 5 years earlier, at age 8. At that time, she presented with disfluency, which was regarded as mild in degree, comprised of word repetitions and mild hesitations apparently related to word retrieval difficulties. Her rate of rapid alternating articulatory movements had been assessed and was considered to be just below normal levels. She appeared to be unaware of her difficulties, and speech was not an issue for her. At this stage, because of *C*'s apparent word retrieval problems, her parents were advised about vocabulary development and about reducing time pressure for *C* during conversations. Some exercises were given to improve the rate (not accuracy) of oromotor skills. The parents were also advised to talk openly with *C* about her speech in order to reduce the likelihood of her developing anxiety about it. Before the episode of therapy under discussion here, *C* had been re-referred because of her mother's awareness of *C*'s disfluency. On assessment, *C*

[1]Instances of *C*'s stuttering are not in evidence in the extracts used; some instances may be occurring during the pauses noted; however, these cannot be verified from the audio recording.

presented with mild overt disfluencies (occasional easy repetitions of initial syllables, repetitions of interjections), with some tension associated with speaking, in the form of occasional silent glottal blocks. Although *C* did not consider her speech to be a problem, she agreed to participate in therapy on a weekly basis to learn a technique to help with fluency. Her personal motivation to change is likely to have been driven by parental concern, and the clinician indicates that motivation was an issue of concern during the therapy sessions overall. The session recorded for analysis was the third session of six, of approximately 45 min in length, which focused on learning an easy onset technique that had already been introduced to *C* during previous sessions. The easy onset technique as used here focuses on the reduction of laryngeal tension, with breath control, gradual onset of phonation and articulation, and slightly extended production of the first phoneme in words as the cardinal features. It is described by Turnbull and Stewart (1999) as effective for some clients whose stuttering is characterized by silent blocks and/or audible prolongations at the beginning of a word.

The therapy session was recorded by the SLP using a Tanberg AudioTutor Model 771 with a built-in microphone, which was situated approximately 3 feet away from *C*. Audiorecording sessions with clients is part of the therapy routine in this clinic and is not regarded as unusual. It is possible that awareness of recording affected the interaction to some degree initially, but it did not interfere in an obvious way with the session overall. (It seems that *C*'s attention was not distracted. Toward the end of the recording, just before the tape recorder was switched off, *C* asked "Is that thing still on?"). The session was audiotaped with *C*'s permission, which was gained before the recording. Videotaping is arguably a preferred means of recording sessions for analysis, as it will provide observation possibilities of nonverbal communication, and in this instance would have revealed what occurred during silent pauses in the interaction.

In transcribing the recorded session, the data were first organized according to turns in the exchanges; there were 383 turns altogether, equally distributed between participants (greetings and initial and closing exchanges in the session were not recorded). An overview of the transcription reveals that *P*'s utterances tended to be longer than those of *C,* but for the majority of exchanges, they were of approximately equal length. At certain points in the session, such as when explaining aspects of the technique, *P* used longer utterances. For ease of reference in the analysis, each line of discourse was numbered. The recording was then listened to repeatedly, and instances of changing intonation, pausing, disfluencies, and so forth, were specified on the transcription following the conventions used by Tannen and Wallat (1993) (See Appendix).

Analysis: Discourse Markers and Use of Pronouns

The recording begins with a series of six turns that are presented at the beginning of the article. The turns are led by *P,* engaging *C* in conversation about school, setting up the exchange sequence that dominates the session, that of RRE, and indicating the authority of *P* and the cooperative nature of the enterprise. The institutional, asymmetric type of discourse is established and maintained throughout the session and is further demonstrated here with *P*'s use of discourse markers "ok, now" to open. She again uses "ok" to change topic to talk about the previous session:

23 *P* mmm ok. so last time we were doing em. easy
24 onset on words and we practiced a bit didn't
25 [we
26 *C* [yeah
27 *P* in conversation
28 *C* yeah

P's use of the discourse markers indicates the authority or directive role in the relationship, contrasting with *C*'s relatively infrequent use of the markers throughout the session, with "ok" used to indicate compliance. Also, *P*'s use of the inclusive "we" (which is not used at all by *C*), replacing the first- or second-person singular "I" and "you," is further evidence of authority (Fairclough, 1989) as it assumes permission to speak for the other and reinforces the role of *C* in acquiescence to *P*'s authority (Simmons-Mackie & Damico, 1999).

P's use of "we" continues, as follows:

69 *C* Just thought like this is taking [too long
70 *P* [too long
71 ok alright well let's think about that today then
72 see if we can work on just speeding it up em..
73 because you CAN: do it quite quickly em
74 I mean you've only been doing it a couple of
75 weeks so it's it's early days /?/ we'll think
76 about that today
77 *C* ok
78 *P* alright.. so we're gonna I'll just. have a look at
79 how you're doing with some words and then
80 we'll do some: reading?

In this instance, the inclusiveness represented in the use of "we" seems to represent warmth in a collaborative effort, both *P* and *C* working together to shape the technique. This is further exemplified by *P*'s overlapping utterance with *C* (69, 70) accepting the explanation and going on to explain and excuse the lack of progress with the technique (71, 72) and offering an immediate solution (73). *P* speaks using a soft vocal tone throughout the exchanges, with emphasis on easy onset of utterances. This may be interpreted alternatively in terms of modeling the technique and using a persuasive tone to engage *C* and maintain her interest in activities.

A further look at *P*'s use of pronouns in this passage indicates shifts between the inclusive "we"/"us" and the impersonal "you" (73), "I" first person singular (78), and "you" interlocative (74, 79). Von Raffler-Engel (1989, p. 9) referred to the use of the pronoun "you" interlocative as "you-talk, the idiom of the sweet talker," the warm image of the person who wants to help is represented, whereas "I" (78) is suitable for the authoritative person in the discourse.

P's use of "I" is relatively infrequent throughout the session and is used in an authoritative way to direct or evaluate performance:

88 *P* alright so I want you to pick a word
89 and I want you to [do
90 *C* [same as last [week
91 *P* [yeah an
92 easy onset at the beginning of the word and
93 make it make that the first word of the
94 sentence so you might do something like em:
95 that one "tongue is an organ in my mouth"
96 *C* ok
97 *P* yep alright
98 *C* fire is very hot

In this sequence, *P* is clearly directing, but with the request "I want you to…" expressed as a desire. An element of softness is included, mitigating the effect of the instruction, reducing its strength, and also reducing the possibility of a refusal to comply with the request (Simmons-Mackie & Damico, 1999). *C* assertively preempts the conclusion of the direction with an overlapping statement (90), indicating knowledge and awareness of the procedure, but although *P* acknowledges this (91), she continues to explain the instruction, maintaining the authoritative, institutional role. *C*'s subordinate role is clearly established.

The example given for the practice sentence is similar to Crystal's postilion example, except that in this instance, the grammatical structure is not "correct"! In the practice sentence, *C* emulates *P*'s model and provides another model or postilion sentence.

Maintenance of Role: The RRE Sequence

In the following sequence, although *P* invites *C* to evaluate her performance in a consultative way (114), *P* then evaluates it, disagreeing with *C,* but mitigating the disagreement with an initial "mm still" (116). She then directs *C,* using the inclusive "we."

113 *C* I:.. I like horse riding
114 *P* ok .. what do you think of that one.
115 *C* yeah it was all right
116 *P* mm still I thought you started it quite hard.
117 we need to make it a little softer and slide into
118 it more
119 *C* I. I like horse riding.
120 *P* can you see the difference when you do it like
121 that…
122 *C* ah: a man walked down the road

The pattern of a three-part sequence of utterance is maintained in the RRE sequence. There is further emphasis on *C*'s role as error-maker in contrast to *P*'s authoritative role (116), as she offers a direct evaluation followed by a suggestion for improvement in the evaluation given (117). The corrective evaluation is provided despite *C*'s positive self-evaluation, providing further evidence of *C* as error-maker in evaluating as well as in speaking. The effect of the authoritative "I thought" is preceded by "mm still," reducing the strength of the evaluation. In 117, *P*'s use of the inclusive "we" is clearly referring to what *C* has to do, and not to a collaborative activity, affirming *P*'s control in the discourse. *C* responds by continuing with the exercise.

The series of model sentences used for technique practice are contextually restricted utterances, removed from the pragmatism of more typical types of utterance. However, this can be justified because the main focus in this stuttering treatment is not on the form or content of the utterance, but on the use of easy onset technique. This parallels the use of academic as opposed to social utterances in language therapy, as the stage in therapy demands direct attention to motor skills. Despite this, however, there is an argument that contextually relevant utterances should be used for maximum effect, reducing the need for technique practice involving a series of stages toward informality in language use. However, this would increase the responsibility of the client to monitor motor speech as well as plan and execute linguistically and pragmatically relevant utterances.

INCREASING PRAGMATIC RELEVANCE: SOCIORELATIONAL FRAME

The session continues with *P* directing *C* in refining her use of technique, within the context of the institutional RRE frame, with *P* asking for *C*'s evaluation regularly and commenting on or evaluating *C*'s response. As the session progresses, an exercise using a question–answer exchange is introduced, providing *C* with the opportunity to use the technique in a different context. However, the meaningfulness of this switch in context is restricted by *P*'s evaluation of *C*'s technique, which she does instead of answering the question. This disturbs the natural turn-taking in the question–answer sequence:

274 *C* do you live round here?
275 *P* ok could you make that just a little bit softer?
276 *C* do you live round here?
277 *P* em I live about four miles away. em you told
278 me last time that you were going to America
279 this summer. can you tell me a bit about the
280 way you're going?
281 *C* I'm not sure well what's going to happen there
282 *P* ok can you say it again?

P's alignment to the role of evaluator represents her adherence to the institutional frame, with her corrective function in 275 and again in 282. Walsh (2002) referred to this type of frame in the interaction as "business-of-the-day frame," being concerned with the task and not the content of the message. Instead of providing a more natural context for technique practice, *P*'s focus on technique consolidates *C*'s role of error-maker. The fact that *C* complies with this role and continues to perform in a relatively passive way

shows an acceptance of the role and an adherence to the framework imposed by the institutional context. It also demonstrates *C*'s ability to align to the institutional frame by responding appropriately, even when she is apparently using a social frame in constructing a more personal context for the technique practice.

There is further evidence later of *C* attempting to shift frames from her institutional role as error-maker as she switches emphasis once again from contextually restricted utterances in the question–answer exercise to conversational or social talk in the following sequence:

321 *C* are you getting your son that dog he wants?
322 *P* (laughs) he's still talking about it. ooh (laughs)
323 *C* don't you want one then?
324 *P* yeah I think so.. it's just we would need to.
325 *C* quite hard work.. what breed do you think he'll
326 be?
327 *P* slightly slower
328 *C* Wha:t breed do you think he'll be?
329 *P* I don't know. what do you reckon?

In this sequence, *C* is practicing the technique, but she initiates a sociorelational frame in generating a natural conversation, to which *P* aligns herself, albeit hesitantly (322, laughs). The personal nature of the topic, with a reference to a different social role of *P* as mother, engages her to the extent that she stops her evaluations of *C*'s technique, focuses on content, and continues the conversational exchange (instead of following her answer by asking a question). *C* maintains this sociorelational frame and demonstrates her competence throughout the sequence, interpreting *P*'s reluctance in the hesitancy in 322/3 and preempting *P*'s response in 325. However, *P* recovers control momentarily and returns to the authoritative institutional frame in 327, evaluating *C*'s use of technique; *C* complies and repeats the question. *P* then realigns herself by engaging in sociorelational talk (328).

The conversation continues for a series of eight turns led by *C,* when *P* takes control once again, moving on to the concluding exercise, a reading task. The complex realignment in the interaction between institutional and sociorelational frames has been negotiated successfully by *C,* whose social and linguistic competence is recognized by *P* in the exchanges.

DISCUSSION

Management features of stuttering therapy that emerge from the discourse analysis of this session are strikingly similar to those described in analyses of therapy in different disorder groups, including child language disorder (Prutting et al., 1978), phonology, (Ripich & Panagos, 1985), and adult aphasia (Simmons-Mackie & Damico, 1999). The asymmetry between the clinician and the client roles is exemplified in the overall structure of the RRE sequence, with the clinician taking the leading role and directing the course of the session. Therapy talk is punctuated throughout by the clinician's distinctive use of discourse markers and her frequent use of the inclusive pronoun "we." There is clear evidence of attention to the client's role as error-maker in the course of treatment. Such similarity in the patterns that appear in the SLP clinic has been observed previously. With reference to their analysis of an aphasia therapy session, Simmons-Mackie and Damico (1999, p. 315) referred to the "routinized therapeutic context, with its well-defined and expected roles" and "standard features which served to reinforce the underlying social contract and therapeutic goals." Similarly, SLP clinical discourse has been described in terms of appearing "scripted and interchangeable from one clinician to another" (Panagos & Bliss, 1990, p. 24). However, some elements of therapy talk necessarily have a clear objective to engage in an asymmetrical way, as the client's communicative ability is the focus of attention and the SLP's role is to evaluate the client's performance and provide the opportunity for change. Where a fluency technique is being learned, the SLP's role is to model, monitor, encourage self-monitoring, and evaluate progress. All of these elements were clearly justified in the session analyzed.

The increasing symmetrical features that have emerged, however, also reveal a recognition on both participants' parts of the client's linguistic and social competence, with *C*'s ability to realign herself, moving from an institutional frame (as error-maker) to performing in a sociorelational frame (as competent communicator). Without *P*'s recognition of this and compliance in following *C*'s moves, it would not have succeeded. This contrasts with reports of dogged adherence to the authoritative role of the SLP in other therapy analyses (e.g., Panagos & Bliss, 1990; Simmons-Mackie & Damico, 1999). *P*'s ability to engage in the social frame following *C*'s lead displays sensitivity to *C*'s move to create a more interesting context for technique work. The mutual engagement comes to a sudden end, however, when *P* returns to the institutional, corrective role of authority.

Key Learning Points From the SLP's Perspective

The analysis presented above was discussed with the SLP, who provided reflective comments that are summarized here. In the first instance, although *P* anticipated reading the report of the analysis with some apprehension, she found the analysis "refreshing" in that it provided a new awareness of how the issues of control and choice in therapy are negotiated. Her interpretation of the use of the inclusive pronoun "we" was that it was an attempt on her part as clinician to drive and motivate *C,* increasing mindfulness of "presumed collaboration" in future interactions. She had not been aware of her use of soft vocal tones as a technique of persuasion and/or modeling. She reports, "In the same way as I may mirror nonverbal behavior in a client as a way of affecting change or highlighting a particular behavior, it strikes me that vocal dynamics have a power in the therapeutic interaction that I have not explored or elaborated." *P* referred to the fact that the analysis demonstrated for her the way multiple tasks

are a part of therapy—engaging a client in a communication task and simultaneously focusing attention and requiring the client to attend to something specific in his or her speech (and/or language) performance. Her conclusion was, "I think I often assume that clients carry out this frame switching, and maybe I need to check this out more and perhaps teach it when appropriate."

The SLP also commented that awareness of a client's ability to use different frames may be assumed sometimes, intuitively determining therapy decision-making about the kind of tasks to be undertaken, and that more attention may be usefully applied to this aspect of communicative performance. Finally, she indicated that she makes choices regarding her interaction style on the basis of initial impressions of the client's personality and communication ability, the nature of the problem presenting, and the immediate focus of attention of the session.

How Therapeutic Discourse Analysis Can Be Applied to Working With CWS

Despite the fact that discourse analysis lends itself to the fine-grained analysis of therapy talk, for many clinicians, it remains largely an academic pursuit. Approaches to discourse analysis are underexploited in most clinical encounters, with the notable exception of the aphasia clinic, where discourse analysis is often used to provide insight into how clients with aphasia use their restricted language abilities to communicate and to build on their expertise to enhance communication. Clinicians who are unfamiliar with the practice of discourse analysis and its use in a clinical context may have reservations about its application generally and as a means of improving therapy. The kinds of reservations frequently voiced include questions about the validity of the process and its basis in the microanalysis of seemingly minor and inconclusive examples of talk-in-interaction. However, parallels are easily identifiable in the way that SLPs make important judgments regarding a client's communicative ability on the basis of selective sampling of behavior in testing procedures. Another reservation that may prevent its implementation is the fact that recording, transcribing, and paying attention to therapeutic discourse is a time-consuming activity. Lesser and Perkins (1999) addressed these kinds of issues with reference to implementing CA in aphasia therapy. They enumerate several advantages of using CA, including the recognition that the ability to engage in conversation is the key to revealing competence and being viewed as a social being, with important psychosocial benefits. They also report on comparative research that supports the long-term clinical cost-effectiveness of spending time examining the minutiae of interaction involved in discourse analysis.

When working with CWS, frequently stated goals of therapy are to facilitate the feeling of fluency control and to help clients to talk openly about their feelings. Generally, CWS will be aware of their communicative efforts being negatively evaluated because of the stuttering, and this in turn increases awareness of being less competent as communicators. However, negative evaluation of the client's communication endeavors continues in therapy. Although it may be balanced with a positive intent of improving performance, there is ample reason to consider the need to review our adherence to the evaluator role of the SLP. The analysis of therapeutic discourse presented also demonstrates that flexibility within therapy roles and relationships is *negotiated* between the client and the SLP, and that such flexibility provides the opportunity for the client to develop a sense of her role as competent communicator.

Analyzing therapeutic discourse is a means for clinicians to use their expertise in language analysis and pragmatics to recognize communicative competence and to consider how CWS naturally use their conversational expertise and their expertise in shifting frames. Looking at how clinical interaction can be shaped to become more symmetrical (e.g., reducing the use of authoritative markers and reducing the evaluator role of the clinician) increases the possibility of a sense of equality developing between *P* and *C* as collaborative partners in talk. Monitoring personal discourse style (e.g., how the use of some pronouns can be influential in therapy and the use of summarizing as a means of recognition of the client's contribution to the conversation) will have the potential to change aspects of the interaction, leading to a more positive therapeutic relationship.

Conclusion

Charles Van Riper (1973, p. 1) described stuttering as "a complicated, multi-dimensioned jigsaw puzzle, with many pieces still missing." As early as 1963, Van Riper made a case for research into the analysis of therapeutic discourse as a means of better understanding the relationship between the clinician and the client. The influence of this relationship has been described in terms of "an elusive, ephemeral, and yet powerful force that most clinicians acknowledge but few can precisely identify" (Emerick, 1974, p. 92). Analyzing therapy talk will not demystify all of the magical elements in the relationship, but as demonstrated in the analysis presented, it will help identify how aspects of the relationship are negotiated through talk, and, crucially, will help develop awareness of factors that serve to influence therapeutic change. Such knowledge and awareness will serve to make us better clinicians and, potentially, provide us with some of the missing pieces of the stuttering jigsaw.

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APPENDIX. TRANSCRIPTION CONVENTIONS (FOLLOWING TANNEN & WALLAT, 1993)

[	Brackets linking two lines show overlap: Two voices heard at once.
:	prolonged or elongated vowel sound
.	falling intonation
?	rising intonation
..	brief pause < .5 seconds
…	longer pause > 1 second
CAPITALS	emphatic stress
/?/	inaudible or unintelligible utterance

Note. From "Interactive frames and knowledge schemas in interaction: Examples from a medical examination/interview," by D. Tannen and C. Wallat (1993) in D. Tannen (Ed.), *Framing discourse*. New York: Oxford University Press. Copyright 1993 by Oxford University Press. Used with permission.