An Investigation of the Manifestations of and Changes to Social Cohesiveness as a Result of
Conversational Group Therapy in Aphasia

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An Investigation of the Manifestations of and Changes to Social Cohesiveness as a Result of
Conversational Group Therapy in Aphasia

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DEDICATION

"I sustain myself with the love of family."
                -Maya Angelou

This body of work that bears my name should rightfully boast the names of my

husband, John Tetnowski, and my daughter, Jessica Tetnowski, whose sacrifice and support

were essential to its completion. My love for you and pride in you abounds.

ACKNOWLEDGMENTS

Words, for me and for the persons upon which this work is based, are not only a means of relating information but creating emotions and identity. My own words of gratitude are often not equal to the depth of my feelings of indebtedness to the following individuals and it is for this reason that I refashion the words of others to acknowledge my thankfulness.

> *Everyone has a transferable commodity-knowledge. Sharing your unique expertise and making introductions for someone creates a lasting legacy.*
> -Marsha Blackburn

My most sincere thankfulness for the generosity of intellect shared with me by my mentor and friend, Jack S. Damico. In addition, the other members of my committee, Dr. Nancye Roussel, Dr. Ryan Nelson, and Dr. Craig Forsyth, deserve my thanks for the gifts each brought to this body of work. I appreciate your scholarship and generosity of time.

> *We are like dwarfs sitting on the shoulders of giants. We see more, and things that are more distant, than they did, not because our sight is superior or because we are taller than they, but because they raise us up, and by their great stature add to ours.*
> -Metalogicon

I am grateful for the researchers in the field of communication disorders and conversation whose work was drawn upon heavily for this book: Jack S. Damico, Nina Simmons-Mackie, Harvey Sacks, Gail Jefferson, Emanuel Schegloff, and Charles and Marjorie Goodwin, to name but a few.

> *It requires the feminine temperament to repeat the same thing three times with unabated zest.*
> -W. Somerset Maugham

I further want to acknowledge my personal and self-appointed nag, the Honorable Mrs. Francie Boullion. I give many thanks to you and other friends, Ben and Anne Blanchet, who continually supported me and asked me for updates on how the dissertation was going.

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CA	Conversation Analysis
CDC	Centers for Disease Control
DVR	Digital Video Recorder
HD	High Definition
ICF	International Classification of Functioning, Disability, and Health
IWA	Individual with Aphasia
LPAA	Life Participation Approach to Aphasia
nsfs	Non-Specific Forward Stare
PICA	Porch Index of Communicative Ability
RCBA	Reading Comprehension Battery for Aphasia
TCU	Turn Construction Unit
TRP	Transition Relevance Place
ULSHC	University of Louisiana Speech and Hearing Clinic
WHO	World Health Organization

CHAPTER ONE: Introduction

The area of exploration in this dissertation is how individuals with aphasia who are members of a conversation therapy group demonstrate the phenomenon of group cohesiveness through the conversational devices employed during conversation treatment sessions. The establishment of cohesiveness and its demonstration through conversational devices becomes a testament to the powerful force of conversation as a socially constructed and identity-shaping activity, capable of transforming an isolating condition to one characterized by affiliation.

Aphasia is an acquired condition that affects not only how a person speaks but how they interact with their community. Research has demonstrated repeatedly the isolating effects of aphasia (Cruice, 2007; Parr, 2007). This isolation begins right after onset with the social construction of aphasia as incompetence where health professionals prescribe treatments to rehabilitate the individual, measuring success in the degree to which they return to "normal" (MacKay, 2003). This expectation of a return to premorbid function is extended then to the sense of self-worth for individuals with aphasia. When the person's residual communication ability is not compatible with their pre-stroke identity, persons often shape an identity of incompetence or of being less "normal" (Shadden, 2005; Shadden & Agan, 2004). This identity is recurrently shaped and reinforced by other people and society as a whole (Howe, Worral, & Hickson, 2008). A majority of persons with aphasia report that they engage in less community participation post- aphasia and research has demonstrated a relationship between the degree of decreased participation and the severity of aphasia (Davidson et al., 2003).

When I left the hospital on June 13, ending my stay of nearly eight months, I was

stepping from one strange world into another. To paraphrase two better poets, I was

(to my thinking) an island; a stranger, and afraid, in a world I never made. (Sies, p.

120)

This account written by Richard Butler in the 1982 edition of L.H. Sies' book

Aphasia Theory and Therapy: Selected Lectures and Papers of Hildred Schuell captures the

feelings of isolation and lack of agency felt by many persons with aphasia (Butler, 1982).

At a monthly aphasia support group meeting, Phil, a first-timer, asked Daisy the co-

leader and also a person with aphasia, "How long was it before you would go into a store and

ask the guy for help?" This sincere question spoke volumes to the stigma he associated with

having aphasia and its effect on how he interacted with his environment. Perhaps more

surprising was Daisy's response that it was several months before she had the "nerve" to

speak in front of people other than her family and closest friends.

Aphasia by the Numbers

In 2005, the Centers for Disease Control (CDC) published its findings on the

prevalence of stroke in the United States, reporting that approximately 2.6% of non-

institutionalized U.S. adults, or approximately 5,839,000 persons, have a history of stroke.

They noted the prevalence of stroke increasing with increasing age where approximately

8.1% of respondents aged 65 years or older reported a history of stroke, compared with 0.8%

of persons aged 18 to 44 years. Contrary to a once widely held belief that men were more

likely to experience heart disease and stroke, the prevalence of stroke among men (2.7%) and

women (2.5%) was similar. A pattern that was significant however was the relationship

between education and stroke. Among persons with less than 12 years of education, 4.4%

reported a history of stroke. This is more than twice the rate than among college graduates (1.8%)."

One common sequela of stroke is aphasia and according to the National Institute of Neurologic Disease it affects nearly 1 million Americans. Aphasia is described as "a neurological disorder caused by damage to the portions of the brain that are responsible for language. Primary signs of the disorder include difficulty in expressing oneself when speaking, trouble understanding speech, and difficulty with reading and writing" (Office of Communications and Public Liaison, 2014).

Evolution of the Treatment of Aphasia

Aphasia and its effect upon language have been documented as early as 1700 B.C. In a document that has been referred to as the Edwin Smith Surgical Papyrus, Egyptian physicians documented 20 cases of head trauma that resulted in speechlessness including the process of prognosticating recovery and various treatments that were implemented (Breasted, 1930). However, it was 19th century France that is credited to be the birthplace of aphasiology as a science. Franz Josef Gall (1764-1828) postulated that you could discern the relative strength of mental faculties from the shape of a person's cranium. This method came to be known as phrenology and although it proved to be inaccurate it lead to the Localizationist theories of brain function that were proposed by pioneers such as Paul Broca (1824-1880) and Carl Wernicke (1848-1905). Theories of localization suggested that speech and language abilities could be isolated into very specific and modular areas of the brain. Contrary to this idea, John Hughlings Jackson (1835-1911) proposed a more holistic conception of brain functioning and that this interconnected organ was more resilient to brain damage. Competing views of the organization of the brain and the methods of assessment

that could provide insight to its organization lead then to competing views of treatment for aphasia. The field of aphasiology experienced an awkward transition from techniques derived from Behaviorism to exercises ascribed to the related theory of Operant Conditioning. This gave way to a Cognitive Stimulation Approach pioneered by Hildred Schuell. These approaches to assessment and treatment often failed to capture a person with aphasia's true communication ability and out of this disparity an orientation to more functional aspects of aphasic language occurred. This movement then evolved further into psychosocial approaches that targeted authentic communication activities for both assessment and treatment. One could argue that the most important development in the psychosocial orientation to aphasia research and management was the creation of the Life Participation Approach to Aphasia, hereafter referred to as LPAA (Chapey, Duchan, Elman, Garcia, Kagan, Lyon, & Simmons-Mackie, 2001). anThis approach, which reads more as a position statement, situates the treatment of aphasia within an authentic context for authentic purposes that are co-constructed by all parties involved along with the environment within which communication takes place. Perhaps the most authentic language activity in which all persons, whether aphasic or non-aphasic, engage is conversation. Conversation is the means by which we relay information, transact business, and form social ties. Conversation therapy is able to exploit naturally occurring opportunities for a multiplicity of language manifestations. Further, conversation is not contextually bound to an isolated situation so that treatment situated within conversation generalizes easily to outside the therapy room. A treatment model that is very well suited to the conveyance of therapy through conversation is that of group therapy.

A group therapy model that is consistent with LPAA is similarly the result of an evolution in the orientation of researchers and therapists toward more functional and authentic therapy goals. According to Eisenson (1973), historically group therapy had been "born out of necessity rather than planned with specific purposes and objectives. Sometimes groups came into being as "holding companies" for patients when clinical time for individual therapy was not available." However, even in the earliest groups treating aphasia, therapists noted improvements in socially constructed attitudes such as adjustment to disability and relating to others (Godfrey & Douglas, 1959). Changes in social adjustment were repeatedly documented by researchers so it made sense when Schuell, Jenkins, and Jiminez- Pabon (1964) asserted that "individual therapy and group therapy are two entirely different classes of events, and should not be confused." Group therapy, as its own event, does have distinct advantages and these were apparent in 1973 when Eisenson reported benefits to include 1) an opportunity for socialization, 2) an opportunity for motivation from peers, 3) providing a situation in which awareness of speech habits can become apparent, 4) an opportunity to observe techniques used by other individuals with aphasia, 5) an opportunity to respond to multiple forms of communication, and 6) it allows for sharing of personal material via the "ventilation of feelings and airing of grievances." These advantages were proffered in an only slightly different form three decades later by Elman (2007) who noted the benefits to generalization outside of a clinic setting gained by the opportunities afforded in the group therapy setting. It is of interest that group aphasia treatment in the 1950s and early 1960s focused on real life activities but this focus shifted away from authentic situations until the 1980s and researchers such as Elman (2007) attribute this shift to the influence of behaviorism that was also evident in individual aphasia treatment. Following a trajectory that

paralleled changes in therapeutic orientation for individual therapy, group therapy design and practices became more functional; eventually mirroring the values set forth in the LPAA. Those therapy groups that were most successful for assisting patients in realizing gains in functional communication demonstrated a commitment to the cooperative and constructive nature of communication for authentic purposes (Simmons-Mackie, Elman, Holland, & Damico, 2007).

Cohesiveness as a Therapeutic Factor

An important theme running through successful treatment groups is the esprit de corps that, according to Yalom (1995), is an index of cohesiveness which is essential to successful outcomes. With the bulk of research into group cohesiveness taking place within psychotherapy, cohesiveness is most often defined as the connectedness of the group, demonstrated by working together toward a common therapeutic goal, constructive engagement around common themes, and an open trusting attitude which allows members to share personal material (Budman, Soldz, Demby, Feldstein, Springer, and Davis, 1989). This concept grew out of research into the relationship between an individual and his or her psychotherapist, called therapeutic alliance. This term, coined by Luborsky (1976), describes a high state of rapport between therapist and 'client' where they work together in a warm relationship. Further, the quality of this relationship influences the client towards achieving positive expectations.

The concept of cohesiveness and its impact on outcomes in group therapy, though examined little in aphasiology, has been extensively researched in other areas. Research in the area of group psychotherapy has reported a causative relationship between cohesiveness and successful outcomes. But to demonstrate that this phenomenon, cohesiveness, is

occurring researchers have depended upon client and therapist report whose subjective nature may undermine the validity with which the phenomenon can be reported. Perhaps in answer to this critique, observational scales were created such as the Harvard Community Health Plan Global Cohesiveness Scale developed by Budman, Demby, Feldstein, Redondo, Scherz, Bennet, Koppenaal, Sabin, Hunter, & Ellis (1987). Creating a uniform scale certainly improves the reliability with which different raters would assign levels of group cohesiveness. However, the glaring question that emerges then is whether they are truly measuring the amount of group cohesiveness or are they merely measuring the extent to which the behaviors of a group match the definition that the same researchers ascribed to the phenomenon under scrutiny. This possibility suggests that the scale itself suffers from paradoxical thinking; developers observe a successful therapy group and construct a definition for cohesiveness that when demonstrated by members in other groups appears to support the definition. A more constructive inquiry into the phenomenon of cohesiveness might be to document what individuals are doing in group therapy situations that demonstrates their orientation to cohesiveness.

Regardless of the therapeutic technique the group facilitator uses, members of any therapy group engage in talk; communication is the vehicle that transports all ideas. So, it stands to reason that the group members would demonstrate their level of cohesiveness through their talk. Their interactions with each other over the course of group treatment would likely demonstrate a growing sense of cohesiveness or, to use a related term, affiliation. By looking at conversation within a group one should be able to locate the conversational devices used by the members to demonstrate to each other moments of affiliation that serve as indices of group cohesiveness.

Analyzing Conversation

Since the 1970s the use of a micro-analysis tool, Conversation Analysis, has been successfully applied in two-party conversations to demonstrate the systematic way interlocutors demonstrate their affiliation or disaffiliation towards the other. The seminal work of Sacks, Schegloff, and Jefferson (1974) demonstrated that persons reliably and systematically order their conversation with regard for the mutual construction of a communication event and that they use recognizable linguistic devices to accomplish this joint action. The conversational devices that are tactfully employed reveal the interlocutor's intentions toward one another. A few of these social actions include the use of devices to politely disagree (Pomerantz, 1984; Sacks, 1987), to soften a potential rejection (Sacks, 1992; Schegloff, 1980), and to repair problems in speaking, hearing, or understanding (Schegloff, Jefferson, & Sacks, 1977). Researchers have successfully used Conversation Analysis to demonstrate affiliation and disaffiliation through the strategic deployment and placement of conversational devices (Jefferson, 1985; Lerner, 1996; Conroy, 1999).

In recent years the use of Conversation Analysis has been extended to the study of multi-party interactions of proficient language users and mixed groups where speakers were less proficient (Bolden, 2011; Bolden, 2012). Research using Conversational Analysis has also studied interactions between two or three persons involving individuals with aphasia (Ferguson, 1994; Laakso, 1997). Further, it has proved useful in identifying preserved communicative strengths of individuals with aphasia (Simmons, 1993; Simmons-Mackie & Damico, 1997; Perkins, Crisp, & Walshaw, 1999; Beeke, Maxim, & Wilkinson, 2007). Ultimately, the use of Conversation Analysis as an assessment technology has illuminated therapy techniques resulting in improved conversation ability as well as increased

satisfaction among conversation members, both aphasic and non-aphasic (Booth & Perkins, 1999; Wilkinson, Bryan, Lock, & Sage, 2010). Conversation Analysis has been utilized to objectively demonstrate a myriad of phenomena under scrutiny in multiple disciplines including anthropology, sociology, psychology, and aphasiology. It is uniquely suited to capturing how moment by moment and conversation turn by conversation turn social cohesiveness builds and is demonstrated in the course of conversation based aphasia treatment.

The Purpose of this Investigation

Interest in exploring aspects of conversation within a therapy group grew out of the cumulative experiences as a clinician, working alongside persons with aphasia and becoming increasingly aware of the therapeutic value of conversation based therapy and group model therapy. Group participants would make statements such as, "in here, we are the normal and ya'll are different." Students would report that strategies they had been working on in an individual session would not generalize to the group until their client observed another person with aphasia using the targeted strategy during a group session. It became clear that there was a force at work that emanated from within the group setting. By reading literature from both disciplines of aphasiology and psychotherapy it became apparent that these observed behaviors related to social cohesiveness. Although the term, cohesiveness had been almost exclusively attached to psychotherapy the concept had been described in aphasiology as engagement and affiliation. The aim of this investigation then is to examine conversation among persons with aphasia and the group therapy facilitator(s) for recurring indicators of cohesiveness or affiliation. Conversations occurring at key points in a semester of treatment were analyzed locally and sequentially for the synergistic effect in which conversation

demonstrated group cohesiveness and social cohesiveness shaped conversation. This study will hopefully lead to a more fully developed understanding of cohesiveness as a therapeutic factor and the power of conversation to build cohesiveness among group members that allows for re-shaping social constructs of aphasia from one of isolation to one of an engaged member of a group committed to a common goal.

In the following chapter, Chapter Two, the concepts that bear upon this investigation (aphasia, group therapy, and social cohesiveness) will be explored. How aphasia isolates previously fully-functioning independent members of a community from the moment of onset and how treatment has evolved to ameliorate this effect will be explicated. To that end, the history of aphasia and therapy, the psychosocial effects of aphasia, the efficacy of group treatment, the development and demonstration of group cohesiveness, and the evidence of cohesiveness or affiliation in conversation will be reviewed. In Chapter Three the methodology most suited to this investigation will be outlined and described. A rationale for the selection and strategic employment of these tools will inform this section as well. Chapter Four will convey the results of the investigation at the participant and clinician level. The documented excerpts of conversation will provide reiterative evidence for the manifestations of social cohesiveness in the conversation of persons with aphasia within a group. Chapter Five will compare and contrast the conversational manifestations of social cohesiveness between participants, facilitator(s), and the group as a whole to reveal consistent conversational devices to demonstrate social cohesiveness as well as how individuals develop consistent but personal means for displaying social cohesiveness. It will present the interactive relationship between group cohesiveness, conversation strategy use, context, and conversation changes. This investigation will culminate in Chapter Six, where conclusions

will be derived, possible implications will be explored, and directions for future research will be posited.

This inquiry has potential significance for applied language and speech sciences with regard to advancement of theory and application to the functional communication treatment of persons with aphasia. The results of this investigation will provide evidence of the naturally occurring phenomenon of cohesiveness as a therapeutic factor with its own ameliorating properties within a group treatment paradigm. Further it will prove that Conversation Analysis is capable of demonstrating the presence or absence of cohesiveness as a more objective index of this therapy component. Within the area of clinical practice, findings will strengthen the assertions of the positive impact of group therapy. This impact has ramifications for payment of services as well as demonstrating the efficacy of services. Also, conversation as an advantageous therapy vehicle will be demonstrated in a new capacity. Previous research has looked at the therapeutic effect of conversation treatment for trained therapists and their clients. This research would support the therapeutic effect inherent in the group interaction through peer modeling, motivation, and validation that occur with increased group cohesiveness. Lastly, the very idea of cohesiveness among group therapy participants has largely been ignored in speech pathology. Demonstration of the value of cohesiveness will provide a springboard for the adoption of practices that encourage cohesiveness in group therapy paradigms in the treatment of aphasia.

CHAPTER TWO: Review of the Literature

This chapter reviews the concepts and research that are integral to a discussion of cohesiveness. Researchers across a variety of disciplines have demonstrated the influence that varying levels of group cohesiveness have upon outcomes. Clinical work in psychotherapy has demonstrated the transformative power of a group model and researchers in this field have proposed that among other therapeutic factors, high cohesiveness among a group is an agent of change. To examine how cohesiveness is demonstrated within conversation group treatment, this chapter will be divided into several interconnected and supporting sections. The first section will define, describe, and consolidate key research into the concept of group cohesiveness. The next section will present the relationship between cohesiveness and affiliation, both sociologic constructs, as well as describe how affiliation is accomplished in conversation. A subsequent section will describe the isolating impact of aphasia and how diminished communication may influence cohesiveness. Following this, a section will describe how differing aphasia treatment models contribute to group cohesiveness. The next section will examine the relationship between conversation therapy and cohesiveness as it is currently in practice. The final section will suggest the potential contributions of this line of inquiry.

Cohesiveness as an Important Therapeutic Factor

Cohesiveness has been proffered to be one of many therapeutic factors that work synergistically to improve patient outcome. According to Yalom (1995), cohesiveness is one of 11 primary factors that explain therapeutic change. He acknowledges that cohesiveness is the product of overlapping dimensions which is why providing a universal definition for this concept is problematic. For the purposes of his discussion, he operationalized cohesiveness

as "the resultant of all the forces acting on all the members to remain in the group", borrowing from Festinger, Schachter, & Back (1950). By this, he implied the state of members "feeling warmth and comfort in the group, feeling they belong, valuing the group and feeling, in turn, that they are valued and unconditionally accepted and supported by other members" (p. 48). This definition is similar to that of Budman et al. (1989) whose definition centered on the key ideas of connectedness, working together toward a goal, constructive engagement, and an open trusting attitude.

Burlingame, Fuhrman, and Johnson (2001) added to the description of cohesiveness by stating that it included "all therapeutic relationships in group psychotherapy, namely member-to-leader, member-to-member, and member-to-group relationships of all kinds (alliance, etc.)" (p. 373). Similar to findings in early aphasia group and psychotherapy research, the researchers noted that the group therapy format formed a curative influence in its own right and not a "watered-down" version of individual therapy. From a review of psychotherapy literature that referenced group cohesiveness, they proffered six principles that support and maintain group cohesiveness. These principles take the shape of intrapersonal and interpersonal dimensions in the group therapy context and relate to pre-group preparation, early group structure, leader interaction, feedback, leader contribution, and member contributions. Specifically Burlingame et al. recommend that psychotherapy group treatment be conducted with group leaders orientating toward the following:

- Pre-group preparation that sets treatment expectations, defines group rules, and instructs members in both roles and skills necessary to effective group participation and cohesion

- Establishing clarity regarding group processes in early session

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- Modeling real-time observations to guide effective interpersonal feedback with demonstrable affiliation

- The timing and delivery of feedback to facilitate a relationship building process

- Managing one's own emotional presence to avoid negative impact on an individual or the group as a whole

- Facilitating group members' emotional expression and responsiveness to that of others as well as facilitating a shared meaning from an individual's

- expression.

These principles strongly resemble the qualities of well-managed discourse in group therapy for aphasia which will be described in further detail later in this chapter.

Within the discipline of psychotherapy, the idea that group cohesiveness impacts the attitudes of group members has been demonstrated for decades (Bales, 1950; Gross, 1954). Over the last 30 years it has been researched extensively with multiple studies demonstrating a causative correlation between high cohesiveness and positive outcome (Dinger & Schauenburg, 2010; Goette et al., 2006; Zaccaro & Lowe, 1988). Zaccaro & Lowe (1988) demonstrated that as part of group cohesiveness is working together toward a common goal, an orientation to task impacts the feelings of likability between non-affiliated members. They assigned introductory psychology students into either a high or low interpersonal cohesion group and engaged them in pre-task exercises designed to encourage or discourage "member liking." In addition to placement in high vs. low interpersonal cohesion groups, the students were randomly assigned to high or low task-based cohesion conditions and the task instructions to groups were scripted to enhance or diminish group cohesiveness; stressing the importance of the project and the availability of extra class credit to the high task-based

cohesion group. All subjects were given modeling and instruction for the production of "moon tents", were reminded to work for 15 minutes, and then told to begin. The researchers found that, as expected, the members of high interpersonal cohesion groups demonstrated increased member liking and members of high task cohesion groups were more committed to task performance. In addition, high interpersonal subjects indicated greater task commitment than low interpersonal subjects. There was also an interaction between task cohesion and interpersonal cohesion with high task/low interpersonal subjects liking fellow members significantly less than their low task/low interpersonal counterparts; demonstrating that where subjects were oriented toward maximal performance to gain reward without regard to a common goal, members did not form affiliative ties. This is analogous to the famous quote and picture that resulted from a historic pact by rival playing card producers to eliminate competition and thus protect their market share, "There is a tie that binds us to our homes"; two dogs, straining at their chains show an intense dislike for one another but a strong commitment, or tie, to the task of protecting their homes.

Goette et al. (2006) found that emerging cohesiveness can impact the commitment and expectations of a group toward its members. In a study of officers in training for the Swiss army, these researchers took advantage of governmental policies for compulsory military service and random assignment to training platoons to study the impact of group membership on cooperation and norm enforcement. 228 subjects participated in two experiments designed to create opportunities to demonstrate, or not, cooperation and norm enforcement. Subjects were placed in groups that were of same platoon (in-group) versus differing platoons (out-group). By designing games with a point allocation system that included opportunities for cooperation and punishment for the lack of cooperation, they

demonstrated that cooperation and the expectation of cooperation by others was significantly higher in the in-group compared to the out-group. What was perhaps less expected was that they found no difference in punishment of in- and out-group members where groups were mixed for platoon membership; strong group ties did not result in increased punishment of outsiders. However, punishment for the lack of cooperation was significantly greater for in-group members as opposed to out-group members for same platoon dyads, not mixed, indicating that groups enforced a norm of cooperative behavior toward platoon members that they did not hold for those outside of their platoons.

Whereas both Zaccaro et al. (1988) and Goette et al. (2006) were studying cohesiveness within groups of non-disordered individuals, Dinger et al. (2010) studied 327 psychotherapy patients receiving inpatient psychotherapy. Their research demonstrated that cohesive groups saw individual benefits among its members. Patients received group therapy for 60 minutes twice each week in addition to individual therapy occurring 1 to 2 times per week for 50 minutes. This multi-modal treatment continued an average of 12 weeks. Using self-report scales, they found that "a higher level of cohesion and an increase of cohesion over time were associated with greater symptomatic improvement" (p.26). They also found "an interaction effect between interpersonal problems related to affiliation and the course of cohesion over time" (p.26); higher levels of cohesion and increases in cohesion over time reported by group members were associated with greater symptomatic improvement. Also, differential effects of cohesion were related to patient pre-group personality self-ratings of "too cold" vs. "too friendly" where the latter reported benefit from achieving greater control and distance within the interpersonal parameters of the group therapy.

Finally, several studies have provided an overview of the impact of cohesiveness by analyzing multiple research findings. Johnson, Burlingame, Strauss, & Borman (2008) reported that there could be found no studies where cohesion was associated with detrimental effects and studies reporting positive outcome associated with cohesion outnumber studies reporting insignificant findings. This study relates effectively with an earlier meta-analysis by Mullen and Copper (1994). These researchers found that cohesiveness impacts performance, and vice versa. In a review of 49 research studies for the relationship between group cohesiveness and performance, their aggregated findings demonstrated that this relationship effect was stronger in smaller groups, among real groups as compared to artificial groups, and within groups that shared an increasing commitment to excellence. Further they found that the greatest contributing factor to the cohesiveness-performance effect was the category of "commitment to task" more than "interpersonal attraction" or "group pride." Lastly, contrary to expectation they found that performance influences cohesiveness to a greater degree than cohesiveness impacts performance although the two influence each other in a synergistic fashion when they wrote:

> Rather, to the extent that cohesiveness exerts any impact on performance, it does not
> seem likely that it does so by serving as a "lubricant" which minimizes friction due to
> the human "grit" in the system. (Mullen and Copper, 1994, p. 39)

All of these previously discussed studies suggest that cohesiveness is a more complicated construct than one might suspect. It is involved in group success if defined by performance changes and is mutually involved in the construction of such successes. Over time, the relationship of cohesiveness and performance has been conceptualized in several

ways. The most explanatory analyses involve the relationship between affiliation and cohesion and their impact on performance.

Affiliation and Cohesiveness: A Sociologic Construct

The attribute of affiliation is requisite for group cohesiveness with some researchers conceptualizing affiliation as a key indicator of cohesiveness and others demonstrating an interaction effect between affiliation and cohesiveness (Dinger & Schauenburg, 2010; Burlingam et al., 2001; Greatbatch & Clark, 2003; Lepper & Mergenthaler, 2005; Sildberg, Koenig, Manderscheid, Meeder, & Hornung, 1975). This is amply verified by a number of careful analyses focusing on the mechanics of conversation and how these analyses have demonstrated a close relationship between cohesion and affiliation.

Conversation Analysis as an Objective Demonstration of Cohesiveness

The tradition of research inquiry known as Conversation Analysis (CA) may be the best fitted tool to demonstrating cohesiveness and affiliation objectively by virtue of its "twin features of being context-free and capable of extraordinary context sensitivity" (Sacks et al., 1974, p. 699). This system of notation that can be reliably interpreted at the local level and allows for comparisons across contexts was the outcome of thousands of observations and recordings of conversations across multiple contexts that were distilled into a "simplest systematics for the organization of turn-taking" (Sacks et al., 1974).

Over forty years of research within this tradition of inquiry has convincingly demonstrated that conversation is negotiated in an orderly fashion for the transactional and interactional purposes at hand and that this system of notation has evolved in response to the conversation phenomena under study to include notations for non-verbal communicative behaviors such as eye gaze, gestures, and applause (Atkinson & Heritage, 1984). It is

indispensable for preserving the authenticity of the data from which research is drawn. Analyzing conversation through the use of an almost universal system of notation has allowed both researchers and practitioners alike to document conversational abilities and the role of affiliation and cohesion. Especially in recent years, the use of CA has been extended to the study of multi-party interactions of both proficient and less proficient language users (Bolden, 2011; Bolden, 2012). Conversation Analysis is uniquely suited to capturing how moment-by-moment and conversation turn-by-conversation turn social cohesiveness builds and is demonstrated in the course of social interaction.

Affiliation accomplished using verbal/vocal devices. Work within the area of sociology has explored the attribute of affiliation since the early 1970s through the analysis of units of talk within a conversation that objectively demonstrates affiliation. Even in the earliest development of a system for analyzing conversation, pioneers in what would become CA, acknowledged the power of conversation for affiliative purposes when they wrote "conversation is a vehicle for interaction between parties with any potential identities, and with any potential familiarity" (Sacks et al., 1974, p. 700).

In discussing how persons in a conversation "unpack a gloss", Jefferson (1985) reported several devices that are used for affiliation. Laughter is used to "pre-affiliate" and either affiliate or disaffiliate. The use of "we" also acted as an affiliating mechanism. She further found, in conversations, a "recurrent configuration wherein a recipient's affiliation provides for a teller's shifting into the 'expressive' mode." (p.455) Thus a more intimate mode of communication was evidence of affiliation. She further reported the use of a "hitch-onset" demonstrating a second pair response in affiliation in progress. Research has

demonstrated that persons in multiple types of conversation, full blown arguments excluded, consistently use conversation devices to establish varying levels of affiliation.

This affiliation is demonstrated in our preference for conversational structures that promote a positive identity for one's self and others. Lerner (1996) noted the societal/ institutional organization of conversational actions when he wrote,

> the privileging of one class of actions over another is not a matter of personal
>
> prerogative, but is constituted by structural preferences built into various aspects of
>
> the sequential organization of talk-in-interaction (p. 304).

By studying how our conversation practices support Goffman's (1967) concept of "face" and "face work", Lerner was able to demonstrate objectively how we collaborate to maintain identities of social and communicative competence in conversation. He demonstrated that we organize our speaking turns to favor agreement, favor offerings over requests, avoid rejecting and being rejected, discourage prideful appearance, and allow others to self-repair any conversation breakdowns or other "threats" to their own face. For example, conversation devices used to maintain and increase levels of affiliation include the use of hesitations, discourse markers, and accounts to soften disagreement. Conversation members use pre-sequences to enable offers over requests and accountings over rejections. A conversational device well suited to converting a dispreferred action into a preferred action is the anticipatory completion of a first speaker's utterance by his conversation partner. This can be used to demonstrate agreement, affiliation, and an assessment of the prior talk. Anticipatory completions also serve the purpose of transforming what would be a dispreferred other-correction into the more acceptable self-correction. Related to this, anticipatory completions are used to speak for another while maintaining the first speaker's

rights of owner/authorship. If cohesiveness is embodied by connectedness, working together toward a goal, constructive engagement, and an open trusting attitude, then the devices that support preferred conversation structures for maintaining one's face provide evidence of this therapeutic agent.

This relationship was demonstrated by Conroy (1999) who studied the affiliation and disaffiliation practices in a joint accounting by affiliated partners. In examining a conversation taken from a televised interview about couples dealing with job loss, Conroy discovered multiple recurring indices of content and structural affiliation. Similar to the findings of Lerner, those conversation devices used to achieve structural affiliation included acknowledgement tokens, agreement tokens, upgrades, topicalizers, and turn collaborative actions-namely anticipatory completions. In addition, these affiliated partners used preferred second pair responses, impropriety appreciators, and appreciative laughter. Just as Lerner was able to link the structural affiliative practices in conversation to social affiliation necessary to maintain face, Conroy demonstrated that we can assume affiliation from the structural practices that are linked to it. He concluded that

> the relationship between content affiliations and structural/ sequential affiliations …
> must be examined in toto; signs signify because they are used to accompany the doing
> of external actions, not because they mark some sort of reified, internalized
> "meaning." (p. 357)

Laughter also has been identified as an index of affiliation in studies looking at differing types of conversation among non-disordered individuals (Conroy, 1999; Glenn, 1989; Jefferson, 1985; Jefferson, Sacks, Schegloff, 1987; Lerner, 1996) and those with brain injury (Heath & Blonder, 2003; Kovarsky, Curran, & Nichols, 2009; Madden, Oelschlager,

& Damico, 2002). Glenn (1989) who looked specifically at shared laughter in a multi-party interaction proposed that "laughter may be most fully realized in its small group manifestations rather than as a one-to-one phenomenon" (p. 127). By looking at the distribution of laughs he found that like turn taking, laughter is sequentially organized. Laughter routinely followed completion of a prior laughable utterance but could also occur within the utterance-in-progress at the recognition point of humor. He found differences for features of shared laughter between two-party interactions and multi-party interactions. In multi-party interactions, someone other than the current speaker provided the first laugh (70% of interactions) where as it was the current speaker laughing first in two party interactions. The occasions where laughter was initiated by the speaker served the function of attributing authorship of the talk to another or to manage "troubles telling." This has implications for how affiliation and ultimately group cohesiveness is established with multiple parties sharing in the building of cohesiveness and any single party having the ability to erode building affiliations. That laughter serves an affiliating function was demonstrated in response to group oriented questions and in episodes of co-storytelling, co-answering another party's question, and teasing.

Madden et al. (2002) looked at laughter in the conversation of a man with aphasia, his wife, and his speech therapist. This man used laughter to affiliate with the emerging conversation. He used laughter to delay and to diminish the dispreferred status of a statement that could have been received as a social impropriety. Further, he used laughter to appreciate the humor of others similar to the function reported by Conroy (1999). In his study of conversational humor among stroke survivors, Heath & Blonder (2003) noted that "the negotiation and sequencing of laughter in conversation is a means of demonstrating

affiliation or distance with other speaker" (p. 92). Laughter was identified as an index of engagement in the communicative interactions of a group of persons with traumatic brain injury in the investigation of Kovarsky, Curran, and Nichols (2009). They found that laughter served as a reliable index of group cohesiveness and was used to establish and maintain face, build rapport, and build solidarity. Simmons-Mackie & Schulz (2003) studied the episodes of humor in 8 therapy sessions of 7 individuals with aphasia and found multiple functions of humor and its related laughter. As a function of building solidarity and affiliation, they found that "sharing humor and laughing together was one method of connecting and joining together to acknowledge mutual appreciation of something" (p. 758). Part of this solidarity was the pursuit of a trusting attitude inherent in cohesiveness accomplished by the self-deprecating humor and associated laughter by the therapist. The therapist also used humor with laughter to minimize the dispreferred status of other correction, when the client struggled in therapy, and of disagreement. The use of humor to build solidarity in these sessions often was the result of a reversal of therapy routine and expectations. By altering the traditional expert clinician-disabled client roles, both parties achieved greater trust, engagement, and connectedness. Heath & Blonder (2003) reported multiple functions of humor in the conversation of IWAs during interviews to include re-asserting autonomy, promoting self-esteem, and maneuvering social distance. This is similar to the role that joking served in the study of small group processes during challenge course experiences (Rothwell, Siharath, Bell, Nguyen, & Baker, 2011) where the authors concluded that the joking culture formed a collective identity through cohesion. They proposed that group facilitators employ joking to "help build trust and cohesion among groups" (p. 351).

Affiliation accomplished through gaze, facial display, and gesture. "Posture, gesture, facial expression, preceding talk, voice quality, and the like all till the soil into which the words are dropped" (Schegloff, 1984, p. 291). Just as conversation was once thought unruly and impossible to reliably study in its natural state, non-verbal signals such as gesture, gaze, posture, and facial changes were thought to hold little reliable relationship to the spoken message. Research, both qualitative and experimental, has demonstrated that speakers and listeners not only deploy non-verbal signals communicatively, they do so strategically (Abramovitch & Daly, 1978; Bavelas & Chovil, 1997; Bavelas, Kenwood, Johnson, & Phillips, 2002; Bavelas & Chovil, 2006; Brunner, 1979; Goodwin & Goodwin, 1986; Kendon, 1996; Krantz, George, & Hursh, 1983; Ruusuvuori & Peräkylä, 2009; Schegloff, 1984; Stivers, 2008).

With regard to the communicative function of gaze, both Abamovitch & Daly (1978) and Krantz et al. (1983) demonstrated that as early as four years of age, children make consistent judgments of affiliation based upon head orientation; whether the speaker was facing them or not. Further, they found that visual gaze and mutual gaze increased developmentally from around four and a half years of age to seven years with children showing an affiliative preference based on eye gaze by six years of age. Krantz et al. further found that there was an increased use of gaze by speaker and listener with utterances of greater length and that gaze related utterances resulted in a greater proportion of relevant language responses. Goodwin (1980) proposed that gaze was one of many interactional devices that contribute to the coordination of the speaker-listener dyad in face to face talk. By analyzing a large corpus of conversations, Goodwin established that speakers and hearers follow implicit rules governing the coordination of gaze. First, a speaker should obtain the

gaze of his recipient during the course of a turn at talk. Second, a recipient should be gazing at the speaker when the speaker is gazing at the hearer. These expectations are strong enough that when they are violated, the speaker will use conversational devices to gain listener gaze such as pauses and restarts. Gaze was employed strategically in a two party conversation when the speaker experienced word finding difficulty (Goodwin & Goodwin, 1986). During word searches the listener increased his gaze at speaker to indicate attention to the activity and orientation to the co-participation of the talk in progress. The speaker however most often averted his gaze during word searches. On occasions where the speaker would enlist the help of the recipient for resolving the word search he would coordinate gaze, thinking face, and gesture which the recipient responded reliably to as a signal for participation in the word search. They further reported that gaze aversion could also be used as a gestural appreciation of the talk in progress or as a preparation for disengagement.

Facial Expression has been an object of study for its ability to express internal states (Ekman & Rosenberg, 1997) and to demonstrate symbolic information for communication (Bavelas & Chovil, 2000; Bavelas & Chovil, 2006; Chovil, 1997; Clark, 1996). Paul Ekman, considered a pioneer in the study of facial expression as a window into a person's emotional state himself commented on the difficulties inherent in distinguishing facial movements made deliberately to communicate from involuntary emotional expression and proffered that there could be no taxonomic distinction (Ekman, 1997). However, Clark (1996) disagreed, writing, "Although many facial expressions depict pain, disgust, surprise, happiness, they don't depend on speakers' being in those emotional states" (p. 181). Because this research agenda is concerned with how cohesiveness in groups is accomplished in conversation and not divining the internal states of our group members, facial expression will be treated as a

symbolic demonstration of a contextually related referent. Little work into the social communicative function of facial expression was done until Chovil (1997). To avoid confusion between the functions of facial expression for communication as opposed to projecting internal states, she adopted the term facial display (Kraut & Johnston, 1979)and that is the term that will be used to operationalize the findings of this research. Chovil, as part of her 1989 doctoral dissertation (unpublished), analyzed more than 1,000 facial displays, not including smiles, with no a priori categories for function and found that the use of facial expression clustered around the following functions for speakers and listeners. In an area she termed semantic, she found that speaker's facial displays were redundant (duplicative) to their speech 60% of the time and both they and the non-redundant (novel information) displays served the purposes of personal reaction, portrayal, thinking/ remembering, facial shrug, and as a "yes." According to Chovil, facial displays also served a syntactic function and this was demonstrated in the use of grammatical markers such as emphasizers, underliners, and question markers as well as in the use of story organizers such as story continuers. Facial displays were also used by the speakers to manage speech corrections. Bavelas & Chovil (2006) demonstrated the ability of a facial expression (puzzlement) to repair and replace the spoken component of "str-" which, based upon context, was to be "strange." Facial displays were also demonstrated by listeners, although with significantly less frequency, and were used as back channels, personal reactions, and motor mimicry; the latter two demonstrating the listener's affiliation to the content of the speaker's message. Brunner (1979) demonstrated that the facial display of smiling was strategically placed at the end of communicative clauses, acting as a back channel similar to nods to signal understanding. As symbolic constructions, facial displays represent a referent in a continuum

from iconic to metaphoric. At the very iconic end is the motor mimicry a listener often engages in during stories of close calls. As part of a co-constructed message, a facial display of disgust might accompany talk of eating tripe and this display closely resembles the attitude the speaker is trying to convey. A more metaphorical display might be that of squinting as a listener response to an incredulous story. The squinting will not improve your sixth sense, vision for lie detection, but its practical relationship to improved sight has become associated with "seeing the truth." According to Krantz et al. (1983), facial displays of the speaker can serve to modify, elaborate, or even negate the literal meaning of an utterance. This feature of facial display was explored by Bavelas and Chovil (2006) in describing how audible and visible signals can contradict each other during the construction of joking and sarcasm. This feature provides significant support to the proposition that we construct meaning as a whole in conversation using multiple methods. Another feature of facial displays is that of temporal flexibility. Facial displays can be rapidly and subtly deployed as well as modified to secure shared understanding and affiliation. Therefore, facial display is "a resource both for the speaker and for the recipient and it serves in the construction of meaning as well as in shaping the relationship between the participants" (Ruusuvuori & Peräkylä, 2009 p. 392). Perhaps the most important feature of facial displays which was alluded to earlier is reliability with which a listener can correctly interpret the signal. Camras (1977) found that in a situation where two children both wanted the same toy when the child holding the toy made an aggressive facial display, the other child would wait longer before attempting to take the toy as compared to when there was not an aggressive visual sign.

Gesture as a communication channel has been studied for much longer and in greater depth than facial display. Even so, there continues to be controversy on whether gesture is a

deliberate communication act or merely the overflow from the effort of speaking (Kendon, 1996). While the self-cuing function of gestures is acknowledged, the research below will demonstrate definitively that gestures are used strategically and in a systematic manner that is tightly coordinated with speech. As evidence of the communicative nature of gesture, research has focused on the selective adaptation of communicative behaviors to a particular listener, also known as recipient design (Garfinkle, 1967). In multiple experimental studies of gesture Bavelas et al. (2002, 2006) and Gerwing & Bavelas (2004) found that speakers adjusted their use of gestures based upon whether or not there was a recipient. They demonstrated that although speakers do gesture when they are unobserved, they gesture significantly more when a recipient will see them. Further, speakers tend to use deictic gestures more often when a recipient will see them. Also, speakers shifted more information from words to non-redundant gestures when recipient would see them. When accompanying new information, gestures were larger and clearer but when the gesture accompanied a referent that was known information, the gestures were smaller and less precise.

Schegloff (1984) transparently outlined the relationship between gesture and talk; demonstrating the precise coordination of the two expressive modes to tailor the message to the listener. He noted that gestures are organized to support talk in four different ways. Gestures used repetitively and with rhythm are used to stress or highlight salient content in the verbal message. Gestures that are iconic, emblematic, or deictic are paired with a lexical affiliate. Gestures often refer to a type of turn or type of action done by the turn such as in the case of spatial gestures. Lastly, just as facial expressions can act to correct speech errors, gestures serve a function for repair operations. They are most often associated with self-repair using a redundant gesture. They are used as a "nonetheless" repair wherein a gesture is

substituted for the speech error. Often gestures are used as the primary vehicle of meaning where in a speaker cuts off a turn construction unit (TCU) to complete the utterance with a gesture that more succinctly demonstrates a complex idea. Schegloff (1984) and Kendon (1996) reported that gesture use is systematic to the point that when, where, and how gestures are deployed can be predicted. Gestures have several phases which include onset, acme or thrust, and retraction. Further, most gestures return to a home position before being redeployed. A pointing gesture is always in the direction of its referent when that object is present. However, if the object is not present the speaker does not consistently point in the direction of the referent. Spatial gestures that act as references to different places employ different local space sectors for their associated gestures and subsequent references to the same place employ the same sector as previously used. An extension of this rule is that a new lexical referent that is associated with a previous one is assigned the same spatial sector. Additional evidence of the synergistic deployment of gesture with speech lies in the fact that the onset of a gesture always precedes its lexical referent. In fact, the acme or thrust and retraction of the gesture often precede the lexical referent. Further, gestures never cross clause boundaries (McNeil, 1985). The type of gesture used for a lexical referent is another indication of recipient design. Gestures are either redundant, demonstrating an idea that is also represented in the talk of a speaker, or non-redundant, contributing novel information. Bavelas et al. (2002) demonstrated that when speakers described an item or event for which they lacked sufficient vocabulary, they used more non-redundant gestures. The evidence for the deliberate and communicative nature of gestures is not only well supported through experimental designs and analysis of naturally occurring conversation, it is supported through commonly accepted conversation principles. In his work on general principles of cooperation

during the establishment of social interaction, H.P. Grice (1975) eloquently outlined maxims of conversation organized along the strands of the quantity, quality, relation, and manner of communication. Of interest to the strategic use of gestures are the maxims of "do not make your contribution more informative than is required", "avoid ambiguity", and "avoid prolixity" (pp. 45, 46). Speakers distribute the construction of meaning across both verbal and visual modalities, which include gesture, facial expression, and gaze to demonstrate their intent to the listener in the most perspicuous fashion possible. Indeed, gestures and speech are so intimately bound up with one another they must be seen as inseparable acts of the same utterance (Kendon, 2004).

Clearly, gesture is intertwined with speech in the demonstration of intent. So, how might aphasia affect this relationship? Goodwin (2000) studied the interaction of a man with aphasia whose spoken contributions to the conversation were limited to "yes", "no", and variously intoned reduplications of the syllable "duh." With the lack of availability for verbal communication as a resource, this man relied on gesture as his primary communication vehicle. He used gesture strategically and in social collaboration to achieve alignment and affiliation with his conversation partners. Of greatest interest was the work he would do to secure listener gaze and how he would shape listeners' responses through gesture modification. Goodwin proffered that in the absence of talk to support gesture, the parties involved in the interaction had to employ an organizing framework for successful interpretation of his gestures. This framework involved beginning with specific hand shapes, recognizing gestures as patterns of movement as opposed to static signs, and recognizing that locating the lexical affiliate of a gesture does not ensure the meaning has been established. Additionally, the gesture space that interlocutors must attend to involves not only the

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speaker's body but the addressee's as well. Further, although a dispreferred action in conversation, when negotiated and agreed upon, an "other party" can speak for the person with aphasia. Lastly, sequential organization of gestures and verbal responses is required to establish meaning.

This hierarchy of frameworks for the establishment of meaning has particular relevance to the achievement of affiliation and cohesiveness in group conversations. In his concluding note, Goodwin aptly describes the complex interaction of context, talk, and gesture in accomplishing meaning:

> The web of meaning implicated in the organization of gesture does not stop at the actor's skins , but encompasses as well features of their environment and historically structured representations of many different kinds (maps, images, graphs, computer screens providing access to worlds beyond the immediate situation, etc.) which give meaning to gesture in a variety of different ways. (p. 96)

The Impact of Aphasia: Isolation in Contrast to Cohesiveness

If cohesiveness describes the connectedness of a group, the impairment of aphasia presents as a barrier to this possibility due to the isolation most often inherent in aphasia. This isolating effect of disability in general and as related to aphasia has been recognized and addressed in the World Health Organization's (WHO) revising of the International Classification of Functioning, Disability, and Health (ICF) in 2001 (World Health Organization, 2001). Within this new position statement, the WHO mandated a "conceptual framework for information that is applicable to personal health care, including prevention, health promotion, and the improvement of participation by removing or mitigating societal hindrances and encouraging the provision of social supports and facilitators." (P. 6). This was

accomplished by indexing disability within both Functional and Contextual domains. The

Functional domain of disability, which reflects an orientation to the disabled as an individual

acting on his environment, includes the components of body structure, body function, and

activity/participation. Contextual contributors, which accounts for the interaction between the

individual and his environment, include Environmental Factors and Personal Factors.

According to the ICF, environmental factors

> make up the physical, social, and attitudinal environment in which people live and
>
> conduct their lives. These factors are external to individuals and can have a positive
>
> or negative influence on the individual's performance as a member of society, on the
>
> individual's capacity to execute actions or tasks, or on the individual's body function
>
> or structure. (p16)

These factors are defined specifically at the individual and societal level with individual

related factors including

> … the immediate environment of the individual, including settings such as home,
>
> workplace and school. Included at this level are the physical and material features of
>
> the environment that an individual comes face to face with, as well as direct contact
>
> with others such as family, acquaintances, peers and strangers. (p. 16)

Factors at the societal level are

> formal and informal social structures, services and overarching approaches or systems
>
> in the community or society that have an impact on individuals. This level includes
>
> organizations and services related to the work environment, community activities,
>
> government agencies, communication and transportation services, and informal social

networks as well as laws, regulations, formal and informal rules, attitudes and

ideologies. (p. 17)

Because disability is the outcome of the complex relationship between individual

health conditions and personal factors, these factors are inherent to the individual with

aphasia and cannot be discounted in their experiences of disability. The ICF defines personal

factors as

the particular background of an individual's life and living, and comprise features of

the individual that are not part of a health condition or health states. These factors

may include gender, race, age, other health conditions, fitness, lifestyle, habits,

upbringing, coping styles, social background, education, profession, past and current

experience (past life events and concurrent events), overall behaviour pattern and

character style, individual psychological assets and other characteristics, all or any of

which may play a role in disability at any level. (p.17)

Among the stated applications of the ICF are its implementation as a research tool and

clinical tool. It is through this lens of societal responsibility that the isolation and

marginalization of aphasia as well as the ameliorating effects of group conversation treatment

can be examined.

Isolation is only one of a multitude of negative social constructs that influence post

stroke identity formation. This isolation begins the moment an individual enters the hospital

with its associated culture of medical practice. Robert Mackay (2003), a researcher,

sociologist, and person with aphasia described aptly how two competing ideologies, medical

and social, alternately affect a person with aphasia's perception and performance of

competency. He described how from the moment of hospitalization people with aphasia have

"begun an internalization of the medical ideology." (p. 813). He described the medical

ideology as a hegemony whose hold is not easily broken. This hegemony, not restricted to

the physician, was perpetuated by the entire medical staff, through power as practice, and it

reinforced persons with aphasia as being marginalized and isolated. He described a medical

culture where a premium is placed on verbal communication without the acknowledgment of

alternate means of expressing competence. With regard to his own treatment he wrote,

> The doctor was controlling my answers with his questions (incompetence) based on
>
> his professional dominance (legitimacy), his expertise in his terms resulting in my
>
> adjustment, my individual adaption, and my identity, which according to him, was to
>
> "help you recover the loss of cognitive function" – i.e. incompetence. (p. 815)

This acculturated passivity can be contrasted with the simultaneous reaffirmation of

his self-agency as a communicator within the social ideology that existed between him and

his friend Paul who recognized that communication is constructed through a multiplicity of

modalities and by all parties involved. Mackay further reported that unfortunately the

influence of medical ideology encourages isolation and marginalization far beyond the walls

of a hospital. Well intentioned caregivers often emulate the carer control model they observe

in the hospital which leads to creating dependency. The hegemony of the medical model,

according to Mackay, results in a moral regulation mandated by our society who holds

normalcy and "fitting in" in high regard. Erving Goffman (1963) summed up this idea best

when he wrote, "Because of the great rewards in being considered normal, almost all persons

who are in a position to pass will do so on some occasions by intent." (p. 74)

For persons with aphasia this demand is not easily met and the conditioned response

has typically been withdrawal from society. This withdrawal from participation, although

often attributed to language deficit, is likely the result of a socially reinforced change in self-identity among persons with aphasia (Shadden, 2005). However, Shadden notes that premorbid issues, what the ICF would call personal factors, play a role in the degree to which a person experiences feelings of isolation and marginalization. These qualities of pre-stroke persona include 1) sense of self-efficacy and sense of self as empowered, b) the degree to which a person relies on others to define self, c) self-perception as active or passive in social contexts, d) characteristic style of responding to change and challenge, e) value of relationships within family and in the larger social context, and f) prior roles and role expectations as care recipient and caregiver. These factors conspire to create either a person who becomes progressively isolated because of aphasia or lives well in spite of aphasia.

Persons can experience feelings of isolation and exclusion at not only a personal level but, according to Parr (2007), at interpersonal and infrastructural levels. At the personal level, the participants reported experiencing alienation, isolation, lack of identity, low self-esteem, passivity, dependence, bewilderment, fear, anger, apathy, low aspirations, and hopelessness. She noted that aspects of these experiences were often shared by family members who found their lives changed in similar ways. Exclusion at the interpersonal level was reflected in a decrease in close personal relationships post–aphasia as contact with friends and workmates dwindled. These prior platonic relationships were often replaced with relationships with service providers. These relationships were beneficial in cases where the provider was able to communicate with them at a level of success that their family could not. However, many times the relationships were characterized by poor communication and a lack of respect which further fed into the construction of incompetence. New relationships also included those with other service users, but in Parr's study these were not satisfying. Finally, her

participants reported exclusion at the infrastructure level. The social rights they felt most alienated from included the restricted ability or inability to return to work and for many, particularly those participants of pre-retirement age, this lead to an additional indicator of social exclusion; making ends meet. Another exclusionary index was that of inadequate housing, either related to their feelings of safety in their neighborhood or the state of repair of their dwelling. Environmental exclusion occurred in the amount of time persons with aphasia (IWAs) were expected to spend waiting for transportation and services, the physical condition and location of the spaces designated for providing services, and the depersonalized décor of institutional dwelling spaces (e.g. nursing facilities). Access to services became another exclusionary indicator with an inequity in the amount and quality of support services available to participants. They reported this access problem as being directly related to the severity of their aphasia; often information about the service could not be understood or the service provided was mismatched to their level of language ability. This indicator is closely related to the next, information. Parr found that little or no adaption is made in the provision of information by health care workers, social workers, volunteers, or public service workers to accommodate their aphasia. Also related is the lack of training provided to service providers that would enable them to communicate more effectively with the IWA. Howe, Worral, and Hickson (2008) found similar environmental factors that acted as either exclusionary barriers or inclusionary support. Barriers and facilitators clustered around other people, physical environment, or societal barriers. Barriers relating to other people involved their knowledge and thus their actions that placed the IWA in a role of disability. Physical barriers included objects, acoustic issues, and spatial characteristics such as high levels of background noise or "unclear written information." Societal barriers were

closely related to environmental ones and related to expectations of literacy and verbal facility; e.g. writing down contact information to complete a form.

The fact that exclusionary practices and communication barriers conspire to compromise both an IWA's identity and their level of participation in their community is well documented (Cruice, Worral, & Hickson, 2006; Davidson, Worral, & Hickson, 2003; Simmons-Mackie & Damico, 2001; Vickers, 2010). In a single case study, Simmons-Mackie and Damico (2001) examined the effect of aphasia and the effect of subsequent targeted communication partner training on social networks. While pre-stroke the IWA participated in 10 key life events, subsequent to stroke and aphasia her participation had reduced to 4 of these prior activities and the 2 newly added ones were solitary. She reported feelings of guilt and dependence, poor self-esteem, and lack of confidence. Post intervention the participant engaged in 8 of the former activities and her feelings shifted toward those of self-confidence, self-esteem and pride. Davidson et al. (2003) also found the isolating effects of aphasia when they compared the communication activities of 15 older people with aphasia and 15 healthy matched cohorts. Although both groups engaged in similar activities there was a significant reduction in the frequency with which persons with aphasia engaged in communication activities. Aphasics engaged in communication activities almost 5 times less than their non-aphasic counterparts. Further, they found that persons with aphasia communicated with a smaller number of persons over more restricted social situations; their social network was reduced. In addition there occurred differences in topic selection, with the conversations of IWA most often focusing on topics that represented the here and now where they could draw on their environment and common ground (Clark, 2007) to support their communication. When examining isolation through quantitative methodology, Vickers found a significant (p

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< .010) reduction in social network size for people with aphasia; from a mean size of 75.35 prior to aphasia to 39.5 after aphasia. In addition to reduced size of social network, the frequency of contact was also reduced for close friends and relatives (p <.002) as well as among acquaintances (p < .006). Using a self-report scale, it was demonstrated that persons with aphasia perceived themselves as isolated more than connected. Vickers also contrasted two groups of IWA in her study, those participating in a communication recovery group and those not receiving group treatments, with regard to social network, social participation, and feelings of isolation vs. connectedness. These findings will be reported later when discussing group therapy and cohesiveness.

Aphasia Treatment Models: A Paradigm Shift from Isolation to Interdependence

Although there is little systematic research focusing on the impact of cohesiveness on aphasia treatment models, attribution of improved outcome related to cohesiveness has occurred anecdotally in group treatment for aphasia since its inception (Agranowitz, Boone, Seacat, & Terr, 1954; Backus, 1952; Corbin, 1951). Corbin (1951) referred to the individual affiliating with others who struggle with the same difficulty and gaining security from the group to be willing to take risks. Backus (1952) reported an atmosphere of belongingness, acceptance, and security as well as a collective commitment to take communicative risks. Agranowitz (1954) noted sympathy, encouragement, humor, understanding, and affiliation among group members. While the implications derived from the findings of group psychotherapy treatment and early group aphasia treatment programs have not been applied in a systematic fashion, many of the principles generated from small group research on cohesiveness are echoed in the current practices and research of educators, audiologists, and speech pathologists.

This notion of cohesiveness impacting self-esteem was also found in the research of speech pathologists Ross, Winslow, Marchant, and Brumfitt (2006) who found that the conversation experiences of individuals with chronic aphasia improved significantly following group treatment using a total communication approach. They postulated that some of the improvement could be attributed to "changes in psychological well-being due to the group experience [that] heightened the motivation of participants to engage in conversation interaction, which enhanced their conversation experiences and abilities." Simmons-Mackie, Elman, Holland, and Damico (2007) studied six different group sessions, 4 well managed and 2 poorly managed, for aphasia therapy and found recurring patterns of discourse management that resulted in successful treatment. These features bear striking resemblance to the principles identified by Burlingame et al (2001) for promoting and maintaining group cohesion. These shared features (Simmons-Mackie et al, 2007) or principles (Burlingame et al, 2001), in that respective order, include 1) establishing the feel of discourse equality and this can be associated with pre-group preparation and establishing clarity regarding group processes recommended in facilitating psychotherapy groups, 2) Focusing on everyday communication events, avoiding rigidly structured discourse, and aiding turn allocation can be associated with facilitating group members' emotional expression, 3) Using multi-modal communication can be associated with leader modeling, 4) Mediating group communication can be associated with facilitating the responsiveness of others and derived shared meaning of each member's contribution, and 5) Calibrating the use of correction is associated with the timing and delivery of feedback.

In 2004, Shadden and Agan studied identity negotiation within group therapy and found characteristics of group cohesiveness that were integral in the formation of individual

post-stroke identities among group members through the core values of a support group which included, "(a) respect for the concerns and competence of each member; (b) acceptance of each other; (c) affirmation and validation of each member (as capable of change and as fundamentally valuable); (d) encouragement of expression of feelings; and (e) focus on the story of each participant as shared through action, as well as words" (p. 182). In this group, persons experienced connectedness, were working toward a common goal, and enjoyed a trusting open atmosphere where they could share personal, identity shaping information.

Certainly the above studies demonstrate the importance of cohesiveness in establishing a more positive communicative identity for the group and the members that comprise the group. It could be said that this connectedness and "togetherness" becomes a palliative force that counteracts the feelings of isolation that often accompany aphasia and its resultant disability. Despite these few studies and the awareness they bring, aphasia therapies conceptualized as more individualized and behavioristic have done little to ameliorate the isolating effects of aphasia and it has been through socially oriented therapy and group treatment models that the antithetical themes of isolation and social affiliation have been targeted and resolved.

Early speech and language treatment for persons with aphasia that was oriented to their deficits contributed to the construction of an identity of incompetence and promoted social isolation (Simmons-Macki & Damico, 1999). The theoretical orientation of researchers toward aphasia as a personal disability construct promoted clinical practices that reinforced the idea of incompetence and the resulting goal setting that drove therapeutic tasks was centered on areas of deficit. Although the intention of this impairment focused intervention

was reducing deficit which was hypothesized to reduce disability, these therapy tasks also brought to the fore the individual's inabilities reinforcing their identity of incompetence.

It was said best by Hildred Schuell, "what you do about aphasia depends on what you think aphasia is" (Butler, 1982). Early treatments of aphasia were based on techniques such as behavior modification. Therapists subscribing to behavior modification techniques were concerned with shaping a behavior through a stimulus-response paradigm paired with incentive feedback on a reinforcement schedule; they were not concerned with the nature of aphasia since it could not be discreetly measured. Also termed operant conditioning, this therapeutic technique was common in the 1960s with such noted researchers as Brookshire (Davis, 2000) and Bloom (1962). Because behavior modification was unable to create theory for the functioning of an impaired mind it fell out of favor and was soon replaced by a Cognitive Stimulation Approach pioneered by Hildred Schuell (1964). This model was an attempt to link theory with practice and additional researchers such as Darley, Eisenson, Brookshire, and Duffy employed this model in their research. According to this model, the therapist treated the underlying processes and strictly adhered to the following guidelines:

- the success principle where in the clinician presents tasks for which the client can achieve 60% to 80% accuracy,

- controlling the number of items,

- feedback upon error for the purpose of re-stimulation or correcting errors.

This programmed stimulation was evident in intervention programs such as *Language Oriented Treatment* (Bandur, 1986), *the Response Contingent Small-Step Therapy* program (Bollinger & Stout, 1976), and *Therapy subsequent to the Porch Index of Communicative Ability,* (Porch, 2001). These treatments did result in patient improvement for language

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functioning on tests of segmented language abilities. Robey (1998) conducted a meta-analysis of 55 treatment studies and found that the majority followed this cognitive stimulation approach. Further, he found that for these treatment types the treatment effect size for acute phase patients was a very strong d=1.39 as compared to "other approaches" where d=.81 and no treatment where d=0.34.

These approaches were built on the latest cognitive theory coming out of neuropsychology which was employing mostly experimental design studies so it is not surprising that the methods did not take into account the fact that language is constructed socially as well as linguistically. Research and practice within the *Cognitive Stimulation Approach* located deficit within the individual only, ignoring family and environmental systems that interacted directly with the language impairment to promote or discourage functional communication. Commonly, families reported communication ability that was superior to the predictions of formal tests of language skills and these claims were initially dismissed as the overly subjective interpretation of hopeful caregivers. Further, clinical gains and experimental task gains often failed to generalize to functional communication. So, researchers began to target generalization through varied training conditions and through using strategies for mediating generalization (Thompson, 1989). Researchers began to employ nonverbal means of communication to support impaired speech by addressing gestural communication in such programs as *Visual Action Therapy* (Helm-Estabrooks, Fitzpatrick, & Barresi, 1982), use of American Indian sign language (Coelho & Duffy, 1987), and pictograms such as Bliss symbols (Johannsen-Hornbach, Cegla, Mager, Schempp, & Wallesch, 1985). But therapies that addressed the sub-skills of language with the intent of "accurate" production had functional limitations. It was Audrey Holland (Holland, 1977)

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who argued that the transaction of meaning is more important than accurate production; stating that "aphasics probably communicate better than they talk" (p. 173).

Holland's focus on language as a construction of meaning that is shared by the participants was an idea that influenced more functional oriented treatments like *Promoting Aphasic's Communicative Effectiveness* (Davis & Wilcox, 1985), *Conversational Coaching* (Holland, 1991), *Communication Partners* (Lyon, 1992), *Supported Communication for Adults* (Kagan, 1998), and *Situation Specific Training* (Hopper & Holland, 1998). This focus on the context and social influences of communication resulted in a philosophy known as the *Life Participation Approach to Aphasia* or LPAA (Chapey, et al., 2001). In their definition of LPAA the authors write,

> The "Life Participation Approach to Aphasia" (LPAA) is a consumer-driven service delivery approach that supports individuals with aphasia and others affected by it in achieving their immediate and long term life goals (note that "approach" refers here to a general philosophy and model of service delivery, rather than to a specific clinical approach). LPAA calls for a broadening and refocusing of clinical practice and research on the consequences of aphasia. It focuses on reengagement in life, beginning with initial assessment and intervention, and continuing, after hospital discharge, until the consumer no longer elects to have communication support. LPAA places the life concerns of those affected by aphasia at the center of all decision making. It empowers the consumer to select and participate in the recovery process and to collaborate on the design of interventions that aim for a more rapid return to active life. These interventions thus have the potential to reduce the consequences of disease and injury that contribute to long-term health-care costs. (p.279)

With orientation toward the LPAA philosophy and using the functional oriented treatments, clinicians are able to affect change that generalizes from the clinic to the community and employ resources from the community to realize change in the clinic setting.

Increasing Credibility of the Group Treatment Model

Since its realization as a viable treatment model, group treatment has undergone a waxing and waning of acceptance and shifting theoretical ideology with competing methodologies rivaling for dominance. In reviewing the literature it became apparent that orientations toward either Behaviorism as conceived by B.F. Skinner (Skinner, 1974) or Social Constructivist Models (Bruner, 1983; Luria, 1959; Vygotsky, 1986) were maintained concurrently although the popularity or hegemony demonstrated by a particular school of thought fluctuated.

As a response to the overwhelming number of World War II veterans with head injuries requiring treatment, group treatment became an accepted method for treating speech and language disorders (Agranowitz et al., 1954; Aronson, Shatin, & Cook, 1956; Corbin, 1951; Godfrey & Douglas, 1959). According to Corbin (1951), group treatment formalized at the Long Beach Veterans Affairs Hospital was by and large a replication of individual treatment at the Group-Level with persons placed in treatment groups organized by linguistic skill set. However, there also occurred a social component aimed at generalizing language skills to communication in the form of "interview coaching" followed by an actual interview with a visiting celebrity as well as situation specific coaching for ordering from a menu at a restaurant. The reported benefits of group therapy were numerous and by 1954, in this same program, it was recommended that group and individual therapies be employed in a complementary fashion (Agranowitz et al., 1954). However, group treatment tasks continued

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to be prescriptive and did not approach social orientations until the patients had matriculated into the "advanced" groups. In 1956, Aronson et al. described group therapy whose orientation was "toward emotional difficulties and interpersonal relationships." This research came out of a social psychology framework which was reflected in group activities selected that were intended to promote "intra-group cohesiveness"; music rhythm, group singing, story-telling with discussion, and group-centered discussion. Patient attitudes associated with participation included preferences for the group structure, for rhythm and singing tasks, and increased acceptance of a group psychotherapy model. The medical staff associated with the group program reported that the program prevented further deterioration of speech and social relationships.

According to Bloom (1962), in the early 1960s most group treatment models throughout the country oriented to one or more of the following approaches; learning language in a cumulative bottom up approach going from sounds to words to phrases and so on, focusing on group dynamics for purposes of psychotherapeutic support, and focusing on interpersonal relations with an orientation to speech as a social function. The first approach, using bottom up approaches targeting sub-skills of vocabulary, morphology, and syntax became the more dominant practice in the later 1960s through the mid-1980s and this has been attributed to the influence of Behaviorism and the resulting stimulus-response methodologies that this ideology inspired (Elman, 2007). In fact, Bloom (1962) wrote that "group treatment is not prescribed for purposes of providing socialization or recreation" and "the rationale of the group program…has been largely suggested by Skinnerian theory of verbal behavior" (p. 12). Vestiges of this brand of behaviorism continued to influence group treatment models into the early 1990s (Pachalska, 1991). However, around the mid-1980s,

there began a shift in ideology toward language as a socially situated action that was likely

influenced by the research on pragmatics generated within the field of child language

(Elman, 2007). Also, research demonstrated a renewed focus on the importance of treating

the psychosocial consequences of aphasia (Avent, 1997). Further, by the early 1990s,

changing public policy that resulted in reimbursement changes made group treatment once

again very attractive (Frattali, 1992). These trends greatly shaped the appearance of aphasia

group therapy that is practiced presently.

       Not limited to the functions of early treatment models, group treatment for aphasia

can employ a multitude of approaches and speech pathologists report that a typical session

addresses multiple functions concurrently (Eisenson, 1973; Fawcus, 1991; Kearns &

Simmons, 1985; Kearns & Elman, 2001). These approaches include psychosocial treatment,

counseling and support for the family and IWA, speech language treatment groups which can

be further differentiated into direct or indirect language treatment, and the hybrid of

sociolinguistic, transition related, and maintenance related treatment. Kearns & Simmons

(1985), utilizing survey methodology, found that these approaches were used in combination

by 80% of their respondents indicating that approaches to group aphasia treatment cannot be

organized into separate modules. Similarly, the benefits of group therapy are seldom

confined to one or two distinct areas but overlap multiple domains. When comparing

multiple studies of group treatment where benefits/ advantages/ values of this model are

reported, recurring themes emerged. One such theme was that of psychosocial support which

involved feelings of validation, belongingness, decreased isolation, and increased self-esteem

and self-agency (Agranowitz, 1954; Backus, 1952; Elman & Bernstein-Ellis, 1999; Corbin,

1951; Eisenson, 1973; Elman & Vickers, 2010). Another advantage to group therapy

reported widely was the authenticity it brings to the therapeutic paradigm which fosters generalization (Agranowitz, 1954; Backus, 1952; Corbin, 1951; Elman & Bernstein-Ellis, 1999; Elman, 2004; Vickers, 2010). A separate and distinct advantage of group therapy for generalization was expressed as an atmosphere that was created in groups that allowed for functional expression and conditions for growth (Backus, 1952; Corbin, 1951; Elman & Bernstein-Ellis, 1999; Vickers, 2010). These advantages were related to the benefit of increased community participation that was evident for groups (Corbin,1951; Eisenson, 1973; Elman & Bernstein-Ellis, 1999; Vickers, 2010).

An additional benefit of the motivational force of therapy groups was reported in 3 of 8 group therapy studies (Backus, 1952; Corbin, 1951; Eisenson, 1973). Inherent to the group structure are opportunities for self-awareness, decreased speech pressure, observational learning, peer modeling, and multimodal "improvisational" language that provide a therapeutic benefit found only in group treatment formats (Agranowitz, 1954; Backus, 1952; Eisenson, 1973; Elman & Bernstein-Ellis, 1999; Elman, 2004). Lastly, Elman & Bernstein-Ellis (1999) was the only study to report the cost benefit to group treatment but in today's economic climate, this benefit of group treatment must be stated. It is not then surprising given the multitude of benefits that the use of a group treatment model is on the rise.

As the application of group treatment models has increased, so has the evidence of the efficacy for group treatment. Efficacy, as reported in the aphasia research literature, has typically been demonstrated as significant improvement in communication, psychosocial well-being, or both. With regard to communication improvement Bollinger, Musson, and Holland (1993) demonstrated that structured group treatment resulted in significant gains for both functional communication and modality specific processing. In this study, ten IWA

participated in two series of 20 week programs with 10 weeks of treatment withdrawal for each series. Both series of structured treatment employed approaches termed Contemporary Group Treatment and Structured Television Viewing Group Treatment. The first focused on specific communication-related activities that addressed discreet language and communication skills that was integrated into activities meant to approximate real life experiences (core activity) and the discussion of personal and current events (greetings and socialization) while the latter involved watching recurring episodes such as "I Love Lucy" using pre-viewing strategies followed by a series of recall, prediction, and verification activities over the course of repeated and extended television segment viewing with group discussion throughout. At the end of the 60 week period, subjects demonstrated significant gains for the Communicative Activities of Daily Living (1980) and the Porch Index of Communicative Ability (1981).

Wertz, Collins, Weiss, Kurtzke, Friden, & Brookshire (1981) conducted a study of 67 individuals with moderate to severe aphasia across five of the Veterans Administration Medical Centers (VAMC). Participants were randomly assigned to either individual treatment or group treatment. Although the individual treatment group demonstrated superior gains for some subtests on the *Porch Index of Communicative Ability* (PICA), both groups demonstrated significant improvements for tests of linguistic function after 22, 33, and 44 weeks of treatment. It is interesting to note that while attrition occurred in this lengthy study, it occurred to a greater degree in the individual treatment group which may have implications for the motivational force inherent in groups that are cohesive.

As stated previously, efficacy studies often focused on psychosocial changes or improvement in quality of life. Hoen, Thelander, and Worsley (1997) studied 35 IWA who

participated in a community based program where they attended a communication group twice each week for a half day and 12 caregivers attended a weekly caregiver support group. By administering a norm-referenced scale of well-being (Ryff, 1989) twice at six month intervals, they demonstrated significant improvements for psychosocial function in the areas of autonomy, environmental mastery, personal growth, purpose, and self-acceptance.

The majority of efficacy studies have focused on both communication and quality of life, as they are interrelated. Using a mixed methodology design, van der Gaag (2005) assessed psychosocial well-being and communication using three quality of life scales, of which one was a caregiver rating, and one scale of communication effectiveness. In addition to these norm referenced tools, they conducted semi-structured interviews which informed their results along more qualitative lines. A participant group of 28 people with chronic aphasia attended group treatment once or twice weekly with new referrals attending an "induction programme." These participants along with 14 relatives or carers formed their sample. At the end of the 6 months, the persons with aphasia demonstrated statistically significant improvement for one of the quality of life measures and the communication effectiveness index. This perception of improvement was reflected in the responses of the IWAs in the semi-structured interviews. Although the relatives/ carers did not demonstrate a perception improvement to a significant degree, the authors reported positive trending. While encouraged by their findings, the authors did note that the lack of comparison group, the small sample size, and the short duration of the program limit the confidence with which the findings can be interpreted.

Using a smaller sample, seven IWAs, Ross, Winslow, Marchant, & Brumfitt (2006) demonstrated similar findings for communication; citing significant improvement for

conversation experiences between pre- and post-treatment and pre-treatment and follow-up. Their measures of psychological well-being did not reach significance. They noted that the small sample size, constraints and subjective nature of some of the reporting scales, and lack of qualitative data limited the confidence from which meaning can be "extrapolated" from their findings.

Perhaps the best evidence for the efficacy of group treatment though comes from an additional study by Elman & Bernstein-Ellis (1999b). With 24 participants, they addressed the limitations of small sample size reported by Ross et al. (2006) and lack of comparison group reported by Van der Gaag (2005). Other factors that strengthen the validity of their results and thus the implications for practice are being a controlled trial, random assignment to treatment vs. deferred treatment groups, the authors adequately described their sample, the groups did not differ for age, education, months post-onset, or severity of aphasia, that at least one outcome measure was valid and reliable, and p-value is reported. Thus this study demonstrated six out of 7 quality indicators for an efficacious treatment outcome study (Frymark, et al., 2009) and so has provided the most definitive objective evidence to date for the efficacy of group therapy. In their study, participants were randomly assigned to either an immediate treatment or deferred treatment group. While waiting for communication group treatment, the deferred group received socialization treatment through activities such as movement or art classes, support group, or church activities to control for social contact. Assessment of linguistic and communicative performance was conducted using norm referenced tests of linguistic function, tests of functional communication, reporting scales, and interviews at intake, after 2 and 4 months of treatment, and from 4 to 6 weeks following treatment. Treatment included 2 ½ hours of group therapy with a 30 minute social break two

days each week for 16 weeks (32 sessions). The group therapy focused on multi-modal functional communication, initiation in conversation, education of how aphasia was manifested in their lives, personal goal setting and awareness of progress made toward those goals, and promoting speaking confidence for communication situations that were relevant to the individual. At the end of treatment, the authors found significant improvement was made for communication as measured by several research tools. They found that there was no significant effect of social stimulation alone when comparing the deferred group to the immediate treatment group. However, this deferred group did make significant change after group communication treatment was begun. In fact, for both groups, the researchers found significant improvement over time for communication and linguistic measures at both 2 months and 4 months of treatment. At follow up, there was no decline in function (Elman & Bernstein-Ellis, 1999b).

In a separate article, Elman & Bernstein-Ellis (1999a) reported the results of the semi-structured interviews collected at the 2 and 4 month treatment intervals from IWAs and their caregivers who participated in the original study. The findings from this qualitative study supported earlier findings and revealed two areas in which IWAs and their caregivers felt improvement occurred: communication skills and psychosocial adjustment. These themes were supported in the scales of communication effectiveness with significant change demonstrated for IWAs. So although continued research into the efficacy of group treatment will only strengthen the acceptance of this therapy model, it has been clearly established that group treatment for aphasia does result in improved communication.

Conversation Therapy and Cohesiveness: A Reciprocal Relationship

Clinicians that conduct well managed group therapy sessions do employ a variety of conversational practices to increase affiliation and thus engagement and cohesiveness. In their review of well managed discourse in aphasia group therapy sessions, Simmons-Mackie, Elman, Holland, & Damico (2007), noted the use of anticipatory completions, and topicalizers that encouraged increased engagement by all members. They used intonation paired with recasting and expansion to demonstrate interest and affiliation. They demonstrated creative conversational practices such as embedded correction through recasting and clarification questions to minimize the dispreferred structures of other correction and disagreement. Experienced clinicians also employed humor and the associated laughter to equalize status within the group members which contributed to increased cohesiveness. These practices were also evident in the conversation therapy groups analyzed by Simmons-Mackie & Damico (2009) for the interactive resources employed by clinicians to maintain engagement. They operationalized engagement and its implications, according to Tannen (1984) in a similar fashion to that of group cohesiveness when they described engagement as "a process through which people establish, maintain, and terminate collaborative interactions, and it implies a degree of affective engrossment in the process." They reported that shared laughter was a reliable and consistent indicator of engagement by the entire group. In addition to verbal conversational devices such as affiliative statements, recasting, and humor, the clinicians employed non-verbal indicators and facilitators of engagement such as directed gaze, body orientation, and gesture.

Potential Impact

The contributions of this research to the areas of aphasia research and treatment may be many. This study may demonstrate the power of CA to document the therapeutic agency of group cohesiveness in an objective fashion that to this point has not been achieved. It may lead to an increased understanding of the reciprocal effects of group cohesiveness and group conversation upon each other. This would include an understanding of how clinicians establish and maintain group cohesiveness through their verbal and non-verbal conversation practices as well as how IWA demonstrate their affiliation toward a group in conversation treatment and the changes in conversation that are influenced by group cohesiveness (member- clinician, member-member, and member-group).

CHAPTER THREE: Methodology

Research agendas focusing on the segregated areas of conversation in aphasia and group treatment in aphasia have grown over the last decade, and a logical extension of this is the study of aphasic conversation at the Group-Level. When studying group treatment paradigms it has been established that many factors conspire to create successful outcomes and group cohesiveness has been demonstrated to make a significant contribution to this effect. This was discussed in the previous chapter. Despite these points, little evidence exists as to the mechanisms that contribute to the impact and efficacy of cohesiveness in aphasia group therapy. Therefore it becomes essential to study aphasic conversation at the Group-Level with an orientation to developing cohesiveness.

An examination of conversation therapy, where IWAs and clinicians are engaging in authentic, naturally occurring, and context-driven interactions, will contribute to the research agenda that demonstrates and supports the advantages of functional aphasia treatment to realize increased communication and social participation. Specifically, by looking at how conversation changes over the course of a semester in group conversation treatment, we can locate the client and clinician strategies and practices related to group cohesiveness, acting as a catalyst, that result in improved communication and participation within conversation. This knowledge will hopefully shape how we conceptualize group treatment and authentic tasks such as conversation to improve communication in additional contexts away from the confines of the treatment group. This, in turn, will enable us to realize noticeable gains for resuming life activities that had been previously reduced due to the social construct of handicap.

To accomplish this goal, an orientation to qualitative research methodology, was employed. Within this tradition of inquiry, tools best suited to the research questions were applied. Conversation, although proven to be systematic, is bound by the context in which it is situated and therefore to remove behaviors from this context would invalidate the event to be examined. As such, a qualitative design allows the researcher to preserve the authenticity of the data being studied. A detailed explication and rationale for the methodology and tools of analysis used will be provided throughout this chapter as they relate to the research questions asked and methods employed in this investigation. The first section will present the research questions and sub-questions that serve to supplement existing knowledge of conversation treatment at the Group-Level. These questions will focus on the *how* cohesiveness is accomplished as well as the *how* it impacts conversation over time within a therapeutic setting. The second section will delineate the scope of this research endeavor and provide operational definitions of the phenomena under study. In section three the rationale for employing qualitative methodological tools as well as an explication of the objectives and advantages of utilizing these tools will be provided. This will be followed (section four) with a description of the decision making involved in participant selection and criteria for inclusion as well as detailed participant descriptions both before and since the onset of aphasia as it relates to their suitability to the study and specifically their propensity for affiliation and the resultant cohesiveness. The next section (section five) will explicate the data collection procedures that have been selected to capture the behaviors of interest. In addition, a description of the contexts in which the data sources were gathered along with the data collection schedule will be provided. The sixth, and final, section details the data

analysis procedures that were deployed in a cyclical fashion with focus returning to the native data.

Research Questions

As discussed in Chapter Two, research in related disciplines has demonstrated the contribution of group cohesiveness to improved therapeutic outcomes, and speech language pathologists have begun to embrace this therapeutic agent in areas of counseling and group treatment. The impact of peer modeling and Group-Level support, validation, and problem solving have been demonstrated in improved psychosocial ratings and in many cases improved scores on discreet assessment tools. Based upon findings in areas that relate to group conversation, clinicians have been designing Group-Level treatments targeting functional communication goals. The small amount of research into group conversation among persons with aphasia and lack of research into the manifestations of group cohesiveness in conversation treatment necessitate further investigation into this area. As a result, the primary research question posed is: *How is cohesiveness manifested in aphasia group conversation therapy?* Inherent in this question is the assumption that cohesiveness exists between member-clinician, member-member, and member-group and, similar to groups receiving psychotherapy treatment, behaviors among the group of persons with aphasia can indicate high levels of cohesiveness. Therefore we must look at the changes in group conversation patterns among and across individuals. Based upon this, the following sub-questions are proposed to refine the primary research question:

1) *How do IWAs demonstrate group cohesiveness?*

2) *What are the possible conversational changes that occur over the course of a semester?*

3) How does the pattern and distribution of conversation strategies used by participants

   change over a semester of treatment?

4) How does the behavior of the clinicians foster group cohesiveness?

5) How does the behavior of the clinicians result in a change in conversational

   strategies?

By addressing the conversational strategies and behaviors of clinicians and IWAs as a

group through the above sub-questions, the general question of how social cohesiveness is

manifested and changes throughout a semester can be most conclusively explicated. Group

cohesiveness involves member to member, member to clinician, and member to group

relationships so by examining the conversation patterns of individuals in conversation with

other IWAs, with clinicians, and within the group as a whole the multiplicity of

manifestations of group cohesiveness can be demonstrated.

Scope and Definitions

As stated previously, conversation and cohesiveness among non-brain injured persons

have been studied extensively and they are broad areas of interest separately, which makes an

exhaustive study of the two combined impractical. This investigation will focus on the areas

of conversation and cohesiveness that inform each other and are most salient within

conversation therapy among persons with aphasia. The scope of this endeavor then is bound

by the context in which the conversations took place and by the behaviors that are readily

observable through video analysis.

In as much as conversation is an achievement requiring the dynamic, synchronous

deployment of a multiplicity of communicative behaviors within an environment that

influences and supports these behaviors to varying degrees, this investigation will examine

those behaviors that contributed to the co-construction of conversation and demonstrated the subject's orientations toward or away from the ensuing cohesiveness. These behaviors include the spoken word, gesture, gaze, facial expression, and body proxemics; rarely does a single behavior carry communicative intent in isolation. Rather, intent is achieved through the strategic application of behaviors in combination which are shaped by the context of the conversation and the common ground that characterizes typical day to day conversation. However, for the purposes of delineating the scope of this investigation they will be operationalized as separate entities. First and foremost, conversation constructed through the spoken word will be examined. It is through examining the verbal conversation turns alone that the methodology of Conversation Analysis (CA) was born. Harvey Sacks developed this tool using telephone conversations from a suicide hotline, with only the spoken words to guide his endeavors. Analyzing the spoken word, however, must be done through a filter of the para-linguistic and extra-linguistic forces that shape the intent of the spoken word (Clark, 1996). Therefore, attention will be paid to the timing and intonation of verbal messages as well as the influence of common ground in the interpretation of the intent of the spoken word, be it literal, figurative, or sarcastic.

Second, gesture as a vehicle for communicating meaning and as a conversation turn taking device will be addressed. Gesture types present in the conversation that serve communicative purposes include deictic, iconic, and symbolic (McNeil, 1985). Third, the use of gaze serves a regulatory role in conversation (Clark, 1996). Directed gaze can be used to signal interest and affiliation with a speaker's message and can signal to a listener a next speaker turn allocation (Argyle & Cook, 1976; Kendon, 1967; Goodwin M. , 1980; Mehrabian, 1972). Among both non-aphasic and aphasic individuals, gaze is often used to

signal a request for assistance in repairing a message (Goodwin, 1996; Hosoda, 2000; Laakso & Klippi, 1999; Simmons-Mackie & Damico, 1997). Diverting one's gaze is communicative as well; signaling disinterest or disaffiliation (Clark, 1996). It also can signal the speaker's desire to self-repair during a message breakdown (Laakso, 1997). A fourth channel of communication lies in the use of facial expression and research has demonstrated the systematicity with which coordination of the movements of eyebrows, eyes, and lips convey attitudes, affect, and emotions that are readily interpreted by conversation participants (Bavelas & Chovil, 2000; Ekman & Rosenberg, 1997). Lastly, the way we orient our bodies toward a conversation, body proxemics, carries meaning. We signal our interest and disinterest in a particular topic by whether or not our bodies lean toward or away from the conversation. In competing conversations or activities, we signal our commitment to one over the other with our body orientation (Kendon, 1996).

These behaviors will be addressed in the communication of our subjects as the limitations of the physical context will allow. Where a subject cannot be viewed due to obstruction by another conversation member or by leaning out of the field of the camera, there will be no report of facial expression or gestures as you cannot report on something you cannot observe. However, each of the above behaviors are useful components of conversation and worthy of study as they are the primary sources of meaning making for the members involved; in varying degrees based on the individual nature of each person's impairment.

Qualitative Research: Objectives, Advantages, and Rationale

Qualitative Research has been successfully employed to explicate social phenomena since the mid-9th century. Through Franz Boas (Boas, 1911) who became known as the

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"father of modern anthropology"; it has steadily climbed in stature as a legitimate method of inquiry. It has been described as a "bricolage", being a pieced-together but carefully constructed set of practices and strategies used to provide solutions to a problem in a concrete situation (Levi-Strauss, 1966). The overarching objective of qualitative research is to "understand and represent the experiences and actions of people as they encounter, engage, and live through situations" (Elliot, Fischer, & Rennie, 1999). Inherent in this understanding is the multiple objectives accomplished through an orientation to qualitative methodology (Damico, Simmons-Mackie, Oelschlaeger, Elman, & Armstrong, 1999). First and foremost, the researcher must be committed to taking a learning role. The researcher enters into the authentic activity with a *novice* perspective, remaining open to the perceptions of the subjects. An additional objective of qualitative research is the understanding of procedural affairs. The qualitative researcher asks *how* and *what* questions when examining an event. He does not ask *why* questions which presupposes a hypothesis. A third objective of qualitative analysis is to present a detailed view. Rich description of the context and behaviors contributes to a more productive interpretation of the event and improves the validity of the research which is often viewed in terms of researcher's ethical responsibility. Qualitative research focuses on the individual. Since a constructivist view maintains that social action and perceptions are created by individuals, shaped by individuals, and maintained by the individuals that form a culture, research into any event must begin with the individuals that comprise and construct that event. Finally, because individuals construct and accomplish social action through day to day events, the objective of qualitative social research is to study and describe these day to day events, also known as *understanding the mundane*.

To achieve these objectives qualitative research is guided by a set of criterion. First qualitative research is oriented to social phenomena; those events that arise from interactions situated within a culture. Second, it is concerned with an activity that is contextualized and authentic. Third, qualitative research involves systematic collection and treatment of data. Fourth, it seeks to describe phenomena in order to stay true to the authenticity of the event.

Researchers have demonstrated that qualitative analysis techniques can more accurately describe and demonstrate social phenomena in situ than can those quantitative design methods that abstract information to generate an "in general" hypothesis (Agar, 1996; Damico et al., 1999; Strauss & Corbin, 1998). The rationale for qualitative analysis in this body of research flows from four themes: contextualization, understanding, pluralism, and expression (Sutton, 1993). First, qualitative procedures such as ethnography, participant observation, phenomenology, grounded theory, and Conversation Analysis allow the researcher to preserve the relationship between the context and the behaviors being studied. This context sensitive approach to inquiry allows the preservation of individual's perceptions and behaviors as socially and culturally constructed facets of experience (Agar, 1982; Damico & Simmons-Mackie, 2003; Spradley, 1980). Second, qualitative forms of research also address the problem of understanding a phenomenon. Whereas quantitative methods are ideally suited to testing an already established theory, the necessary restrictions in the form of dependent variables hinder the ability to generate new theory or discover the unexpected. Qualitative inquiry, on the other hand, though not concerned with investigative efficiency, is concerned with maintaining greater openness to unanticipated relationships that may suggest new theory. It is also concerned with empathic understanding by faithfully representing authentic action without distortion (Simmons-Mackie & Damico, 1997; Spradley, 1980).

Qualitative researchers have at their disposal a multitude of techniques for organizing,

analyzing, and explaining behaviors which are selected to be ideally suited to the orientations

of the subjects of the research themselves (Damico et al., 1999; Nelson, Treicherler, &

Grossberg, 1992). It is the constant commitment by the researcher to the preservation of the

subject's intent and the use of triangulation of data sources that act as invigilators for

qualitative methods. Third, the "problem" of plurality is inherent in any research tradition,

quantitative or qualitative. However, where the potential for multiple explanations of an

outcome or examiner bias is quite problematic in a positivist approach to research, it

becomes less a problem in interpretive research where the goal is to account for and explicate

findings in relation to the context of occurrence. In other words, examiner bias can never be

completely removed from any method of inquiry. However, the qualitative researcher

acknowledges the influence of her perceptions, which are socially and culturally constructed,

and relates these to the data being interpreted. Lastly, qualitative traditions of inquiry rely

upon very different methods of expressing the results. The focus on maintaining fidelity to

the socially, culturally, and contextually bound data not only requires methods of

interpretation that are suited to this goal, it also requires methods of explication that will be

faithful to the phenomena. Qualitative researchers employ a writing style that acknowledges

a tripartite relationship between the subject, the researcher, and the consumer of the research.

Just as the subjects in qualitative studies are not passive objects and the examiner is not a

neutral entity, the audience to whom results of a qualitative endeavor is aimed is not

irrelevant and requires explication of the results in a way that secures both their ability to

understand the phenomena through the lens of the researcher and their opportunity to

perceive the phenomena through their own interpretation, linking data with interpretation that is faithful to the data and the process.

Within the above rationale for a qualitative methodological orientation, the limitations to both qualitative and quantitative design were alluded to. While either tradition of inquiry will have its limitations, they are mitigated by selecting the appropriate design which in turn informs the selection of the appropriate tools which are best suited to the phenomenon under scrutiny. Experimental design seeks to verify an examiner's a priori assumptions through the collection of very specific data through highly controlled experiments; this leaves little room for the emergence of new facts. While designed to minimize examiner bias and the influence of unintended variables, this process often divorces the behavior being examined from its naturally occurring state, thus distorting the behavior; transforming it from an authentic behavior into a contrived one that no longer represents the intended target of inquiry. This same process often results in such over-generalization that results cannot be applied to specific problems. Vygotsky (1986) explicates this faulty conception well in his analogy of a water droplet:

This method is not true analysis, helpful in solving concrete problems. It leads, rather,

to generalization. We compared it to the analysis of water into hydrogen and oxygen-

which can result only in findings applicable to all water existing in nature,

from the Pacific Ocean to a raindrop. (p. 211)

Quantitative methods are largely concerned with determining how much of an entity there is (Smith & Osborn, 2008) so this research can only answer "either-or" problems. Often, quantitative methods have required that the research question be shaped to fit the paradigm of experimental design and this has resulted in the study of a behavior that in the

end requires great conjecture to associate it with its real life occurrence. For example, see the work of M.J. Pickering who uses computer generated models and laboratory experiments to generate theory related to alignment in conversation (Pickering & Garrod, 2006). In order to fit the data generated by the experimental designs, it must be assigned a numerical value which has now divorced the data from the actual event precluding the faithful expression of the phenomenon under investigation. While there exist many questions that are more readily answered through these methods, questions concerning social action and more specifically, the questions prompting this inquiry are not and therefore a methodology of qualitative design is better suited to answer the question of how cohesiveness is manifested through the conversation changes over the course of a semester for group conversation therapy among persons with aphasia.

The strengths of the qualitative design that make it best suited to the investigation at hand are the very things that differentiate it from quantitatively oriented methods. First, qualitative research is designed to study phenomena in natural settings and the event to be examined in this study is conversation occurring as part of a group therapy setting. The therapeutic nature of group treatment, the influence of the facilitator, and the relationships between members and the facilitator must be represented at all levels of data collection and therefore cannot be quantified or viewed out of context (Damico et al, 1999; Glaser & Strauss, 1967; Goodwin, 1995; Lincoln & Guba, 1985). Another advantage of the qualitative design is the sustained preference for open and relatively unstructured research designs (Damico et al, 1999; Simmons-Mackie & Damico, 1997; Spradley, 1980). While researchers who are more comfortable with experimental design would consider this lack of organization a fatal flaw, it is this very lack of initial structure that allows the researcher to view an event

without preconceptions, ask functional questions, and then employ the design that will allow

for maximal descriptiveness and lead to discovery. An additional advantage of qualitative

research is that it is designed to use the researcher as the central instrument of data collection

(Damico et al, 1999; Denzin, 1989). This allows for the flexible use of data collection and

data analysis techniques which are governed by the situation being investigated (Eisner,

1991; Maxwell, 1996). Using the researcher as the key instrument of data collection also

acknowledges potential examiner bias and accounts for it to maintain the investigation's

fidelity. A fourth advantage of qualitative research is that it is designed to collect descriptive

data (Damico et al, 1999). This enables the researcher and her audience to view results within

the context of the event that has been studied. It maintains researcher transparency for the

conclusions she derives from her data which supports the validity of the work. Still another

advantage to qualitative design is that it is oriented to a more focused description rather than

a broader one (Damico et al, 1999; Lincoln & Guba, 1994). Social action is an extremely

complex entity and by maintaining a more focused description the researcher can address

multiple variables that affect an inter-dependence of social actions within an event. An

important strength of qualitative research is its focus on process over product; looking at how

social action is accomplished as opposed to documenting that it merely occurred (Damico et

al, 1999; Garfinkel, 1967; Sacks, 1992). As mentioned earlier, there are a multitude of

studies that demonstrate the product of improved communication through group therapy but

to consistently achieve this outcome, practitioners need to understand the process by which

this happens. Lastly, qualitative design relies upon the participants' perspectives in

developing a complete understanding of the data (Agar, 1996; Bryman, 1988; Damico et al,

1999). Since social action is constructed by individuals acting within socially and culturally

constructed norms during everyday events, the perspective of those individuals becomes the cornerstone of any examination of the event of interest.

In summary, the rationale for using a qualitative design for this research enterprise is that the methods attendant to it are best suited to understanding and faithfully explicating the phenomena under investigation. This design will promote the study of how conversation is shaped by group cohesiveness, preserving the context of the group therapy session. It will be more amenable to understanding new and emerging conversation behaviors that relate to conversation at the Group-Level and among communication disordered individuals. The qualitative methods employed will be able to address potential ambiguity of behaviors and what they signify. They will also allow the researcher to account for any potential bias. Lastly, qualitative design is ideally suited to explicate the conclusions drawn from the investigation of Group-Level communication-disordered conversation related to individual and Group-Level actions in a fashion that preserves the context from which the conclusions are drawn.

Participants

This section will describe in detail the process and motivations for selecting the individuals to participate in this study. In keeping with the sensibilities of qualitative design as they relate to the emphasis on focused description over broad generalizations, this investigation is limited to three persons with aphasia. By focusing on fewer participants, a more detailed analysis of the conversational behaviors employed by the individual can be achieved. These participants represent both commonalities and differences that are intended to strengthen the findings. The commonalities between these individuals include having a left sided infarct, being between 11 and 15 months post-onset at the beginning of treatment, and

engaging in the group therapy setting for the first time since acquiring aphasia. However, there are differences in the way aphasia is manifested in each of these individuals. Each participant demonstrates a unique profile of communicative strengths and weaknesses as well as the compensatory strategies deployed. Each participant demonstrates varying proclivities toward Group-Level affiliation. These differences represent a range of behaviors within the conversations that form the primary data.

With strict adherence to the policies established by the Institutional Review Board at the University of Louisiana at Lafayette, each participant signed an informed consent document. The consent forms were written in "aphasia friendly" language (Brennan, Worral, & McKenna, 2005) and presented to the IWA through the use of multiple modalities and rephrased repetition of questions to improve comprehension of its contents as well as the use of clarification questions and verification statements as a metric that the material was, in fact, understood (Luck & Rose, 2007). To protect each participants' expected right to confidentiality, pseudonyms have been created and any other identifying characteristics have been eliminated.

Criteria for inclusion. To view changes in conversation that could be attributed to evolving group cohesiveness, it was an asset to have members in the group that were new to the group therapy experience. Of the 4 new members, the 3 selected for participation demonstrated a range of communication abilities that would be most representative without being duplicative. The following criteria for selection were met by these individuals:

1. The individual had a current diagnosis of mild-moderate to moderate aphasia as documented by normative data referenced tests that were administered by a certified speech-language pathologist. This range in level of impairment was

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important to ensure that the participants possessed the symbolic capacity to participate in conversation and that a range of meaning making devices could be demonstrated.

2. The individual attended the majority of sessions. Group cohesiveness develops over time and with repeated opportunities to engage in goal directed activities so it was imperative that enough group therapy sessions were attended and, in fact, the attendance rate ranged from 90% to 95%.

3. The individual was a proficient speaker of English.

4. The individual had the physical ability to use methods of communication that were in addition to any verbal ability, including facial expression and gesture.

5. The individual was at least 9 months post onset. This time constraint would support the finding that changes in conversation were more likely attributed to treatment than spontaneous recovery. Further, this length of time would likely provide the IWA the opportunity to adjust to aphasia and begin to develop compensatory communication strategies.

6. The individual agreed to a release of medical and / or therapy records as well as provided informed permission to be videotaped, tested, and interviewed.

Because qualitative methods account for variability in the design rather than attempt to control it, there was no need to control for age, education, the etiology of the impairment, level of family support, or other diagnosed medical conditions such as heart disease, respiratory ailments, or diabetes, or mental or psychological impairment as long as the individual was of sufficient health to participate fully in the group therapy setting. It should

be noted that one of the participants had a secondary diagnosis of being status post-brain tumor removal but this is accounted for in the interpretation of the data.

Description of the participants. A tenant of qualitative design is the rich description of the context in which an event takes place and it follows from this that the participants in the event are described in detail. In the section that follows, each participant is going to be described with reference to the social and medical history, stroke history, overall communicative function at the start and end of the semester of treatment, and the content of their concurrent individual therapy. This information was obtained from medical and therapy records as well as the post-semester interview conducted with each participant. To ensure confidentiality, a pseudonym has been used for each participant.

Participant one (designated Althea). This 54 year old woman suffered a stroke while undergoing brain resection to remove two tumors in February of 2011. Subsequent to the onset of aphasia, she received speech therapy as an inpatient at the Lafayette Rehabilitation Center and then on an outpatient basis at Our Lady of Lourdes Rehabilitation Center until January 2012. So at the time of the initial treatment sessions she was approximately 11 months post-onset of aphasia. Althea had been working as a classroom assistant for children with special needs and caring for one of her grandchildren prior to her stroke. Since the stroke she has been unable to work and instead requires a nursing aide to assist her with many activities of daily living such as cooking, bathing, and transportation to appointments. She continues to live with her grandson and her significant other of many years. At present, she enjoys taking walks in the park and her neighborhood, some gardening, and assisted cooking. Althea has a good sized social network that is comprised by her very large family and neighbors.

She was evaluated at the University of Louisiana Speech and Hearing Clinic (ULSHC) mid- January 2012 and findings indicated that she displayed behaviors indicative of mild receptive and moderate expressive aphasia.

Subtests of the *Boston Diagnostic Aphasia Examination* (Goodglass & Kaplan, 1972) were administered to observe behaviors attributed to auditory comprehension and both written and verbal expression. Her responses for those tasks that were designed to target auditory comprehension indicated that Althea was able to identify body parts and discriminate basic spatial concepts. She was able to carry out simple commands but as the length and complexity of the command increased she demonstrated increasing delays before responding and decreasing accuracy, requiring multiple repetitions of the commands. Tasks designed to elicit written expression revealed that she was able to copy letters, numbers, and short words. She was able to write her first, middle, and last name as well as the alphabet and numbers 1-21. Verbal expression subtests yielded moderate ability by the client to produce automatized sequences, repeat high probability phrases, and a good ability to imitate rhythm sequences. Singing and recitation proved problematic for Althea.

A related test, the *Boston Naming Test* (Kaplan, Goodglass, & Weintraub, 1983) elicited naming in response to a line drawn picture. Althea was able to name 19 pictures which equates to a moderate severity rating. Her average response latency was 2.6 seconds.

Subtests of the Western Aphasia Battery (Kertesz, 1982) were used to elicit reading behaviors for following commands, sentences, and paragraphs. Her performance indicated decreasing comprehension with increasing length for all stimuli. Further, as the length increased she demonstrated word substitutions that demonstrated her attention to how the word looked and not what it meant, such as "pick" for "point" and "lock" for "knock."

Administration of the *Porch Index of Communicative Ability* more commonly referred to as the PICA (Porch, 2001) yielded information about her processing abilities for communication across multiple modalities; writing, copying, reading, pantomime, verbal, auditory, and visual. This test not only measures the quality of a person's processing as conceptualized as accuracy, responsiveness, promptness, and efficiency, it also captures the amount of variability in the system for each of the above modalities and as well as the processing system as a whole which serves as an index of potential for improvement. Althea demonstrated an overall variability in her performance of 434 which indicated that there was good potential for improvement in her language processing. Specific scores and percentile rank by modality are listed below (See Table 3.1):

Table 3.1. *PICA* Raw Scores and Percentile Ranks by Modality for Althea

Overall	Writing	Copying	Reading	Pantomime	Verbal	Auditory	Visual	Total
10.85	8.0	11.55	11.8	7.1	11.13	14.1	14.9	Variability
49	64	45	51	18	52	46	33	434

In addition, her communication ability for a one-to-one conversation was assessed by the clinician for a spontaneous conversation about mutual interests. Her conversation ability was characterized by appropriate turn taking, relevance to the topic, and strategic repair. She clarified her message upon request and sought clarification when needed. She did require encouragement and clinician collaboration to use strategies during word-finding problems but was able to provide key words and use gestures to resolve communication breakdowns; often cuing self to the desired word through the use of these strategies. Her conversation turn length ranged from 1 to 3 separate idea clauses (turn construction units).

The spring of 2012 was Althea's first semester of treatment at ULSHC where she attended 19 of 21 sessions. In addition to group treatment, she received individual therapy

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which targeted improving word finding, repair of conversation breakdowns, increasing reading comprehension for authentic texts, and linguistic processing in the written modality. The student clinician addressed word finding and message repair through the use of the compensatory strategies of writing, gestures, and drawing during authentic conversations with targeted feedback after the conversation. Reading was addressed using shared reading techniques where the clinician used summarizing, foreshadowing, thinking aloud, and reading most of the text to support Althea taking progressively longer reading turns. Althea participated in the reading through cloze procedure opportunities of increasing length and decreasing saliency as she took on more of the shared reading. Because linguistic processing for writing was characterized by an especially large amount of variability, post-PICA therapy (Porch, 1994) was implemented where Althea was able to write the names of pictured objects after being shown the picture for 3 seconds and then removed.

Participant two (designated Alan). Alan is shorter than the average male (5'4"), wears glasses, witty T-shirts, and sensible shoes, he describes himself as a "tech. geek" and as "anti-social." At the time of this study Alan was 57 years old and 15 months post onset. He suffered a stroke on October of 2010 which he attributed to the heart surgery he underwent less than two weeks prior. After being hospitalized for 7 days, he was discharged to his home and he received outpatient treatment through various agencies in Dallas, TX, and then Lafayette, LA, until October of 2011 when he was discharged due to funding issues. Significant social history includes his tobacco use prior to as well as after his stroke.

Alan had completed four years of college receiving a Bachelor of Arts degree, double majoring in Math and Computer Science and minoring in Business Administration. At the

time of his stroke, Alan was employed by a software firm as senior architect on Capacity and Forecasting group (computer specialist).

When it became apparent to him that he would not be able to return to work, he sold his home in Dallas and moved into his second home in Lafayette, LA. He currently resides with a longtime friend, considered to be family, and several Yorkshire terriers; this friend and some of her extended family comprise the extent of his social network. He is able to drive himself but ventures out only to attend therapy, doctor's visits, and "family" events. He often complains of the isolating effect of aphasia.

He was evaluated at the ULSHC on October 7, 2011 and findings indicated that he displayed behaviors indicative of mild to moderate receptive and expressive aphasia along with mild verbal apraxia. Administration of the *Porch Index of Communicative Ability* (Porch, 2001) yielded information about his processing abilities for communication across multiple modalities; writing, copying, reading, pantomime, verbal, auditory, and visual. Alan's amount of variability across 18 subtests was 306 which indicated good potential for improvement. Specific scores and percentile rank by modality are listed below (See Table 3.2):

Table 3.2. *PICA* Raw Scores and Percentile Ranks by Modality for Alan

Overall	Writing	Copying	Reading	Pantomime	Verbal	Visual	Auditory	Total
13.13	13.4	12.85	13.65	10.65	12.43	14.7	14.7	Variability
78%	92%	63%	74%	47%	61%	18/99%	63%	306

Interpretation of his overall score suggests that he is able to communicate fairly independently on a day-to-day basis and is able to handle many communicative tasks with little assistance, although aphasic symptoms are observable. Many delays in processing were noted and scores on many of the subtests were lowered by requests for repetition or

clarification of the instructions. Although Alan's output was characterized by the ability to communicate his message to someone who was familiar with the various topics of interest, his output was often incomplete and may not have been adequate for a communication partner who did not have prior knowledge of the communicative tasks.

Alan's ability to name pictures was tested using the *Boston Naming Test* (Kaplan, Goodglass, & Weintraub, 1983). For this 60 item probe, the client obtained a total score of 33. These results indicate moderate severity for naming ability. The client was often able to produce the target when the clinician gave a phonemic cue. Across all 60 items, 25 phonemic cues were given and 13 resulted in correct productions by the client. There were a few instances in which it was not evident that the client knew what the target word was supposed to be (i.e. "yoke," "trellis," and "palette"). In all other cases, it was obvious that the client's difficulty in executing the production of the targets was linked to a motor planning issue where the client was aware of the targeted word, but due to verbal apraxia, he was unable to produce it.

Alan's literacy abilities were further assessed using a standardized tool for reading and an authentic writing task. Due to the presence of verbal apraxia, Alan's reading ability was assessed using the *Reading Comprehension Battery for Aphasia* (RCBA) (LaPointe & Horner, 1998). Scores were based on the client's performance among ten subtests. It took the client a total of 24 minutes to complete the exam and his overall score was a 97/100. When this test was given to non-aphasic subjects, the average score was a 97 and the average test completion time was 22 minutes. This indicates that Alan's silent reading comprehension is within normal limits. The client engaged in writing a letter to a friend explaining what life has been like for him since his stroke. The writing sample that was taken consisted of 64

words that were written over a 15-minute period of time, which averaged 4 words per minute. He wrote a short note of 7 simple, cohesive sentences. His writing consisted of mostly capital letters and he displayed many corrections as evidence of his scratch-outs in the letter. Throughout the short note, his writing occasionally was missing some appropriate articles and appropriate verbs, as well as the omission of some prepositions that would have allowed the note to flow more smoothly, however it could still be read and understood.

The clinician engaged Alan in conversation on a topic of mutual interest (dogs). He appropriately acknowledged his communicative partner by making eye contact, responding appropriately to questions, and elaborating on the topic being discussed. He exhibited expressive language difficulty as shown by his word finding difficulty. He compensated for this difficulty by taking some extra time (seconds) to produce the word, and accepting voluntary help from his conversational partner. When participating in conversation, he maintained an appropriate balance of speaker turns as well as listener turns. His receptive language skills appeared to be appropriate as evidence of his participation during the conversation, which revealed his ability to contribute knowledgeable information related to the topic at hand and allowing the conversation to flow smoothly.

To document the presence of verbal apraxia, Alan was administered an apraxia checklist (Damico, 1984). Of the 16 descriptions on the apraxia checklist, the client exhibited 7 of the items. He experienced effortful, trial and error articulatory movements and attempts at self-correction. Utterances were interrupted by extended periods of silence while he tried to correct his productions, which were incorrectly articulated. These errors were inconsistent from one production to another of the same utterance. He occasionally exhibited an intelligibility problem, but it varied according to the task (i.e., reading aloud had multiple

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moments of unintelligibility, whereas automatic speech showed no signs of unintelligibility whatsoever. Imitative speech fell in between with some moments of unintelligibility occurring as the length of utterances increased). His articulation was generally better for automatic/reactive speech than for volitional speech. He had more errors when more complex articulatory adjustment was required and errors increased as words increased in length.

The spring of 2012 was Alan's first semester of treatment at ULSHC where he attended 19 of 21 scheduled sessions. In addition to group treatment, he received individual therapy which targeted improving word finding and apraxic errors in conversation, number comprehension deficits in activities of daily living, decreased reading comprehension for extended text, and written expression deficits for email composition. Therapy for word finding difficulties involved targeted practice of frequent problem words identified by client as well as the use of compensatory strategies including use of gestures, oral spelling of the word, meaningful substitutions, and circumlocutions. The use of writing and drawing to support speech was introduced. The clinician and client addressed his difficulty transcribing numbers through strategies of chunking numbers into pairs, use of clarification and request for repetition, as well as requesting numbers to be written down within the role play of frequently occurring situations such as writing phone messages and paying bills. Although Alan was reading within normal limits according to the RCBA, he indicated that he experiences trouble with lengthier texts and this was addressed through both in-clinic work and a home program where the clinician and client engaged in shared reading aloud and parallel silent reading with discussions during the session and then completed chapters at home. He demonstrated increased reading efficiency, rate, and increased reported enjoyment levels. In addressing Alan's difficulty composing emails, he and the client exchanged emails

and edited the emails in the clinic session. Alan's speed of composition increased from 6 words per minute to 10 words per minute. While the length of his texts grew longer, the number of spelling errors or omissions remained the same which indicates a decreasing percentage of initial errors; from 5% to 3.5%.

Participant three (designated Jesse). Standing at about 6'3" and weighing in at over 230 pounds, Jesse poses an intimidating figure. His facial expression usually remains guarded but when he does smile, his grin is contagious. Jesse was 52 years of age at the time of this study, and having sustained a cerebral vascular accident in December of 2010, he was 13 months post onset when group conversation treatment began. Prior to his stroke, Jesse worked hard and played hard. He had risen to the level of supervisor for the oil field company he had joined upon graduation from high school. His work took him to South America, the Middle East, and Alaska. When he wasn't working, his primary interests were lifting weights or riding one of the 5 motorcycles he owned. He was living in Shreveport with his girlfriend when he had his stroke and according to the emergency room records, he weighed 330 pounds and had a medical history of high blood pressure with non-compliance, coronary artery disease, and a myocardial infarction approximately 2 years prior to his stroke. He received inpatient and outpatient treatment in Shreveport but his girlfriend was not able to act as his caregiver so he sold his motorcycles and moved to Lafayette to live with his mother. In the time that he has been living in Lafayette, he has begun driving. His social network is extremely limited, consisting of only his mother who is hard of hearing. His social activities include lifting weights at a local gym and drinking at the bar nearest his house; both of which he reports to do alone.

Jesse was first evaluated at the ULSHC in January of 2012. The results of the assessment indicated moderate aphasia characterized by relative strengths in reading, pantomime and writing.

Selected subtests from the *Boston Diagnostic Aphasic Examination* (Goodglass & Kaplan, 1972) revealed auditory comprehension that required support from repetition, visual, and verbal cues for identifying body parts, pictures, and following simple instructions. His reading comprehension was limited to short sentences as he was unable to indicate the correct completion word or phrases for longer sentences and paragraphs. Jesse was able to write his name, address, days of the week, and months so this area appeared to be a relative strength. Expressive language was characterized by jargon with some automatic speech (e.g. "stroke", "four", and "five"). He was unable to recite serial speech tasks or name common objects. He was able to complete serial speech tasks when performed in choral recitation with the examiner. He was often able to repeat the last word of a phrase though not the entire phrase.

Administration of the *Porch Index of Communicative Ability* (Porch, 2001) yielded information about his processing abilities for communication across multiple modalities; writing, copying, reading, pantomime, verbal, auditory, and visual. Jesse's amount of variability across 18 subtests was 483 which indicated a good to excellent prognosis. However, the examiner noted that Jesse was uncomfortable with the testing situation, becoming easily frustrated and rejecting difficult tasks. This might have negatively affected his scores for processing; especially for subtests I and A which are sentence level verbal and writing tasks, respectively. Specific scores and percentile rank by modality are listed below (See Table 3.3):

Table 3.3. *PICA* Raw Scores and Percentile Ranks by Modality for Jesse

Overall	Writing	Copying	Reading	Pantomime	Verbal	Visual	Auditory	Total
11	8.8	12.05	12.7	11.55	8.575	15	13.35	Variability
52	68	50	64	65	38	99/35	36	483

In addition, his communication ability in a one-to-one conversation was analyzed for strategic communication patterns. A sample lasting 35 minutes was analyzed and results indicated several reoccurring behaviors which acted to strengthen the client's communication. The client frequently used the discourse markers, "you know", "see", and "yes" throughout the conversation. These discourse markers were used several times to express receipt of information, demonstrate competence, and as a way of taking a turn in the conversation. Jesse also used facial expressions along with gestures as a strategy to communicate. He maintained eye contact to monitor whether or not the clinician understood what he was communicating. Analysis of the conversation sample also revealed use of laughter and joking to increase affiliation with speaker, which demonstrated comprehension and often served as a conversational turn. The client also effectively used the writing modality to supplement the verbal modality during the majority of his speaking turns. Negative patterns of behavior were characterized by abandonment of utterances. Jesse would often become frustrated and use automatic phrases "I can't" or "no" to abandon his conversation turn, leaving the message unrepaired.

The spring of 2012 was Jesse' first semester of treatment at ULSHC where he attended 20 of 21 scheduled sessions. In addition to group treatment, he received individual therapy which, due to both the severity of and his relatively low variability for auditory processing, targeted improving visual and writing modalities to support communication. *Therapy Subsequent to the PICA* (Porch, 1994) was implemented to improve writing and

drawing. Jesse improved from writing the names of pictured objects to writing two words to complete a phrase related to the pictured items. He improved from drawing a picture given a word to drawing a picture to represent a group of related words. Due to Jesse's severe auditory processing deficit, shared reading had to be heavily supported with visuals. To do this, graphic novels and photographs that represented key points in the story were used. Jesse participated in shared reading by completing cloze opportunities and he improved from completing clozes with 60% to 83% meaningful words. Jesse had a tendency to abandon his message when it was not easily understood and was reluctant to use writing and gesture strategies in conversation. This was addressed through modeled and encouraged use of alternate communication modalities as well as positive contingent response when he used writing, drawing, or gesturing. Jesse began to use combined drawing of maps, labeling of roads, and gesturing to communicate his favorite places to drink. He began to repair his message with an alternate modality as opposed to abandoning the attempt.

Data Collection

With an orientation to maintaining the authentic representation of the contextualized data while verifying the reliability of the conclusions drawn from that data, data collection employed a number of forms to create the "bricolage" that addressed the question of how conversation changed as a manifestation of group cohesiveness. This section will detail the data collection tools used, why they were selected, and how they were employed.

Videotaping. To construct a multi-party conversation, the participants must orient themselves to a multiplicity of simultaneously occurring messages. The speaker has at his disposal a variety of meaning making devices such as the spoken word, gesture, facial expression, body language, and intonation which he uses in conjunction with the

environment where conversation is taking place and the background knowledge that is shared among participants. The listener's must monitor each mode of expression simultaneously to infer the speakers intended meaning; is their message to be interpreted literally, figuratively, or sarcastically? Further, just as the listeners are monitoring the many modes of message transmission, the speaker must do the same as he monitors the listener's reactions to his message for signs of affiliation versus disaffiliation, agreement versus disagreement, or misunderstanding. Each of these reactions entails adjustment on the part of the speaker. Now add to this the burden of interpreting communicative attempts that are often obscured by the language impairment that comes from aphasia. With such complex social action, it is impossible to capture this action in the detail it deserves without creating an almost exact representation for study. The use of video-taping allows the researcher to capture the complexities of a conversation which can be reviewed and analyzed at a later date.

Group therapy sessions were recorded routinely over the course of a semester for the purposes of clinical instruction and student clinician data collection for writing weekly clinical notes. Recordings were captured through a hard wired surveillance system using a mounted camera and microphone that was positioned in the corner of the room and out of the line of sight for the participants (*Panasonic WV CP450*). In general, members of the therapy session disregarded the presence of the camera due to its inconspicuous placement. However, participant three, Jesse, maintained an awareness and occasional gaze toward the camera for the first several therapy sessions. The recorded group sessions totaled 21 and of these 4 sessions were selected as the primary data source; 2 from the beginning of the semester and 2 from the end of the semester. A description of the dates of the video recordings, the primary facilitator, and length of the conversations is found in Table 3.4.

Table 3.4. Dates and Lengths of Videotaped Sessions in Minutes: Seconds

Conversation	Date	Facilitator	Time
1	01/31/12	Clinical Supervisor	16:07
2	02/07/12	Clinical Supervisor	20:16
3	03/29/12	Clinician 2	19:32
4	04/03/12	Clinician 1 with Clinician 2	19:45

This data collection technique has been used for the multimodal analysis of conversation since 1955 when a project entitled *Natural History of an Interview* was initiated which involved filming a psychiatric interview between Gregory Bateson and his client and analyzing it for a "pluridisciplinary analysis of communication, language, paralanguage, and kinesics" (Mondada, 2008; p.3). It has been recognized as an important tool for the study of social action and in particular conversation (Goodwin, 1981, 1985, 1996; Heath, 1986; Schegloff, 1984).

Artifacts. As stated earlier, qualitative methodologies allow for a better understanding of the context in which the phenomena under study takes place. Through the use of artifact analysis, a more complete picture of the participants' communication abilities could be illustrated. Therefore, the final data collection procedure included the review of medical documents and those documents that were generated by the ULSHC over the course of the semester's treatment. From available medical discharge reports, the researcher was able to glean accurate dates and circumstances surrounding the onset of aphasia as well as social and medical histories that contributed to an understanding of pre-morbid attitudes toward vocation, health, and propensity to comply with health related recommendations. From the Initial evaluations, Beginning of Semester Status, and Final Semester Summary reports generated by student clinicians operating under the authority of the ULSHC, the researcher extracted information regarding their initial and then final communication ability,

language processing, and conversation ability. This large amount of data was integrated with the primary and other secondary data sources to form a "tapestry" that would faithfully represent each participant's conversation abilities related to group cohesiveness.

Post-semester interviews. Any inquiry that uses social action as its subject matter must situate that inquiry within the perceptions of the individuals constructing that action. Therefore, the perceptions of the participants with aphasia were essential to informing the researcher's conclusion. The method of ethnographic interviewing as outlined by Spradley (1979) promoted the elicitation of the participants' perspectives while reducing preconceptions or assumptions of the interviewer. Interviews were further governed by the adaptions made to the interview technique by Luck and Rose (2007) in the use of multiple modes of communication, rephrasing questions, the use of clarification questions, and verification statements. By employing open-ended questions that moved from general to specific in conjunction with comprehension checks and restatement, participants were able to describe their lived experience with regard to their aphasia, and the conversation group therapy. Interviews took place in a clinic treatment room where they were video-recorded using the same clinic surveillance system. This allowed the researcher to review all modalities of communication that informed the interview. The date of participant interviews and the duration of each is reported in Table 3.5.

Table 3.5. Dates and Times of Videotaped Interviews in Minutes

Participant	Date of Interview	Length of Interview
Althea	05/14/2012	0:48
Alan	05/18/2012	0:36
Jesse	05/11/2012	0:31

These interviews were analyzed with regard to each individual's perception of the group experience with regard to connectedness, feelings of isolation, differences between conversation in and outside of the group, and its relative benefit for improving their conversation in addition to those themes that emerged as important to the participant.

Formal tests of language processing. There are few assessment tools designed to capture the language performance of individuals with aphasia that meet the criteria of a psychometrically sound test. *The Porch Index of Communicative Ability* (PICA) is the acme of all available assessment tools. A test cannot be considered informative and its results trustworthy if it does not meet strict guidelines of validity, reliability, and utility and this is why the PICA is the preferred assessment technology among researchers. It demonstrates concurrent, predictive, and construct validity meaning the information gained from the test is consistent with tests measuring similar abilities, the information gained from the test accurately predicts future ability, and the test items measure the ability the test purports to measure. The PICA also demonstrates excellent reliability with test-retest reliability greater than .96, and inter-judge reliability of .8 to .85, and an intra-rater reliability of greater than .93. As far as clinical utility, the PICA is useful for a descriptive diagnosis, for localizing lesions, and for planning treatment.

The *PICA* assesses the communication of persons with aphasia as it relates to their general level of symbolic processing through various input and output modalities. Specifically, the test battery consists of 18 subtests that inform on seven symbolic modalities important in language usage. Four of the modalities are output modalities (verbal, pantomime, writing, copying) and three are input modalities (auditory, visual, and reading). Additionally, there is a measure of overall general communicative ability based upon the

seven specific modality scores as well as a score of overall variability (fluctuations in processing ability) that implies the degree to which improved processing and thus communication can be expected. Using a complex scoring system designed to focus on five dimensions of neurological response (accuracy, responsiveness, completeness, promptness, and efficiency), the *PICA* is a sensitive tool for determining one's abilities and it is useful in comparing an individual's performance to both the aphasic and the normal population.

The participants were administered the *PICA* as part of the assessment protocol when they initiated services from the ULSHC and then again after their completion of a semester in group conversation treatment. This assessment occurred at the same time as the post-semester interview; following the interview for Participants One (Althea) and Three (Jesse) and preceding the interview for Participant Two (Alan). The date of participant PICA testing and the duration of each is reported in Table 3.6.

Table 3.6. Dates and Times of PICA Testing in Minutes for Each Participant

Participant	Date of Testing	Length of Testing
Althea	05/14/2012	74 minutes
Alan	05/18/2012	34 minutes
Jesse	05/11/2012	53 minutes

The results of PICA testing were analyzed and organized according to the dimensions of neurologic response. They were interpreted with regard to significant change in a modality's average score and in how the modality was reflected in conversation.

Data Compilation and Transcription

Converting the multiple data sources above into documents that removed identifying information and allowed the manipulation of data was the final component of data collection. Four video-taped therapy sessions, 3 participant interviews, and 3 student clinician

interviews were each transcribed removing all identifying information. The four therapy

sessions were organized with reference to speaker, modality, and sequentiality. An example

of this organization is presented in Figure 3.1 where the coordination of verbal, gestural, and

facial display as well as gaze are coordinated with dashes (-) used as place holders for timing

to allow the tightly interwoven turn taking to be displayed.

10:38:00	Alan	V	an:d eventua[lly th]ey had three channels
	Alan	Gst	---------------------------((holds up three fingers)
	Althea	V	----------------[yeah] --yeah,
	Althea	Exp	---pursed lips
	Althea	Gst	---------------((nodding))
	Althea	Gz	Alan--
	Alan	V	[and that's] all you got!
	Althea	V	[yeah,] --------------------Yeah, (.) three channels. That's it
	Althea	Gst	((nodding))-----------------------((holds up three fingers))
	Althea	Exp	-----------raise eyebrows
	Althea	Gz	Alan-----------------------------C2------------------------------

Figure 3.1. Organization of Multiple Modality Transcription

This representation allowed the researcher to look at how turns were constructed using

varying modalities as well as how these productions were timed to reduce overlap but still

secure a turn at talk (Damico & Simmons-Mackie, 2002). Further, to aid the researcher in

moving between the native data in the form of video-recording and the transcribed data, the

transcriptions were reported by time stamp instead of line number. For three of the four

transcribed sessions, the time stamp refers to the actual time of day such as 10:25:32 which

indicates that the behavior being transcribed occurred at 10:25 a.m. and 32 seconds into the

minute. Session four, although recorded using the same system, had been preset to record

rather than retrieved from a server and the time stamp reflected the duration of the video

recorded sample. For instance, a time stamp of 0:04:23 indicated that the behavior occurred

at 4 minutes and 23 seconds into the recorded sample. Therefore, the reader will see excerpts

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that portray the time stamp in both ways. However, the data is easily referenced in the appendices using both forms of time stamp depending upon the session being referenced. Within this transcription, verbal productions were transcribed with reference to de-naturalized orthographic transcription (Bucholtz, 2000) to capture oral discourse conventions when occurring and using conversation analytic notation (Atkinson & Heritage, 1984) to capture the paralinguistic features of discourse that inform meaning construction in conversation. According to CA transcription procedures, segments of specific interest will be marked using an arrow (→) in the results section (Chapter Four). A guide to the symbols employed in CA transcript notation, as presented by Atkinson & Heritage (1984) is presented below. There is included an additional symbol, not present in prior CA research to denote the use of a nasal aspiration as a non-speech conversation turn.

1) Notations referencing timing of utterances:

[]	Simultaneous or overlapping utterances
=	Contiguous utterances where latching occurs
//	interruption of another's utterance in progress
(.)	A fleeting pause between or within an utterance, less than one second
(2)	A two second pause between or within an utterance

2) Characteristics of speech delivery

:	colon indicates the extension of a sound or syllable as in, No:::::
.	period indicates a stopping fall in tone, not the end of a sentence
,	coma indicates continuing intonation, not clausal delineation
?	question mark indicates rising inflection, not necessarily a question
?,	combined, the above indicate rising intonation weaker than ? alone

!	exclamation point indicates an animated tone, not always exclamation
-	dash indicates an abrupt cutoff or, in multiples, a stammering quality
↑↓	marked rising or falling intonation placed immediately prior to event
° °	degree signs bracket passages of talk quieter than surrounding talk
hhh	audible aspirations/ exhalations
·hhh	audbile inhalations
˜hhh	audible nasal aspirations/ exhalations
(( ))	double parentheses bracket descriptions of events not easily transcribed as well as descriptions of gestures, facial expression, and gaze trajectory

3) Other transcript symbols:

| → | right facing arrow indicates the feature(s) of interest in a segment of transcribed conversation |
| … | horizontal ellipsis indicates that an utterance is being reported only in part, with additional speech coming before, in the middle of, or after the reported fragment. |

Data Analysis

Conversation Analysis, a qualitative methodology uniquely capable of analyzing the complex social action of conversation, was pioneered by Harvey Sacks (1963, 1972, 1992), further developed by other social scientists (Goodwin, 1980; Jefferson, 1973, 1974; Schegloff, 1968, 1977), and applied to the study of aphasic persons' conversation behaviors (Ferguson, 1994; Goodwin, 1995; Milroy & Perkins, 1992; Simmons- Mackie & Damico, 1997; Wilkinson, 1995). This tradition of inquiry, at its inception, emerged as a fusion of the

tradition of "context analysis" (Kendon, 1979,2004) and ethno-methodological traditions (Garfinkel, 1952, 1967) in which interactional materials were used to investigate how persons reasoned and navigated through the worlds they inhabited (Goodwin & Heritage, 1990). Sharing features of one or both of the contributing methodologies, CA is informed by a number of methodological precepts. With regard to the social action most amenable to CA, it is crucial that any social interaction being studied is drawn from "real life" situations and, more specifically, ordinary conversation interaction (Goodwin & Heritage, 1990).

Several methodological assumptions exist that govern the employment of Conversation Analysis which relate to the structural organization of talk and the sequential ordering of talk by the participants. The assumption that social action projects organized patterns of stable and identifiable structural features is fundamental to the collection, transcription, and analysis of data in CA. Conversation, as the primary form of social interaction for everyday events, is systematic and oriented to as such by participants in a conversation (Garfinkel, 1967; Sacks et al., 1974). Therefore, any study of conversation must focus upon the structural features and organized patterns demonstrated by the interactants that give rise to the actions, expectations, and shared meanings which shape and are synergistically shaped by the conversational context. Further, research inquiry involving conversation must, as its purpose, determine how the systematicity and shared meaning of conversation is accomplished using the authentically occurring talk as data (Damico, Oelschlaeger, & Simmons-Mackie, 1999). The structural organization of talk cannot be viewed as an extracted piece of data from a single individual but must be viewed as part of a conversation dyad. In other words, the researcher focuses not only on intra-turn structures but inter-turn organization (Levinson, 1983). This leads to the methodological assumption of the

sequential ordering of conversation where actions project next actions (Heritage, 1984) and the manifestation of this in the adjacency principle where adjacency pairs operate in such tight alignment and so frequently that they are treated as such. The sequential ordering of conversation is oriented to by all interactants to such a degree that an utterance placed immediately after another is understood to be related to or contingent upon the prior and if a speaker wishes his utterance to be interpreted as unrelated he must first preface the utterance with a linguistic device or other accounting.

Similar to other qualitative methodologies but perhaps more exacting and certainly more literal is the methodological assumption that the researcher maintains empirical grounding of all data and findings. This commitment avoids the reductionist approach to collecting data where the research consumer is forced to "trust" the veracity of the researcher and instead gives the reader complete access to the actual data which then makes more defensible the researcher's claims (Damico et al., 1999; Heritage, 1984; Silverman, 1993). Consistent with this assumption is the analysis of talk at the "local level" where the researcher discovers the order in a set of conversational data rather than imposing it with a priori assumptions (Goodwin & Heritage, 1990). It is only after exhaustive and cyclical analysis that the researcher considers her findings in relation to past research (Schegloff E. , 1987).

Attendant to the mandates of qualitative inquiry, that the data be rich and descriptive and the importance of triangulation to strengthen findings, there were two levels of data sets. The primary data set consisted of the four group conversation therapy sessions that were described previously. The secondary set consisted of post-semester interviews with the participants, interviews with the student clinicians, and the results of artifact analyses. The

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primary analysis method described below occurs with the four group conversation treatment

sessions (primary data set) and the post-semester interviews (a secondary set). For the

purpose of establishing the fidelity of the researcher to the emerging interpretation of the

data, a step-by-step description of the process of analysis for these data sets will be

presented.

Step one: narrowing the focus. Videotaped sessions from a semester of group

conversation treatment were reviewed and of these, 4 representative sessions were selected

for transcription using the transcription notation system developed for Conversation Analysis

(Atkinson & Heritage, 1984; Sacks et al., 1974). Group Conversation treatment sessions from

the first two weeks and final two weeks were designated as beginning and final group

conversations. Of the eight sessions meeting this qualification, four were selected that met

the criteria of conversation. In these sessions, the discourse was characterized by a free

exchange of turns where each member had equal rights to the conversation and there was no

set order imposed by the clinician. It should be noted that in the first conversation Jesse

initiated a routine discourse sequence when he in turn asked each member their name, but

this was brief and was the only occurrence of talk that violated this criteria. Conversations

were also characterized by a topic of mutual interest; topics usually revolved around food,

pets, television shows, and any sort of travel. The final criterion was that the conversation

never devolved into a question answer sequence. For example, the clinician never asked the

same question to each member in turn.

Each session was initially reviewed by the researcher to gain an overall impression of

participant and clinician conversation use and to note any behaviors of interest that might be

indicative of group cohesiveness. Forming initial impressions prior to analysis of the data is

consistent with the tenet that Conversation Analysis "...is quite straightforward: a conversation interaction is observed, a question about the interaction is formulated: '*how was this outcome accomplished?*' and, the interaction is carefully analyzed to describe the participants' methods for producing orderly social interactions" (Damico et al., 1999; p. 669). Owing to the relatively novel application of CA to group conversation among persons with aphasia, after an initial impression was formed, a detailed transcription of entire group conversation segments was conducted. During this time, a single video session was cyclically reviewed to uncover conversation behaviors that reflected participant meaning making ability and an orientation to cohesiveness across multiple modalities, e.g. verbal, gestural, facial expression, and gaze, and they were faithfully transcribed. For each session, the researcher became an observer and scribe for participant behaviors, clinician behaviors, and contextual variables that had the potential to influence conversation (e.g. presence of visual referents, interruptions, extraneous distractions). The first step of analysis then involved the selection of specific behaviors as indices of emerging group cohesiveness which was accomplished by establishing the following procedure for each participant in the study:

1) A set of working criteria to identify behaviors oriented to emerging group cohesiveness was established as follows:

   a. The behavior must be identifiable. There were many occasions where the view of a participant's face or hands was obscured and there were occasional instances where their talk was inaudible, due to being spoken at low volume, overlapping talk, or poor sound quality. Behaviors were never assumed to occur when they were not visible or audible.

b. Regardless of modality, behaviors must carry a communicative message. The conversation turns of a participant must contain, in any modality, a culturally accepted meaning assignment.

c. The behavior must be recurrent. Conversation behaviors must accomplish the same action multiple times to reliably associate that action with the behavior.

d. The behavior must be contextually salient. The behavior, to be considered related to group cohesiveness, must be oriented to the ongoing group meaning construction. Behaviors that are unrelated to group conversation or activity are to be considered disaffiliative.

e. Novel behaviors must be comprehensible by another group member. Unusual or atypical behaviors (verbal or non-verbal) cannot be considered oriented to group cohesiveness if they are not interpretable by another group member as demonstrated by their next turn at talk.

f. The imitation of another member's communication behavior must likewise be comprehensible as a meaningful communicative act. Using all or part of a prior speaker's message or gesture must result in a contribution that carries meaning for the participant producing the turn at talk.

2) With attention to the working criteria, the transcribed data for conversation one, was cyclically reviewed for conversation devices that served as the mechanism for *how* meaning making related to group cohesiveness is accomplished. Continual review of the video tape and transcript simultaneously allowed the researcher to identify behaviors related to group cohesiveness which were then

labeled and described in writing next to their occurrence in the transcript to preserve context.

3) Once the behaviors were identified and described for conversation 1, the same simultaneous and cyclical review was applied to conversation 4; identifying both previously labeled behaviors and newly occurring behaviors. The identification of novel behaviors resulted in the return to conversation 1 for an additional review of data and video for comparative and contrastive purposes.

4) The recurrent and cyclical process of viewing, transcribing, labeling, and describing occurred then for conversations 2 and 3 with the same open stance to discovering new conversation devices for demonstrating group cohesiveness.

5) After all four conversations had been viewed, transcribed, and analyzed in a synergistic and recurrent fashion for all participants and facilitating clinicians, the identified behaviors were counted for each. This was done to ensure that behaviors identified were stable, recurrent behaviors that served as reliable indices of emerging group cohesiveness.

Step two: determining potential patterns of significance. In the second stage of analysis, the researcher looked for patterns in the occurrences of the behaviors that uniformly indicated an orientation toward or against forming group cohesiveness. When looking at individual behaviors it was necessary to operationalize an individual's orientation to group cohesiveness as affiliation versus disaffiliation. Further, because the knowledge and experiences of the researcher cannot be discounted it was anticipated that some devices would be indices of group affiliation or disaffiliation. Therefore a tentative set of criteria

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were established as an initial guide for the interpretation of a behavior as either affiliative or disaffiliative. The criteria were as follows:

1) Indices of affiliation can be accomplished through verbal or gestural means as well as facial expression.

2) Affiliation is most often accomplished through the following devices:

   a. Acknowledgement tokens

   b. Agreement

   c. Positive assessments

   d. Pre-sequences that pre-empt or mitigate a dispreferred action

   e. Shared laughter

   f. A shift from reporting to evaluative language

   g. Collaborative repair which relates to other repair that is offered or invited

3) Disaffiliation is most often accomplished through the following devices:

   a. Sustained gaze away from the group

   b. Body orientation turned away from the group

   c. Disagreement without pre-sequence

   d. Negative assessments that do not positively affiliate

However, because conversation is an complex amalgam of communication signals that are carried through multiple transmission modes that are shaped by the conversational context which includes the conversation participant's experiences and attitudes, behaviors that demonstrated reliable indication of emerging cohesiveness can vary for each individual. It again becomes paramount that the researcher maintains an open stance. It will become apparent in Chapter Four that the participants did indeed vary in their use of affiliatory and

disaffiliatory devices and they employed novel means of demonstrating their orientation to group cohesiveness.

Step three: analysis for distributional accountability. Once behaviors had been identified as potential indices of affiliation or disaffiliation, the transcripts were cyclically reviewed to identify all occurrences of these potential structures and verify patterns that demonstrated a participant's orientation to group cohesiveness. To accomplish this, the varied multitude of behaviors was organized into a table that tracked instances of occurrence of the behaviors of interest for each participant across each conversation and a table that organized the same for the facilitating clinicians. This study sought to strengthen its findings through occurrence patterns that demonstrated the increased use of affiliative devices and the decreased use of disaffiliative devices. Using this method of instances (Schiffrin, 1987) the data verifies that the conversational devices were indices of affiliation or disaffiliation and its distribution across sessions 1,2 and 3,4 supported an emerging orientation toward group cohesiveness among the individuals with aphasia.

After behaviors of interest were identified as being either affiliative or disaffiliative, the conversations were reviewed for objective evidence of group cohesiveness through conversational practices. The conversations were then reviewed for therapist behaviors that facilitated group cohesiveness. Additionally, conversations were reviewed for changes in participant conversation that reflected emerging group cohesiveness.

Step four: verification of initial findings. After patterns emerged from the four group conversation sessions that served as the primary data source, they were subject to verification procedures. This verification took the form of post-semester interviews, artifact analysis, and formal testing.

Interviews were conducted with each participant following the semester of group conversation treatment. These interviews were also video-taped and then transcribed in the same fashion as the group treatment, with regard to all modalities employed and the use of CA transcript notation. The interviews were reviewed to describe the participant's perceptions of their group experience. To accomplish this, the participant's comments were labeled using their words to preserve the context and remain faithful to their "lived experience." The number of occurrences for each label was then counted and the behaviors were then organized into tentative categories. These categories were further reorganized and combined as they informed each other and the guiding interview questions regarding their group experience. Both the conversational devices employed by the participants and the coded responses of the participants were useful in verifying, qualifying, or juxtaposing the patterns of conversation that demonstrate the participant's orientation to group cohesiveness and their perception of cohesiveness with the group members with aphasia, the facilitating clinicians, and the group as a whole.

Artifact Analysis for verification involved reviewing medical histories from the initial treating hospitals, when available, and documents generated by the ULSHC which included initial evaluations, beginning of semester treatment plans, and final semester summaries. These documents served as verification of the client's manifestations of social cohesiveness and the changes that occurred in their conversation over the course of a semester. Additionally, the artifacts illuminated the relationship between the participant's language ability and the changing manifestations of group cohesiveness.

Formal testing involved the re-administration of the PICA. Initial testing and final testing occurred less than 5 months apart but due to the nature of the assessment tool there does not

exist the phenomena of test learning to influence scores. The differences in average scores for modalities served as verification of the changes in modality usage for demonstrating group cohesiveness.

Step five: rich description and in-depth explanation. Once significant patterns of behavior had been identified through cyclical review of the primary data and then verified through triangulation that employed the secondary data, the interaction between patterns and across data sources was synthesized into a cohesive narrative. This involved synthesizing conversation behaviors in the group conversation treatment sessions and in the post-semester interviews with the documented social history and communication ability, both at the beginning and end of the semester, to create an overall picture of each participant. This memo-writing "gives you a handle on your material and a place to consider, question, and clarify what you see as happening in your data. Memo-writing is a form of interacting with your data and nascent analysis." (Charmaz, 2012, p. 9). This step of the analysis process fostered a renewed open stance to discovering what the data revealed as opposed to imposing assumptions or examiner biases upon the data. This step was integral in conceptualizing how personal factors such as experiences and attitudes toward group membership interacted with residual communication ability to constrain how a participant manifested their orientation toward group cohesiveness and their changes over the course of a semester.

Conclusion

This investigation relied upon a methodological orientation to Qualitative Design and as such employed data collection and analysis procedures that were committed to the preservation of the authentic event. Conversation Analysis as conceived by Sacks, Schegloff, and Jefferson (1974) and outlined by Atkinson & Heritage (1984) for the study of persons

with aphasia formed the primary tool of analysis to identify and describe patterns in

conversation that demonstrated the manifestations of and changes to group cohesiveness

during a semester of group conversation therapy. Chapters Four and Five detail these results.

CHAPTER FOUR: Results

What will follow in this chapter are the results of the data collection and subsequent analysis for each of the three participants which was attendant to the methodologies described in Chapter Three. The relationship between group cohesiveness and conversation was examined utilizing video recorded conversation therapy sessions, post-semester interviews, review of clinic documents generated during the course of treatment, and a test instrument that documents the processing for modalities used in conversation. Additionally, interviews with the treating student clinicians were conducted to gain their perspectives on group cohesiveness and changes to conversation.

The presentations of results that follow are organized by each participant separately. Any findings that form a pattern of similarities or differences between the participants will be discussed in a subsequent section within this chapter. Therefore, comparisons of the manifestations of cohesiveness in conversational behaviors and the themes and patterns that emerge from this comparison will be established and described in Chapter Five. The aim, then, of this chapter is to document, display, and describe the verbal and non-verbal conversational behaviors and devices utilized by each participant creating a snapshot of that individual. This will be accomplished using the native data from the conversation treatment sessions and intertwining the individual's own perception of their orientation to group cohesiveness and the related changes to conversation and processing.

The results for each individual with aphasia will be presented employing identical organization to ease readability. Results will be organized in such a fashion as to make the process of moving between the data and the impressions more transparent.

To that end, first a comparison of the participant's language processing as well as conversational ability prior to, and subsequent to, the term of group therapy will be presented. These data will assist in accounting for the changes noted in individual and group cohesiveness that speaks to the synergistic relationship between conversation treatment and improved ability. Second, a description of the conversation changes that took place for the individual participant demonstrating increased group cohesiveness will be reported and subsequently explicated with examples of these behaviors from the primary data set (Group therapy sessions). Again, the comments of the clinicians and data from reports will be inserted where they elucidate a behavior. Third, the conversation strategies that were employed by the participant as an assistance to increased group cohesiveness will be reported, presented through excerpts of the conversation, and then explicated. This will enable comments on the strategic nature of the change toward cohesiveness.

Following the presentation of results for the participants, this chapter will present the results of clinician conversational behaviors related to group cohesiveness. The conversational behaviors that facilitated group cohesiveness will be described and, as with the participants, CA coded excerpts from the authentic conversations will be provided to illustrate these behaviors.

Participant One (Designated Althea)

As was stated in the participant description in Chapter Three, Althea suffered a stroke connected to the removal of 2 brain tumors from her left parietal lobe and the effects of the stroke cannot be extricated from the effects of the tumor removal, only accounted for. Althea received speech therapy in both the hospital and an outpatient setting prior to her enrollment in the university clinic setting. Medical records indicated that all prior speech therapy had

been deficit-oriented and conducted in a one to one setting so this was her first experience with both group treatment and conversation treatment that was oriented to strategic compensations to improve authentic communication. As stated previously, this was her first semester of treatment at the university based clinic. Group treatment focused on improved meaning construction in reading as well as conversation and in a 50 minute session conversation was usually allocated 20 to 25 minutes. In addition to group treatment, Althea received individual treatment after each group session. Based upon archived treatment plans, individual treatment also addressed Althea's reading and on occasion conversation but in addition to this her writing ability was facilitated through functional tasks such as writing card sentiments, grocery lists, and short messages.

Althea was initially the lowest functioning participant in this study as evidenced by her overall score for the *Porch Index of Communicative Ability* (*PICA*) where her symbolic processing placed her in the 49th percentile when compared to a sample of 357 individuals with aphasia. However, due to a large amount of variability in her scores (434) it was apparent that she had the potential to make significant change. She demonstrated other indicators of potential to improve communication as well. Specifically, Althea was a consistent attendee of the group and she had a wide social network consisting of a significant other, many children, grandchildren, and a strong neighbor community.

Her communication functioning was best characterized as lacking initiation and requiring extended periods of time to formulate a response; related to this was her presentation of lethargy. In some cases, however, she required mediation in the form of speaking in unison for accurate verbal output. Althea could respond fairly consistently to yes/no and either/ or questions but sometimes needed repetition or verification by the

communication partner. Her auditory comprehension was characterized by growing difficulty with increasing length of the stimuli. She often closed her eyes during group therapy sessions and occasionally in the individual sessions.

In the sections to follow, a portrait of Althea's changing conversation ability and her displays of group cohesiveness will be reported. As a safeguard for researcher veracity, excerpts of the group conversation treatment sessions are reproduced as they were transcribed in the primary data set. The full transcripts are further attached in the form of appendices to act as a digital record (Appendices AS1-4).

Pre- and post-treatment language ability. Over the course of the semester Althea demonstrated gains in her symbolic processing ability as well as her conversation ability. The section to follow will provide the evidence for changes in her language ability that arose from the secondary data sources. This includes a comparative description of her symbolic processing ability and her conversation ability across the treatment sessions with explication of each.

Symbolic processing ability before and after group conversation treatment. With regard to symbolic processing, as the time post onset of aphasia lengthens, the amount of improvement typically made by IWA becomes progressively smaller. The greatest amount of recovery of function occurs in the spontaneous recovery state which lasts from onset until between 5 and 8 months post onset of aphasia with diminishing gains after that point (Basso, Capitani, & Vignolo, 1979; Darley, 1982; Kertesz & McCabe, 1977; Koura, Taher, Barrada, & Mostafa, 1978). Althea was approximately a year post-onset and would be considered by medical professionals to have chronic aphasia; consequently, expectations of her potential for significant improvement are typically diminished. However, by the end of the treatment

sessions there was a discernable change in Althea's language processing for specific

modalities. As discussed in Chapter Three, symbolic processing ability was evaluated by

using the *Porch Index of Communicative Ability (PICA)*. Modality scores and percentiles for

two administrations of the PICA (representing pre- and post- assessments) are reported below

in Table 4.1 with the dates indicated.

Table 4.1. Pre- and post-Treatment *PICA* Raw Scores and Percentiles by Modality for Althea

Modality	1-11-2012		5-14-2012	
	Score	percentile	Score	percentile
Overall	10.850	49	11.550	75
Writing	8.000	64	8.375	80
Copying	11.550	45	12.650	60
Reading	11.800	51	11.750	49
Pantomime	7.100	18	10.400	43
Verbal	11.130	52	12.225	59
Auditory	14.100	46	14.450	56
Visual	14.900	33	15.00	99/35

The changes in symbolic processing subsequent to her therapy are indications of

Althea's improvement. Of course, the co-occurring brain damage from tumor removal or the

medication levels to prevent seizures could have impacted her attention levels and language

ability, contributing to an inflation of the post-treatment *PICA* scores. However, other group

treatment studies have reported improved performance on formal assessments of language

subsequent to group therapy (Bollinger et al., 1993; Elman & Bernstein-Ellis, 1999b) with

the Bollinger study specfically finding improved *PICA* scores. Whether these changes were

due to the efficacy of the therapy, physiological recovery, change in medications, or a

combination is difficult to determine. However, this question is outside of the scope of this

study. It is sufficient to note that she did make improvement in her symbolic processing and

this likely had an impact on her ability to become a more effective conversationalist and assisted in her increased manifestations of cohesiveness.

It is interesting to note that prior to this investigation, her exhibited overall processing performance (as specified by the PICA overall score) placed her at the 49th percentile for the normed sample (N=357). According to Bruce Porch, this indicates that she might "...have marked difficulty with most communication skills" (Porch 2001, p.86). Similarly, her verbal processing (52%ile), auditory processing (46%ile), and pantomime ability (16%ile) suggests difficulty in these specific modalities. Subsequent to the therapeutic period of this investigation, her overall score improved to the 58%ile, and her verbal scores (59%ile), auditory scores (56%ile), and pantomime ability (43%ile) improved as well. This suggests that her overall symbolic processing abilities had improved to the extent that her "...attempts at various forms of output are becoming more appropriate and accurate." (Porch, 2001, p. 86).

Conversation ability before and after group conversation treatment. Althea's ability to use language for conversation in her individual session mirrored her ability in the group setting except for the influence of the inherent partner mediation that occurs in a one to one conversation. As documented by her clinician in the *Final Semester Summary Report*, Althea initially "did require encouragement and clinician collaboration to use strategies during word-finding problems but was able to provide key words and use gestures" (Appendix A-FSS). However, as the semester progressed, Althea became more self-reliant in her conversation through the use of multiple conversation strategies with the clinician reporting these end of semester results in this same document wherein Althea

met her goal of use of strategies to convey her intended thoughts and ideas. During a

five minute conversation sample about Althea's new spring outfits, 32 opportunities

for use of conversation strategies were identified. Of these opportunities, strategies

were used 24 times or 75%. None of the communication breakdowns resulted in

abandonment of an idea and Althea continued the conversation until the message was

conveyed. She used writing, her environment, her conversational partner, and

gestures to communicate. She used linguistic non-fluencies and "wait" to hold a turn

during individual conversation. (Appendix A-FSS)

The result of Althea's strategic use of gestures, writing, conversation context, and directing

her partner resulted in a decrease in communication breakdowns that were left unrepaired

and an increase in her turn lengths which increased from one turn construction unit to some

turns consisting of eight units.

Our ability to engage in conversation is integral to shaping our identity (Goffman,

1967; MacKay, 2003; Shadden & Agan, 2004; Shadden , 2005) and as Althea became a more

successful communicator her restored identity was apparent in the changes for her

appearance to her clinician. This excerpt documents this change where, in the end of

semester results of the same document, the clinician writes

A change was also noted in Althea's appearance as the semester progressed. Toward

the end of the semester, she began to attend sessions wearing make-up and a dress.

This indicates an increase in self-confidence which was also indicated by the increase

of conversation initiations and number of turns during the group therapy session.

(Appendix A-FSS)

Conversational changes. Althea demonstrated a progressive increase in the amount and quality of her participation in the conversation. She increased her rate of self-initiated turns and the length of her turns while decreasing the rate of conversational breakdown. Despite her self-initiated turns increasing in frequency and length, her rate of self-repair remained consistent. This change in the distribution of turn-taking is represented below in Table 4.2 and suggests that she became more engaged over time in the group interactions.

Table 4.2. Distribution of turn allocation and repair for Participant One (Althea)

Reported by Session	Session 1	Session 2	Session 3	Session 4
Turn Allocation Distribution				
# turns self-initiated	2	0	22	53
% turns self-initiated	22%	0%	64%	77%
# turns other initiated	7	14	12	15
% turns other-initiated	77%	100%	35%	22%
Conversational Turn Repair Distribution				
% of TCUs with breakdown	88%	0%	4%	10%
Self-repair, same turn (RT1)	7	0	1	9
Self-repair, third turn (RT3)	1	0	1	0
Ask for assistance (RT6)	0	0	0	1

Althea's improved ability for engaging in group conversation was further supported by her clinician's report of this increased ability in her post-semester interview. Clinician Two went so far as to provide an example of Althea's increased conversational co-construction ability when she said,

And she, ya know if they were talking about restaurants, she could talk more about that and maybe express more opinion and not just surprise, like "yes, that's good" or- It was more like opinion than agreement (Appendix D-C2-I).

Increased self-initiated turns. When Sacks, Schegloff, and Jefferson (1974) outlined the systematic nature of turn taking, they described how turns are allocated at the junctures where a turn under construction could plausibly terminate; called transition relevance places

(TRPs). At these TRPs a speaker can continue her/his turn, can select another to speak (other-initiated) or another individual can self-initiate as the next speaker. Althea's increasing proficiency in the conversation was perhaps most evident in the increase of her continuing as the speaker or her taking a turn herself at the TRP when someone else relinquished their turn (self-initiated). Where her involvement in early sessions was largely accomplished through other-initiated turns, those given to her by the clinician, in the latter sessions she increased the length of her turns or she self-initiated as the next speaker. From conversations one to four the percentage of her self-initiated turn-at-talk increased from 22%, 0%, 64%, and 77%, respectively. This pattern can be seen below in Figure 4.1 where the lightly dotted bars represented the number of turns that were other-initiated and the darker bars represent the turns that were self-initiated. In other words, lighter bars reflect that the clinician or another group member asked her a question or made a statement that required her comment.
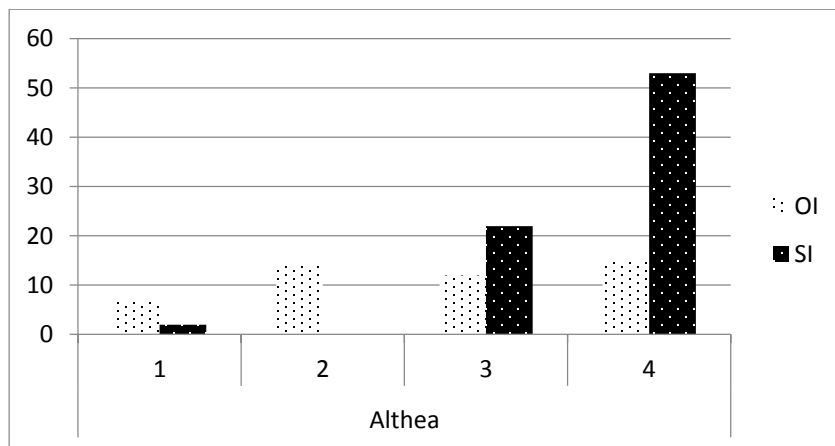
Figure 4.1. Pattern of Self-initiated Turn Construction Units

Increasing length of conversational turns. At the terminal juncture of a turn construction unit, the speaker may select a next speaker, terminate her turn-at-talk, or continue her turn at talk (Sacks et al., 1974). The length of a conversation turn was operationalized as the number of turn construction units that composed a turn-at-talk ; that is

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to say the number of times where her turn at talk could conceivably end marked by a transition relevance place (TRP). The increasing number of turn construction units that made up a turn-at-talk for Althea provides evidence of the growing length of her turn-at-talk. During the initial sessions, she did not continue her turn-at-talk beyond a single TCU. However, she continued her turn-at-talk across more than one TCU 15 and 25 times for sessions three and four, respectively. As we see in the example below, in a conversation about how to clean dishes when you have no water, it has been suggested that Clinician Two use paper plates and plastic cups and as the clinician accepts their advice, Althea self-initiates and then continues her turn-at-talk to continue the advice giving.

Session Three at 10:35:22
C2:	It would save me some time too, wouldn't it,
C2:	if I would break down and buy paper goods.
→Althea:	You have to, you have to. (.) I::t comes in handy for me.
C2:	mhm
→Althea:	cause it comes in handy for me.

Althea self-initiates a turn and then continues her turn by recycling her first TCU for emphasis. She continues her turn-at-talk across the TCU and then continues her turn-at-talk a third time by recycling the previous TCU for emphasis (Leiwo & Klippi, 2000).

Decreasing rate of conversational breakdown. Another indication of positive change was that as Althea's conversation turns became more self-initiated, her communication breakdowns decreased. This is significant because often in the conversational behavior of an IWA the complexity of the linguistic formulation required to accomplish lengthier turns at talk is increased and this may result in greater conversational breakdown; this is a driving principle that governs the construction of many tests of aphasia (Goodglass & Kaplan, 1972; Kertesz, 1982; Schuell et al., 1964). While Althea contributed 23 turns across the first two sessions, 8 or 34% of her turns required repair and she self-initiated all of them. This is

significant since the bulk of Althea's turns-at-talk were other initiated which provided

linguistic support for the formulation of her response as she built on the previous speaker's

talk (Hengst, Duff, & Dettmer, 2010; Oelshlager & Damico, 1998).

<u>Stability of self-repair</u>. Althea's improving language ability for conversation was also

evident in the immediacy with which she self-repaired conversation breakdown.

Conversation among persons with aphasia often breaks down, but overwhelmingly the person

with aphasia opts for self-repair whenever possible (Laakso, 1997). This repair can take place

at multiple points in the conversation and Althea demonstrated conversational repair just

after the breakdown, and within the same turn construction unit, for 10 of 11 self-initiated

conversational repairs occurring in sessions three and four. This consistency is noteworthy

because with an increase in self-initiated conversation turns there is less clinician support in

the form of linguistic models that can be exploited for other-initiated turns-at-talk; which

often allow for a yes/ no or an either/or recasted response. We can see this self-reliance

during a conversation about the rodeo that took place over the weekend.

> Session Four at 0:6:13
>   C1:   They had a rodeo this past weekend?
> →Althea: Yeah. There was too many horse, I gitn, didn't go.

The example above illustrates nicely how speakers orient to a preference for self-correction

and completing the repair efficiently so as to move conversation forward (Ferguson, 1994;

Laakso, 1997; Schegloff, Jefferson, & Sacks, 1977).

Conversation behaviors demonstrating group cohesiveness. Once the data

documenting positive changes in Althea's symbolic processing and overall improvement in

conversational interaction are presented, the data pertaining to the main focus of the

investigation can be presented. The impact of improved processing and conversational skills

on manifestations of cohesiveness will be discussed in subsequent chapters of this dissertation.

As stated before, Althea is the participant that demonstrated the greatest amount of change in her conversation behaviors and this may be due in part to her significant lack of involvement in the group when it first began, as evident by frequent occurrences of her eyes being closed and head bowed. What follows is a description of how she increasingly demonstrated conversation behaviors that indicated her growing orientation toward group cohesiveness. These data are divided into two sections, behaviors that serve as manifestations of cohesiveness, and various conversational strategies that are indicative of engagement and cohesiveness.

Conversational Behaviors that Serve as Indices of Progressive Cohesiveness. The analyses of the conversational interactions during group therapy reveal that the following ten conversational behaviors may serve as indices of increased cohesiveness for Althea. These behaviors include Eye gaze, Acknowledgments, Affiliations, Agreements, Continuers, Assessments, Facial display, Shared laughter, Mimicry, and Overlap. The frequency of occurrence for those conversation behaviors that proved systematic, are shown for each conversation by date in Table 4.3.

Table 4.3. Affiliating Conversation Behaviors for Participant One (Althea)

Conversational Behavior	1.31.12	2.7.12	3.29.12	4.3.12
Eye Gaze	43%	78.6%	95.5%	93%
Anticipatory gaze shift	0	5	13	11
Inclusive gaze	0	1	8	4
expressed as % for total turns	0%	0.3%	2.4%	0.8%
Acknowledgments	4	0	11	15
Agreement	2	6	17	5
Continuers	0	4	22	16
expressed as % for total turns	0%	1.7%	3.9%	2.3%
Overlap	4	4	18	56
Shared Laughter	0	1	10	6
Facial Display	6	12	13	21
Mimicking	0	0	3	2
Assessment	2	6	15	29

Eye Gaze. In determining frequency of eye gaze a criterion was established which stipulated that if a person's gaze was directed at a speaker or the referent of conversation at any time during that speaker's turn, then gaze was considered engaged (Argyle & Cook, 1976; Damico & Simmons-Mackie, 2002; Goodwin, 1980). As described earlier, Althea was often seated with her head bowed and her gaze down at the table or with her eyes closed in earlier sessions and as a result, her gaze was directed at a speaker or a referent only about 43% of the turns in Session One and 78.6% of the turns in Session Two. This significantly differs from the frequency with which her gaze was engaged in sessions three and four which was 95.5% and 93% respectively. This is significant as eye gaze is a reliable indicator of engagement in a conversation as listener collaboration and affiliation toward the speaker (Argyle & Dean, 1965; Abramovitch & Daly, 1978; Bavelas, Coates, & Johnson, 2002). When employed in this way, eye gaze is an index of the extent to which the participant establishes a social bond; and as such is also a measure of cohesiveness with the other participants (Goodwin, 1980). Regardless of the underlying cause for the earlier lack of

occasional, recurrent eye gaze at the other speakers, Althea increased this beahvior significantly from the initial to the latter sessions.

Anticipatory Gaze Shift. Perhaps a more striking indicator of how her gaze demonstrated her increased engagement in the group conversation was the increase in her anticipatory gaze shift. Where she demonstrated next speaker anticipation 5 times in the two early sessions, she anticipated the next speaker 24 times in the latter two sessions. This occurred not only when a current speaker used the next speaker's name but when a current speaker's turn had been in response to an earlier speaker's question that formed what might have moved from a second position in an adjacency pair to the first position of a new sequential pair as seen in the example below where a clinician is answering Aud's query as to where Rosa is.

```
Session Three at 10:49:29
Aud:          She's not coming today?
C6:           She had a doctor's appointment in Biloxi and she's still there.
→Althea:      ((Aud----C6---------------------------------------------------------Aud))
  Alan:       (3.5) That's a long way
→Althea:      ((Aud--------------Alan))
```

Because Clinician Six's turn is in response to Aud's query, Althea anticipated that Aud would have rights to the next turn-at-talk and began to shift her gaze toward Aud just prior to the TRP of Clinician Six's turn. She maintains her gaze on Aud for a non-verbal acknowledgment of the clinician's turn before shifting her gaze to the current speaker, Alan.

Inclusive Gaze. Just as our gaze when directed at the speaker or a shared referent can indicate that we are attentive and engaged in the conversation, when we direct our gaze serially to all conversation partners we are either monitoring the receipt of our message or inviting Group-Level connectedness (Argyle & Dean, 1965; Argyle & Cook, 1976; Bavelas, Coates, & Johnson, 2002; Krantz, George, & Hursh, 1983). Althea employed this device 12

times in the latter two sessions by using a scanning gaze that was directed toward at least 4

conversation partners. She demonstrated this scanning gaze only once in the earlier sessions.

Her use of gaze to include members of the group was evident in her response to being teased

by Alan about how one can get rid of Lovebirds when they over-populate.

Session Four at 0:18:16
C1:   He wants to=
C2:   = put your birds in the gumbo?
Althea: Oh NO! haha Oh no:, Oh no. (.) Oh no:, Oh no.
Althea: ((raised fist   ))
→Althea: ((Alan----------------Iris-Charlotte-----------Aud----C2))

By shifting her gaze from Alan, who was the author of the message though it was

rephrased by the clinicians, to four other conversation members she ensured that they all

shared in Alan's joke and her response.

Acknowledgments. One of the typical ways of becoming engaged in a conversation

and relaying group cohesiveness is through acknowledgment tokens wherein the speaker is

encouraged in her interaction by the hearer and this creates the potential for on-going

dialogue (Schegloff, 2007). While Althea demonstrated five occurrences of acknowledgment

in the earlier sessions exclusively through facial displays such as smiling, raised eyebrows, or

pouting, there occurred 26 instances in the final two sessions. These acknowledgment tokens

took the forms of discourse markers such as "oh", continuers such as "yeah", and gestures

such as nodding as well as facial display. As evidence of her increased engagement with the

group conversation she employed these devices relatively equally. Althea's use of a

continuer as an acknowledgment token can be read below where she employed the device

twice in rapid succession.

Session 4 at 8:22
C1:   That's them at the (.)   the gazebo. [Sayin'] their vows.
→Althea: yeah   [°yeah°]

While the utterance "yeah" is sometimes used for agreement (Jefferson, 2004), in this case it is used as an acknowledging continuer. The listener's production of continuers collaborates in the construction of multi-unit turns-at-talk by passing the opportunity to self-select a turn or to decline the repair on the talk just heard (Goodwin, 1986; Schegloff, 1982). We see above that Althea accomplishes both. Her first use of "yeah" as an acknowledgment token occurs as Clinician One's production falters as indicated by his fleeting pause which sends the signal that she understands his intent. She uses "yeah" a second time, produced more quietly, with the purpose of encouraging Clinician One to continue his turn-at-talk. To accomplish this, Althea placed her acknowledgment token just after the TRP which resulted in overlap when the clinician chose to continue his turn-at-talk.

Althea employed discourse markers to indicate her interest in the conversation nine times, typically using "oh." In the example below, the group is discussing Clinician Three's hand that was broken when Alan makes a joke and Althea uses a discourse marker as a turn that acknowledges his teasing.

> Session 3 at the time of 10:32:43
> C3:   it's not as swollen [anymore]\
> Alan: [but (.)] she can't use the phone.
> →Althea: Oh:, oh:
> C3:   Alan was trying to call me but apparently the service is like spotty

Again, Althea's use of "oh" is positioned at the TRP and she declines to self-select a turn-at-talk. However, acknowledgment tokens also serve as "change-of-state tokens" that indicate change of information or knowledge state as well as changes in state of awareness (Heritage, 1984, 1998). This is certainly the case when her use of "oh" as a continuer both affords and encourages Clinician Three to provide an accounting (Bolden, 2006). According to Bolden (2006), her "response cry "oh" does not simply suggest a change of state, but

conveys the sense of immediacy of this change, indexing the point at which the change has taken place." This is apparent from the sequential turn by Clinician Three that accounts for why she did not answer Alan's phone call.

According to (Stivers, 2008), nodding is a resource by which listeners demonstrate alignment and affiliation during story telling. Nods, not only acknowledge that the current speaker has speaking rights, they claim access toward the teller's stance toward the events and convey at least tentative affiliation with the teller's position. In Session Four, Althea employed nodding a total of six times in response to another's talk. In this example, she is nodding her understanding of Iris' suggestion to look at the "junk art" statues that have been placed along a nearby street.

```
Session 4 at 0:2:13
    Iris:        Have you see::n?  They having an exhibit? >I don't know<, you'd
    Althea:      ((gaze at table-Iris--------------photo--------------------------------))
    Iris:        ↑probably like to see that. They have this guy has strap uh art? (.)
    Althea:      ((gaze at photo-------------------------------------------------------------))
    Iris:        And if you get (.) a chance when you go on the um Coolidge?
    Althea:      ((gaze at photo-Iris----------------------------photo------Iris----- ))
    Iris:          Boulevard?
→Althea:          ((nodding))
    Althea:      ((gaze at Iris))
```

Iris had been showing a newspaper article with photos to tell the group about the statues she saw and Althea's nodding served to demonstrate that she was familiar with Coolidge Boulevard, thus claiming affiliation with Iris.

Lastly, Althea continued to use facial display to indicate acknowledgment and with a slight increase in occurrence from five to seven, she demonstrated that these nonverbal acknowledgment tokens were a consistent interactional resource (Goodwin, 1986). In the example below, Clinician Two is telling the group that after receiving colored chicks for Easter, her family began raising chickens.

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Session 4 at 20 minutes: 1 second
```
 C2:         That's how my family got started with
 C2:         chickens.
→Althea:              ((open mouth/raise eyebrows)
 C2:         Somebody gave us a bunch of colored
 C2:         ones.
→Althea:           ((eyes widen/raise eyebrows))
```

Paul Ekman (1979) pioneered the study of facial expression as a consistent and interpretable meaning system and reported that depending on the conversational context, raising eyebrows can have several functions, as a question mark or as a baton. Here Althea demonstrates her interest and affiliation through the raised eyebrows and first the open mouth and then with widened eyes, suggesting a question mark and as a surprise.

Agreement. Agreements in conversation can take the form of both vocal and non-vocal acts (Goodwin, 1986) and they work toward affiliating the listener with the speaker (Goodwin & Heritage, 1990; Stivers, 2008). Althea increasingly demonstrated agreement statements which can be attributed to her growing participation in the conversation and her increasing engagement with the group. Where in initial sessions she made 10 agreement statements, she performed 22 agreements in the final sessions, with the bulk of those occurring in the third conversation session transcribed. In the initial sessions, her agreement took the form of nods, occurring with or without verbal agreement on six of the ten occasions, and they were often contextually tied to the clinician using speaking for behaviors as we can see in the example below.

Session One at 11:23:53
```
 C0:         Did you hand write letters (.) to [people] too?  Okay, yeah. It's uh, it's
→Althea:                          yeah  [to]
→Althea:                                ((nodding))
 C0:         frustrating the way that changes, huh?
→Althea:                                     YES, yes
→Althea:                                     ((nodding))
```

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In the above exchange, Althea uses agreement to affiliate with the clinician's

"speaking for" turn-at-talk but this agreement is as much oriented to the work of repair as it

is to affiliation (Goodwin, 1995; Simmons-Mackie & Schultz, 2004). The clinician's turn has

been designed to encourage affiliation between Althea and the rest of the group, note the

modifier "too." Althea's agreements serve to ratify her own authorship of the clinician's turn-

at-talk which the clinician has offered up to her through the question inflection.

In later sessions, Althea's agreement statements took the form of commenting to demonstrate

an affiliative stance with the current speakers turn at talk as can be seen in the example

below.

```
Session Three at 10:38:00
    Alan:        And eventua[lly th]ey had three channels      [and that's] all you got!
→Althea:                  [yeah]                       yeah,[yeah]
→Althea:                  ((nodding))                      ((nodding))
→Althea:        Yeah, (.) three channels. That's it.
→Althea:               ((holds up three fingers))
```

Althea combines "yeah" as agreement with nodding to affiliate with Alan's

assessment that when he was a kid, he had only three channels to watch on the television.

She demonstrates the level of her affiliation through agreement that is both verbal and non-

verbal. The timing of her agreements, within Alan's turn and then at the TRP suggest an

immediacy that testifies to a heightened level of affiliation with the content of his turn

(Pomerantz, 1984). Further, the use of nodding as a co-speech gesture provides emphasis to

her agreement (Kendon A. , 2004) and demonstrates her perception of common ground with

Alan (Clark, 1996; Gerwing & Bavelas, 2004).

Continuers. While acknowledgment tokens demonstrate that a listener is attending to

the talk of another and even acknowledging when another speaker and their talk overlap

(Jefferson, 1983), continuers through their timing of production within the talk of another and intonation can serve as

actions displaying [a] recipient's understanding that an extended turn at talk is in progress but not yet complete, while simultaneously collaborating in the achievement of that multi-unit utterance by passing the opportunity to either (a) produce a more extended turn of their own or (b) initate repair on the talk just hear (Goodwin, 1986, p. 207).

Even when a speaker takes an extended turn-at-talk, this talk is an interactive accomplishment between the speaker and the listener (Mandelbaum, 1989). During the multi-unit turn constructions of others it is through the use of continuers that listeners demonstrate their understanding that the speaker's turn will continue. Althea used continuers, some of which have been referred to by non-CA researchers as back-channels, during another's turn-at-talk in the latter sessions 38 times to indicate not only her understanding of the state of the speaker's turn but to demonstrate agreement, assessment, to affiliate, and to encourage their continued turn-at-talk (Duncan, 1974;Goodwin, 1986). This compares dramatically with four occurrences of a continuer in conversation two and none in the initial conversation. Althea effectively used continuers as an assessment of the current speaker's talk while supporting their continued turn as seen in the example below (Appendix A-S4).

Session Four at 0:07:26
  C1:   He's two. (.) That's her little boy,   (1)   So he got to be…..
→Althea: Ooh, yeah.

And again in Session Four at 0:07:50
  C1:   …he turned around went [back to his] dad
→Althea: [Oh:::]

In the first excerpt, Clinician One is showing the group photographs from his sister's wedding. The length of a person's turn is not specified in advance, and his recounting becomes conversational storytelling as his turn-at-talk is extended through multiple TCUs (Goodwin, 1984; Sacks et al., 1974). Althea demonstrates her understanding that the storytelling will resume despite his pause at a TRP; indicated through his mid-rising inflection (,). In the second excerpt she projects a possible completion to his turn at talk and encourages him to continue. Through the use of a discourse marker that signals she is "proposing that [her] co-participant is still in the midst of some course of talk, and shall go on talking" (Jefferson, 1983, p. 84). As a testament to the utility of Althea's employment of these specific continuers, her choice of "yeah" and "oh" rate as the first and second most oft used interjections for recipients during conversational storytelling, with "ooh" coming in at 14 (Norrick, 2008).

Overlap. Many of Althea's continuers overlapped the talk of others as she demonstrated agreement with and acknowledgment and assessment of their turns-at-talk. However, self-initiated turns at talk also overlapped the turns of others. According to Sacks et al. (1974), "overlap serves to minimize the gap between speakers within systematic organization of turn-taking where the participants orient to 'one party talking at a time'" (p. 700). However, overlap also is often used by a next speaker as a demonstration of independent knowledge or recognition of what the current speaker will say (Jefferson, 2004). Further, overlap has been shown to be deployed strategically to co-opt a portion of the current speaker's turn to produce a next turn-at-talk (Goodwin, 1995). Althea's display of overlap increased progressively over the treatment sessions analyzed with 4, 4, 18, and 56 occurrences across sessions one through four, respectively. An example of this occurred in

Session Three when during a discussion of high definition (HD) TV with surround sound,

Alan shares that since his stroke he has difficulty attending to the dialogue over the

background noises and music and that it is worse when using surround sound. Althea eagerly

gives him advice for this problem, overlapping the conversation turn of Clinician Three and

Charlotte.

Session Three at 10:41:17
    Alan: Yeah I can't do that [sometimes].
     Charlotte: [Oh:!]-----------Oh! Dyo:!
     C3:   You <u>like</u> surround s[ound?]
     Charlotte: [I do:----------------I dyeh:!]
→Althea: [yeah you have to lower it you have to lower it.]

In this sample, Althea projects a completion of the clinician's turn-at-talk and begins

an overlapping turn (Jefferson, 1986). In fact, she demonstrates her eagerness to select a turn-

at-talk so much so that her overlapping utterance lacked sequentiality to the turn of C3 and

directly responded to the prior turn of Alan. She used overlap of the prior utterance to negate

its sequentiality and thus move the conversation back to the topic of Alan's auditory

difficulties demonstrating her affiliation with Alan (Jefferson, 1986; Schegloff, 2000). A

related interpretation of this event is her strategic overlap to move her turn-at-talk more

adjacent to Alan's as a foundation upon which she co-constructs the topic of problems with

surround sound (Goodwin, 1995).

Shared Laughter. Laughter, although a non-speech sound, is demonstrably a

conversational activity where it can be a next action to a prior turn and is referenced by

conversation participants as a sequential action in the ongoing construction of conversation

(Jefferson, 1984). An additional index of Althea's growing engagement was her laughter.

While joint laughter occurred only once in the first two sessions, it occurred 16 times in the

final two sessions. Shared laughter has been reported to be associated with engagement and

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affiliation in one-on-one dyads (Jefferson et al., 1987; Madden et al., 2002) and in groups of

non-impaired as well as brain injured individuals (Glenn, 1989; Greatbatch & Clark, 2003;

Kovarsky, Curran, & Nichols, 2009). While in Session Two where Althea's shared laughter

was in response to a clinician joke and modelled laughter, as her engagement with the group

increased not only did the occurrence of laughter increase but so did the spontaneity of her

laughter. In Session Four, during a discussion of the colored baby chicks that kids would

receive each Easter and how the speaker played with hers which ultimately ended the young

chicken's life, Althea laughed with other group members in a tightly timed sequence that

indicated her engagement and affiliation (through shared negative assessment) with the

speaker.

      Session Four at 0:19:46
        Iris: I always- my uh my little chick ya know. °I'd kill 'em° hhh. We:ll,
    →Althea: ((laughter))
    →Althea: ((shakes head))
      Laughter: ((C2, Charlotte))
      Iris: it's fun to PLAY with it you know and stuff.

Here Althea, demonstrates both her understanding of Iris' self-deprecating humor and

a shared stance with Iris (Jefferson, 1984; Pomeroy, 2013) through her laughter. She

affiliates with Iris and the other members that laugh with her; namely Clinician Two and

Charlotte, as well as Iris who laughed at herself.

Facial Display. Althea increasingly employed facial displays to demonstrate her

engagement with and affiliation toward the group conversation and its members (Bickmore,

2004). She demonstrated assessments of her own talk as well as the talk of others

(Ruusuvuori & Peräkylä, 2009). Her use of facial expression allowed her to communicate her

affective reactions to the conversation topic beyond what her speech could accomplish which

served the purpose of creating evaluative language (Armstrong & Ulatowska, 2007; Bavelas

& Chovil, 2000). Her progressively increasing use of facial display provides evidence of her growing orientation toward group cohesiveness and can be viewed in Figure 4.2
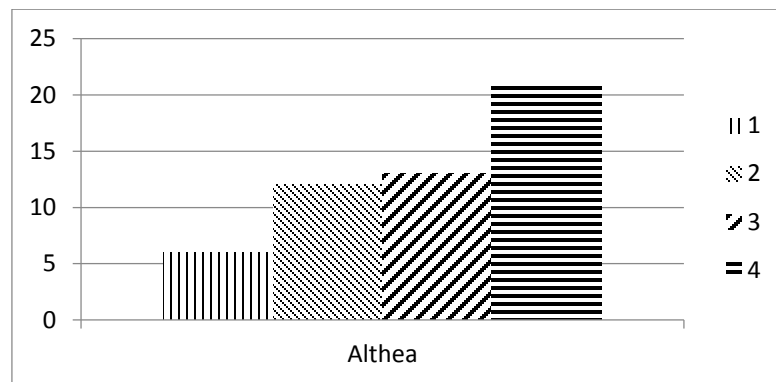
Figure 4.2. Occurrence of Facial Display for Participant One (Althea)

The clinician alluded to Althea's increased ability to rely on shared knowledge and other's facial expression when she reported, "as she became more familiar I guess, I would say that she knew maybe what their thoughts were on certain things, they could maybe like use [facial] expression like…" while using her own facial expressions to illustrate her point (Appendix D-C2-I).

Mimicking. During tight alignment with our communication partners we often find our gestures and word choices mirroring theirs (Clark, 1996; Kendon, 2004; Holler & Wilkin, 2011) and this was apparent in the conversation turns of Althea for the latter two sessions where she mimicked the clinicians or other group members on five occasions with no occurrences in the earlier two sessions. For example, Althea demonstrated verbal and gestural mimicking separately when affiliating with Alan over how different television was when they were younger. She mimicked both that there were "three channels" and used the same gesture to indicate three (Appendix A-S3).

Session Three at 10:38:00
    Alan: And eventua[lly th]ey had three channels   [and that's] all you got!
    Alan: ((holds up three fingers))

Althea:	[yeah]	yeah,[yeah]
Althea:	((nodding))	((nodding))
→Althea:	Yeah, (.) three channels. That's it.	
→Althea:	((holds up three fingers)	

We can see through Althea's agreements in the form of overlapping continuers that she is affiliating with Alan's story about TV in the olden days. It is this alignment that encourages her to mimic Alan's gesture as well as portion of his speech; she demonstrates comprehension of his talk as well as interpersonal involvement in the talk (Tannen, 1987). This alignment and related mimicking further acted as a resource for the linguistic formulation of her sequential turn-at-talk which will be discussed under the section of conversation strategies.

Assessments. Assessments are the actions on the part of listeners that "rather than simply acknowledging receipt of the talk just heard, assesses what was said by treating it as something remarkable" (Goodwin, 1986, p. 207). These actions have three sites for their occurrence being 1) on the occasion of participation in joint-activities, 2) within speakers' report of participation in activies, and 3) in next turns to initial assessments; in other words, assessments occur as either a first or second assessment in systematically ordered talk (Pomerantz, 1984). Assessments can indicate a positive or negative stance toward a speaker's talk. In ordinary and instiutional conversation where sequentiality is the foundation of co-constructed meaning, positive and negative assessment can become either affiliative or disaffiliative based upon the speaker's own assessments. The increasing assessments made by Althea occurred as part of the ongoing participation and as a report of participation in an earlier occurring activity.

Negative Assessments that disagree. There were no instances of negative assessment in the early conversations but four instances in each of the latter conversations. This can

relate to the fact that Althea was minimally engaged in the conversation during Session One and only marginally more engaged in Session Two. However, it may also relate to her growing familiarity or intimacy with the group and this may be akin to troubles talk as discussed by Jefferson (1980, 1986) where the author describes the dichotomy of troubles telling and "business as usual" which is the preferred action. The troubles telling not only required conversational alignment and common ground, it resulted in increased negative assessments by the recipient to the troubles talk. Althea demonstrated negative assessments exclusively through visual channels of communication, by furrowing her brow or shaking her head. For example, in the following excerpt, when Clinician One was explaining why he prefers a regular television screen to a high definition one, Althea shakes her head in disapproval.

> Session Three at 10:41:05
> C1:   … too real,(1)like I don't like the way (2) like the way they move,
> C1:   I feel like they gonna (.) come out the TV, I don't like, (.) I just rather
> →Althea: ((shakes head))

In negatively assessing the clinician's talk, she communicates her preference for HDTV but by using a gestural back-channel to perform this assessment, she minimizes its dispreferred status (Duncan, 1974; Lerner, 1996).

    <u>Negative assessment with positive affiliation</u>. In conversation, we often demonstrate both verbal and non-verbal negative assessments. However, when negative assessments are related to the negative assessments of the previous speaker, they accomplish a positive affiliation (Kotthoff, 1993; Lerner, 1996). This is seen commonly following self-deprecatory remarks of the prior speaker and as suggested above it does serve the purpose of affiliating the next speaker with the prior speaker.

Althea employed negative assessments for affiliative purposes in each of the sessions through facial display, gesture, and speech. Increasingly, Althea demonstrated these behaviors over the course of the semester. While this behavior was observed eight times during the first two sessions, it was observed 14 times in the latter two sessions. This was quite evident in a conversation where a clinician was making light of the fact that, after a festival, she still had paint in her hair; through her facial display and gesture Althea indicates that she is surprised and in agreement that paint in one's hair is "terrible" (Appendix A-S4).

> Session Four at 0:12:00
> C2:   we ….still have like color in our hair and it was terrible Hhhh, so…
> →Althea: ((raise eyebrows/wide eyes))
> →Althea: ((shakes head))

Of course, negative assessments with positive affiliations occurred using verbal channels as well and Althea verbalized her affiliating negative assessment when the group was discussing Clinician Two's revelation that she did not own nor watch a television.

> Session Three at 10:37:13
>   Althea: but I knew you hadn't any TV (.) I knew you hadn't any TV
>   C2:   you knew? Ha[haha]
>   Althea: [yeah](2) yeah
>   C2:   that bad, huh?, hahaha
> →Althea: it not goo:d, not good. Ge- TV. I like TV
> →Althea: ((nods))

In the above excerpt, Althea makes an overtly affiliating statement when she reminds the clinician that she already knew she didn't have a TV; insider information. Then following Clinician Two's admission of being in the minority, she appropriately negatively assesses her comment to agree with her.

Assessment as report of participation in a prior activity. Speakers can make assessments of prior events, as opposed to the ongoing talk, in their own turns at talk which often serve as invitations for agreement (Lindstrom & Mondada, 2009; Pomerantz, 1984).

These assessments demonstrate a speaker's attitude toward the talk they are producing and as such involve the sharing of personal information. This is often inherent in successful therapy groups where a climate of trust and respect is established (Burlingame, Fuhriman, & Johnson, 2001; Simmons-Mackie, Elman, Holland, & Damico, 2007). Althea certainly felt comfortable enough to begin to share how things made her feel and this was evident in the increased occurrences of assessments for prior events where she reported what was useful to her or what "had to go" (Armstrong & Ulatowska, 2007). In the same conversation about mating birds and before Alan tells her to make gumbo out of them, she complains that she told her significant other she did not want more birds.

> Session Four at 0:17:52
> →Althea: …look again. Have some <u>more</u> babies. I say "Oh no. You got to go.
> →Althea: You got to go." (.) I'm Fin- I give for 35 years, got to go. Got to go.
> →Althea: You got to go//

Conversation Strategy Changes. After identifying the various conversational behaviors that appeared to be indices of affiliation and engagement that enable the inference of cohesiveness, it was also noted that there were several strategies that also served as manifestations of cohesiveness and that increased in usage over time. These strategies may be seen as being of two types. First, normal conversational strategies that are employed to increase and/or indicate cohesiveness and those strategies that serve as compensatory strategies. Compensatory strategies are the conversational devices through which persons with aphasia "manage disordered talk and jointly accomplish communicative competence" (Bloch & Beeke, 2008, p. 986). These kinds of strategies can be employed by the person with aphasia such as the use of agrammatic speech as a resource (Heeschen & Schegloff, 1999), topicalization to overcome agrammatism (Beeks, Wilkinson, & Maxim, 2007), gestures employed to negotiate unintelligibility (Damico, Wilson, Simmons-Mackie, & Tetnowski,

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2008) or increased utilization of a visual communication system (Kitzing, Ahlsen, & Jonsson, 2005). These typically arise out of an interactional context (Beeke, Wilkinson, & Maxim, 2001; Hengst, Frame, Neuman-Stritzel, & Gannaway, 2005; Simmons-Mackie & Damico, 1995). Althea drew upon her improving language ability as well as the interactional context to manage co-constructed talk and emerge as a more competent communicator. Those strategies of greatest interest are reported below in Table 4.4 and explicated in the paragraphs to follow.

Table 4.4. Distribution of Conversation Strategies for Participant One (Althea)

Conversation Behavior	1.31.12	2.7.12	3.29.12	4.3.12
Clarification Question	0	0	1	3
Multi-modality	0	3	11	15
Gesture (% turns)	0	28.5	16.3	30.1
Repetitions				
Recasting	0	1	1	3
Recycle TCU	0	1 (6%)	11(23%)	18(19%)
"Wait" strategy	0	0	1	0

Use of clarification questions. Clarification questions act as repair initiators which signal the need for the current speaker to provide additional information to the conversation partner (Goodwin, 1987; Schegloff et al., 1977). As such, they are indices of increased awareness of the need for common ground and the desire for increased cohesiveness. The asking for clarification represents an interpersonal risk that is itself indicative of increased cohesiveness (Burlingame, Fuhriman, & Johnson, 2001). Althea demonstrated clarification requests only in the latter conversation sessions. She employed clarification questions for varying purposes, with varying conversational devices, and the same linguistic strategy. Althea actively seeks a conversation repair from Alan as seen below during the previously

described conversation about Althea's problematic over-population of lovebirds and Alan's

humorous advice.

Session Four at 0:18:16
    Alan: Gumbo.   Gumbo!
    C2:   [oh:.]
→Althea: [oh?]   Gumbo?
    C2:   He wants to//
    C1:   //put your birds in the gumbo?
→Althea: Oh NO! ((laughter))
    Multi: ((Aud, Iris, Charlotte, Alan, C1,C2,C3 laughter))

Althea produces a clarification question twice in the above excerpt and both times the

question acts as a repair initiator for Alan's turn at talk suggesting the need for establishing a

common referent or common ground. Further, Althea appears to co-opt the speech of another

in both cases; first the continuer "oh" and then by recasting Alan's production of "gumbo."

This further indicates the cohesive nature of this applied strategy. In this instance, the

clinicians resolve the communication breakdown for her but her initiation of the repair is

what supported the progressivity of the conversation and resulted in the ensuing affiliative

shared laughter that is shared by everyone in the group except Jesse. While the repair

initiated by Althea's clarification question above required a collaborative effort, the next

example demonstrates a self-repair completed by Alan subsequent to Althea's clarification

question. An additional example of Althea's self-agency through the initiation of a

clarification question occurred in Session Three when she uses it as a verification strategy.

Session Three at 10:44:32
    Alan: but you kee- you gotta buy one dollar or [won't-]
→Althea: [One dollar?]
    Alan: Well you're not gonna get any chance(.) to win
    Alan: …. if you don't buy a one dollar tick[et].
→Althea: [Oh.] ((laughter))okay hh okay

In the above conversation Alan had been teasing Clinician One over his admission of not playing the lottery and he was making the point that it would only cost him a dollar but he might win 400 million dollars. Based upon her reaction following Alan's repair, Althea appears to have understood Alan as saying with a one dollar purchase one would win 400 million dollars and so asks the clarification question as a verification strategy; she requests that Alan restate his assertion. As in the earlier excerpt, she recasts the talk in Alan's turn to formulate her clarification request (Leiwo & Klippi, 2000; Oelshlager & Damico, 1998).

Increasing multiple modality turn construction. Gestures and facial display provide an invaluable resource for the construction of meaning and assigning that meaning to turns-at-talk through their function as a linguistic self-cue as well as a cue and invitation to the conversation partner to collobaratively assign meaning (Damico, Wilson, Simmons-Mackie, & Tetnowski, 2008; Goodwin , 1995; Goodwin & Goodwin, 1986; Goodwin, 2000). Again, this is a manifestation of greater awareness of the need to communicate and a strategic use of multiple modalities to join in the conversation even when verbally limited due to her heightened state of group cohesiveness. Multiple modalities were increasingly combined by Althea to accomplish such turns-at-talk. Althea began to combine multiple modes of communication to create a meaningful contribution to the conversation; specifically verbal and gestural along with facial display to a lesser degree. Where in initial sessions, she employed multiple modalities a total of 4 times, she combined modalities 26 times in sessions three and four. This progressive shift is represented below in figure 4.3.
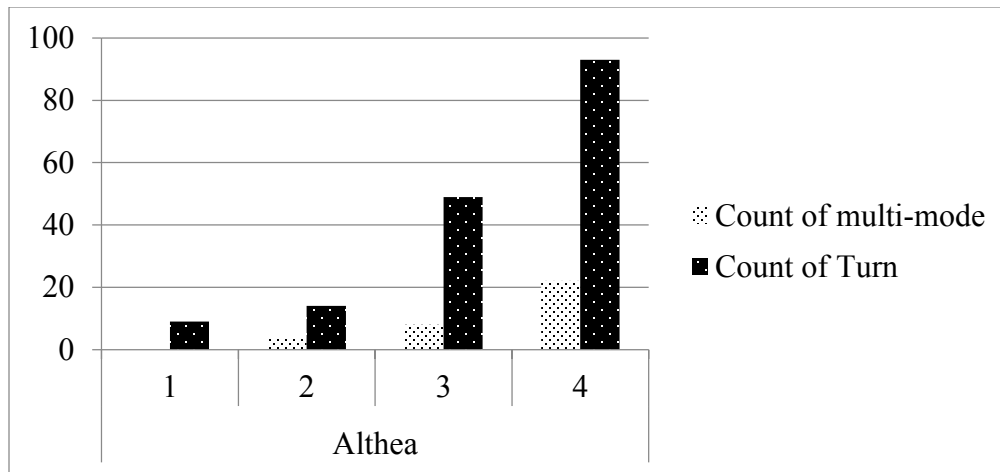
Figure 4.3. Multiple Modality Turn Construction for Participant One (Althea)

In the above figure, we see that as Althea's number of conversational turns-at-talk increases, so does her use of additional modalities. When the frequency of multiple modality usage is analyzed as a percentage of total turns constructed Althea demonstrates an increase in its deployment with a rate of occurrence as 28.5%, 16.5%, and 30.1% for sessions two through four respectively. As a note of interpretation, Althea did not use an additional modality at any time for her nine turns at talk in Session One and her reduced number of turns in Session Two, 14, resulted in an over-inflated representation of multiple modality use. A probable interpretation of the increased use of multiple modalities is a complex interaction between improving language ability and gestural ability that is supported by her improved scores for language processing as well as research findings that "the processes of underlying language and co-speech gesture production, although partly separate, are closely linked" (Mol, Krahmer, & van de Sandt-Koenderman, 2013).

We certainly see evidence of Althea's burgeoning facility coordinating speech and gesture to both emphasize her response as well as to convey an evaluation of the clinician's prior talk. Althea both strategically and animatedly used multiple modalities to construct a

response to Clinician Two's query as to why she would need a television in the example below (Appendix A-S3).

> Session Three at 10:37:24
> C2:   Okay, what would be the main purpose of having a TV, (.) [like (.)]
> →Althea: [((brows raised/ eyes wide/ mouth open))]
> →Althea: the weather! (.) the weather! (1) the weather!
> →Althea: ((raise left arm, palm up))

Her strategic combination of visual and verbal channels of communication allowed her to convey to Clinician Two and the group, her shock at the clinician's assertion that television is unnecessary as well as add emphasis to her claims for the necessity of having a television. This was accomplished through the immediacy and positioning of the gesture. According to Kendon 92004) Althea's open handed, supine gesture serves to present an idea and the degree to which she extends this gesture signifies the intensity of her intent.

Recasting. Recasting involves the strategic repetition of another's turn-at-talk, co-opting or repurposing it to construct the speaker's next turn-at-talk (Simmons-Mackie & Damico, 1997). The use of recasting relies upon the engagement and affiliation attendant to group cohesiveness as one speaker incorporates the talk of another. It supports the increased cohesiveness of the conversational discourse by allowing a speaker to produce their conversation turn with greater efficiency and fluency (Hengst, Duff, & Dettmer, 2010; Oelshlager & Damico, 1998; Tannen, 1987) to manage turn-taking (Tannen, 1987), and to create humor (Hengst et al, 2010; Tannen, 1987). Althea employed recasting four times during sessions three and four while only once in the earlier sessions. She employed recasting for the purposes of clarification questions as presented in the example under that section. Althea also employed recasting to formulate an other-initiated turn as we can be seen in the excerpt to follow.

Session Four at 0:05:44
    C1:   You had a good day today? (.) It's a good-
    Althea: yeah.
    C1:   it's <u>nice</u>.
→Althea: yeah, it's nice, I er- went outside earlier.
    C1:   oh really.
    Althea: yeah. went outside earlier.

By initiating her response to Clinician One using other-repetition, she provides to

herself a linguistic springboard in the form of lexical content as well as processing time

before she offers new information. This practice is employed routinely by non-aphasic

speakers as they "are 'gearing up to answer or speak' so that their contributions continue to

be collaborative and coherent to the on-going stream of talk." (Tannen, 1987, p. 583)

        Using recycled turn construction units. Another strategy that suggests the increasing

awareness of the need for and desire for social cohesiveness during the group therapy

sessions involved Althea's use of recycled TCUs. Recycling one's own TCUs supports more

efficient turn construction that is less linguistically demanding (Tannen, 1987). This verbal

self-repetition also enables the speaker to initiate or continue a turn-at-talk and it can be used

to express emphasis (Leiwo & Klippi, 2000). The emphasis of strategic content in a turn-at-

talk can communicate an affective reaction to the event a speaker is describing which thereby

invites the assessments of others. This strategy was used by Althea to construct her turn and

maintain both her turn and the topic, in which she recycled her turn construction units. That

is, she used a portion or all of a TCU to either initiate a turn-at-talk or continue her turn-at-

talk. She used recycled TCUs once in the initial two sessions and 29 times in the latter. This

was done sometimes for emphasis and other times it served the function of holding her turn

while she formulated the rest of her utterance. Althea recycled TCUs for emphasis in the

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conversation about the problem of having birds for pets when you have a mating pair ((Appendix A-S4).

Session Four at 17 minutes, 10 seconds
→Althea: Um they had the babies got older. They had some more babies (.)
→Althea: ((left hand arcing to the right))
→Althea: and some more babies and some more.
→Althea: ((repeat gesture))   ((repeat gesture))

In the above excerpt, Althea recycles her gesture in addition to her speech. It is well established that there is a predictable alignment between our speech and our gestures, with the gesture often preceding the speech it represents by a beat or two and that we coordinate our gestures as grammatical units within our talk (Kendon A. , 2004; Kendon A. , 1996; McNeil, 1985). Convincingly demonstrating that relationship in the talk above, Althea recycled the gesture as well as the speech it represented and timed the gesture with its lexical referent "more."

Using a wait strategy. Although this device occurred only once in the third conversation it was reported to occur with frequency in individual treatment. Althea's use of a "wait" strategy to direct the group members to give her more processing time was a dramatic example of her commitment to accomplishing her turn-at-talk and contributing to the topic of the conversation as well as her increasing self- advocacy and interest in achieving cohesive ties. It highlights her expectation that others will similarly orient to the pursuit of cohesiveness. During a conversation about how Clinician Two should clean her dishes when her hot water heater was broken, Althea asked Alan to wait so she could formulate her turn under construction (Appendix A-S3).

Session Three at 10:34:57
    C2:   …= or do you just (.) wash in cold.
    Althea: Nu no:. (.) It's hot, it's hot.
    C2:   gotta be [hot]

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Althea:	[it's] hot. Oh yeah, it's hot. Oh [yeah]
Alan:	[paper] plates
Althea:	Uh I- I- I-
Alan:	Plastic. Plastic cup.
→Althea:	wait a minute. I use those ((unintelligible)) things too.

When she was trying to formulate her response to Clinician Two and Alan kept interjecting turns, Althea needed time to construct her turn and so asked Alan to give her that processing time. This type of strategy has been discussed by Alan Grimshaw (1980) in his discussion of mis-hearings during conversation and is not unusual in conversation. Even normal speakers, given uncertainty during conversations, employ various strategies to highlight their need for reflection during ambiguity (Jefferson, 2004) or to heighten the prominence of some earlier speaker comments when the hearer is uncertain (Goodwin, 1987).

Asking for assistance. Similar to the meta-language strategy just described as using a "wait" strategy, Althea also exhibited a more overt strategy to enhance her comprehension and her cohesiveness within the group. In the final session Althea initiated a repair by asking for assistance which demonstrated her reliance on working together as a group to construct conversation. For example, during the conversation on owning birds, Althea is having word finding difficulty and requests assistance from the group (Appendix A-S4).

Session Four at 17 minutes, 5 seconds	
C1:	they- was it lovebirds? Or uh//
→Althea:	//yeah. I had um (2) how you- how you say that. Um
C1:	[○babies○.]
Althea:	[they had] the babies got older. They had some more babies (.)

Althea responds to Clinician One's question prior to his completion taking advantage of his producing the word lovebirds and responding in the affirmative before he has a chance to produce an incorrect name. She then continues her turn-at-talk where she begins to

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experience conversation breakdown in the form of formulation difficulties. She requests

assistance and just as Clinician One provides a repair completion, she starts over

incorporating his offering later in the turn construction unit. By requesting assistance and

then efficiently incorporating the offered word into her continued turn-at-talk, Althea

efficiently moved the conversation forward.

Increasing self-initiations. Another indication of increased cohesiveness involved

Althea's progressive use of self-initiations during turns-at-talk. She increased from 22% and

0% self-initiations in the first two sessions to 64%, and 77%, respectively in the latter two

sessions (See Figure 4.1). While this does suggest increased proficiency and greater

independence since she did not require others to choose her as the next speaker, it also

indicates aspects of affiliation and cohesion within the group activities. As she increased her

number of self-initiations across the four analyzed group sessions, the employment of this

strategy illustrates a person who is engaged in self-initiated collaboration toward a common

group endeavor; becoming less dependent upon others to include her in the co-construction

of group conversation. An example of her self-initiated turn construction can be found in the

conversation about television watching where Clinician One tells the group that while he has

a television, he has only basic cable and does not have a digital video recorder, or DVR

(Appendix A-S3).

> Session Three at 10:39:40
> C1:   You have DVR?, you can like fast forward?
> C1:   ((pantomime pushing button on remote control))
> Jesse: Oh! <yeah yeah yeah yeah yeah.>
> Jesse: ((mimic C1 gesture))
> C1:   I don't have that 'cept (1)
> Jesse: uh- What?
> C1:   Cable. Regular cable
> Mary: Aw::
> →Althea: You don't have it? You don't have?

This self-initiated turn provides strong evidence of her engagement with the group and affiliation toward the topic of conversation as well as her commitment to co-construct conversation. This is especially noted since Althea provided evidence of not only self-initiating, she also indicated awareness and desire of the gaze of the others as an affiliation. In this example, since the clinician had been directing his talk to Jesse and so his gaze was on Jesse, Althea self-initiated and then employed a restart to more completely obtain the recipient gazes (Goodwin, 1980).

Participant's orientation toward group cohesiveness and conversation. As reported previously, interviews were conducted with each participant following the semester of group conversation treatment to elicit their perceptions regarding their affinity for the group and any change to their ability to communicate in conversation. These interviews involved supported communication through the use of repetitions, clarification questions, verification statements, and the use of multiple modalities similar to that outlined by Luck and Rose (2007). Their responses formed a second tier of data, or lamination, which served to support or refute the findings from the Conversation Analysis applied to the group treatment conversations, the primary data. Based upon a thematic analysis of the post-treatment interview with Althea, a number of themes emerged from the initial codes that were taken from her actual responses; the instances of initial codes that informed the themes are reported as (number of times) or (#x). Althea's perception of the group conversation therapy and of her role as a group member supported her orientation toward group cohesiveness through her conversational turns. Further she perceived herself as a more competent communicator following group treatment and reported benefitting from group and individual treatment during the semester. Thus the themes of group affiliation, positive

response to combined treatment, and identity of self as a competent communicator emerged from the interview data.

   Group affiliation. Based upon a thematic analysis of the post-treatment interview with Althea, a number of themes emerged that enabled further indications of her progressive affiliation with the group; this was reflected in an over-riding theme of community interdependence within the group and is expressed by feeling less alone in her disability (6x), feeling connected to the group (15x) but with varied affiliation (7x), and giving and receiving help (4x). In the post-treatment interview, Althea referenced feeling less alone in her disability through her reports of feeling isolated after stroke (1x), feeling less alone (3x), and the group making her feel better. However, on two occasions she did indicate to the interviewer that she did not feel isolated after her stroke. The researcher did engage in clarification questions and restatements to verify that this was her intent and was satisfied that it was. It is possible that she felt differing levels of isolation for differing areas of her life. Also, because she has a large family, she was less likely to feel isolated. Regardless, Althea indicated that she felt less alone in her impairment when she said, "That's not jus' me, everybody else has a problem. That everybody has a problem" (Appendix A-I). This sentiment which expresses common ground certainly contributes to feeling connected to the group and Althea perceived herself to be a part of the group when she reported feelings of togetherness (2x), and being both accepted by (8x) and comfortable with (3x) group members, and being close to everybody (2x). However, she did report increased affiliation with some members and less with others when she reported which members were more helpful (3x), that the clinician was helpful (1x), and when her statements demonstrated a discord between herself and Participant Three, Jesse (3x). If group cohesiveness is comprised

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by the relationships that form a group, namely member-member, member-clinician, and member-group (Burlingame et al., 2001), then it is expected that an individual might have varying levels of affiliation within a group. Part of group cohesiveness is working together and Althea's responses did reference this when she reported receiving help from others (2x) and helping others (2x).

   Positive response to combined treatment. The findings of decreased absenteeism (Mullen & Copper, 1994; Zaccaro, 1991) and improved outcomes (Dinger & Schauenburg, 2010; Mullen & Copper, 1994) are indicative of a positive response to group psychotherapy. Althea's interview responses formed a theme of positive response to group and individual therapy combined, which is also conisistent with Dinger & Schauenburg's study. Althea reported both that group therapy benefitted her and that she enjoyed it. Her responses formed a pattern of indicating group therapy benefit (6x) and individual benefit (4x) with the benefits of group therapy being greater than individual (3x). This is in contrast to her perception that the treatment she received in an area rehabilitation hospital was of less benefit (3x). Althea even reported generalization of conversation from the group to outside. When asked by the interviewer, "Okay, so, we're talking about conversation. Okay, in the group.(2) versus outside, okay?", Althea responded "same thing, same thing."

   Identity of self as a competent communicator. Research has shown that group cohesiveness contributed to improved outcomes in psychotherapy (Dinger & Schauenburg, 2010) and in education (Schectman & Katz, 2007). The positive affect of group cohesiveness and the positive response to therapy by Althea, ultimately resulted in a shift in identity from a passive "aphasic" to a valued conversation group member with a unique contribution. She would correct the researcher's misinterpretations and she portrayed herself as a curative

influence in the group when she told the researcher "but I talk too, but I muh I uh make him talk" (Appendix A-I). Further, by her report of applying strategies learned in the group conversation treatment sessions to conversations at home, Althea was surely demonstrating her competence as a communicator. She repeatedly referenced elements of this competence as the importance of communication and being a strategic communicator. Althea continually referenced the importance of communication when she reported the importance of others listening to her talk (9x) and the importance of her listening to others (3x). She referenced the importance of talk (10x) in the form of being encouraged to talk, talk as therapy, and having the opportunity to talk. Her perceptions regarding the importance of communication were related to those perceptions about being a strategic communicator. Althea referenced the importance of being patient (6x), accepting that her speech was slower now (4x), and compensating for speaking difficulties (5x) by not giving up, waiting before she talked, and using related words. Althea, herself describes the strategic nature of how she compensates for her aphasia to communicate what she wants when, during interview, she said, "you have to think about it first. Then take your time and just say it. But you don't perf-, say it slow, where cause say cause-, You can say what- what you saying but just have, have to take your time" (Appendix A-I).

Summary of Althea. Althea began the semester of group conversation treatment as a by-stander who contributed little to the conversation and required verbal invitation to do so. She required clinician support in the form of direct questions and "speaking for" behaviors to urge her to participate in the conversation. Over time, and as she became more comfortable with the group she engaged more, found herself connecting with other members over shared experiences, began to use strategies to initiate more turns-at-talk, and began to share her

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feelings and opinions. She demonstrated the effects of group cohesiveness on conversation which then, in turn, was the vehicle for her to demonstrate her increasing orientation toward group cohesiveness. Althea's conversational ability was observably changed by the end of the semester and she is now perceived as a more strategic communicator who advances her own identity and asserts her independence through her verbal and gestural initiations as well as strategic conversational behaviors that demonstrate increased self- agency. For Althea, a reciprocating relationship between social cohesiveness, language ability, and her strategic co-construction of conversation was evident through her conversation, her perceptions of group treatment, and the clinician's perceptions of her improving conversation.

Participant Two (Designated Alan)

Alan is a 57 year old white male who considers himself an uber geek and worked as a computer specialist prior to his stroke. In that job, he supervised a team that designed logistical software. Alan has a long history of smoking which he continues to this day and frequently refers to himself as "anti-social." Alan suffered a stroke in the fall of 2010 when he developed an embolic blood clot after heart surgery. He received outpatient speech therapy from a local hospital prior to attending this university-based speech therapy clinic. This treatment was predominantly impairment-based intervention that addressed decreased auditory comprehension through tasks of following 2-step commands, answering comparative yes/ no questions, and answering question of verbally presented paragraph information. Alan's decreased verbal expression was addressed through tasks targeting imitation of multi-syllable words, confrontational naming of objects, responsive naming, and stating functions of objects. According to the treating therapist, he produced many

neologisms and semantic paraphasias and had difficulty producing grammatically correct sentences. He additionally was reported to have difficulty reading words and sentences. Similar to Althea, this was Alan's first semester of treatment at the university-based clinic. He received a combination of group and individual treatment addressing communication impairment through socially oriented treatment. Group therapy focused on improved meaning construction in reading as well as conversation; each session was divided about equally between these two foci. In addition to group treatment, Alan received individual treatment after each group session. Based upon archived treatment plans, individual treatment also addressed conversation, focusing on the use of multiple modalities to repair communication breakdown and practicing the production of words that he identified as being consistently problematic. Additional targets in individual therapy were improving numerical ability, written expression for email, and improving comprehension and enjoyment of novels. Alan was the highest functioning participant as evidenced by his overall score for the *Porch Index of Communicative Ability* (PICA) where his symbolic processing placed him in the 78th percentile when compared to a sample of 357 individuals with aphasia. He demonstrated a good amount of variability in his scores indicating potential to make significant change in symbolic processing. However, potentially limiting factors were present that could impact the amount of functional improvement he would gain from group conversation treatment. Specifically, this was due to Alan considering himself "anti-social" with only a small network of communication partners. Given his frequent references to himself as a person who does not integrate well into social situations, he might be expected to demonstrate few manifestations of group cohesiveness, and while he verbally maintains his anti-social

identity, his conversational actions would indicate that he operates under the same social-communicative conditions as persons that would not consider themselves anti-social.

Pre- and post-treatment language ability. Over the course of the investigation Alan's language ability did in fact improve as demonstrated by improved symbolic processing as well as improved conversation ability. As with Participant One, this section will provide the evidence for these changes. This includes a comparative description of his symbolic processing scores and a comparison of his documented conversation ability.

Symbolic Processing Ability before and after group conversation treatment. As with Participant One, the *Porch Index of Communicative Ability (PICA)* was administered to document change in symbolic processing. Upon follow up PICA administration, Alan's pantomime modality increased from 10.65 to 12.5 and his verbal modality improved from 12.4 to 13.4. The scores for processing ability across all modalities can be viewed in Table 4.5 below, where highlighted modalities represent an improvement by at least one dimension.

Table 4.5. Pre- and Post-Treatment *PICA* Raw Scores by Modality for Alan

Modality	10-7-11		5-11-2012	
	Score	Percentile	Score	Percentile
Overall	13.13	78	13.850	88
Writing	13.40	92	13.725	96
Copying	12.85	63	14.250	87
Reading	13.65	74	13.950	78
Pantomime	10.65	47	12.500	79
Verbal	12.43	61	13.425	74
Auditory	14.70	63	15.000	74/99
Visual	14.70	18/99	14.700	18/99

It is interesting to note that prior to this investigation, his exhibited overall processing performance (as specified by the PICA overall score) placed him at the 78th percentile for the normed sample (N=357). According to Bruce Porch, this indicates that "while his aphasic

symptoms are apparent, [he] functions fairly well and handles most basic communication tasks without requiring much assistance… needs time to retrieve and organize" (Porch 2001, p. 86). Similarly, his auditory processing (63%) and verbal processing (61%) reflect a need for additional time. Alan's processing for pantomime (47%) represent someone with marked difficulty demonstrating gesture in a communicative capacity. Subsequent to the therapeutic period of this investigation, his overall score improved to the 88%ile and his auditory scores (74/99%ile)), verbal scores (74%ile), and pantomime ability (79%ile) as well. While his improvement was not as significant as Althea's and his percentile remained in the mild range, he demonstrated improvements in the efficiency of his responses. Alan's ability to copy linguistic and non-linguistic information improved from performance that was delayed and incomplete to one that was complete and immediate but with some motoric distortion. His ability to pantomime was initially characterized by self-corrections to construct a representation of object function that was sometimes incomplete for accuracy. After a semester of therapy which addressed gesture only as naturally occurring in conversation, his processing for demonstrating a gesture no longer required self or other correction or cuing. Lastly, Alan's initial verbal processing was characterized by responses that were delayed and incomplete. After group conversation treatment, he demonstrated complete although sometimes delayed processing in the verbal modality. These changes in language ability and processing reflect an increasingly competent language system that resulted in and from conversational changes related to group conversation treatment.

   Conversation ability before and after group conversation treatment. By the end of the semester, Alan demonstrated more commitment and more success in co-constructing conversation, both in group and in individual treatment. The change in his determination was

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apparent in his performance over the course of the semester when the student clinician assigned to treat him individually noted that in an initial conversation he abandoned a conversation repair approximately 30% of the time a repair attempt was initiated but in the final individual session he did not abandon a repair at any time. Further, his proportion of self-repair of the total repairs completed increased from 69% to 93% (Appendix B-FSS).

Conversational Changes. According to the *Final Semester Summary* written by his clinician, Alan's communication functioning was characterized as the ability to engage in conversation with some support at outset of treatment. His turns-at-talk often contained paraphasias or apraxic errors (approximately half the time) and he attempted to correct himself using circumlocutions and revisions. Additionally, he would use continuers such as "uh" and "um" as place holders to indicate he required extended formulation time to complete and/ or repair his turn-at-talk. More significant is the fact that Alan initially abandoned problematic turns-at-talk. In summary, Alan was able to construct a meaningful turn in the conversation when given support from his partner and additional time during the initial sessions (Appendix B-FSS).

Over the course of the semester, Alan demonstrated increasing facility in conversation with regard to his efficiency, accuracy, and his use of conversation to support the conversational turns of others. The pattern and distribution of these behaviors across the 4 sessions can be seen in Table 4.6. Each of these documented changes over the course of the investigation will be discussed following the table.

Table 4.6. Distribution of Turn Allocation and Repair for Participant Two (Alan)

Turn Allocation Distribution				
Session	1	2	3	4
# turns self-initiated	22	23	55	21
% turns self-initiated	62%	65%	80%	61%
# turns other initiated	13	13	13	13
% turns other-initiated	37%	34%	19%	38%
Average TCUs per turn	1.77	1.63	1.5	1.17
Giving turns to others	1	2	4	2
Conversational Turn Repair Distribution				
% of TCUs with breakdown	38%	20%	19%	14%
Self-repair, same turn (RT1)	15	6	16	5
Self-repair, second turn (RT3)	2		0	0
Other initiate, self-repair (RT5)	0	1	0	0
Ask for assistance (RT6)	4	1	0	1
Unrepaired	3	1	0	0

Decreasing turn length. One pattern observed during the semester group conversation treatment that could support a commitment to working as a group was the decrease in the turn length. When examining Alan's length of turn in a similar fashion as Althea's, the number of TCUs, we see a decrease in the length of his turns-at-talk. Alan constructed turns at talk that were, on average, 1.77 TCUs in the first session. Over the period of treatment for this investigation, he progressively decreased the length of his turn at talk; constructing turns that were, on average, 1.17 TCUs for the final session. This may have been an orientation toward allowing or encouraging others to participate in the conversation. While a rare occasion, in the final session during a conversation about a wedding the clinician attended he asked the clinician a question, allocating a continued turn to him (Appendix B-S4).

    Session Four at 7 minutes, 3 seconds
      C1:   We got to do it outside. It was (.) it was hot but it was really nice.
  →Alan: Did it stink?
      C1:   Did it stink? Oh. Actually, well the wedding was in Abbeville so that
      C1:   was good. The reception stunk.

Alan demonstrated increasing affiliation toward the group by decreasing the length of his turns which allowed other's to participate at a more equitable rate. Further, he used more of his turns to allocate a next speaker as opposed to self-selecting and then terminating his turn-at-talk without next speaker specification. His turn length is significant in that it supports the establishment and ongoing development of group cohesiveness as outlined in the psychotherapy literature as establishing clarity regarding group processes and facilitating the responsiveness of others (Burlingame, Fuhriman, & Johnson, 2001). This reduction in turn length also reflects the quality of well managed discourse in group treatment for aphasia in that it promotes the feeling of discourse equality (Simmons-Mackie, Elman, Holland, & Damico, 2007).

Increasing turns allocated to others. Related to his decrease in self-continuing turns-at-talk was Alan's increasing use of questions that specified a next speaker turn-at-talk. While he did direct a question to Charlotte in Session One, it acted more as a pre-story sequence so that he could talk about how to set up a wireless router; for which he had expertise. In later sessions he continued to use questions as pre-story sequences but began to ask others questions that were not designed to continue his turn at talk but their own. He demonstrated the bulk of these other turn allocating questions in Session Three. We see him ask a question designed to allocate next speakership to another when the group was discussing Rosa's absence that day.

Session Three at 10:49:12
   Aud: She's not coming today?,
   C6:   She had a doctor's appointment in Biloxi and she's still there.
→Alan: (3.5) That's a long way?,
   C6:   I think she lived in Biloxi, I know she lived in Washington D.C.,

After a lengthy pause with Clinician Six neither self-selecting a continued turn at talk nor another member self-selecting a next turn, Alan self-selects a turn that encourages Clinician Six to continue the conversation topic. He uses his talk to allocate a next turn to her by using a minimized questioning inflection. Alan's turns-at-talk which allocated next speakership similarly promoted the responsiveness of others and the establishment of discourse equality (Burlingame, et al. 2001; Simmons-Mackie et al., 2007) .

Decreasing rate of conversational breakdown. Alan's rate of participation in the conversation, in the form of the percentage of total conversation turns that were taken by him, fluctuated over the course of the semester; where Alan participated in conversations one through four at a rate of 13.1%, 12.6%, 20.6%, and 7.2%, respectively. His rate of conversational breakdowns however decreased over the course of the semester; with the percentage of his TCUs requiring repair diminishing from 38%, 20%, 19%, to 14%, respectively. In other words, fewer of his turns at talk were problematic, requiring repair work. This progressive decline is depicted in Figure 4.4.
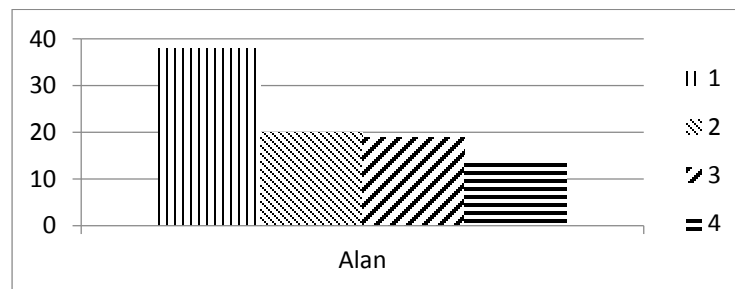
Figure 4.4. Distribution of Conversational Breakdowns for Participant Two (Alan)

However, a relationship between his decreasing turn length and rate of conversational breakdowns would suggest that his decreasing need for conversation repair is related to the reduced complexity of his turns. It has been long established that performance decays with increased syntactic complexity and semantic abstraction (Gardner, 1973; Holland, 1971). He

did, in fact, reduce the length of his turns as evidenced by the decreased TCUs which eases the burden of linguistic formulation. However, for conversation three he dramatically increased his rate of self-initiated turns which increases the demand on linguistic resources; he was less able to use the talk of the previous speaker in his own turn construction (Hengst, Frame, Neuman-Stritzel, & Gannaway, 2005; Oelshlager & Damico, 1998). Further, without a turn-allocating construction by the prior speaker, the TRP was more competitive for a next turn-at-talk (Jefferson, 2004; Sacks, Schegloff, & Jefferson, 1974). However, despite the decreased contextual resources, he maintained stability in the rate of conversational breakdown, thus demonstrating improved language ability. The above data also demonstrate the complex nature of language use, with its many influences, for conversation that is dependent upon multiple factors to achieve interactive success.

Increasing orientation toward repair. Alan demonstrated a good ability to initiate the repair of conversation breakdown from the very first session. However, while he left 4 or 12.9% of breakdowns unrepaired in the first two sessions, he left no breakdown unrepaired in the latter sessions. Further, for earlier group conversations he initiated his repairs within a time frame that spanned the first turn construction unit to just after the transition relevance place, or by requesting assistance to complete the repair. In the latter sessions the place of repair became more immediate as Alan made his repairs increasingly adjacent to conversation breakdown; all self-completed repairs occurred as part of the TCU in which the problematic talk occurred; which is categorized as repair trajectory one (RT1). In fact by the final session all repairs, with the exception of one request for assistance, were completed in this time frame demonstrating increased efficiency in self-repair. An example of this occurred when Alan experienced a phonemic paraphasia and with the next word, corrects it.

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As a point of clarity, the reader will note that Alan completes the verbal component of this

utterance with a vocal demonstration using laminar alveolar fricated clicks (ǀ) to provide

sound effects for his re-enactment of a rabbit hopping around the house (Appendix B-S4).

Session Four at 21 minutes, 40 seconds
Iris:	Yeah, you know, that big do:g ya know (.) and he couldn't wait and it
Iris:	was like (.) "GET THE BUNNIES" (1) you know. (1)] get 'em
→Alan:	plus they go across the floor and mace make a little plup as they
→Alan:	walk around the house. ǀ-ǀ-ǀ-ǀ
Alan:	((raises hand/ down curved "C" making hopping motion L to R))

This decrease in conversation breakdown may be attributed to his improved verbal

processing ability, but may also relate to the growing common ground that is a characteristic

of group cohesiveness that allowed him to construct his turns with less effort; principle of the

least collaborative effort (Clark, 1996).The overall absence of problematic talk that was left

unrepaired provided evidence of Alan's increasing commitment to the conversation which

supports his task cohesiveness which is an integral part of group cohesiveness (Zaccaro S. J.,

1991).

Conversational behaviors demonstrating group cohesiveness. Once the data

documenting positive changes in Alan's symbolic processing and overall improvement in

conversational interaction are presented, the data pertaining to the main focus of the

investigation can be presented. The impact of improved processing and conversational skills

on manifestations of cohesiveness will be discussed in subsequent chapters of this

dissertation.

In addition to the ways in which the patterns of change in turn-taking reflected not

only increasing language ability but a growing orientation to group cohesiveness, Alan

demonstrated a multitude of behaviors within his conversation turns that support his growing

orientation toward group cohesiveness. His conversation behaviors, however, also indicated

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his level of cohesiveness was different in terms of interpersonal cohesion and task cohesion (Zaccaro S. J., 1991). Alan reported from the onset of treatment that he was not given to social affiliation, or cohesiveness. His self-perception was supported by his treating clinician's perceptions of him when, during the post-semester interview, she made three references to Alan's stance that was incompatible with group cohesiveness when referring to him as grouchy, awkward, and as maintaining separation from the group. She even noted that Alan referred to himself as "anti-social." Specific changes will be documented and discussed below. These data are divided into two sections, behaviors that serve as manifestations of cohesiveness, and various conversational strategies that are indicative of engagement and cohesiveness.

Conversational behaviors that serve as indices of progressive cohesiveness. Alan's level of social cohesiveness did move toward group cohesiveness over the course of the semester. His conversation sampled from two sessions at the beginning of the semester (a combined total of 36 minutes and 23 seconds) and two conversations at the end of the semester (a combined total of 39 minutes and 22 seconds) provided evidence of growing affiliation as demonstrated by eight conversational behaviors which are reported in Table 4.7 and then subsequently explicated.

Table 4.7. Affiliating Conversation Behaviors for Participant Two (Alan)

Conversational Behavior	1.31.12	2.7.12	3.29.12	4.3.12
Acknowledgment	15	3	13	7
Affiliation	6	4	22	4
Agreement	8	3	2	1
Assessment	0	3	3	0
Humor Initiated(gr.)	4(2)	3 (2)	14 (4)	9 (5)
Mimicking	3	0	3	0
Shared laughter	2	1	13	7
As % total turns all group	.50	.20	2.56	.56
Overlap	11	8	63	32

Acknowledgment. With 18 acknowledgment tokens in the initial sessions and 20

tokens in the final sessions, it is apparent that from the outset of treatment Alan employed

acknowledgment tokens as an indicator that he was orienting to the speaker and her message.

He did this equally for the facilitating clinicians and group members with aphasia. His

acknowledgment tokens took the form of nods in earlier sessions and continuers such as

"oh", "yeah", and "okay" in the latter ones. He employed acknowledgment tokens to

encourage a current speaker to continue with her turn as we see below when Rosa is telling

the group how she enjoys using Skype to talk to her friend (Appendix B-S1).

```
Session One at 11:25:33
  Rosa:        A::nd if I am in the kitchen?(2) I set my uh computer in the kitchen?
→Alan:                                    ((nod))                              ((nod))
  Rosa:        And do what I'm doin'.
→Alan:                          ((nod))
```

With six self-continuing turns-at-talk prior to this exchange, Rosa's turns indicate a

segment of conversational storytelling which is a modification of the usual system by which

we take turns (Sacks etal., 1974). In conversational storytelling, the teller takes extended

turns while the listener contributes minimally through acknowledgments that indicate

attention and appreciation ((Mandelbaum, 1989). Alan employed nodding consistently at the

TRP to indicate to Rosa that he both understood the content and that her story would

continue (Stivers, 2008).

There appear to be qualitative differences in the latter sessions where we see Alan

begin to shift from nonverbal acknowledgment tokens to verbal ones, using "okay" and

"yeah." This shift represented Alan's increasing participation in the group conversation

where he moved from a predominantly listening role to a more active speaking, self-

initiating, role. Where Alan demonstrated 15 acknowledgment tokens in the first session,

only two or 13% were verbal and were directed toward demonstrating his understanding of

the talk of another to the group as a whole (Stivers, 2008). Further, Alan demonstrated non-

verbal acknowledgment only for Session Two. In contrast, as Alan increased his self-initiated

turns at talk, he decreased the use of non-verbal acknowledgment tokens. He demonstrated

no acknowledgment tokens for conversation three which can be attributed to the fact that he

took the largest share of conversation turns, placing himself in a speaker role the majority of

the time; he constructed 20.6% of the conversation turns for a group of 11 people for which

equitable turn taking would be 9%. As acknowledgment tokens are a recipient oriented

behavior his opportunities for demonstration of acknowledgment was reduced. However, in

Session Four where the turn taking was more balanced and he resumed more of a listener

role, he employed only verbal tokens such as "yeah" and "okay"; doing so on six occasions.

While primary tokens such as "oh" or "hmm" indicate recipient acknowledgment only.

Discourse markers such as "yeah" act as tokens that go beyond mere acknowledging the

speaker's turn-at-talk but acknowledge that the information is consistent with current active

information (Jucker & Smith, 1998; Norrick, 2008). This serves as evidence that Alan was

taking on a more engaged and affiliating role in the conversation. We see this when Alan,

using the fake laugh of "Hah" and "okay", acknowledges the clinicians' turns and that the

clinicians are teasing him about his dogs being the preferred social outlet (Appendix B-S4).

> Session Four at 0:15:40
> C2:   °you could make a little scrap book of her°   ((laughter))
> C1:   yeah.
> →Alan: okay?,
> C1:   start on that tonight and bring it Thursday.
> →Alan: Ha:ah
> C2:   We have to see a picture of (.) Maggie. I mean c'm[on!]   Yeah!
> →Alan: [O]kay,

With his use of "okay" twice he demonstrates his acknowledgment of their turn and their intent of teasing which he accomplishes through his varied inflection. It is through this inflection that Alan's production of "okay" also acts as a continuer (Goodwin, 1986). He is acknowledging their turn and their teasing, while his inflection cautions their next turn at talk.

Affiliation. Affiliation is the demonstration of positive alignment by the listener for the speaker and can be demonstrated over multiple channels such as head orientation, nodding, gesture, and facial display (Abramovitch & Daly, 1978; Argyle & Dean, 1965; Cheng & Chartrand, 2003; Conroy, 1999; Stivers, 2008). For Alan, affiliation tokens took the form of smiling when demonstrated while in the recipient role during talk. Unlike other group members that engage in smiling regularly as acknowledgment of another speaker's turn, Alan is not one who smiles readily. Therefore, the nonverbal communication signal takes on greater significance when employed by him. We see him smiling more frequently in latter sessions, demonstrating 10 instances in the early two sessions and 26 in the latter two, and this is tied to the increase in instances of humor (Appendix B-S4).

```
Session Four at 10:20:02
    C2:         That's how my family first got started with chickens. Somebody gave
    C2:         us a bunch of colored ones…. They were all roosters. But um so but
→Alan:                                                    ((smiling------------))
    C2:         we got some- bought some hens after that (.)
    Alan:                                                  obviously
→Alan:          smiling---------------------------------------))
```

In the above excerpt, Alan smiles in response to the clinician's telling of raising chickens. The position of his initiation of smiling demonstrates his affiliative stance with the previous talk and the upcoming talk (Goodwin, M., 1980). In fact as evidence of his alignment with the clinician, his facial display, or facial demonstration, is tightly organized

with her talk and then his own talk (Fridlund, 1991) which is why he remains smiling and then verifies the intent of his facial display with his own turn of talk that assesses her turn.

Agreement. Overwhelmingly, in conversation there exists a preference organization related to identity, or face, and agreement holds a preferred status to disagreement (Atkinson & Heritage, 1984; Sacks, 1992). Therefore, a decline in agreement statements may represent a conversation member's orientation that is contrary to the idea of growing social cohesiveness. While in the first two sessions, Alan demonstrated agreement through nodding or affirmation statements on 11 occasions, he demonstrated agreement only three times in the latter two sessions. While a reduction here might suggest less employment of agreement in these sessions, it is also possible that this change in conversational behavior could relate to the change in facilitating clinician as the earlier sessions were facilitated by the researcher who was the clinical supervisor and the later sessions were facilitated by two student clinicians. When looking at specific incidents of agreement six of the eight instances in the first conversation were the result of either a clarification question or a verification statement made by the clinician; they were part of collaborative repair. For example, when asked the difference in video chat technologies, a topic on which he possesses expertise, by Clinician Zero he nods his agreement with her assessments (Appendix B-S1.

> Session One at 11:25:15
>   C0:   I notice on my iPhone I have <u>Face</u>Time. [and] I guess, is that a similar
>   C0:   technology?   So um, I was gonna ask you if that was an iPad?
> →Alan: ((nods))
>   C0:   Or some-,a different tablet.
> →Alan: ((nods))

Alan demonstrates the nodded "yes" as verification that the clinician is correct in her assumptions. Contrary to this, in the latter sessions, Alan verbalizes agreement not as verification but to second another member's opinion. This occurred in the conversation about

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the importance of owning a DVR, a belief held perhaps more firmly by Clinician Three. He

demonstrates working together with Clinician Three to the degree that a hitch onset occurs as

the two volley the points of their position at Clinician Two (Appendix B-S3).

```
Session Three at 10:38:45
    C3:         It's time management becau//se
    C2:         //Okay. How is it time mana[gement, This I want to know.]
    C3:                                     [you fast forward th]rough the
    C3:         commericals, (.)    so you watch ((laugh)) a third less time=
→Alan:                      YES!             Exactly!
    Alan:       = you get so good at that (1)
```

In this excerpt, Alan demonstrates his agreement more emphatically through a verbal

channel and with his increased vocal and prosodic intensity. The increasing specificity of his

agreement, moving from "yes" to "exactly" suggests that he is becoming increasingly

affiliated with Clinician Three's stance on the time saving use of DVRs. Further, through his

use of these agreement tokens, he demonstrates not only his affiliation with her stance on

DVR ownership, but through his verbal tokens of agreement becomes co-teller of her turn-at-

talk (Norrick, 2007).

Assessment as report of participation in a prior activity. Assessments are the actions

on the part of listeners that "rather than simply acknowledging receipt of the talk just heard,

assesses what was said by treating it as something remarkable" (Goodwin, 1986, p. 207).

These actions have three sites for their occurrence, one of those loci being within speakers'

report of participation in activies (Pomerantz, 1984). In other words, speakers can make

assessments of prior events, as opposed to the ongoing talk, in their own turns at talk which

often serve as invitations for agreement (Lindstrom & Mondada, 2009; Pomerantz, 1984).

Assessments when produced by a speaker provide the opportunity for the demonstration of

affiliation in a next turn-at-talk which builds social cohesiveness and so function to construct

and maintain relations between the speaker and the hearer (Hunston & Thompson, 2003). According to Martin & White (2005), bonds are formed when a conversation participant proposes an attitude about something and the subsequent speaker attends to it. In the sessions sampled to form the primary data set, Alan demonstrated 3 instances of assessment for prior events in Session Two and again in Session Three, with no instances in sessions one and four. Therefore while this provides evidence toward neither waxing nor waning social cohesiveness, it does mean that some level of trust was present by the second session sampled. This was apparent in Session Three when Alan was enthusiastically and loudly communicating his dislike of watching television live as opposed to through the DVR, as evidenced by his intoned dialogue to connote his distaste for watching live television (Appendix B-S).

> Session Three at 10:40:30
> →Alan: [WHEN YOU WATCH IT LIVE YOU] GO AND GO OVER GO
>   Alan: ((gestures pushing button on pretend remote   ))
> →Alan: FAST FORWARD, YOU GO "OH! It's not being recorded."
>   Alan: ((pushing button on remote))
>   Charlotte: ((laughing   ))
>   C3:   ((laughing   ))
>   C3:   ((smiling   ))
>   Althea: ((brow furrowed, mouth open   ))

Alan's demonstrated assessments through his use of repetition and direct speech as he narrates his action of attempting to fast forward the TV show using a remote. The assessments in Alan's turn-at-talk invites a second assessment which is completed by Althea through a facial expression that negatively assesses for the purpose of affiliation and Clinician Three and Charlotte who affiliate with Alan's turn through laughter, which will be discussed in the following section.

Humor. Humor is an essential component to achieving well-managed group treatment (Elman, 2007). It acts a tool for creating group solidarity and as an index for measuring solidarity through its reciprocating relationship (Greatbatch & Clark, 2003; Rothwell, Siharath, Bell, Nguyen, & Baker, 2011). At a personal level, humor serves multiple functions which include adjusting to reduced capabilities and social support, expressing stress, presenting "troubles talk", reasserting autonomy and self-esteem, as well as maneuvering social distance (Heath & Blonder, 2003; Jefferson, Sacks, & Schegloff, 1987). Alan's clinician reported his use of humor to promote friendship on two occasions and that instances of humor were conspicuously absent from a session if he was not present when she reported that the other members would miss his teasing (Appendix D-C5).

Alan began to employ humor increasingly as the semester conversation group treatments progressed. As the participant with the greatest amount of linguistic facility, he also wielded the greatest amount of conversational clout. This was never more evident than in his use of humor which served to unite the group; either as a whole or as an *us versus them* with the members with aphasia as the *us* and the clinicians as the *them*. This social influence was noted by Clinician One in the post-semester interview (Appendix D-C1-1).

Clinician One Interview at 0:12:05

I know that whenever we would read stories it mainly depended on, and to say this is weird but, Alan; how well he took the story and I think that that was kinda the direction that conversation would go in, who was gonna get teased and that kinda thing.

Alan's humor did often take the form of teasing an individual, usually the facilitating clinicians. He also demonstrated Group-Level jokes that relied upon the developing common

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ground among the group. As will be discussed below, he demonstrated a shift in how this humor was deployed over the course of the semester.

Teasing. While Alan engaged in teasing clinicians twice in Session One and twice in Session Two, he teased either clinicians or group members four and five times in sessions three and four, respectively. Alan is given to teasing, referring to himself as a "smart ass", but in demonstration to his orientation to group cohesiveness and the social constructs that will support it, he directs his teasing mostly toward the clinicians (Simmons-Mackie & Schultz, 2003). In his interview he reasoned that he felt it was okay teasing the persons that don't have aphasia when he said "more the workers than the people that were in there" (Appendix B-I). His perception was supported by his clinician in her post-semester interview where on three occasions she noted Alan's differentiation between clinician and group member with aphasia (Appendix D-C5-1).

Clinician Five Interview at 0:23:15

Like I think that my client would feel like if you poke fun at another client that they wouldn't get it or more worried about offending them whereas he knew he could poke fun at us and we would laugh it off or we're not gonna feel as threatened maybe?

In fact, it isn't until sessions three and four that he teases another member once in each session. In this first example, Alan is teasing Clinician Three about not answering her phone when he attempted to call her earlier that morning (Appendix B-S3).

Session Three at 10:32:43
   C2:   So, C3, your hand is feeling better?
   C3:   mHm, it's not as swollen [anymore]
→Alan: [but (.)   ] she can't use the phone.
   C3:   Alan was trying to call me but apparently the service is like spotty…

Alan uses humor to convert a dispreferred turn into a preferred one; he situates his chastisement of Clinician Three in the form of a joke to mitigate conflict (Norrick & Sptiz, 2010; Simmons-Mackie & Schultz, 2003). Where Alan could have explicitly and without orienting to the sequentiality of the ongoing talk negatively assessed the clinicians lack of responsivity to his attempt to reach her by phone, he instead orients to rules of politeness in conversation through his exploitation of her turn-at-talk to construct a humorous account for why she might not have responded to his attempts to call her (Hay, 2001; Lerner, 1996). As discussed earlier, teasing that was initially confined to clinicians as targets was later extended to group members with aphasia as Alan felt more connected to them (Heath & Blonder, 2003). His teasing took a playful tone when he suggested a culinary solution to Althea's problem of her pet bird's reproduction ((Appendix B-S4).

<pre>
Session Four at 0:18:05
    Althea: I told him 35 years? And you go- and them babies? Oh no.
    Althea: you got to go.
    C3:   you gotta leave with this
    Althea: Oh yeah. Got to go. No no no. (2)
→Alan: Gumbo//
    C1:   //Take care//
→Alan: //Gumbo
    Althea: Gumbo?
    C1:   He wants to=
    C2:   = put your birds in the gumbo?
    Althea: Oh NO! haha Oh no:, Oh no. (.) Oh no:, Oh no.
    Althea: ((raised fist   ))
</pre>

By teasing Althea, Alan has demonstrated an allegiance with her, closing social boundaries. Because Alan himself has been a bird owner and he has recently experienced the problem of puppy over-population he has rights through common ground to tease her. In this instance, Althea responds positively through her laughter and returned joking when she raises her fist at him.

Group-Level jokes. Alan did not limit his humor to teasing individuals. As the semester progressed he employed Group-Level jokes that required the participation of multiple group members, often recalling previous conversations to make jokes that required the group's shared knowledge or common ground. His use of these Group-Level jokes increased from 3 instances in the earlier sessions to 14 occasions in the latter. During the conversation where the clinician told the group that her broken water heater has made it difficult to wash her dishes by hand, Alan recalls an earlier conversation where she revealed that she does not own a TV and makes the following joke that was shared by the entire group (Appendix B-S3).

<pre>
Session Three at 10:36:25
    C2:   That's what my roommates do.(1)they use the dishwasher. I hand wash
    C2:   everything,<cause I don't have that many dishes> see if I had paper
    C2:   goods then I'd have dishes. But hehe so I hand wash (.) everything.
→Alan: Cause you got time, cause (.) you don't have any TV.
    C1, C2,C3:   ((laughing))
    Althea, Iris: ((laughing))
    Jesse, Aud: ((laughing))
</pre>

The group members were able to rely on prior conversations to amass a large amount of common ground and Alan exploited this to create clinician-targeted but group-oriented humor. His humorous turn-at-talk created solidarity and affiliation as evidenced by the laughter after his comment that was shared by all conversation participants, even Jesse (Kovarsky, Shaw, & Andingono-Smith, 2007; Simmons-Mackie & Schultz, 2003;).

Mimicking. During tight alignment with our communication partners we often find our gestures and word choices mirroring theirs (Clark, 1996; Kendon, 2004; Holler & Wilkin, 2011). The linguistic alignment in the form of mimicking serves several interactive functions such as self-initiating or continuing a turn-at-talk, gearing up to answer, minimizing a dispreferred status, and humor among others (Tannen, 1987). Mimicking is

also employed as a device that can be used to ease linguistic formulation and for interpersonal involvement (Hengst, Frame, Neuman-Stritzel, & Gannaway, 2005; Tannen, 1987). Alan employed mimic inconsistently across sessions, but with three occurrences for sessions one and three, he demonstrated its strategic deployment as dictated by the context. Alan demonstrated great resourcefulness in his varied use of mimicking. In Session One he used mimicking twice for humor. The use of delayed mimicking for humor is presented in the following excerpt where the group is talking about using Skype to keep in touch with distant loved ones.

> Session One at 11:22:19
>   C0:   Well, do you all, do you and your family use Skype now? Or no.
>   Aud: No. (1) Umm
>   C0:   It's ↑free:
> ….
> continues at 11:24:08
>   Rosa: Well I use uh Skype.
>   C0:   Do you use Skype? Good for you.
> →Alan: It's ↑free!
> ….
> continues at 11:25:02
>   Rosa: But you know uh, we talked, and talked, and talked ((laughter))
> →Alan: Good thing it's <u>free</u>!

According to Tannen (1987), repetitions are identified according to several criteria, one of which is temporal where repetitions are classified as immediate or delayed. While Alan's mimicked production occurs two minutes following the clinician's production, his use of the identical lexical construction with the identical prosodic intonation, demonstrates his intent to use repetition for humor.

Alternately, in Session Three mimicking was used all three times for interpersonal involvement and these involved gesture, speech, an even timing to relay the intended function. Patterned rhythm is a form of repetition where "wholly different words are uttered

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in the same syntactic and rhythmic paradigm as a preceding utterance" (Tannen, 1987, p.

586). This shift in how mimicking was employed, transitioning from linguistic formulation to

purely interpersonal involvement, may represent a shift in Alan's orientation toward group

cohesiveness. An example of Alan incorporating first a clinician's gesture and then another

member's speech demonstrates his interpersonal involvement in the conversation for which

he is quite passionate; the merits of DVRs.

```
Session Three at 10:39:57
   C2:          He has a TV.
   C2:          ((raises hands fingers splayed toward C1))
→Alan:                      ((raises hands fingers splayed toward C1))
   C1:          I Can't afford all the DVR and stuff that['s (.)] that's a lot of money.
   Jesse:                                          [it's eh]
   Iris:        Yeah it is!
   C3:          It's a sacrifi[ce]      = I won't shop as much. ((laughing))
→Alan:                    [yeah] it is.=                          ((laughing))
```

In the above interaction, Alan first mimics Clinician Two's gesture which according

to Kendon as a "palm presentation" gesture serves the communicative function of

representing the associated spoken message as "expounding the premises or conditions for

understanding something" (Kendon, 1996, p. 266). The clinician is demonstrating to the rest

of the group that they should understand that while he may only have basic cable, at least he

has a TV and they should recall from a minute earlier in the discussion that she did not have

one. Alan, by mimicking her exact gesture, is affiliating with her inference of how sad it is

that she doesn't have a TV. Alan is tightly affiliated with the conversation at this point and

goes on to use mimicking to agree with Iris that even if money is tight, a DVR is worth the

sacrifice. He produces the exact utterance and with the same rhythm, although less intensity,

as that constructed by Iris. This is consistent with Tannen's (1987) description of allo-

repetition placed at the extreme end of a scale of fixity in form.

Shared Laughter. As a signal of interpersonal involvement, laughter doesn't simply

attest to the fact that people are engaged with one another; "it provides insights into the

nature of that involvement" (Kovarsky, Curran, & Nichols, 2009, p. 28). For a person that

refers to himself as anti-social, it is quite significant that while Alan engaged in shared

laughter only 3 times out of 16 occurrences for group shared laughter (18%) in the initial

sessions, he engaged in shared laughter 20 times out of 33 instances for group shared

laughter (60%) in the latter sessions. This is significant because through the negotiating and

sequencing of laughter in conversation, participants demonstrate affiliation with other

speakers (Heath & Blonder, 2003). Alan does, in fact, demonstrate increasing engagement

with the group through shared laughter when, in the segment below, a joke is made while

discussing the importance of owning a DVR (Appendix B-S3).

```
Session Three at 10:39:57
    C1:        I can't affort all the DVR stuff that['s  (.)  ] that's a lot of money
    Jesse:                                        [it's eh]
    Iris:      Yeah it is!
→C3:           It's a sacrifi[ce]         =I won't shop as much.   ((laughter))
→Alan:                       [yeah] it is.=                            ((laughter))
→C1:                                                      ((laughter))
→C2:                                                      ((laughter))
→Jesse:                                                             ((laughter))
```

Alan's laughter demonstrates an alignment with Clinician Three's self-deprecating

joke, that she is a DVR addicted shopaholic, through the immediacy of its deployment. His

decision to respond positively to the prior speaker's joke served to demonstrate agreement

with the position taken by the speaker (Jefferson 1979, 1984).

Overlap. According to Sacks et al. (1974), overlap serves to minimize the gap

between speaker's within systematic organization of turn-taking where the participants orient

to "one party talking at a time" (p. 700). However, overlap also is often used by a next

speaker as a demonstration of independent knowledge or recognition of what the current speaker will say (Jefferson, 2004). Further, overlap has been shown to be deployed strategically to co-opt a portion of the current speaker's turn to produce a next turn-at-talk (Goodwin, 1995). Alan demonstrated overlap to both minimize conversation gap as well as to exploit the linguistic content of the prior speaker's turn-at-talk to reduce his own burden of formulation. To accomplish these functions, however, the next speaker must be aligned with the current speaker's turn-at-talk. Alan's display of overlap increased over the treatment sessions analyzed from 11 and 8 occurrences for Session One and two, respectively, to 63 and 32 occurrences in sessions three and four, respectively. This increasing incidence of overlap provides evidence of Alan's growing engagement with the group conversation where overlap provides a resource for demonstrating agreement and for co-production (Lerner G. H., 2002).   An example of this co-production for conversational storytelling is presented below.

> Session Three at 10:32:43
>   C2:   So, C3, your hand is feeling better?
>   C3:   mHm, it's not as swollen [anymore]
> →Alan: [but (.)] she can't use the phone.
>   C3:   Alan was trying to call me but apparently the service is like spotty
>   C3:   because when I looked at my phone I had like all my little bars and I
>   C3:   was looking at it, making sure he hadn't call[ed]
> →Alan: [it]was, it was connected because we got the answering machine=
>   C3:   =and I didn't get any of them.
>   Alan: ((laugh))

In the above segment of talk, Alan first teases the clinician about not returning his phone calls which prompt her to give an accounting to the rest of the group (Norrick & Sptiz, 2010). Her explanation becomes an extended turn, seven TCUs, characterized by conversational storytelling. At the completion of her seventh TCU Alan overlaps to take over the storytelling and after he constructs a self-continuing turn, Clinician Three completes the

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story which invites a laugh from Alan. These shared turns at talk through overlap demonstrated Alan's affiliation in the conversation.

Conversation strategy changes. After identifying the various conversational behaviors that appeared to be indices of affiliation and engagement that enable the inference of cohesiveness, it was also noted that there were several strategies that also served as manifestations of cohesiveness and that increased in usage over time. These strategies may be seen as being of two types. First, normal conversational strategies that are employed to increase and/or indicate cohesiveness and then those strategies that serve as compensatory strategies.

Although Alan maintained a perception of small therapy benefit, his conversation patterns did change for the better as reported in an earlier section. Much of this improvement in conversation is due to changes in Alan's conversational strategies. While Alan began the semester as a more strategic communicator than the other participants, he did demonstrate increasing employment of some conversational strategies and all conversation strategies used with consistency are reported in Table 4.8.

Table 4.8. Distribution of Conversation Strategies for Participant Two (Alan)

Conversational Behavior	1.31.12	2.7.12	3.29.12	4.3.12
Clarification Question	0	1	3	1
Multi-modality	6	4	25	2
Gesture Use (% turns)	0%	1.6%	19.6%	2.5%
Overlap	11	8	63	32
Recycle TCU	5	2	6	4

Use of clarification question. Clarification questions act as repair initiators which signal the need for the current speaker to provide additional information to the conversation partner (Goodwin, 1987; Schegloff et al., 1977). Alan routinely employed clarification

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questions to initiate repair when another's turn at talk referenced information that was not

common knowledge. He also used clarification questions to support his ongoing

comprehension of the conversation. He volleyed two contiguous clarification questions when

Aud was telling the group about a coincidence.

Session Three at 10:49:42
<pre>
    Aud: that's funny that she and I will meet o- on this (.) group um my in-laws
    Aud: live in Ocean Springs which is right next to where she's been working
    Aud: but ↑we found out //   (.) Ocean Springs?
→Alan: //who? (.) Where at?   Akay.
</pre>

Alan, who reports having trouble filtering out distracting stimuli, has not

comprehended the name of the city to which Aud was referring, but Aud herself has

constructed problematic talk when there is no anaphoric reference for "we." Alan's

clarification questions then serve two purposes. The first question, "who?" initiates repair of

Aud's problematic talk for which she declines to complete. Alan's second question, "where

at?" serves to correct his own misunderstanding and this request is complied with through her

repetition of "Ocean Springs." Alan signals his acknowledgment of this repair with his token

"Akay." He is now aligned with Aud's talk and since neither he nor any other conversation

member requests that Aud repair the "we" reference, they have relied on common ground,

their knowledge that Aud is married, to resolve the "we" as she and her husband.

Multiple modalities. Gestures and facial display provide an invaluable resource for

the construction of meaning and assigning that meaning to turns-at-talk through their

function as a linguistic self-cue as well as a cue and invitation to the comversation partner to

colloboratively assign meaning (Damico, Wilson, Simmons-Mackie, & Tetnowski, 2008;

Goodwin , 1995; Goodwin & Goodwin, 1986; Goodwin, 2000). Alan increasingly employed

multiple modalities to construct his turn-at-talk. The distribution of multi-modality turn

construction per TCU is reported in Table 4.9.

Table 4.9. Distribution of TCUs Employing Multiple Modalities

Session	One	Two	Three	Four
Number of TCUs	62	59	102	40
Occurrence Gesture	1	1	17	2
Distribution gesture	1.6%	1.6%	16.6%	5.0%

Alan used gesture to repair problematic turns at talk and to enhance his meaning

construction for turns that referenced visual information. An example of this latter use is

presented in the following excerpt where, during a conversation about owning rabbits as pets,

Alan becomes quite animated, using both gesture and laminal alveolar fricated clicks, in his

talk about how messy they can be (Appendix B-S4).

Session Four at 0:21:41
   Alan: plus they go across the floor and mace- make a little plup as they walk
→Alan: ((hand moving away from body, palm down wobbling
   Alan: around the house.(1) |, |, |, |, |,
→Alan: ((wobbling-----Hand in a down curved "C" w/ hopping motion L to

R))

Alan has strategically synchronized his iconic gesturing with his speech (Clark, 1996;

Goodwin, 1995;Kendon, 2004; Schegloff, 1984) which maximizes the communicative force

of his utterance. Similar to the findings of Kendon (2004) and McNeil (1985), Alan positions

his gestural representations relative to the actions they represent. His gestures precede the

verbal and later vocal demonstrations to which they are tied. In the first instance of gesture,

Alan depicts the action of a rabbit "make[ing] a little plup" to slightly precede the talk and

then he extends the gesture to co-occur with the talk to provide context for "plup" a sound

effect of dropping pellets. Alan completes the verbal component of this utterance but then

shifts to a vocal demonstration using the laminar alveolar fricated clicks (ǀ) to provide sound effects for his re-enactment of a rabbit hopping around the house. Both gestures serve as semantic specifiers in that they provide additional information that Alan could not accomplish using talk alone (Kendon, 2004).

   Overlap. During conversation, turns frequently overlap as one speaker nears the terminal juncture of a turn construction unit. Overlap can arise from a speaker's desire to self-initiate a turn or to contribute a continuer that while demonstrating acknowledgment or agreement, encourages the previous speaker to continue (Sacks, Schegloff & Jefferson, 1974). Overlap may be used to demonstrate that a person had not ended his turn-at-talk when it is used to regain speakership so in this sense overlap is intended to continue a turn-at-talk (Jefferson , 2004). Alan demonstrated overlap a total of 19 times over sessions one and two. The occurrence of overlap increased dramatically to 95 for sessions three and four and this is illustrated below in Figure 4.5.
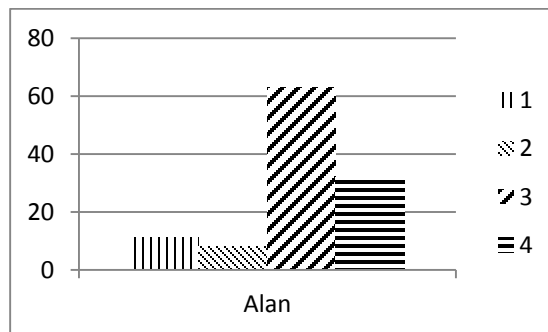
Figure 4.5. Distribution of Overlap for Participant Two (Alan)

   In addition to overlap being indicative of growing affiliation, it also represents strategic turn-initiation. Alan often uses overlap as the prior speaker nears the TRP of their utterance and, by placing his turn at talk prior to its terminal juncture, he is able to assert potential speaker rights for the next turn-at-talk (Jefferson, 1973; Jefferson G, 2004;

Schegloff, 2000). Overlap also occurs when a prior speaker has paused and another either

interprets this pause as a turn completion or is strategically self-selecting during the pause.

Intermittent pauses are a frequent occurrence in aphasic conversation where linguistic

impairment often degrades formulation. A representative example for both forms of overlap

occurred during a conversation about surround sound when watching high definition

television (HDTV).

```
Session Three at 10:41:34
    C1:         You'd rather the-the high definition?
    Althea:     Oh yeah:!
    C1:         I don't notice a huge difference.
    C3:         Oh: No:: [you watch Blue Ray?]
→Alan:              [y- every tv has got ]HD on it
    Iris:       turn the sound off for me. Surround? Turn it [off.]
→Alan:                                          [I ha]ve to turn off the
→Alan:      surround off cause I [can't ] (1) I can't do that any[more] (.)
    Iris:                        [too much noise]
    C4:                                                [I don't like
    C4:         that.]
→Alan:      [and I]'ve got (.) really good
    Iris:       It's when you feel it from the side, yeah.
```

The preceding example accurately depicts a portion of the communicative melee that

characterizes group conversation. We have four members vying for conversation turns and

all employing overlap to self-initiate or continue a turn-at-talk. Alan's initial occurrence of

overlap is the result of his and Clinician Three's simultaneous self-initiated turns and they

both treat the overlap as unproblematic as they complete their turn-at-talk unaffected. This

provides an example of occasions where overlap is, in fact, not problematic. She had been

orienting her talk to Althea while Alan had been directing his talk to Clinician One which

formed a schism in the conversation (Jefferson, 2004; Schegloff, 2000). In Alan's second

instance of overlap he anticipates that Iris' talk is approaching the TRP and gets a jump on it

to secure the next turn-at-talk. We then see two overlaps occur during Alan's turn at talk, the

first used by Iris to agree with Alan's talk and the next by Clinician Four to self-select a turn-at-talk. Alan resolves this latter overlap by aborting the completion of his TCU (Schegloff , 2000) but then resumes his turn as he hears her near the terminal juncture of her turn-at-talk, employing the discourse marker "and" to signify to Clinician Four that he is well within his rights to overlap her turn as a turn still in progress (Sacks, Schegloff, & Jefferson, 1974). Alan's increasing flexibility with the use of overlap may relate to both his improved language ability and his ability to use increased group cohesion as a resource for negotiating turns with the other group members.

Using recycled turn construction units. Recycling one's own TCUs supports more efficient turn construction that is less linguistically demanding (Tannen, 1987). This verbal self-repetition also enables the speaker to initiate or continue a turn-at-talk and it can be used to express emphasis (Leiwo & Klippi, 2000). Initially Alan's self-repetitions were employed as place holders to keep his conversational turn. In later sessions self-repetitions were also employed for humor and assessments (emphasis). In the conversation below about the lottery jackpot that had surpassed 400 million, Alan used a recycled TCU to persuade a fellow individual with aphasia, using humor, to buy a ticket. He even employed increased stress on the self-repetition to add importance to his position (Appendix B-S3).

```
Session Three at 10:46:20
    C2:         Jesse? Do you buy uh tickets? (1) do you buy lottery tickets?
    Jesse:      No. ○no.○
    C1:         Me either. I like the scratch offs. I like those, =
    Alan:                                                    = that's not 400 million.
    C1:         I know.      [it's] fun to scratch them off.
 →Alan:             one do[llar]                    one dollar ((laughter))
    Alan:             ((holds up one finger--------------------------------))
    Multi:            ((laughter shared by Alan, Charlotte, Aud, C2, and Iris))
```

In the above excerpt, Alan is recycling his TCU to use as a device of humor (Tannen , 1987). In fact, by the time the conversation has reached the above excerpt, Alan has demonstrated an allophonic, or exact, repetition of "one dollar" three times, making these repetitions the fifth and sixth times. It is finally on the sixth repetition of "one dollar" that Alan does in fact achieve the desired laughter, shared by most of the group members (Leiwo & Klippi, 2000). What is interesting about the preceding excerpt and the larger conversation in which Alan recycles the same TCU is that he co-ordinates the same gesture with all of the instances of his verbal self-repetition. The two modalities form one unit of expression where the gesture is associated with the one unit of speech (Kendon, 1980).

Participant's orientation toward group cohesiveness and conversation. The post treatment interview with Alan was conducted to ascertain Alan's orientation toward or away from group cohesiveness and questions revolved around his feelings of alliance or cohesiveness with the group and its members. Because the researcher became interested in the idea of cohesiveness as a driving mechanism for group conversation therapy in a similar fashion as that of group psychotherapy, Alan was asked for his perceptions regarding how affiliated, or cohesive, he felt with the group and how his feelings may or may not have changed over the course of the semester of group treatment. Further, since the isolating impact of aphasia has been well documented and it is antithetical to the idea of group cohesiveness; he was asked whether or not he felt the group impacted any feelings of isolation. Alan's responses, as well as any additional statements, were then coded using his words to form the initial codes which were then synthesized into ever broader categories. These labels formed patterns that supported Alan's disinclination toward interpersonal cohesiveness with greater responsivity to task cohesiveness (Zaccaro S. J., 1991).

Alan, the most linguistically facile participant, engaged in interview discourse the longest, 25 minutes, 42 seconds, as he had the most to say. Alan's responses often became tangential to the original questions which resulted in themes that more richly describe his perceptions of group conversation therapy than if his responses echoed the clinician's questions. For purposes of researcher transparency, it is noted that for only one occasion did the interviewer need to rephrase a question for purposes of verification. Over the course of the interview Alan's responses yielded a total of 117 primary codes which when organized, ultimately informed 5 themes which included evolving adjustment to disability, humor as an interactional resource, decreased social cohesiveness, commitment to therapy task driving interpersonal relations, and overall treatment benefit. These themes will be discussed in the paragraphs to follow with the frequency of occurrences for the data codes that support them being reported as (#x). Quotes taken directly from the interview can be read in context in Appendix B-I.

Evolving adjustment to disability. Alan's responses frequently referenced issues that related to an evolving adjustment to disability. He referenced his pre-stroke identity as his loss of ability (17x) when reporting things like "I lost all- a lot of my abil- ability" and "some my social- my spatial (1) stuff is not what (1) use to was." Alan referred to his pre-stroke identity involving intellectual activity four times with statements like "I <u>worked</u> that way I mean that's what my brain <u>worked</u>. Cause I took repaired beat systems I mean I- in fact I lay in bed and and think about the whole (.) concepts ya know I I could figure out how (.)" Alan also referenced his pre-stroke identity as being "anti-social" (2x). Alan reported that his evolving adjustment has been difficult, citing isolation after stroke (2x) and depression (2x). However, his responses also demonstrated an orientation to adjusting to his disability with

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his downplaying his isolation (1x), referring to social support (1x) and compensating for his deficits (7x). Most of this compensation revolved around his difficulty attending to a primary stimulus and blocking out distracting stimuli such as when he reported "if I try to read, I can't have anything going on, that clock's driving me <u>nuts</u>, (.) a:nd so I buy Boiz, Bose-(1) Headphones?,." Alan's responses in the interview demonstrated a perception of himself as constructing a post-stroke identity that is characterized by his continued "anti-social" nature but also an identity of creating humor (7x) from his clinician and group targeting jokes. Alan demonstrated his adherence to socio-cultural norms of teasing by directly referencing the inappropriateness of jokes at the expense of an individual with aphasia (1x) which led to teasing focusing more on the clinicians (5x). Alan then employed humor within social constraints as a frequent resource for interaction. As reported under the conversational behaviors demonstrating cohesiveness, Alan's use of humor acted to unify the group and he referenced group oriented humor through mentions of teasing another member about not paying attention (2x), shared humor (1x), and the group understanding jokes (1x).

Decreased Social Cohesiveness. However, Alan demonstrated perceptions of decreased social cohesiveness that supported his frequent report of being "anti-social." Contributing to his overall decreased social cohesiveness were responses that indicate maintaining separateness from the group, disaffiliating comparisons, and a reported lack of group therapy benefit. Alan demonstrated a preference for maintaining distance when he reported being unable to remember a group member's name (3x) and not feeling close to the group (2x); instead reporting that he "got to know them" on an acquaintance level. Alan demonstrated decreased social cohesiveness most strongly through his disaffiliating comparisons. Throughout the interview and in contrast to the questions about how connected

he felt to the group, Alan made comparisons regarding the group with statements of comparison between group members (14x) and clinicians (5x). Alan also made comparisons between himself and other group members (13x) and himself to others in general (3x). Alan reported differential affiliation with group members and clinicians (4x) as well as differentiating members with aphasia ability to assist in collaborative repair during conversation breakdowns.

  Task Cohesiveness. Distilled into a heading of task cohesiveness is the more expanded theme of a commitment to therapy task that drives interpersonal relations. This theme was informed by responses that organized themselves into categories of tolerating group treatment, group treatment task commitment, relating with others, and togetherness. When Alan echoed the interviewer's question to indicate that he felt comfortable but that comfort remained stable over the course of the semester rather than increasing, he demonstrated a perception of tolerating treatment (3x). Alan's responses did support self-perceptions of commitment not to abandon conversation in the group(2x) while often abandoning an unsuccessful turn out of group (2x) as well as "not give[ing] up" on reading aloud tasks. Alan reported relating to other group members on some level when he reported that his communication was understood (2x) and in his sympathy for another group member whose severe expressive aphasia masked her obvious intellect. Alan also referenced a sense of working together as a group when he used "we" affiliating statements (2x) and referenced the group members engaging in collaborative repair to resolve a problematic turn at talk (4x). So, Alan's reports of and references to tolerating Group-Level treatment and his task commitment led to his report of relating to others and togetherness as his commitment to the

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task of improving his conversation supported the social cohesion necessary to achieve task success.

Overall treatment benefit. Alan did feel that his speech had improved somewhat, though not at the rate he had hoped for. His responses that referenced group benefit (1), friends and co-workers noting improved speech (2), and his own observations of "I couldn't say that before" (2) form a less robust but yet present theme of an overall benefit of treatment. However, as Alan received both individual and group therapy any interpretation of the group conversation therapy paradigm as the impetus to his assessments of improved speech would be irresponsible.

Summary of Alan. In summary, while Alan demonstrated many conversational manifestations of group cohesiveness, these may be more attributable to task cohesiveness than to interpersonal cohesion. However, since the two are inextricably connected, and, based upon Alan's perceptions, his clinician's perceptions, his conversational changes, and his strategies, there is plausible evidence for an orientation to task cohesiveness that promotes interpersonal cohesiveness and influences Alan toward increased social cohesiveness.

In the examined sessions, Alan demonstrated behaviors and asserted opinions that indicate he maintains a high-task, low-interpersonal orientation (Zaccaro & Lowe, 1988; Zaccaro, 1991) and as the participant with the greatest linguistic prowess, he was able to most easily employ both linguistic and non-linguistic strategies to repair breakdowns and keep the conversation moving forward. His commitment to a successful conversation, however, required engagement, connectedness, and working together with all group members so while he indicated having little interpersonal attraction to the group, he did demonstrate overall group cohesiveness. At times, he even allowed himself to affiliate with

the group. For example, when asked during the interview why he would often give up on what he is trying to say to others outside of therapy but didn't give up on what he wanted to say in the group, he reported "They all- you're not- (3) the rest (.) of the group's all messed up too. It's different" (Appendix B-I at 1:05:02).

Participant Three (designated Jesse)

Jesse, a 53 year old white male suffered a stroke in December of 2010. Even after the stroke, he presented a strong physical presence. He stood about 6 feet 3 inches tall, was a weightlifter, and was not given to smiling or laughing. While Jesse remained committed to improving his communication, he stated that he did not see value in being a part of the group. Prior to his stroke, Jesse completed high school and worked as an oilfield supervisor for 30 years. He enjoyed lifting weights and riding motorcycles. He had no speech or language difficulties prior to the stroke. According to medical records, Jesse's stroke was consistent with an extensive left cerebral infarct, in the territory of the middle cerebral artery. Additional medical history was significant for high blood pressure with non-compliance, coronary artery disease, and myocardial infarction approximately 2 years prior to his stroke. According to Emergency Room records, at the time of his admission he weighed 330 pounds. Having been under the care of a physician and thus made aware of the need to control his diet and take all prescribed medication, this medical history is suggestive of a person that is less inclined to follow direction and expectations, one of which being the socio-cultural norm of forming cohesive ties within group interaction.

Jesse remained in the hospital for 17 days and on December 22, 2010 he was discharged to his home with only outpatient speech therapy recommended. He reportedly attended speech therapy briefly before returning to the area where he could move in with his

mother. Since moving to this area, Jesse's social network has become quite constricted being reduced to his mother and the persons he sees at the neighborhood bar he frequents. He reported no additional contacts.

Consistent with the criteria for eligibility in this research, this was Jesse's first semester of treatment at the university based clinic. Group treatment focused on improved meaning construction in reading as well as conversation and in a 50 minute session conversation was usually allocated 20 to 25 minutes. In addition to group treatment, Jesse received individual treatment before each group session. Based upon archived treatment plans, individual treatment addressed the use of communication strategies in one on one conversation for reducing abandonment of utterances. Additionally, therapy addressed linguistic processing in the writing modality and shared reading of graphic novels to provide additional visual support. As reported in more detail in Chapter Three, Jesse demonstrated moderate to severe mixed aphasia and his communication was characterized by the need for visual support to comprehend contextual, functional speech and verbal ability that was limited to automatic phrases and single words that were spoken or written.

Pre- and post-treatment language ability. While demonstrations of an increasing orientation toward group cohesiveness were fewer in Jesse than the other two participants, he did make changes in his conversation. These changes are attributed largely to his commitment toward improving communication, to the communication opportunities afforded by group conversation, and to improved language processing.

Symbolic processing ability before and after group conversation treatment. With regard to symbolic processing, as the time post onset of aphasia lengthens, the amount of improvement typically made by IWA becomes progressively smaller. The greatest amount of

recovery of function occurs in the spontaneous recovery state which lasts from onset until between 5 and 8 months post onset of aphasia with diminishing gains after that point (Basso, Capitani, & Vignolo, 1979; Darley, 1982; Kertesz & McCabe, 1977;Koura, Taher, Barrada, & Mostafa, 1978). Jesse was approximately a year post-onset and would be considered by medical professionals to have chronic aphasia; consequently, expectations of his potential for significant improvement are typically diminished. However, by the end of the treatment sessions there was a discernable change in Jesse's language processing for specific modalities. As discussed in Chapter Three, symbolic processing ability was evaluated by using the *Porch Index of Communicative Ability (PICA)*. Modality scores and percentiles for two administrations of the PICA (representing pre- and post- assessments) are reported below in Table 4.10 with the dates indicated.

Table 4.10. Pre- and post-Treatment *PICA* Raw Scores by Modality for Jesse

Modality	1-27-2012		5-11-2012	
	Score	percentile	Score	percentile
Overall	11	52	11.23	54
Writing	8.8	68	9.625	74
Copying	12.05	50	12.8	62
Reading	12.7	64	11.05	40
Pantomime	11.55	65	12.65	82
Verbal	8.575	38	8.425	37
Auditory	13.35	36	12	26
Visual	15	99/35	14.8	20/24

Jesse's overall processing performance did not show tremendous gains as his performance on specific subtests varied. Prior to this investigation his overall processing performance (as specified by the PICA overall score) placed him at the 52%ile and subsequent to the therapeutic period of this investigation, his overall score improved marginally to the 54%ile. Performance in this range indicates that, according to Bruce Porch,

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"he is beginning to understand and carry out instructions to the point where he is able to now function independently in a familiar environment." (Porch, 2001, p. 86).

While improved language processing for the writing modality was expected, his improved pantomime ability was not anticipated. Individual treatment had targeted writing through a processing oriented procedure, Therapy Subsequent to the PICA (Porch, 2001) and the client progressed nicely from copying to naming photos to completing phrases. Therefore, it was not surprising to see Jesse improve in his written language processing from requiring a model to copy (8.8) to the ability to write a word after either repetition or with self-correction (9.625). By contrast, gestures were modelled by the clinician as part of conversation in individual treatment and they were demonstrated by clinicians and members with aphasia alike in conversation repair during the group conversation treatment sessions. Gestures were encouraged but never practiced out of their naturally occurring context yet we see Jesse improve from the level of gestures whose meaning is incomplete and performance is delayed (11.55) to gestures that while still delayed are most often complete (12.65).

Conversation ability before and after group conversation treatment. The clinician and Jesse engaged in a conversation at the beginning of the semester to obtain baseline information related to his language; a full report of the results can be found in Appendix C-FSS. In a 35 minute sample of conversation with his treating clinician at the beginning of the semester, Jesse demonstrated several reoccurring behaviors which acted to strengthen his communication. He used the discourse markers, "you know", "see", and "yes" throughout the conversation to express receipt of information, demonstrate competence, and as a way of taking a turn in the conversation. Jesse also maintained eye contact to monitor whether or not the clinician understood what he was communicating. Jesse used facial expressions along

with gestures as a strategy to communicate. For example, when telling the clinician how much he used to bench press, he gestured by raising his arms up and down and changing his facial expression by puckering his lips and blowing air as if he were straining. These strategies were useful in that they allowed Jesse to actively participate, despite his limitations in the verbal modality.

Analysis of a conversation sample also revealed use of laughter and joking to increase affiliation with speaker, which demonstrated comprehension and often served as a conversational turn. Jesse effectively used the writing modality to supplement the verbal modality during a majority of his speaking turns. He used writing approximately 27 times during the conversation. For example, when having a conversation about hunting, Jesse wrote the words deer, alligator, and duck to add to the conversation. He also used his writing modality to draw a map to describe where a friend lives. The client demonstrated some level of auditory comprehension during the conversation by responding to comments and questions made by the clinician. On multiple occasions the client would begin to express a thought and then back away from what he wanted to say. He would say "I can't" or "no" when abandoning utterances. He demonstrated frustration when a breakdown occurred and would repeat the word "stroke" and point to his head.

According to Jesse's clinician in the *Final Semester Summary* (Appendix C-FSS), while his pattern of conversation strategies did not change significantly, he did demonstrate increased commitment to conversation through decreased opting out and increased topic initiations. Further, he was quicker to switch modalities as a resource for conversational repair. Evidence of his increasing commitment to successful conversation came from his

decrease in abandoning conversation turns when they broke down with his treating clinician reporting that,

> During the week of 1/31/12, the client abandoned topic four times. On 2/23/12, the client abandoned the topic twice. As the client became more comfortable with the use of writing, drawing, and gestures during conversation, he gradually stopped abandoning topics. On 3/29, the client abandoned the topic, but later returned to the conversation. During the week of 4/3/12, the client did not abandon the topic.

In fact, over the course of the semester the treating clinician observed not only this decrease in abandoned utterances but an increase in topic initiation and he wrote,

> As the abandonment of topics decreased, the initiation of conversations using gestures and writing increased. In the first seven sessions, the client initiated conversation [topic] once through the use of writing and gesture, but was reluctant to do so. On 3/12/12, the client initiated conversation [topic] three times and on 3/27/12, the client initiated conversation [topic] four times with the use of writing, drawing, and gesture.

> The client began applying these modalities during reading and conversation (individual and group). On 3/15/12 and 3/22/12, the client drew maps, labeling roads and buildings to indicate some of his favorite places. It was also noted that when the clinician used more gestures, the client was more comfortable using them. The client still made attempts at verbalizing what he wanted to say, but when he could not get it out, he quickly resorted to gestures, writing, and/or drawing with little or no frustration

> *Conversational Changes.* While Jesse demonstrated improved conversation in his clinic sessions and improved linguistic processing for the conversation supporting modalities of writing and pantomime (gesture), his patterns of conversation turn-taking in the group do

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not show the same level of improvement. The distribution of his turn-taking behaviors

follows in Table 4.11.

Table 4.11. Distribution of turn allocation and repair for Participant Three (Jesse)

Distribution of Turn Allocation				
# turns self-initiated	*10	4	3	5
% turns self-initiated	*62%	12.0%	27.0%	28.0%
# turns other initiated	6	27	8	2
% turns other-initiated	37%	87.0%	82.0%	81.0%
Participation distribution for conversation	6%	10.9%	3.3%	1.4%

* refers to a ritual greeting routine in which Jesse employed gaze and no to direct the
sequence of introductions.

Jesse did demonstrate increased self-initiation of turns over sessions one through four.

His higher number and rate of self-initiation in Session One provides a false picture of his

actual ability since six of the ten self-initiated turns arose from an introduction routine where

Jesse was able to use the conversation context and his directed gaze that was sometimes

paired with a head nod to request, in turn, each member's name. If these turns are discounted,

he self-initiated at an identical rate to Session Two. Jesse's increased self-initiations may be

related to his increased use of multiple modalities, especially gesturing; this will be discussed

at length in the section on conversation strategies. However, it is equally likely that with

fewer turns allocated to him by the clinician and the resulting fewer turns taken in

conversation, a stable amount of self-initiation would appear to be an increased rate of

initiation.

It is apparent from the data reported in Table 4.10 that Jesse's level of participation

decreased from the beginning of the semester to the end of the semester. It is likely that his

ability to participate in the co-construction of conversation is impeded by the severity of his

aphasia. This is supported by a pattern in his proportion of turn taking as part of the entire

group which is directly related to the clinician's mediation attempts with Jesse taking 6%,

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10.9%, 3.3%, and 1.4% of the turns that were constructed by the entire group for sessions one through four, respectively. These figures are reduced from what would represent an equal proportion of the total of conversation turns being 14% for sessions one and two and 9% for sessions three and four. We see that as the clinicians prompted him less through turn allocations with 6, 27, 8, and 2 occurrences for sessions one through four, respectively, Jesse contributed less turns-at-talk relative to the group. This relationship became apparent to his clinician who reported during the post-semester interview that Jesse had to be "pulled in" or "asked a question" to involve him in many of the group conversations during the semester (Appendix D-C1-I).

Conversation behaviors demonstrating group cohesiveness. Engagement has been operationalized by Simmons-Mackie & Damico (2009, p.19) as "a process through which people establish, maintain, and terminate collaborative interactions, and it implies a degree of affective engrossment in the process" and Jesse initially showed minimal indication of engagement in the group. Over the course of the semester, Jesse showed increasing levels of engagement in the group conversation through his gaze patterns and use of acknowledgment tokens. While Jesse did not demonstrate the degree of social cohesion displayed by Althea and even Alan, he did move away from an orientation of separateness. This increase in his level of commitment to the group was reported by Clinicians One and Two for three occasions during a post-semester interview with Clinician Two reporting that despite Jesse's informing the clinician that he would not be saying goodbye to the group, "he still walked down and he walked into the group. He was only in there for a couple of minutes but you know he tried"(Appendix D-C2-I). Jesse's behaviors support this progressive orientation away from separateness through changes in his frequency for the demonstration of

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disaffiliation, negative assessment, positive affiliation, and shared laughter. His specific

indices of group cohesiveness are reported in table 4.12.

Table 4.12. Affiliating Conversation Behaviors for Participant Three (Jesse)

Behavior	1.31.12	2.7.12	3.29	4.3.12
Rate of gaze engagement	39%	63%	88%	^80/75%
Anticipatory gaze shift	2	10	19	8
expressed as % for total turns	0.7%	3.5%	5.7%	1.7%
Inclusive gaze	0	0	3	0
Acknowledgment	*8	1	8	6
Disaffiliation	6	0	0	1
Negative Assessment	3	0	0	0
Negative Assessment for positive affiliation	0	1	14	6
Positive Affiliation	2	4	13	2
Shared Laughter	0	0	9	0

^ indicates that the participant was on occasion out of view of the video

Gaze increasingly socially engaged. As reported under Participant One (Althea), a

criterion was established to determine eye gaze that related the gaze to either the speaker or

the referent in which if gaze occurs at any time during a speaker's turn it is considered

socially engaged for that turn (Argyle & Cook, 1976; Bavelas, Coates, & Johnson, 2002;

Goodwin, 1980). Whereas the two initial sessions were characterized by a wandering gaze

that often settled on the door, the window, or the clock, the latter two sessions saw an

increase in gaze at the speaker or a shared referent (photo or map) when his speaker/referent

oriented gaze increased from 49.5% to 84% of opportunities. An example of Jesse's initial

disaffiliation through wandering gaze is evident during a conversation about travel and the

places group members have visited. Clinician Zero is drawing the state of Alaska while

responding to Alan's teasing that she isn't a very good illustrator. While the rest of the group

has their gaze alternating between her and the drawing, Jesse's gaze is at his wristwatch, the

ceiling, door, and window (Appendix C-S2).

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Session Two at 10:53:41
    C0: You know I don't even know what shape Alaska is. I just know what it's
    C0: like way up he:re, and it's got some little islands that come off of it, And
→Jesse:((gaze at drawing--------------------------wristwatch----------------------))
    C0: it's more like that, there we go. (.) There's Alaska and we can make
→Jesse:((watch—ceiling---------door----out window-----------------------------))
    C0: Hawaii, How many islands does Hawaii have?
→Jesse:((window---))

Gaze functions to signal recipient attention and affiliation to the speaker and

disaffiliation or disagreement when it is conspicuously absent (Bavelas, Coates, & Johnson,

2002). Through his inattention, Jesse is likely signaling to the group his disaffiliation. This

provides a contrastive example to the later conversations where Jesse demonstrates

significantly increased engagement of gaze. An example of his increased gaze engagement

occurred in the following example where after another member teases Clinician Two about

not owning a TV, the topic shifts to what TV was like when they were younger. During the

four turns in the conversation, Jesse directs his gaze to the participants involved in the

exchange. It is only as Alan is completing his turn-at-talk that Jesse appears to disengage

from the conversation with a non-specific forward stare (nsfs) (Appendix C-S3).

Session Three at 10:37:49
    Althea: (1)Yeah but you know [know]
    Alan: [but see] some of us remember TV before TVs.
→Jesse: ((gaze at Althea---------------------Alan-------------------------------))
    Charlotte: (1) I dʒu!   [I dʒu::   ]
    Charlotte: ((raises arm and points to ceiling))
    Alan: Like [BLACK AND WHITE], you have [two] channels.
    Althea: [Eh. YEP. YEAH!   ]   [YEP!]
→Jesse: ((lap-Charlotte--nsfs-

Jesse alternately gazes at each of the speakers during a portion of their turn-at-talk

which demonstrated his engagement in the conversation. Jesse's level of engagement as

demonstrated through gaze resulted in increasing displays of anticipatory gaze where he was

so aligned with the conversation that he anticipated which conversation member would construct the next turn-at-talk.

Anticipatory gaze shift. Jesse demonstrated his engagement and interest in the topic of conversation with an increase in anticipatory gaze shift, where he shifted his gaze to the next intended speaker prior to the current speaker completing their conversation turn. His demonstration of anticipatory gaze shift increased from 12 instances in sessions one and two to 27 occurrences in sessions three and four. He became engaged in the conversation to the point that his gaze was tightly aligned to the talk in progress. This occurred three times, in the following example, when after a rapid and animated conversation between Clinician Three, Clinician Two, and Alan, primarily, about why everyone who owns a television should have a DVR, Clinician Two asks Aud if she has a digital video recorder.

```
Session Three at 10:40:10
   C2:          Do you use this?  The DVR?
   Aud:                            No, No I don't (2) I'm picky what I watch.
→Jesse:        ((Table-C2-----------Aud----------------------table----Aud---------------))
   Alan:        (2) Okay,(1) but you can pi-(1)picky and (.)fast forward all the
→Jesse:        ((C2-lap--Alan-----------------------------------nsfs---------Charlotte))
   Alan:        commercials.
→Jesse:        ((Charlotte-C3))
   Multi:                         ((laughter from C2, C3, and Charlotte))
```

Jesse anticipates Aud's response to Clinician Two and Clinician Two's response to Aud. When Alan teases her referencing the merits of the DVR, Jesse anticipates that Alan's greatest ally in the debate, Clinician Three, will be responding and so shifts his gaze to her as he waits for her response (Appendix C-S3). Researchers have demonstrated that listeners project transition relevance places by utilizing prosodic, syntactic, and pragmatic cues (Ford & Thompson, 1996). In fact, persons with aphasia that results in agrammatism use prosodic features to manage turn taking for both continuing and a terminating their turn at talk and

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these cues are oriented to by listeners for their intended turn trajectory; despite significant

pauses and severe grammatical disruption (Beeke, Wilkinson, & Maxim, 2009). Further, it

has been demonstrated that listeners signal their prediction of next speaker through their gaze

(Casillas & Frank, 2013; Tice & Henetz, 2011). Jesse was most likely orienting to the

prosodic features of other's talk, as opposed to syntactic cues, as his auditory comprehension

was moderately to severely impaired.

 Inclusive gaze. Just as our gaze when directed at the speaker or a shared referent can

indicate that we are attentive and engaged in the conversation, when we direct our gaze

serially to all conversation partners we are either monitoring the receipt of our message or

inviting Group-Level connectedness (Argyle & Dean, 1965; Argyle & Cook, 1976; Bavelas,

Coates, & Johnson, 2002; Krantz, George, & Hursh, 1983). Jesse was observed to direct his

gaze serially in an inclusive fashion during only one of the four sessions analyzed, but he did

so three times. For Jesse, inclusive gaze may be heavily influenced by topic as two of three

instances of his use of inclusive gaze occurred in the same conversation about digital video

recorders where conversation was animated which would further support his decreased

auditory comprehension (Appendix C-S3).

```
Session Three at 10:38:23
  C3:         I record on two different channels so that I can go back and watch
→Jesse:      ((gaze C3-C6-------------C2---------C3----------------------------------))
  C3:         what I  missed while I was watching the other one.
→Jesse:      ((gaze C3--------------------------------------------------))
```

Demonstrations of inclusive gaze also appear tied either to topic or to group-level

jokes as all three instances of inclusive gaze occurred in conversation topics that involved

teasing. Where the first two occurrences were related to the topic of television watching

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preferences, the third instance occurred during a conversation about winning the lottery

where Clinician Three pokes fun at herself, confessing a shoe addiction (Appendix C-S).

Session Three at 10:47:26
```
C5:        So from now on we all need to check out C3's shoes
C3:        you know the shoes would be happening.
C2:                                                    that'll be the clue.
Alan:      ((Laughing                                                   ))
Althea:    ((Laughing                                                   ))
Jesse:     ((Laughing                                                   ))
→Jesse:    C3-------off camera-------------------------------C2----------C5----C3
```

In a demonstration of affiliation with the clinicians in the group that have been

teasing Clinician Three, Jesse serially looks first at Clinician Three who is good naturedly

playing along with the teasing and then the clinicians who had been the primary teasers.

Acknowledgments. Jesse demonstrated a consistent pattern of acknowledgment

tokens; using eight, one, eight, and six acknowledgments in sessions one through four,

respectively. These nonverbal conversation actions took the form of nods and shrugs. Nods

serve to demonstrate not only understanding that a speaker is talking but that the recipient

has access to the speaker's turn-at-talk and as such can demonstrate agreement, affiliation,

and recognition (Stivers, 2008). Most of the acknowledgment behaviors demonstrated by

Jesse were in response to the facilitating clinician mediating conversation. However, in the

latter sessions we do note Jesse demonstrating acknowledgment of conversation turns other

than direct mediations; however, these are clinician turns-at-talk and not the turns of other

members with aphasia. In a conversation that has followed the humorous anecdotes about

receiving live bunnies and chicks for Easter and their untimely death, Clinician Three

announces that she avoids that problem through purchasing plastic chicks that will peep and

Clinician Five wants to know how to get one for her daughter. (Appendix C-S4).

Session Four at 20 minutes, 44 seconds
    C5:   Where'd you find it? The, the ,the thing
    C3:   at um: Walgreens
    C5:   cause[Ky]
    C3:   [and] they have different colors.
    C5:   Kyle wants to buy Annalee a real <u>bunny</u> (.) for Easter
→Jesse: ((slight nod))
    Jesse: ((gaze at C5---))

Jesse demonstrates his understanding and recognition of what Clinician Five is saying; that her husband would prefer a real baby animal for Easter. He achieves this by strategically placing his nod after the word "real" and as the clinician begins the predicted next word. Jesse may also be demonstrating agreement with the reported stance of Clinician Five's husband based upon the placement of his nod after "real" and his negative assessment just before this exchange which will be discussed in the next section on disaffiliation.

Decreased disaffiliation. Jesse did become somewhat less separate from the group as demonstrated by his decrease in disaffiliative actions such as shaking his head, without affiliative smiling, or rolling his eyes during another's turn-at-talk; reducing the occurrence from six in the initial session to zero in sessions two and three. There occurred one instance in Session Four that related to a negative assessment of either plastic Easter chicks over live ones or the noise that the plastic chicks make (Appendix C-S4).

Session Four at 20 minutes, 26 seconds
    C3:   Well I bought my god-daughter the little (.) uh s- play chicken? And
    C3:   [when you] hold it in your hand? (1)
    C1:   it tweets?
    C3:   It tweets because it's warm.
→Jesse: ((raises eyebrows, eyes slight squint))
→Jesse: ((rolls head away from C1))

If we view this excerpt in the larger context by including the section of talk that followed it, it is most likely that Jesse is negatively assessing and thus disaffiliating with the stance that a plastic chick would be a better Easter gift than a real baby chick. Jesse employs

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facial display in a first part pair of his disaffiliative action. Supported by one of several premises of the Facial Expression Program as outlined by Russel and Fernández-Dols (1997), the raised eyebrows and squinted eyes is "an evolutionary adaption to some of life's major problems" (p. 11). Jesse's facial display then represents the biologic facial response when one has difficulty seeing, thus demonstrating a state of disbelieving. Jesse has initiated this facial display prior to mention of the toy making noise and has continued the negative assessment through the completion of Clinician Three's turn with his head rolling away from Clinician One (Abramovitch & Daly, 1978). Therefore, the above behaviors combined with his subsequent acknowledgment token referencing a "real" bunny, his disaffiliation is most likely related to the idea of a plastic baby chick rather than the noise it makes.

Decreased negative assessment and increased negative assessment for positive affiliation. Additional evidence of Jesse's diminishing orientation of separateness was a decrease in negative assessments that were disaffiliative, from three instances in the initial session to zero instances for the remaining sessions, while there was an increase in negative assessments that were positively affiliating, from one in the first session to 19 for sessions three and four combined. When negative assessments demonstrate positive valence, they most often follow self-deprecating statements or other negative statements that invite agreement through similarly negative assessments (Kotthoff, 1993; Lerner, 1996;).
One instance of this was when the facilitating clinician was talking of his sister's wedding, of which the clinician did not approve. Jesse uses shaking his head and smiling to negatively assess Clinician One's attitude toward attending his sister's ill-fated wedding but he is smiling because clinician one has already negatively assessed this through his own talk (Appendix C-S4).

Session Four at 6 minutes, 44 seconds
```
    C1:          (3) Well yeah, so uh my sister got married, this weekend.
    C1:          [So,  I have some] pictures from the wedding.
→Jesse:        [~Hhhhhhh]
→Jesse:        ((smilling with gaze toward C1                ))
→Jesse:              ((shaking head   ))
```

While Jesse's shaking of his head and producing a nasal sigh demonstrates a negative

assessment, both his smile and the larger context of the conversation make it apparent that a

negative assessment was required for affiliative purposes; it has been stated that the clinician

was not happy about the wedding and that he did not expect to have a good time. We can also

surmise from this direct context that Clinician One may be gearing up for a dispreferred

action such as troubles talk with his excessive use of discourse markers of "well", "yeah",

"so", and "uh" to delay initiating his talk (Jucker, 1993; Lerner, 1996).

Increased Positive Affiliation. Affiliation is the demonstration of positive alignment

by the listener for the speaker and can be demonstrated over multiple channels such as head

orientation, nodding, gesture, and facial display (Argyle & Dean, 1965; Abramovitch &

Daly, 1978; Cheng & Chartrand, 2003; Conroy, 1999; Stivers, 2008). Jesse consistently

demonstrated some level of positive affiliation alone through smiling and nodding over the

course of the semester with two, four, thirteen, and two instances for sessions one through

four, respectively. One example of this occurred in Session Four during the same

conversation about Easter toys for kids, when he affiliates with Clinician Three's visual

demonstration of a bunny hopping (Appendix C-S4).

Session Four at 20:54
```
    C3:          They have the bunnies too.
    C3:          You wind them [and they hop]
    C3:                              ((both fists raised as paws hopping))
    Iris:                [so CU:TE]
→Jesse:                              slight smile
```

While his other actions in this conversation demonstrate his disaffiliation with the idea of a fake bunny or chick to replace the real thing, see discussions about negative assessments and disaffiliation, he responds positively to Clinician Three's demonstration of a bunny hopping. It is likely that this visual demonstration by the clinician appealed to Jesse because his meaning making system was supported by providing information over a visual channel and because the reenactment was humorous.

However, with so few demonstrations of positive affiliation, Jesse does not present himself as being socially cohesive overall; except during conversation three. This outlier from an otherwise consistent pattern then requires explication. Why might Jesse demonstrate significantly more positive affiliation tokens in that particular conversation? When conversation three was examined in comparison with the other conversations, there occurred a higher rate of gesture, 12% of turns, than that of conversations one and two but a lower rate than conversation four where gesture use occurred at a rate of 16%. Therefore, increased visual mediation was likely not a causative factor. Within conversation three, the conversation turns centered on four topics; Clinician Two's troubles talk about her broken water heater, TV watching which included DVR and surround sound, winning the lottery, and Clinician One's troubles telling of his sister's wedding. Jesse's demonstrations of positive affiliation co-occurred during these topics with the following frequencies for each conversation being 2, 4, 4, and 3 instances, respectively. The hot water sequence was briefer than the topics of TV and Lottery which explains the decreased occurrence of affiliation tokens. The terrible wedding troubles talk was the shortest exchange but the teller was Jesse's clinician and he had heard the story before during individual treatment; being more affiliated with the teller and more familiar with the story likely resulted in increased

demonstrations of affiliation. It is plausible then that topic and differential affiliation influenced his increased demonstrations of affiliation for this session.

Increased shared laughter. Laughter is a socially organized communication activity where it forms a next action to some prior one and becomes a resource for demonstrating affiliation. (Jefferson, Sacks, & Schegloff, 1987). It is through shared laughter that we signal engagement, assessment, and affiliation as we negotiate and sequence this laughter within the talk and laughter of others (Heath & Blonder, 2003; Kovarsky, Curran, & Nichols, 2009; Madden, Oelschlager, & Damico, 2002). A possible indicator that Jesse has established some degree of social cohesiveness is his demonstration of shared laughter. This may be significant because Jesse seldom laughed or smiled throughout the semester. Shared laughter occurred only in the Session Three but it occurred nine times. The context surrounding these instances creates the possibility that topic was a driving force behind his shared laughter; television watching, the lottery, and an unfortunate wedding. One example of shared laughter was presented earlier in the text under the discussion for inclusive gaze. An additional example of his shared laughter occurred during the conversation where Clinician One shares his attitude toward his sister's wedding (Appendix C-S3).

```
Session Three at 10:50:56
   C1:          I'm not very excited about it <I mean> I'm excited about-
   C1:          I told you- the open bar and everything (1) that's about it
   Alan:                                      ((laughing      ))
   Aud:                                       ((laughing      ))
   Charlotte:                                 ((laughing      ))
   C2:                                        ((laughing      ))
→Jesse:                                       ((laughing      ))
   Jesse:                                     ((nods,       shakes head))
   Jesse:                                                 ((smiling))
```

The clinician has been engaged in troubles telling about his sister's upcoming wedding; specifically that he doesn't like the groom, the wedding venue smells, and he

doesn't think the marriage will last. He has reached the point in this loosely organized activity where he is making light of what he perceives to be a bad situation (Jefferson, 1988). He has signaled this through the discourse marker "I mean" as a hedge and then presented an optimistic projection that at least there is an open bar. The laughter shared by Jesse, Alan, Aud, Charlotte, and Clinician Two acts as an appreciation of his talk as well as an affiliative stance that then encourages Clinician Two to produce a conversation closure in his next turn-at-talk.

Conversation Strategy Changes. As described for Participant One, compensatory strategies are used by the individual with aphasia to "manage disordered talk and jointly accomplish communicative competence" (Bloch & Beeke, 2008, p. 986). Furthermore, these strategies can emanate from the individual with aphasia through the use of strategies such as gesture or agrammatic speech. They can arise from the shared environment that supports deictic gestures, or pointing. Strategies can also emerge from the communicative interaction. Group cohesiveness that emanates from the shared environment and is built upon communicative interaction provides the soil from which strategic communicaiton behaviors can arise. Jesse drew upon his improved processing and the immediate environment to employ multiple modalities at an increasing rate. He also exploited the conversation as a resource to employ overlap, clarification questions, and repetitions as strategies. The pattern with which he employed these strategies across the four conversations is presented in Table 4.13 and discussed in the text to follow.

Table 4.13. Distribution of Conversation Strategies for Participant Three (Jesse)

Behavior	1.31.12	2.7.12	3.29	4.3.12
Multi-modality	3	9	4	2
Gesture Use as % of turns	52.9%	58.8%	33.3%	100%
Facial Display	12	5	25	7
Overlap	1	2	9	8
Clarification Question	1	0	2	0
Recasting	1	2	0	0
Recycling TCU	0	2	4	0

Multiple Modality Use. Gestures and facial display provide invaluable resources for the construction of meaning and assigning that meaning to turns-at-talk through their function as a linguistic self-cue as well as a cue and invitation to the conversation partner to collobaratively assign meaning (Damico, Wilson, Simmons-Mackie, & Tetnowski, 2008; Goodwin , 1995; Goodwin & Goodwin, 1986; Goodwin, 2000). Jesse employed multiple modalities to a consistent degree for conversations one, three, and four where he demonstrated an additional modality three, four, and two times respectively. It is only for conversation two that he increased the frequency with which he employed an additional modality when he combined modalities nine times to construct his turn at talk. This was likely related to the conversation topics, favorite sports teams and travel in Alaska, which encouraged gesture use from both the clinician and Jesse in sequences that were supported by the clinician. An example of this occurred when after a discussion about snowmobiles, the clinician asked Jesse about what he did for fun while he was working in Alaska (Appendix C-S2).

Session Two at 10:55:34
C0:   (2) you prob- you probably did a lot of fun stuff in Alaska
Jesse: yeah. YEAH:
C0:   Did you do some (.) fishin'?
C0:   ((casting a rod and reeling in))

```
Jesse:        (.) no              just uh
→Jesse:       ((shakes head))((hands apart parallel))
  C0:                no?                  big ones?
  C0:                                     ((arms wide))
Jesse:        Bad. Grrrrr.
→Jesse:         ((hands apart look like holding handle bars))
  C0:         hhh  just a lot of snow[mobiles.]
Jesse:                         [yeah oh uh uh] and (2) Hhhhh.
→Jesse:                                        ((starts to write))
Jesse:        Rrrrr.                  bear, bear.
→Jesse:       ((hands up like holding something huge))
  C0:                         Ohp. Bears?
```

This conversation exchange occurred as a direct result of the clinician allocating a turn to him and then the collaborative repair sequence that ensued. The clinician initiated the use of gesture to support speech which may have encouraged Jesse's employment of gesture. In fact, four of the nine total times Jesse combined modalities on this date occur in the above sequence and three of the four gestures were involved in repair. Ultimately, it is his combination of gesture and sound effects of "Rrr" that finally repairs the problematic conversation turn resulting in the clinician's recognition of "bear" (Bloch & Beeke, 2008; Goodwin, 1995; Goodwin, 2000).

Facial Display. Jesse employed facial display with variable frequency, demonstrating its use more for conversations one and three, with a dramatic increase for Session Three. He did demonstrate a shift in how he employed facial display. In the first session, his facial display was characterized by disaffiliative actions such as eye rolling on three occasions (Chovil, 1989; Haugh, 2010;) and the use of questioning expressions (Ekman P. , 1979). Because any disaffiliating action is a dispreferred social action, his facial display acts as strong evidence of his disaffiliation with the group conversation and one such occurrence is illustrated in the following excerpt from the initial conversation session.

Session One at 11:19:48

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```
Aud:        I'm going to mail this to my sister in England. She and I have had so
Jesse:      ((gaze at Aud-------------------------------------------------------------))
Aud:        many times together having fun and playing and she'll enjoy this.
Jesse:      ((gaze at floor--------------at door-------------at Aud-----------------))
Aud:        She's an old teacher too, [so [she] can appre]ciate this.
Charlotte:                          [Oh, Doo::]
C0:                                   [Oh Yeah:]
→Jesse:     ((gaze at Aud-------------ceiling------rolls eyes----floor))
→Jesse:     ((neutral posture-------------leans back in chair-----------lowers head))
```

In the preceding sequence, Jesse's gaze direction indicates that he is only mildly

attending to Aud's turn at talk and when her turn at talk is appreciated by Charlotte and the

facilitating clinician Jesse rolls his eyes and leans back in his chair. Both of these nonverbal

signals demonstrate his disaffiliation (Clark, 1996; Kendon, 2004).

In later sessions, the majority of Jesse's facial displays was affiliative in nature and

accomplished through smiling (Bavelas & Chovil, 2000; Clark, 1996). He continued to

employ facial display as a clarification request in later sessions, often paired with "huh?" or

"what?." An example of his strategic use of facial expression to initiate repair of the

clinician's message is presented in the following sequence.

```
Session Three at 10:39:16
   C2:      Do- do you use one of those Jesse? Where you can um (.) skip the
   C2:      commercials?  Where you record it?, then skip (.) [the commercials]?
→Jesse:                                      ((raised/ knitted brow))
   C1:                                                   [What's the-]
   C1:      what kind of cable is that?
   C4:      [DVR]
   Alan:    [anybo-] anybody that has a DVR will have it=
   C1:      = yeah, DVR.          You have DVR?, you can like fast forward
   Jesse:                °Huh?°
   Jesse:   Oh! <yeah yeah yeah yeah yeah.>
```

The preceding sequence aptly demonstrates how with a subtle facial gesture, or

display, the recipient can shape the unfolding turns-at-talk. Clinician Two's inability to

access the name, DVR, prompts an other-initiated repair sequence where Jesse through

raising and knitting his eyebrows communicates to everyone that her message is problematic. A collaborative repair sequence ensues where the members first resolve the object name and then address Jesse's need for clarification (Goodwin , 1995; Perkins, 2003).

Clarification questions. The preceding excerpt not only depicts the use of facial expression as a resource but the use of clarification questions to resolve problematic turns at talk in the most expedient way to ensure efficient co-construction of conversation. Like assessments, the use of clarification questions demonstrates to the speaker that the recipient has access to the speaker's turn at talk and is able to change the trajectory of the talk (Mandelbaum, 1989; Ruusuvuori & Peräkylä, 2009; Stivers, 2008).

> Session at Three 10:39:16
> C2:   Do- do you use one of those Jesse? Where you can um (.) skip the
> C2:   commercials? Where you record it?, then skip (.) [the commercials]?
> Jesse: ((raised/ knitted brow))
> C1:   [What's the-]
> C1:   what kind of cable is that?
> C4:   [DVR]
> Alan: [anybo-] anybody that has a DVR will have it=
> C1:   = yeah, DVR.   You have DVR?, you can like fast forward
> →Jesse: °Huh?°
> Jesse: Oh! <yeah yeah yeah yeah yeah.>

In the preceding excerpt, Jesse uses as simple "huh" to ask Clinician One to repeat and expand his turn-at-talk to resolve his miscomprehension. Although Jesse did not demonstrate clarification requests with great frequency, its use represents a larger percentage of his total turns at talk which suggests that this is an important strategy to enable his participation in the conversation.

Overlap. Overlap becomes an extremely flexible resource for managing conversation when it is used to minimize the gap between conversation turns (Sacks, Schegloff, & Jefferson, 1974), as a demonstration of recognition for what the speaker is about to say

(Jefferson G. , A sketch of some orderly aspects of overlap in natural conversation, 2004), or to co-opt the prior speaker's turn-at-talk to assign meaning to the overlapping turn (Goodwin, 1995). Similar to both Althea and Alan, Jesse increasingly demonstrated overlap in his talk. The bulk of Jesse's overlap was in the form of laughter or a schism in the conversation (Schegloff, 2000). However, Jesse also used overlap for constructing a turn-at-talk that was strategic in that it allowed him to create a temporal link between his talk and another's ongoing turn-at-talk to not only assign meaning but to move the trajectory of the repair closer to completion (Goodwin, 1995). This is presented in the following conversation excerpt about things to do in Alaska which has followed an earlier conversation about riding snowmobiles.

> Session Two at 10:55:34
> C0:   (2) you prob- you probably did a lot of fun stuff in Alaska
> Jesse: yeah. YEAH:
> C0:   Did you do some (.) fishin?   No?   big ones?
> Jesse: no   Just uh   Bad. Grrr
> C0:   hhh just a lot of snowm[obiles].
> →Jesse: [yeah oh uh uh] and
> Jesse: (2) Hhhh.   Rrrr
> Jesse: starts to write-((hands up like holding something huge))
> C0:   Ohp. Bears?
> Jesse: bear, bear

Jesse anticipates the clinician's proxy talk of "snowmobile" and uses overlap to demonstrate his recognition of what she was about to say by producing "yeah" (Jefferson, 2004). However, he continues in overlap with "oh" to signal a change of state (Heritage, 1984, 1988). Here Jesse is signaling the clinician that while she is correct that he rode snowmobiles, that was not his intended message and that he intends to continue his turn-at-talk in attempt at self-repair which he completes through his imitation of a bear.

Recasting. Recasting involves the strategic repetition of another's turn-at-talk,

coopting or repurposing it to construct the speaker's next turn-at-talk (Simmons-Mackie &

Damico, 1997). It supports conversational discourse by allowing a speaker to produce their

conversation turn with greater efficiency and fluency (Hengst, Duff, & Dettmer, 2010;

Oelshlager & Damico, 1998; Tannen, 1987) to manage turn-taking (Tannen, 1987), and to

create humor (Hengst et al, 2010; Tannen, 1987). Jesse used repetition of the clinician's talk,

recasting, only during the first two sessions and this may be related to the increased other-

initiated turn allocations that provided the linguistic resource for successful recasting; all

recasted responses occurred in other-initiated responses and the rate of other-initiated turn

allocations was decreased in sessions three and four. The previous excerpt provides a great

example of Jesse using the clinician's candidate guess of "bear" to formulate his verification

of "bear, bear" which he then recycled to emphasize the final resolution of the problematic

talk. An example of Jesse recasting a group member's talk twice occurred in the first session

during the routinized social interaction of introductions.

Session One at 10:36:09
Rosa: Okay? Jesse? I'm uh: ROSA yeah, yeah
C0: (.) This is Jesse
→Jesse: Jesse Okay?

Rosa, a veteran of the group, is waiting for the new members to be introduced and

initiates this sequence with "okay?." After the clinician introduces Jesse using proxy talk, he

takes ownership of the talk by recasting part of her talk; his name. After Rosa introduces

herself, Jesse recasts an earlier turn of Rosa, "okay?" with identical lexicon and intonation

(Leiwo & Klippi, 2000).

Using recycled turn construction units. The excerpt about bears in Alaska that was

presented for a discussion of overlap also provides an example of self-repetition, or recycling

one's own TCUs. Recycling one's own TCUs supports more efficient turn construction that is less linguistically demanding (Tannen, 1987). This verbal self-repetition also enables the speaker to initiate or continue a turn-at-talk and it can manage be used to express emphasis (Leiwo & Klippi, 2000). Jesse also used this strategy less frequently than other's but as a person with severely impaired language he benefitted from whichever strategy was most effective in a particular situational context. In the previously presented discussion about DVRs, Jesse repeats his production of "yeah" as emphasis that he has now understood the repaired talk of the clinician.

<pre>
    Session Three at 10:39:37
      C1:   = yeah, DVR.   You have DVR?, you can like fast forward
      C1:   ((pushing button on pretend remote))
      Jesse: °Huh?°
  →Jesse: Oh! <yeah yeah yeah yeah yeah.>
      Jess: ((nodding, pushing button on pretend remote))
</pre>

As can be seen, Clinician One has presented Jesse with the question as to whether he owns a DVR but with little information, Jesse must initiate a repair through his clarification question of "huh?" Conversational breakdowns and repairs are tricky business as they can become a threat to face, with decreased understanding potentially creating an identity of incompetence (Perkins, 2003; Schegloff, Jefferson, & Sacks, 1977). As a face saving device, Jesse demonstrates self-repetition for emphasis to communicate "yes, I understand you" and "of course, I have DVR" and this competence as well as affiliation is further demonstrated through the iconic gesture mimicked from Clinician One.

Participant's orientation toward group cohesiveness and conversation. It was essential to supplement the conversations that were the primary data source with secondary sources to support or refute the emerging patterns. This lamination was accomplished through an interview that was conducted shortly after the completion of the semester's

treatment. During the post treatment interview with Jesse, questions revolved around his feelings of alliance or cohesiveness with the group and its members. Because the researcher became interested in the idea of cohesiveness as a driving mechanism for group conversation therapy in a similar fashion as that of group psychotherapy, Jesse was asked for his perceptions regarding how affiliated, or cohesive, he felt with the group and how his feelings may or may not have changed over the course of the semester of group treatment. Further, since the isolating impact of aphasia is not only well documented it is antithetical to the idea of group cohesiveness (Davidson et al., 2003; Shadden, 2005; Vickers, 2010); he was asked whether or not he felt the group impacted any feelings of isolation. It is important to interpret this interview in light of the amount of mediation required by the researcher to ensure that Jesse's responses reflected his comprehension of the questions as well as his actual intent. Therefore, the researcher employed repetition, revision, multiple modalities, and verification statements as recommended by Luck and Rose (2007). In fact, the researcher elicited verification from Jesse on nine occasions and to illustrate this practice as well as the additional communication supports, a lengthy excerpt from the 9 minute, 51 second interview is presented below. This same excerpt will then be used as an example for some of Jesse's perceptions regarding group affiliation and conversation therapy referenced in the ensuing paragraphs. As a note of context, the interviewer has been using drawing to support her speech and is now referring to stick figures separated by an oval which is the agreed upon representation of the group conversation treatment table. The actual drawing can be seen in Figure 4.6.
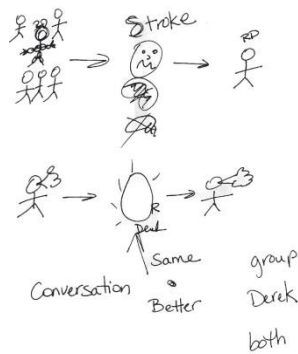
Figure 4.6. Drawing for Supported Conversation during Interview with Jesse

Interview at 0:9:58
C0:   Do you feel like your ability to um, not just the words, but, do you feel like
C0:   ((Pointing to Jesse))   ((fingers circle mouth, spread fingers on hands))
C0:   your-to tell people or show people what you want?
C0:   ((moving right hand away from body/ toward/ away))
C0:   Do you feel like it's better?   or the same?
C0:   ((pointing last stickman w/ bubble-bringing hands together))
Jesse: ((brows knitted and raised suggesting confusion then nods))
C0:   Okay? So. Is it- okay. Conversation.   Conversation.
C0:   ((writing "conversation"))
C0:   Ya know, you, me talk talk or gestures. (.)   okay. Okay.
Jesse: okay
Jesse: ((nodding))
C0:   Is it the Same?   (.) or better?
C0:   ((writing "same" then writing below "better", then showing words to Jesse))
Jesse: ((Lift hand off table and back down then shrug))
C0:   Same or better?
C0:   ((pointing to words as they are said))
Jesse: ((points under "same" but above "better"))
C0:   You feel like it's the same?
C0:   ((pointing to "same"))
Jesse: no
Jesse: ((moving finger between the two words))
C0:   (2) you feel like it's right there?
C0:   ((drawing a large dot between the two words))
Jesse: yeah.

As evidenced above, Jesse required significant mediation to participate in the

conversational interview and, therefore, he was least able to provide his perceptions of the

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experience. His responses that demonstrated feelings toward the conversation therapy group

were reduced and were influenced by the clinician due to the amount of support required.

The result then is that the themes drawn from his responses are less robust and the supporting

data organized itself around the general content of the interviewer's questions; the organized

data points fell into categories of differential alliance, some clinical improvement, no socio-

communicative improvement, and decreased comprehension. These themes are discussed

below and to indicate the strength of a theme through the occurrences of related responses

the frequency of reporting for a data point will be notated as (#).

Differential alliance. While Jesse did agree to feeling comfortable with the group, he

indicated affiliating with the clinicians more than the group with his responses that

demonstrated being close to Clinician One (2x) and close to the clinician leader (3x). He

further indicated that he felt disaffiliated with the group with statements that indicated he

disliked the group (2x) and did not feel close to the group (2x). Because of Jesse's extreme

language impairment it required multiple turns that employed researcher verification to

ensure she understood his intended message. An example of his differential affiliation is

presented below and can be read in full context in Appendix C-I

Interview with Jesse at 3:58
C0:   How close, did you feel pretty (.)   pretty close?
C0:   ((brings hands together 3x to sign "close"))
Jesse: ((shakes head   shakes head))
C0:   No? okay,
C0:   ((writes no on separate page))
C0:   Uh. Were there people, any of these people.
C0:   any of them that you felt closer too?
C0:   ((pointing to the initials written around the oval-signs "close"))
Jesse: ((shakes head))
C0:   No? (2) okay. °no not closer°. Okay:,
C0:   ((Writes "no, not closer" on page))
C0:   Um. What about C1
C0:   ((points to initials on page))

Jesse: ((shrugs, lifts left palm up, nods))
    C0:   yeah?
    Jesse   yeah?

In the above sequence the researcher has used all the means at her disposal to ensure that 1) Jesse has comprehended her question and 2) that she has comprehended his response. She has used shorter and syntactically simpler units of speech that are repeated or rephrased. Multiple modalities were oriented to in the construction of her turn, including writing, drawing, gesture, and referring to previous drawings. She has also used verification statements after Jesse's responses to provide the opportunity for him to correct her and while this does not occur in this segment it can be seen in the earlier segment provided. (Basso, 2010; Lindsay & Wilkinson, 1999; Lyon, 1992).

Some clinical improvement. Jesse did feel like his performance during clinic sessions improved when he noted that his conversation was a little better (3x) and that there was an individual therapy benefit (1x). Jesse also conceded that the group helped "some" with isolation (1x) and he referenced group therapy benefit on one occasion. Supporting this perception, Clinicians One and Two felt that Jesse made improvements in his conversation and referenced this perception on four occasions (Appendices D-C1-I and D-C2-I). The first segment of talk following Figure 4.6, the drawing for supported conversation, illustrates Jesse's feeling that his communication had improved a little.

No socio-communicative improvement. While he did express some indications of change and possible affiliation, Jesse's responses indicated that he did not feel as if therapy made a difference in his communication outside of treatment. He reported that while he had a premorbid social network that included a lot of people (1x), he was isolated since his stroke (1x). This is consistent with his social history reported in Chapter Three. Jesse also indicated

feeling that there was no difference in his conversation inside versus outside of the clinic (1x) but that he doesn't talk out of the clinic (1x). Some of this lack of generalization outside of the clinic may be related to Jesse's difficulty adjusting to his disability. His clinician viewed Jesse as having a difficult time adjusting to his disability (2x) when he reported his preference for using the verbal modality and disinclination for writing by saying "he wants to talk again. He doesn't see the writing and the drawing as like improving." Jesse's clinician noted his emotional distress as a reaction to disability during a discussion about "how his life was before compared to now…it just got to him" (Appendix D-C1-I).

　　　　Summary of Jesse. In summary, Jesse's history and attitudes support an individual who is not inclined to developing group cohesiveness, aligning more with the professional assisting him in reducing the impact of his communication deficit. However, Jesse recognizes that group treatment does provide the opportunity for improving his communication ability and therefore, is of benefit. He is attracted to the group but not necessarily the individuals in the group. This is evident in his increased use of both writing and gestures as a communication alternative.

Jesse's level of group cohesiveness seems to be highly correlated to topic which resulted in his increased demonstrations of behaviors that related to group cohesiveness and conversation strategies for the group conversation in Session Three. Jesse's behaviors that indicated affiliation were demonstrated more in Session Three than any other and his disaffiliating behaviors were demonstrated the least amount in the same session. This relationship holds true even when the session data is adjusted for the number of total turns; number of instances are interpreted as a percentage of the total turns. The same patterns holds

true for his use of conversation strategies where his deployment of each reaches its acme in Session Three.

Perhaps the action on Jesse's part that encapsulates his orientation to group cohesiveness, in the form of high task commitment with lower interpersonal attraction, is his behavior on the final day of therapy. The group had been reading *Marley and Me*, by John Grogan during group literacy facilitation and had planned an end of semester party to watch the movie that included food, drink, and socializing. After Jesse's individual treatment, during which time he had become emotional, he informed the clinician that he would not be attending the party but then did walk, out of his way, down the hall and stood by the door to wave farewell to the rest of the group. His clinician captured this conflict between his orientation away from group cohesiveness with his commitment to the group when he reported to the researcher, "and I think the reason at the end that he didn't want to go to the party was just his pride, and he was upset, and he had the little melt down before cause he was outside the door waiting, he was pacing and you could tell he wanted to go in and then he saw me coming and he was like, "I can't, I can't" s- he had tears in his eyes."

Participating Clinicians

Group cohesiveness in conversation treatment cannot be examined without addressing the clinician's influence upon conversation. The clinicians that formed part of the conversation group varied in level of expertise, in the amount of shared experiences, and in their cultural knowledge; the latter two relating to common ground (Clark, 1996). The clinician (Clinician Zero) that led the first two sessions was the supervising clinician and researcher who possessed over twenty years' experience working with individuals with aphasia. As a group member whose age was closer to the participants she shared many of the

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same life experiences. Finally, having resided in the community for 14 years at the time of the study, she shared many, though not all, of their cultural experiences. The clinicians that led the sessions at the end of the semester were first year graduate students who were concurrently taking a course on aphasia that included theory about group treatment through lectures, readings and video demonstrations. They also had observed the clinical supervisor and led a group session at least twice prior to the conversation sessions analyzed. These clinicians, then, would be described as having some experience working with individuals with aphasia. Both students were in their twenties and therefore may have possessed less shared experiences. Finally, one student (Clinician One) was from this unique cultural area, Acadiana, and one (Clinician Two) was not. Differences between their cultural experiences did sometimes surface in the conversation becoming sometimes a barrier but other times an asset as Clinician Two's lack of cultural experiences allowed participants to often take on an "expert" role in the conversation. This expert role promoted improved identity and became an equalizing force for conversational clout which promoted increased affiliation (Simmons-Mackie & Damico, 1999). The influence of the clinicians on conversation extended then to influence on the participants that were members of the conversation through their actions that promoted a more supportive or less supportive context in terms of the interactional resources and attitudes demonstrated by the clinicians (World Health Organization, 2001). Where relevant the influence of expertise, shared experiences, and shared cultural knowledge will be discussed as it relates to clinician behaviors that fostered cohesiveness and that shaped conversation.

Conversational behaviors in group treatment that fostered group cohesiveness. Clinicians that led group conversation treatment fostered group cohesiveness in similar and

differing ways. The first two conversations, from the beginning of the semester, required greater mediation on the clinician's part to initiate an orientation toward group cohesiveness. The clinician accomplished this by demonstrating engagement, affiliation and interest through her own conversational practices. Later conversations were able to rely on the amassed shared knowledge, or common ground, and established expectations for group conversations to promote group cohesiveness. Throughout the semester the clinicians employed conversational behaviors and mediational strategies that fostered this development. These behaviors and strategies are presented in Table 4.14.

Table 4.14. Clinician Conversational Behaviors for Each Session

Facilitation Strategies - Group Cohesiveness	1-31-12	2-7-12	3-29-12	4-3-12
Acknowledgment	12	6	2	14
Agreement	8	8	18	11
Anticipatory completion	8	3	1	8
Continuers	9	3	1	1
Assessments	5	5	9	7
Humor	3	5	11	12
Mimic / recast	1	9	5	2
Multi-modality turn construction	22	43	13	49
Overlap	11	6	10	34
Pause	11	3	0	15
Positive contingent	11	20	20	13
Proxy turn	8	23	7	1
Rephrase	1	6	3	7 (4)
Topic management	7	2	4	7
Use of turn allocation - % of total turns	3.3%	4.5%	3%	2.7%
Inviting turn: verbal	6	11	6	8
Inviting turn: gestural	3	2	4	5
Verifications	4	6	1	3

Acknowledgment. As reported for the participants, the use of acknowledgment tokens functioned to demonstrate understanding, affiliation, and encouraged continuation of the speakers' turns-at-talk (Jefferson, 1983). Acknowledgment tokens took the form of nods as well as verbal markers of interest such as *oh*, *mhm*, and *yeah*. With the exception of Session

Three, the acknowledgment tokens remained consistent across the facilitating clinicians as a demonstration of engagement in the conversation, occurring 12, 6, 2, and 10 times, respectively. It is likely that that the frequency with which a clinician employed acknowledgment tokens related to personal factors such as conversation style with Clinician Zero employing acknowledgment tokens routinely and Clinicians One and Two employing them less often. The increase in Session Four resulted from the use of acknowledgment tokens to encourage Althea during self-repair of her conversational turns. With Session Four being the conversation for which Althea was the most participatory, 14% of total turns, the effect would be increased acknowledgment tokens. An example of this follows where Althea was telling the clinicians why she didn't attend the rodeo.

> Session Four at 0:06:13
>   C1:   They had a rodeo this past weekend?
>   Althea: Yeah. There was too many horse, I gitn, didn't go
> →C1:   Oh.
>   Althea: there's too many horses.
> →C1:   °okay°

Althea's initial turn contained two errors in production with the second error being self-corrected within the same turn construction unit. The clinician in response acknowledges her turn as understandable with his production of the acknowledgment token "oh." Althea goes on in a third turn to self-correct the first turn construction unit, to pluralize horses, and the clinician responds again with an acknowledgment of her having completed the repair which improved an already understood turn-at-talk but in acknowledging her turn-at-talk he is also acknowledging her competence as a speaker (Ferguson, 1994; Laakso, 1997; Simmons-Mackie & Kagan, 1999).

Agreement. As reported for the participants, agreements take both vocal and non-vocal forms and they demonstrate an affiliative stance that is aligned temporally and

semantically for the turn-at-talk in progress (Goodwin, 1986; Goodwin & Heritage, 1990; Schegloff, 1982; Stivers, 2008). Over the four sessions, the facilitating clinicians demonstrated agreements 8, 8, 18, and 11 times respectively. These were manifested through gestural (i.e., nodding) and verbal forms. Agreements made by the clinicians were as simple as "yes" and as complex as an expansion on the previous turn of an individual with aphasia. Examples of both are presented below and come from the conversation about the necessity of owning a DVR for the ability to skip commercials (Appendix D-S3).

```
Session Three at 10:39:36
    Alan:       I mean fast forward that you- it's a s- science(.)  till you hit it just
    Alan:       ((pushing button on pretend remote x 3))
→C3:                                                    Yes
→C3:                                                    ((nod))
    Alan:       perfectly.       and it starts the show!
    Alan:       ((exaggerated pushing button on pretend remote, thumbs up))
→C3:                   mHm
→C3:                   ((nods))                                    ((nod))
    Iris:                                          It's a ar:t, huh? It's a art.
….
Session Three at 10:40:10
    C2:         Do you use this Aud?, the (.) DVR?
    C2:         ((Points to Aud with pen-----traces square in air))
    Aud:        No, No I don't (2) I'm picky what I watch. (2)
    Alan:       Okay,  (1) but you can pi-(1) picky and (.) fast forward all the
    Alan:       commercials.
→C2:        That[ MIGHT EVEN make you pickier.]
```

In the first segment, Clinician Three is using both verbal and gestural tokens of agreement while within the next segment Clinician Two is expanding on Alan's turn-at-talk to not only agree with him but to join him in teasing Aud.

Anticipatory completions. "Anticipatory completion of a speaking turn by another speaker can be used to preempt an emerging dispreferred action and change it into the alternative preferred action" (Lerner, 1996, p. 303). These devices may occur in overlap or as the latching of the second pair part and similar to overlap, anticipatory completions can also

demonstrate agreement with and recognition for what the speaker is planning to say

(Jefferson, 2004). These face saving and identity renewing activities do a considerable

amount of group affiliation work (Oelschlager & Damico, 1998). In each session, the

facilitating clinician employed anticipatory completion at least once with these behaviors

occurring 8, 3, 1, and 6 times during sessions one through four, respectively. Anticipatory

completion involves the synchronously timed completion of a prior speaker's turn by the

next speaker and indicates a tightly aligned collaborative effort. This occurred when

Clinician Zero completed Aud's turn in unison with her during the conversation about getting

recorded letters from Denmark (Appendix D-S1).

> Session One at 11:22:19
>   Aud: and that was really not just to hear the news but to he[ar   her voice]
> →C0:   [hear her voice]

It is likely because Aud is using self-repetition which created a rhythmic pattern to

her response that Clinician Zero is able to anticipate the completion of her turn-at-talk and

match it word for word (Tannen, 1987). The clinician was able to rely on this and upon the

expected syntactic structure to project Aud's turn-at-talk (Oelschlager & Damico, 1998).

However, anticipatory completions were also used as an embedded other-repair that

modelled participants working together to resolve a breakdown and kept the conversation

moving forward with little attention to the business of repair. This occurred during a

conversation about Alan's Yorkshire terrier who was soon to deliver a litter (Appendix D-

S4).

> Session Four at 14 minutes, 59 seconds
>   Alan: and (2) Maggie looks like a (3) something peg? [Pot?]   yeah.
> →C5:   [Pot]belly Pig.

Alan signals conversation breakdown first in the three-second pause in his turn

construction and then through the generic term "something" and the questioning intonation

applied to his paraphasia (Cutler & Pearson, 1986). This formed a question-answer adjacency

pair that enlisted the clinician's help (Sacks, 1992) in resolving a word search. Another

student clinician (Clinician Five) is Alan's assigned clinician and so shares the most common

ground with him and as such is able to quickly interpret his paraphasia and supply the correct

form. Alan is at the same time engaged in self-repair but is asking for assistance in verifying

he has the correct form with his questioning prosody (Beeke, Wilkinson, & Maxim, 2009).

Her anticipatory completion of his turn-at-talk in progress "Maggie looks like a" minimizes

the time spent in repair which acts as a face saving device where Alan, through his

verification of her completion, maintains a role of competent communicator (Goffman, 1963;

Oelschlager & Damico, 1998).

Continuers. Continuers were employed predominantly by Clinician Zero (12 times)

but only once by Clinicians One and Two to encourage continued turns-at-talk for the

individuals with aphasia and took a similar form as acknowledgment tokens; it was only their

purpose that varied. Where acknowledgment tokens served to notify the speaker that the

clinician understood the content of their message, often occurring at the end of a turn, the

continuers were placed at transition relevance places that while providing the opportunity for

a "next speaker" were dispreferred for such action due to the content of the speaker's turn

being not yet complete (Goodwin, 1986). An example of the use of continuers and

acknowledgment tokens is provided below when Clinician Zero is encouraging Aud to

continue her turn-at-talk and acknowledging the information she is sharing (Appendix D-S1).

Session One at 11:21:54
    Aud: my mother did something I really appreciated after I had moved over

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Aud:          here. Uh, should would uh make up a (.)   cassette tape and tell me
→C0:             ((nod))                          ((nod))
Aud:          [all a]bout what was happening in her every day and talk about people
Charlotte:    [°Aw:°]
→C0:             ((nod))                     ((nod))
Aud:          I knew from when I use to be around.
→C0:             ((nodding))                     Mm, yeah,↑ ye[ah]
```

Here we see the clinician placing gestural continuers at trouble spots such as "uh",

pauses, and overlap to encourage Aud to keep her turn-at-talk and, in the case of overlap,

discourage another from interrupting her turn-at-talk. The next two nods served to continue

Aud's turn as they were placed at syntactic junctures that might have signaled the end of a

turn construction unit. Finally, the clinician verbally acknowledged Aud's message using the

discourse markers "Mm" and "yeah."

Embedded Correction. Embedded correction as a conversation management device is

the hallmark of a well facilitated conversation (Lindsay & Wilkinson, 1999; Schegloff,

Jefferson, & Sacks, 1977; Simmons-Mackie, Elman, Holland, & Damico, 2007) where the

primary attention of the interactants is on the content of a conversation turn rather than its

production. Embedded correction has been shown to be employed to a greater degree in

speech language therapists than spouses (Lindsay & Wilkinson, 1999) and was one of several

defining characteristics of good versus poor speaking partners in aphasic-volunteer dyads

(Simmons-Mackie & Kagan, 1999). To employ embedded correction, the clinician must

possess a degree of linguistic flexibility as well as shared knowledge, and it may be these

criteria that resulted in the increased use of this device by Clinician Zero who demonstrated

embedded correction six times over sessions one and two compared to three instances of

embedded correction completed by Clinicians One and Two for the later sessions.

```
Session One at 11:26:13
    C0:          now do you, do you find that uh Skype is better than Facetime?=
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```
Alan:        =well the trouble is, you got 5 people that have-, you gotta have a
Alan:        iPhone 4 or an iPad=    =to get Face Time
C0:                              =right=                    True=
Alan:                    =cause it's Apple, I mean Apple, they (.)
→C0:         protect their tech[nol]ogy, yeah?
Alan:                                  [yes.]
```

Alan self-initiated and completed the repair of his talk in his first turn immediately but when he encountered a production problem and paused, the clinician employed anticipatory completion to avoid a noticeable halt in the conversation which avoided presenting Alan as a less than competent communicator (Simmons-Mackie & Damico, 1995). His overlapping verification of her completion served to reinforce his competence. Clinician Zero completed embedded corrections through the use of anticipatory completion for the majority (four of six) of instances making it an extremely powerful conversational tool.

An additional factor influencing the decreased demonstration of embedded correction may be an interactional context which did not necessitate this action by the clinicians. Althea and Alan both demonstrated increasing self-initiation with stable or decreasing production errors. In fact, all communication breakdowns were self-repaired which made obsolete the need for clinicians to perform embedded correction.

Assessments. The clinicians uniformly employed assessments within their talk related either to participation in a joint activity or to participation in a prior activity; e.g. what they did over the weekend. Assessments by design invite second assessments or agreement (Lindstrom & Mondada, 2009). The ability to construct turns-at-talk that employ evaluative language that is inherent in assessments has been linked to an individual with aphasia's ability to express his or her identity (Armstrong & Ulatowska, 2007; MacKay, 2003) which makes the demonstration of assessments by the clinicians an important contribution to

establishing and maintaining group cohesiveness as members of cohesive groups demonstrate

responsiveness to each other and derive shared meaning from each member's contribution

(Burlingame, Fuhriman, & Johnson, 2001). The use of evaluative language in assessments

requires a willingness to take the risk of being vulnerable or contradicted and forms an

integral part of successful treatment groups (Burlingame, Fuhriman, & Johnson, 2001;

Simmons-Mackie, Elman, Holland, & Damico, 2007). All clinicians did demonstrate this

self-assessment and its deployment increased in the latter sessions with occurrences across

the four sessions as 5, 5, 9, and 7, respectively. This is likely the result of a shift from using

assessments to foster trust to those that emerged organically as a natural component of a

cohesive conversation group. An instance of assessment to foster trust is seen in the first

session when Clinician Zero inquired after the health of Charlotte who had been extremely ill

the week prior (Appendix D-S1).

> Session One at 10:35:23
> | C0: | How are you <u>feeling</u>? | You feel good. |
> | Charlotte: | I djo way! | Oh Why! |
> | Charlotte: | ((nodding)) | ((nodding)) |
> →C0: Good. I was worried. You had me worried.

In the above segment, the clinician performs an assessment of a prior event,

Charlotte's absence in the early session, and uses words that convey her state of mind and her

caring for Charlotte by using verbs that carried emotion such as "feeling" and "worried."

This demonstration of caring through a positive assessment modelled the connectedness that

she is hoping for the entire group to achieve over time.

In later sessions, evaluative language appeared more as an extension of the ongoing

conversation where clinicians are sharing their personal lives with the other conversation

members. For example, this was demonstrated when Clinician One shared his feelings about

his sister's upcoming nuptials, using negative assessment multiple times (Appendix D-S3).

Session Three at 10:51:19
```
  C1:       First of all the wedding's in Delc[amber.]  No offense if anybody
  C1:       //[lives in Delcambre]
  Alan:     //[Now I don't know] (.) places around here.
→C1:        Uh.(.)it smells like shrimp![It's like(.)the BAY]ou ru[ns right through.]
  Alan:                                                      [I know where it is]
→C1:        Well it smells terrible, the wedding is like right (.) off (.) the little
→C1:        harbor so it (.)          that's terrible, it's outside.  S'posed to rain.
  Charlotte:               Uugh↓
→C1:        I don't like the guy she's marrying very much(.) but I don't have a say.
  C1:        Urm (.) So (.) I'm gonna be in the wedding and then I'm gonna drink
  C1:       and dance all night so that's that's all//
```

Clinician One's repetitive use of the verb "smells", as in gives off an odor, as well as

the qualifier "terrible" shared with the group his negative assessment of the upcoming

wedding. He went on to demonstrate further negative assessment by stating "don't like."

Clinician One's display of this negatively positioned talk demonstrated his orientation to the

group as intimates that are privy to his troubles (Jefferson, 1984) and provided multiple

invitations for a second assessment; one of which was taken up by Charlotte when she agreed

with his negative assessment with one of her own, "Ugh." Clinician One verified the

cohesive status that these assessments achieved in the post-semester interview when after the

researcher's comment that she was sad the semester was over, he reported, "I feel like I'm

being torn apart from a family" (Appendix D-C1-I).

Humor. Humor worked to aid in the IWAs adjustment to disability, express

frustration, and maneuver social distance (Heath & Blonder, 2003). The humor that occurred

increasingly created solidarity during the moments of shared humor (Greatbatch & Clark,

2003; Rothwell, Siharath, Bell, Nguyen, & Baker, 2011). The clinicians used humor as a

consistent device to achieve connectedness either extending another's initiated humor or

initiating their own. In fact, the use of humor by the clinicians increased dramatically over the four sessions; occurring 3, 5, 11, and 12 times, respectively. Humor was directed at self, at the group, and at an individual within the group, with that individual most often being Alan who was himself the most frequent user of humor. An illustration of group-directed humor comes from a discussion of raising colored Easter chicks into full grown chickens where the clinician references an earlier joke made by Alan; the one where he suggested that Althea dispose of her abundance of lovebirds by making gumbo (Appendix D-S4).

Session Four at 20 minutes, 6 seconds
C2:   [some]body gave us a bunch of Colored ones. And (.) we had (.) we
C2:   had about four that survived about from eight. Half of them did live.
C2:   They were all roosters But um so but we got some- bought some hens
C2:   after that (.) [and you] build a pe:n.
Alan: ob[viously]
→C2:   And then we killed some for Gumbo:.

The clinician is sharing her affiliating story of raising chickens that used to be Easter chicks; an experience similar to Iris'. Her turn-at-talk has continued through six TCUs and being ever mindful of not dominating the conversation she is working to close her turn at talk. When Alan makes a disaffiliating humorous remark, she responds in her next turn with an affiliating humorous conversation move. By referencing Alan's earlier joke, she establishes a link between her talk and his thus demonstrating an affiliative stance toward his talk.

The use of humor appeared to follow socially constructed norms that constrained who was teased and the content focus. This is likely why the humor, when initiated by the clinicians, initially took the form of self-deprecatory statements (Rothwell, Siharath, Bell, Nguyen, & Baker, 2011). It was over time, and after the group members with aphasia teased the clinicians, that the clinicians felt comfortable teasing the individuals with aphasia.

Humor as self-deprecatory. In initial sessions the clinician used humor with herself as the butt of the joke to foster an atmosphere of conviviality. Self-deprecatory humor acts as a resource to encourage either agreement or affiliative disagreement (Hay, 2001). This is apparent in the conversation below when the clinician mocks her own attempt at drawing (Appendix D-S2).

```
Session Two at 10:53:32
    C0:         How far- what's the farthest you went.
    Althea:     (.) um (1) um (3) um (4) um (5)
    C0:         ((slides US map picture over then points))
    C0:               you can point too if you want.
    Althea:     (((10) gets pen out of notebook tries to open it))
→C0:            ∘know my drawing isn't very good.∘=
    Alan:       =I thought about that too.
    C0:         what. That my drawing [wasn't good?,]
    Alan:                             [hh. I just- I just] saw that.
→C0:            Well it's not very goo:d.  Oh. And I didn't add Alaska.
```

The clinician's remarks did considerable interactional work. First they presented her as having problems, just as the IWAs have difficulty, which served to balance any differential feelings of (in)competence (Simmons-Mackie & Damico, 1999). This was an extremely important conversation move in that it served to smooth over any conversation breakdown that resulted from Althea having expressive difficulty (Heath & Blonder, 2003). Second, it provided an opportunity for affiliation through teasing where she became Alan's straight man for his collaborative teasing; with her initial self-deprecatory remark, she signaled that teasing of her by Alan would be acceptable. Alan's seconding her humor, or contributing more humor, formed a humor support strategy that modelled affiliation (Hay, 2001). Lastly, this move provided the opportunity for the group to unite in their appreciation of the humor surrounding her poor drawing skills (Norrick, 1993).

Humor as teasing. A joking culture arises from not only the immediate context from which humor is drawn but the repeated humorous interactions that occur over time as the group members develop shared beliefs, feelings, and values as a result of shared experiences and common learning (Rothwell, Siharath, Bell, Nguyen, & Baker, 2011; Schein, 1985). The clinicians eventually reciprocated when it came to teasing, by the end of the semester with Clinician One perhaps going too far at one point when good natured teasing by both clinicians crosses into face threatening territory (Appendix D-S4).

Session Four at 15 minutes, 31 seconds
```
  C2:        °you could make a little scrap book of her° [((laughter))]
  C1:        [yeah] [((laughter ))] start on that tonight and bring it Thursday.
  Alan:             [Okay:?,]                                                    Ha:h
  C2:        We have to see a picture of (.) Maggie. I mean c'm[on!]   Yeah!
  Alan:                                                        [o]kay        good.
→C1:        that's, that's (.) what th- the animals are that you're communicate with
→C1:        the most we need to see who you communicate with. (1) Since you
→C1:        don't talk to us and you're not social. (1.5)
  Charlotte: Oh:! No! wee do wai:.
  Alan:      I talk to the bird.
   Multi:    ((shared laughter Alan, Charlotte, C5)
  C5:        Does the bird talk back?
```

In the preceding conversational excerpt, the clinicians are teasing Alan about his professed anti-social nature with subsequently restricted social network that is limited to one friend and his dogs. Clinician One is attempting humor when he first suggests that since he mostly communicates with animals, they "need to see who [he] communicate[s] with." This attempt at humor fails and is marked by a lack of response or appreciation by the group members (Priego-Valverde, 2009). After an unfilled pause, Clinician One continues his pursuit of humor where he tells Alan "you're not social" which violates a socio-cultural tenet that parties in conversation work, through their verbal and non-verbal signals, to maintain positive identities for themselves and each other (Goffman, 1967; Lerner G. , 1996).

Clinician One's transgression is apparent to all and a noticeable pause ensues after which

Charlotte protests the offending conversation turn. In a display of conversation prowess, the

faux pas is subsequently repaired by Alan, the target of the offending tease, to save face for

Clinician One (Goffman, 1963). Then we see the return to better natured teasing by Clinician

Five.

  Mimicking. As was suggested earlier, it is possible that the clinicians were unaware

of their use of mimicking at the time but research has shown that as speakers align they

engage in more mirror or mimicry behaviors, postural, gestural, or verbal (Clark, 1996;

Kendon A. , 2004; Holler & Wilkin, 2011). This phenomenon was observed in all four

sessions; occurring 1, 9, 5, and 2 times, respectively. An example of gestural mimicking can

be seen during a conversation about the Superbowl commercials when Clinician Zero and

Jesse are talking about the dog in the Doritos advertisement (Appendix D-S2).

> Session Two at 10:40:35
> C0: There's that Great Dane.(1)lookin' at em(1)with another bag of Doritos
> C0: in his mouth. ((laughing))
> Jesse: Hey (.) Damn.   Huh!
> →Jesse: ((hand palm down, parallel to ground at shoulder level))
> C0:   It's a big do:g.   Those Great Danes are hu::ge.
> →C0:   ((mimics Hercules gesture))

Similar to the functions of nods as acknowledgment tokens, the gestural mimicry of

Jesse's big dog sign by the clinician served to demonstrate her understanding of the meaning

attached to the gesture by Jesse, agree with his stance that the dog in the commercial was

large, and affiliate with this stance (Stivers, 2008). The timing of the gesture, being placed

just after the associated speech, demonstrates that as opposed to mimicking the gesture as a

resource to construct her own turn at talk, she is doing affiliative work (Goodwin, 2000;

Kendon, 2004; Holler & Wilkin, 2011).

Multiple Modalities Construction. Aphasia is, at its heart, characterized by an impaired language system for meaning making but that does not necessarily mean that an IWA has an impaired meaning making system. This necessitates exploring all communication channels to express and comprehend in the pursuit of constructing meaning. The clinicians made use of verbal, gestural, writing, drawing, and mimicking with varying frequency in their pursuit of co-constructed conversation (Basso, 2010). In interaction with the context of topic and the environment in which the conversation occurred, clinicians flexibly adapted their turn construction by accommodating comprehension difficulties of specific group members by employing the more expedient channel of communication (Simmons-Mackie & Kagan, 1999; Simmons-Mackie, Elman, Holland, & Damico, 2007). The use of multiple modalities in conversation turn construction by the clinicians became one of the most oft employed conversation devices for demonstrating engagement and engaging in collaborative repair with a frequency across sessions one through four of 22, 43, 13, and 49, respectively. Clinicians combined in varying arrangements the modalities of verbal, gestural, writing, drawing, and facial expression. An illustration of the flexible use of multiple modality turn construction can be viewed when, during a conversation about the "junk art" commissioned to decorate a nearby boulevard, Clinician Two supplements her talk with two metaphoric gestures and two deictic gestures (Appendix D-S4).

```
Session Four at 4 minutes, 55 seconds
  C2:        [THE FACE] loo[ks the same.]  It looks as if he's making a smaller
→C2:         ((hand circle motion front of face, point to photo, raise/lower L hand ))
  Iris:                         [Where is that?]
  C2:        one.=
  Iris:      =>but whe-< where did yall get(.)[the article]. °okay°
→C2:                                    ((points to Charlotte))
```

The clinician demonstrated two language-like gestures (Kendon A. , 1996) to support her speech that, based on its timing, was designed for recipient benefit. First she circled her face with her hand, a gesture which comes close to the actual ASL sign for "face", and later raised and lowered her left hand to indicate size. Both of these gestures would further be classified as metaphorical which communicated, on an abstract level, the speech for which they co-occurred (McNeil, Hand and Mind: What Gestures Reveal About Thought, 1992). The clinician further used the interactional environment to support pointing, a deictic gesture, as an additional mode of communication two times. By pointing to a photo of two junk art statues, she was able to reference her spoken word "same." She later was able to use pointing as an alternate modality to respond to Iris' question while it was still being constructed and thus avoid interruption or overlap. This alternate mode not only supported understanding and alignment, but promoted efficient conversation that was able to rely upon the principle of least collaborative effort (Clark, 1996) as Iris verbally responded to her pointing as a next turn with no gap in between.

As stated before, the use of additional modalities to support speech took various forms. The use of gesture and drawing was facilitative when, during a conversation about favorite basketball teams, the clinician supported Charlotte's conversation turn to communicate her favorite team (Basso, 2010).

Session Two at 10:42:58
    C0:   (.) you know what will help? ○I'm gonna borrow your paper (.)
→C0:   ((takes paper and begins to draw))
    C0:   ○Here(.) let's do thi:s○(8) Where(.) your team(.) your basketball team.
→C0:   ((draws outline of lower 48 states, puts map in front of Charlotte))

Through the use of a hastily and poorly drawn map paired with a series of yes /no questions from two clinicians and Alan that were progressively specific with regard to

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geographic location, the group was able to complete the conversation repair to surmise that Charlotte's favorite team was a college team, not professional one, and was the Duke University Blue Devils. This particular combination of modalities supports the construction of meaning in conversation through not only duplicating a message over both auditory/verbal and visual channels; it creates a richer context upon which to draw meaning. While the clinician only drew an outline of the lower 48 states, it was through the negotiation of spatial relationships within this outline that allowed the question-answer adjacency pair sequence that followed to progressively narrow toward Charlotte's intended message (Kagan, Black, Duchan, Simmons-Mackie, & Square, 2001).

Overlap. Overlap is a conversational device and achievement that may often distinguish "good" from "poor" speaking partners (Simmons-Mackie & Kagan, 1999). Research into the systematicity of turn taking in conversation has found unequivocally that overlap frequently occurs in conversation and is usually brief (Sacks, Schegloff, & Jefferson, 1974). While overlap serves a turn management function, it also is employed to demonstrate understanding, agreement and affiliation (Jefferson, 2004; Schegloff, 2000). Overlap often co-occurred with problematic talk and served to complete conversation repair as an anticipatory completion which promoted an identity of communicative competence for the participants (Oelschlager & Damico, 1998). Overlap by the clinicians increased over the course of the semester from eleven and six instances in the earlier sessions to ten and 34 for the latter ones. Most instances of overlap were related to problematic turn-taking with the increase in overlap reflecting the more tightly coordinated initiations of turns-at-talk which is described under each participant. This change reflected an increasing sense of the group as being cohesive (Maxwell, 1993; Tannen, 1984). However, many instances of overlap

reflected conversation repair for word searches (Oelschlager & Damico, 1998). This occurred

reciprocally, however, in that there were instances when a member with aphasia overlapped a

stalled turn-at-talk of the clinician to repair the clinician's turn. Examples of both the

instances are presented and the full context surrounding these excerpts can be found in

Appendix D-S4.

    Session Four at 0:03:46
       Iris: =That's the end of it.(.)It's a::ll [(.) the way down]
    →C0:   [all the way down] to the hospital, Huh.
       Iris: Champagnes? But it's behind that.

In this example, Iris signals her impending problematic talk with the pause and then stretched

vowel in "all" followed by another pause. However, the clinician senses her difficulty and,

possessing shared information, attempts to complete her turn; thus demonstrating her own

understanding and promoting a competent communicator identity (Ferrara, 1992). The

clinician recognizes that this is done in overlap and marks its occurrence through the

discourse marker "huh" (Jefferson, 2004).

        Proving that conversation is a co-constructed activity that requires collaborative

interaction for its accomplishment, Iris initiates an overlapping turn when the clinician

signals problematic talk to assist her in a word search.

    Session Four at 0:18:27
       C2:   But I'll admit the Easter with the (.) [rabbit] spaghetti.
    →Iris: the [bunny?]
       Iris: Oh. The rabbit? (.) Spaghetti rabbit. Yeah. Yeah.

Demonstrating the power of shared knowledge, Iris was in a unique position to assist the

clinician with the word search and, while it could not be viewed on the camera, the clinician

may have employed gaze to recruit Iris. The clinician was referencing a story told a week

earlier by Iris about cooking Easter bunnies when they had become rabbits. Iris, hearing the

pause, offered a candidate word to resolve the search while the clinician self-repaired with the related word. As in the earlier example the overlap was marked with an acknowledgment token "oh" and further the overlapped talk was embedded in Iris' next turn as a repetition to demonstrate agreement and understanding (Jefferson, 2004; Tannen, 1987).

Pause. The use of pause serves to alert the conversation recipient to the speaker's desire for attention and engagement as a participating recipient during the turn-at-talk in progress (Goodwin, 1980; Ruusuvuori , 2001). It further acts as a resource for the listener, affording them time to process and understand the speaker's message (Tannen D. , 1987). The strategic use of pausing by the clinicians occurred in all but Session Three with 11, 3, 0, and 15 instances, respectively, and it served two purposes in the conversation. First it created a larger space in the conversation at the transition relevance place that afforded the members with aphasia greater processing time to initiate a turn. Second it was used as an attention requesting or alerting device, used often when switching topics abruptly. An example of this latter use occurred when Clinician Zero was closing a conversation, about the support group, that had run its course and was initiating a new conversation regarding a participant's recent illness; signaling this shift with pause, gesture, and gaze (Appendix D-S1).

> Session One at   10:35:11
>   C0:   those of you who have the early appointment anyway, you might as
> →C0:   well come an hour early.(.) How are you feeling?
>   C0:   ((pats both hands on table/ gazes at Charlotte))

In the above excerpt the clinician has closed the prior conversation topic which was when the next aphasia support group meeting would take place. This conversation occurred while the group members were still filtering into the room and now that she has a quorum, she is ready to transition away from "business at hand" talk with a few members and move into conversation treatment. She uses the pause to signal that there will be a change coming

and as an additional signal, she uses a "beat" gesture to punctuate this transition (Basso, 2010; McNeill, 1992).

Positive Contingent Response. Listeners engage in active collaboration with the speaker through their response tokens that can indicate affiliation and agreement or disaffiliation and disagreement (Conroy, 1999; Lerner, 1996; Pomerantz, 1984; Sacks, 1987). Further, positive contingent responses can operate to signal surprise (Wilkinson & Kitzinger, 2006). These responses can encourage a speaker to continue their turn-at-talk or act as an assessment of the speaker's talk and stance (Goodwin C, 1986). With the occurrences of positive contingent response remaining relatively stable at 11, 20, 20, and 13 for treatment sessions one through four, respectively, it is apparent that this is a useful and frequently used tool to model and promote engagement in the conversation. Positive contingent responses were carried out through laughter at humorous conversation turns, turns that responded positively to the speaker's turn, and questions that extended a speaker's turn. A good example of this is when Clinician Two provided both an acknowledgment token and positive contingent response through her comment accepting Althea's advice that one could lower the surround sound on their television to lessen the background noise (Appendix D-S3).

```
Session Three at 10:41:57
  C3:          You like surround s[ound?]
  Charlotte:                    [I do:]
  Althea:                          [yeah] you have to lower it you have to lower it.
→C2:          Oh. you have to lower the sound too.
```

The clinician's positive contingent response took the form of an acknowledgment token paired with an other-repetition and as such the individual merits of each device, being affiliation, understanding, and agreement, are combined to provide positive reinforcement for the speaker's turn at talk (Jefferson, 1983; Tannen, 1987). This served to maintain Althea's

participation in the conversation through her own agreement tokens later. An additional

example comes from Clinician One who asks Althea a conversation turn extending question

twice in succession when they are discussing owning birds as pets (Appendix D-S4).

> Session Four at 16 minutes, 47 seconds
> C2:   you had some birds?
> Althea: 25 years. Um //
> →C1:   //what kind?
> Althea: male and female and they had some babies.
> →C1:   they- was it love birds? Or uh//
> Althea: // yeah.

Clinician One demonstrates his interest in and attention to Althea's turn-at-talk and

her experiences owning a bird through his turn extending questions (Simmons-Mackie,

Elman, Holland, & Damico, 2007). By expanding her turn, he is helping Althea construct a

narrative similar to Alan's story of owning cockatiels and the clinician's story of owning a

parrot. These "small talk" responses demonstrate a level of engagement that is interpersonal

and affective and the end result here is Althea's continued turns-at-talk that are identity

shaping and group affiliating (McCarthy, 2003).

Proxy Turns-at-talk. The individuals with aphasia that formed the members of the

conversation treatment group demonstrated a wide range in severity with less impaired

individuals requiring only extra processing time for formulation and self-repair while more

impaired members required support in the form of a communication proxy (Simmons-

Mackie & Schultz, 2004). This term is used to reflect the attribution of the conversation turn

to the person with aphasia as the author of the turn-at-talk. This is in sharp contrast to

speaking for behaviors that do not use accompanying gaze and intonation cues that request

verification of the statement by the individual with aphasia (Croteau, Vychytil, Lafeuil, &

LeDorze, 2004). The use of proxy turns allowed the participation of Jesse and Althea at a

more complex level by offering candidate turns that were subjected to their approval with a "yes" or nod. Proxy turns were used by all three clinicians but while they occurred 31 times in the earlier sessions, they occurred only eight times in the latter ones with a single occurrence during Session Four. The best illustration of how proxy turns allow for authorship of a turn to remain with the individual with aphasia, via their ratification or denial of the proxy turn, can be seen below when Clinician Zero was giving an accounting for Althea not watching the Superbowl; that she had her grandson with her (Appendix D-S2).

Session Two at 10:47:34
→C0:   Right. So he was there.(.)   You just hung out with him.
  Althea: yeah   yeah.
→C0:   You're n- your probably watching Sesame Street. (.) kid shows on TV.
  Althea: UH uh. I don't watch that.

In the preceding excerpt, we see Althea ratify the clinician's first two proxy statements and negate the third. She and the clinician have entered into a well-coordinated joint production where Althea assesses the clinician's proxy turns-at-talk as a tightly timed insertion into a micro-pause, less than a second. When the clinician's turn-at-talk does not faithfully represent her television viewing habits she inserts a discourse marker to disagree and then constructs a next turn-at-talk to account for it. Through the use of proxy talk, as opposed to speaking for, the clinician supported Althea's contribution of three facts about herself; that her grandson was at her house, that she spent time with him, and that they did not watch any kid shows.

Rephrasing. Rephrasing, or self-repetition with variation as described by Tannen (1987), supports meaning construction in conversation through its presentation of redundant information where "the hearer benefits from the same dead space and redundancy [as the speaker] while absorbing what was just said" (Tannen, 1987, p. 582). The facilitating

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clinicians employed rephrasing of their own turn-at-talk in each of the four sessions (1, 5, 3, 7), with increased use in sessions two and four. Rephrasing was employed by the clinicians as a positive contingent and for reasons of conversation repair such as when a member's comprehension of the clinician's turn-at-talk was in question or as a verification device. This use for verification was present during a conversation about travel when Clinician Zero was attempting to draw Althea into the conversation with a turn allocation (Appendix D-S2).

> Session Two at 10:54:12
>   C0:   What state did you go to? (.)I bet you been to Texas
>   Althea: (.) yeah.
> →C0:   Tex[as?]
>   Althea: [Tex]a:s

As stated above, rephrase was also used when the clinician suspected the client had difficulty comprehending their turn or needed additional processing time. When Clinician One was asking Althea about her day, he rephrased his turn to elicit a response from her and then rephrased again as a positive contingent to her response.

> Session Four at 5minutes, 33 seconds
> →C1:   you had a good day today? (.) It's a good,//   it's <u>nice</u>.
>   Althea: //yeah   yeah

Clinician One was working with Clinician Two to draw Althea into the conversation by asking her a direct question and then using a pause to give her time to formulate. When she didn't signal a forthcoming response he began to rephrase his question. Althea interrupts the next turn-at-talk with a generic "yeah" and so the clinician completes his rephrased turn to verify that she had a good day.

     Topic management. The clinicians also demonstrated topic management behaviors during each of the four conversation sessions analyzed. The amount of work varied across sessions one through four with 7, 2, 4, and 7 occurrences, respectively. Typically

conversations have openings, bodies, and closings (Button and Casey, 1988; Schegloff, 1968; and Schegloff and Sacks, 1973). Most of the topic management served the purpose of either initiating a new topic or transitioning to a related topic while some conversational moves effectively closed a topic. It is through such topic management that the participants have the opportunity to become progressively more engaged and affiliated through their identity shaping turns-at-talk (Burlingame, Fuhriman, & Johnson, 2001; Goffman, 1967; Simmons-Mackie, Elman, Holland, & Damico, 2007).

Initiating topics. The most frequently occurring topic management work was topic initiation where the clinicians introduced a new topic; one that was not tied in any way to prior talk (Basso, 2010; Maynard, 1980; Schegloff, 1968; Wilson, 1987). This occurred when the closing of the current topic was signaled by two group members using recycled turn constructions, laughter, and then a silence where no one took up a next turn-at-talk. In the following example, the group had been talking about how technology has changed the way people communicate and after several conversation devices made it apparent that the topic was exhausting itself, the clinician used sharing of personal information to encourage affiliation and continued conversation (Appendix D-S1).

> Session One at 11:20:45
> Iris: People, everybody, on the email too. They text. Everybody's texting
> Alan: Me no text=
> Iris: =everybody's texting now.
> C0:   Yes. Everyone but Alan is texting now.
> Alan: Me no text
> ((four seconds of shared laughter between C0, Iris, Rosa, Alan, Charlotte))
> →C0:   (1) yep, Well my uh birthday, my <u>birthday</u> is this Saturday=

The closing of a topic is accomplished by an organized sequence of turns that progressively orient the conversation participants to the resolution of the topic (Schegloff & Sacks, 1973). The imminent closing of the topic was clearly signaled through the cycles of

self-repetition, summarizing, and pause. Iris signals that she is no longer interested in the topic when, after Alan's contribution, she repeats a variation of her own turn construction for the third time without producing a sequentially oriented turn. The clinician then acknowledges Alan's turn and links it to Iris' contribution in an attempt to perpetuate the topic to which Alan merely responds with his own self-repetition which serves to create humor. After four seconds of diminishing laughter and a one second unfilled pause, it is apparent that the topic is closed. The clinician, unable to transition the topic to a related one first acknowledges the topic closure with "yep" and then signals a change in topic with the discourse marker "well" (Jucker, 1993).

Transitioning topics. Clinicians often extended a topic by transitioning to a related one (Basso, 2010; Drew and Holt, 1998; Ridley, 2002). This was certainly true when Clinician Two became aware that the topic of her broken water heater was drawing to a close; again signaled by a recycled turn construction, shared laughter, and a pause (Appendix D-S3).

> Session Three at 10:35:45
>   Althea: …you have to.((use paper goods)) (.) I::t comes in handy for me.
>   C2:   mHm
>   Althea: cause it comes in handy for me.
>   C2:   Yeah. Probably during finals especially I'd appreciate that, huh?,
>   Althea: Yeah.
>   ((shared laughter of C2 and Charlotte))
>   C2:   (2) Well hopefully we'll get that water heater fixed soon.
>   C2:   (3)but it's not fun. (.) I miss that hot water, (.)
> →C2:   it's amazing how spoiled we get to conveniences,

Following the shared laughter of Clinician Two and Charlotte there occurred a two second unfilled pause which initiates Clinician Two's attempt to transition the topic away from using paper products. She navigated the transition through three turn construction

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units, with no up take from another group member, before arriving at the related topic of modern conveniences.

Closing topics. Clinicians not only used conversation turns to transition topics as we saw above, they strategically closed topics that were either losing momentum or did not have enough universal appeal to include the majority of group members (Maynard, 1980; Myers, 1998; Schegloff and Sacks, 1973). It was due to the lack of continued turns by other members that Clinician Two closed the topic of raising Easter Chicks (Appendix D-S4).

```
Session Four at 19 minutes, 58 seconds
→C2:        That's how my family first got started with chickens.
  Iris:      Yeah! B[ut eh]
  C2:             [some]body gave us a bunch of colored ones and (.) we  had (.)
  C2:        we had about four that survived        about from eight
  Iris:                                      uhHah                uhHah
  C2:        Half of them did live.(.)They were all roosters
  Iris:                                             mHm
  C2:        But um so but we got some- bought some hens after that (.) [and you]
  Alan:                                                        [obviously]
→C2:        build a pe:n. And then we killed some for Gumbo:.
→C2:        That's how we- that's when we first got started with chickens.
```

After taking 7 turns with pausing in between to encourage a turn-at-talk by another member with no uptake, only the continuer "uh-hah" by Iris, Clinician Two employs first a delayed other-repetition and then a self-repetition. She co-opts Alan's joke about making gumbo out of Althea's love birds in a delayed repetition of a portion of his talk (Tannen, 1987). She then recycles her initial self-initiated turn construction as a book-end to her turn at talk.

Use of Turn Allocation. An indicator of a group cohesion and a well-managed conversation group is facilitating shared meaning and the feeling of discourse equality (Burlingame, Fuhriman, & Johnson, 2001; Simmons-Mackie, Elman, Holland, & Damico, 2007). It is not surprising, then, that all three facilitating clinicians employed other-initiated

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turn allocations where they invited members to participate using verification questions or requests for information directed toward the participants. The clinicians received training regarding this technique via orientation and modeling from Clinician Zero so it was expected that the use of turn allocation would be prevalent. Over the course of the semester the frequency of turn allocations progressively decreased in frequency for the other-initiated turn allocations that brought group members into the conversation; occurring 16,13,6, and 8 times, respectively. When examined as a percentage of the total conversation turns there is a similar reduction of other-initiated turn allocations by the clinicians with 3.3%, 4.5%, 3%, and 2.2% for sessions one through four, respectively. These turn allocations were completed predominantly using the verbal modality but also with gesture and or gaze. An illustration of other-initiated turn allocations that make use of verification statements and requests for information can be seen below when Clinicians One and Two work together to involve Althea in a conversation about what everyone did over the weekend. (Appendix D-S4).

Session Four at 5 minutes, 33 seconds:
→C2:   You said that you had (.) uh a <u>good</u> day. Was that something you
→C2:   wanted to tell us about? Something s-, y- you're just
  C2:   //[having a good day?]
→C1:   //[you had a good] day today?
→C1:   It's good?   It's nice.
  Althea: yeah.   Yeah. It's nice, I er-, went outside earlier.

What is significant is that they progressively move from a less structured and thus less supporting turn allocation to a maximally facilitative turn allocation that was structured for a yes or no response. Clinician Two, who had a conversation with Althea before group, began with a proxy statement designed to encourage Althea to comment. When she did not immediately respond, the clinician moved to a more direct question. Clinician Two, at this point, also asks a direct question and it is now phrased in a yes/ no format to further ease any

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linguistic formulation burden to promote her participation in group conversation. The progressively supported turn allocation resulted in Althea's confirmation that she had a good day and then a continued turn-at-talk to account for her good day.

Relating clinician behaviors to changes in conversational behaviors. While it is impossible to relate clinician behaviors to the conversational behaviors of the participants in a causal relationship with certainty, several patterns emerged that suggest a correlative relationship. The data supporting these patterns is reported in Table 4.15.

Table 4.15. Distribution of Conversation Turn Taking across Sessions

Participant	1.31.12		2.7.12		3.29.12		4.3.12	
Length of Conversation	16:07		20:16		19:32		19:50	
	#	%	#	%	#	%	#	%
Althea	9	3.3	14	4.9	34	10.3	68	14.4
Alan	35	13.1	36	12.6	68	20.6	34	7.2
Jesse	16	6.0	31	10.9	11	3.3	7	1.4
Total IWA turns	167	62.7	144	50.7	174	52.7	279	59.4
Clinician Leader(s)	98	36.8	111	39.0	101	30.6	125	26.6
All clinicians combined	99	37.2	140	49.2	156	47.2	190	40.5
Total Turns	266		284		330		469	
= distributed turns per person	7	14%	7	14%	11	9%	11	9%

Increasing agreement statements. Agreement statements arise from a first part of a conversation pair, where a speaker has a prior conversation turn with which to agree. The increase in clinician's agreement statements likely arose from an increase in the number of turns taken by the individuals with aphasia. It can be seen in Table 4.15 above that two of our three participants increased their relative amount of turns over the course of the semester and that the amount of the clinician turns remained stable for conversations two, three, and four averaging around 50% of the turns.

Decreasing verification statements. The clinicians demonstrated decreasing verification statements across the four sessions and with 10 verifications in the first two

sessions and four verifications in the latter ones, this most likely relates to the improved self-repair ability on the part of the individuals with aphasia.

Decreasing proxy turns by clinician. While it was reported earlier that the increased proxy turns in sessions one and two (see Proxy turns-at-talk in an earlier section) by the Clinician Zero served the purpose of encouraging engagement and affiliation among members, it is equally possible that the decreased use in later sessions reflects the decreased need for clinician initiated affiliating statements. Related to this is the progressive increase in self-initiated conversation turns for Althea, who was the participant most in need of proxy turns during the initial sessions.

Variable gesture use. As can be seen in Table 4.16, the use of gesture relative to the number of conversation turns did not remain consistent and it is likely a complex interaction of forces that resulted in the variable nature for the gesture use of the clinicians. As part of their clinical training, Clinicians One and Two had been instructed to employ gesture as a supplementing modality. However, in Session Three when the student clinicians led the group conversation treatment, a total of 13 instances of gesture occurred which was significantly less than the instances demonstrated in Session Two by Clinician Zero. In contrast to this, in Session Four 31 instances of gesture usage occurred. The sessions examined were contiguous so it is less likely that the increase can be attributed to developing competence in facilitation of treatment. An additional driving force may be a reciprocal relationship of gesture between the participants and the clinicians; that increased gesture use by the participants affects gesture use by the clinicians and vice versa. We do see similar patterns in gesture use between the clinicians and Althea and Jesse with an increased percentage of turns employing gestures in sessions two and four with a decrease in sessions

one and three. Alan, who requires less use of gesture to support his speech, does not show the same relationship.

Table 4.16. Distribution of Gesture Use by Clinicians across Sessions

Session	Count of TCU	Count of Gesture	% Gesture for TCU
1	168	12	7.1%
2	223	49	21.9%
3	178	13	7.3%
4	293	31	10.5%
Grand Total	862	105	

An equally likely contributor to the pattern of gesture usage is the idea of topic influencing the use of gestures. Persons are more likely to self-initiate turns for those topics that are of interest to them and the interest in the topic or the lexical demand of an initiated turn appears to be related to increased use of gesture. Further, when the turns-at-talk reference visual information, increased gesture is employed (Bavelas & Chovil, 2000; Gerwing & Bavelas, 2004; Kendon A. , 2004). That may be why we see an increase in gesture use for Session Four as compared to Session Three. Clinician One had engaged in conversational storytelling at one point and his anecdote about the terrible wedding was enhanced by his pantomime. Similarly, Clinician Two in her conversation turns about a festival she attended required visual demonstrations. As is presented in Table 4.17, the effect of their storytelling related pantomime, resulted in overall increased gesture use for the session.

Table 4.17. Distribution of Gesture Use by Clinician One and Two across Sessions

Clinician	Session 3 Gesture	Session 3 Turn	% of turns gestured	Session 4 Gesture	Session 4 turn	% turns gestured
C1	5	78	6.4%	15	150	10%
C2	8	100	8.0%	15	107	14%

Summary of participating clinicians. It is apparent from the conversation strategies employed by the clinicians, their report of affiliation, and from the patterns of conversational changes with regard to turn-taking and affiliative work that, for the latter sessions, group cohesiveness did exist. The strategies and conversation devices used by the clinicians to facilitate and support group cohesiveness as well as conversation were varied across clinicians with regard to the frequency of their use but were demonstrated consistently by all. The clinicians consistently used positive contingent responses and acknowledgment tokens to demonstrate and foster engagement among conversation treatment group members. However, only Clinician Zero used frequent continuers for this purpose. To establish and maintain connectedness, all three clinicians employed agreement and humor and, with increased group cohesiveness in latter sessions, the frequency of agreement and humor initiated by the clinicians also increased. All three clinicians encouraged engagement in conversation through turn allocation and, as the group became more affiliated, the frequency of its use declined. Instances of proxy turns demonstrated by all clinicians also declined as the participants, especially Althea, increased their ability to self-initiate a turn-at-talk. The clinicians consistently used devices such as anticipatory completions, pausing, rephrasing, and multiple modality turn construction to encourage collaborative construction of conversation as well as collaborative repair of problematic turns-at-talk. Further, clinicians reliably provided topic management through initiation, transition, and closing moves. While humor promoted engagement and affiliation, it also fostered an open, trusting attitude among all group members as it smoothed over any threats to communicative competence and acted as an agent of solidarity; the clinicians increasingly used this device as the group became more cohesive. Further they shifted from self-directed humor to occasionally teasing the

members with aphasia, who routinely teased them. Probably more as an extension of group cohesiveness than a causative agent was the demonstration of assessments, where clinicians increasingly shared their feelings and attitudes in their turns-at-talk.

The behaviors of the clinicians formed a correlative and, perhaps for some areas, causative relationship with the conversational behaviors of the participants with aphasia. The increasing agreement statements may have resulted from increasing self-initiated conversation turns by the participants. The improved self-agency of the participants, namely Althea, is also likely responsible for the decreased need for proxy turns. Further, decreasing embedded correction, and the related decrease in verification statements, reflected the decreased need to repair conversation as two of three participants increased their ability to self-repair any breakdowns. Perhaps the most confusing relationship is that of gesture use by clinicians and by participants which could have been influenced by reciprocity, or synergy, or by the topic of conversation.

However, it can be clearly observed that clinician behavior did foster group cohesiveness and that their behavior did result in a change in the use of conversational strategies.

Summary

This chapter endeavored to present a complete and thorough picture of three participants with varying levels of aphasia and group affiliation as well as faithfully describe the clinician actions that facilitated group cohesiveness in group conversation treatment. Through the employment of rich description and excerpts from the primary data, the voices and perspectives of each participant and the clinicians reveal the patterns of conversation that prove affiliative and at the same time compensatory, resulting in changes to the conversation

for each participant. In the next chapter, the similarities across these participants will be

noted and single participant differences explicated.

CHAPTER FIVE: Group-Level Results

The individual results reported in Chapter Four revealed a pattern of both commonality and difference that explicates the research questions posed in Chapter Three. In this chapter, the salient patterns that emerged when comparing individual results will be discussed. The patterns of conversation strategies and behaviors of both the participants and clinicians suggest themes that may result in a deeper understanding of how group cohesiveness is expressed in conversation and how it shapes conversation. To address these concerns, this chapter will be divided into three constructs: group cohesiveness in conversation, strategic conversational behaviors, and conversational changes. The first section, group cohesiveness, will describe the patterns that uniformly indicated how the participants demonstrated group cohesiveness as well as how personal factors related to individual differences in orientation toward or away from group cohesiveness. The behaviors of the clinicians that fostered group cohesiveness will be addressed. Specifically, techniques and conversational devices employed by clinicians will be explicated. The second section, strategic conversational behaviors, will describe how the pattern and distribution of conversation strategies used by participants changed over a semester of treatment. In this section, the participant's shared conversation strategies will be described as well as how the use changed over the course of a semester of treatment. Further, the impact of contextual variables will be accounted for when describing conversation strategy usage. The clinician behaviors that resulted in a change in the conversation strategies employed by the participants, such as strategies modelled and conversation devices used, will also be discussed. The third and final section, conversational changes, will discuss the patterns of change that occurred in conversation over the course of the semester. This will involve a

discussion of the devices employed and overall efficiency of conversation with regard to

breakdowns and repairs. Because multiple interacting forces shape the trajectories of a

conversation, this discussion will be situated within a discussion of the reciprocal influences

of clinician on conversation and conversation upon clinician as well as clinician upon

participant and participant upon clinician. This complex interaction makes it clear that the

segmenting of results into discrete sections as described above serves merely to organize the

vast amount of data in such a way as to ease readability and to inform the specific research

questions. Through the review of the literature and the individual results it is apparent that

conversation as part of group treatment is a dynamic and multifaceted event that arises from

the many relationships inherent in a group (clinician to member, member to member, and

both clinician and member to group), the strategies brought to bear on the conversation by

any member, and contextual factors such as environment, agenda, and topic. It must, then, be

recognized that these components are intertwined and synergistically influence one another.

Therefore, after an attempt to describe group conversation treatment related to group

cohesiveness, the answers to the specific research questions posed in Chapter Three will be

addressed in Chapter Six.

Group Cohesiveness in Conversation

Group cohesiveness was reliably demonstrated through the patterns and behaviors

that uniformly indicated how the participants oriented toward group cohesiveness. Due to

functional differences related to communicative ability as well as personal factors related to

individual differences in orientation toward or away from group cohesiveness, there also

occurred indices that were unique to each individual. Because the group is defined by all the

relationships inherent to group therapy, the behaviors of the clinicians that fostered group

cohesiveness will also be addressed. Specifically, techniques and conversational devices employed by clinicians will be explicated. As examples of each behavior were provided in Chapter Four, they will not be repeated here.

Cohesiveness demonstrated as defined by attributes. Using the Budman et al. (1989) definition of group cohesiveness as being "…the connectedness of the group, demonstrated by working together toward a common therapeutic goal, constructive engagement around common themes, and an open trusting attitude" (p.341) as a point of conceptual organization, it is not surprising to find that the conversation behaviors of all three participants demonstrated these noted features to varying degrees. Some conversational behaviors were employed by all participants to accomplish engagement, connectedness, working together, and an open, trusting attitude while other conversation devices were exclusive to one of the participants. First, those conversational behaviors that readily identified an orientation toward group cohesiveness for at least two of the three participants will be discussed in this section. The behaviors that were specific to an individual will then be separately accounted for in terms of the contextual contributors (WHO, 2001) that related to both personal factors and environmental factors.

Uniform indices of group cohesiveness. What became apparent in the results of this investigation is that the conversational behaviors that demonstrated one component of group cohesiveness such as engagement, similarly demonstrated another such connectedness or working together. This occurrence made it evident that the compartmentalized definition of group cohesiveness is merely an explanatory framework; the components overlap and must be interpreted as a whole. Therefore the indices reported below will be discussed with

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reference as to how the participants used these devices to demonstrate group cohesiveness. A list of the uniformly demonstrated indices for group cohesiveness is presented in Table 5.1.

Table 5.1. Uniform Indices of Cohesiveness across Participants

Indices	Althea	Alan	Jesse
Overlap	√	√	√
Laughter	√	√	√
Agreement	√	√	√
Eye Gaze Engaged	√	*	√
Anticipatory Gaze Shift	√	*	√
Inclusive Gaze	√	*	√
Affiliation tokens	√	-	√
↑ing -Assessment w/ + affiliation	√	-	√
Humor	√	√	-
Approaching = turn taking	↑ing	↓ing	^
Assessments	√	√	^

√ indicates the behavior was present across sessions
* indicates that the participant's gaze was too frequently obstructed from view
- indicates that the behaviors were not consistent enough to form a pattern
↑↓ing indicates increasing (↑) or decreasing (↓) behavior
^ indicates that severe expressive aphasia limiting ability to demonstrate the behavior

Overlap. An unexpected behavior that strongly emerged from the data was that of overlap, with all three participants and the clinicians demonstrating a steady increase in this behavior over the course of the semester. This increase is illustrated below in Figure 5.1.
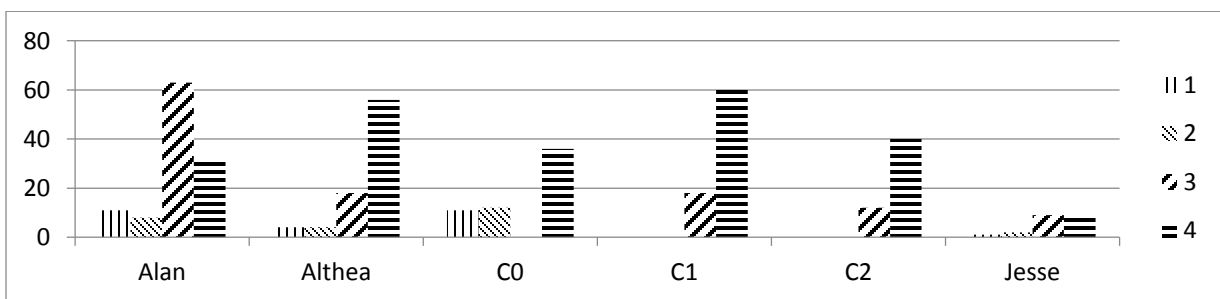
Figure 5.1. Occurrence of Overlap across Participants and Clinicians

The above graph clearly demonstrates the increased overlap for all participants in the latter two sessions compared with the earlier conversations. However, what may be less obvious is the increased overlap in the talk of the clinicians. When Clinician Zero was the

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facilitator (Sessions One and Two) and a participant in the first 2 minutes, 27 seconds of the

final conversation, she dramatically increases her demonstration of overlap. Clinicians One

and Two also demonstrated increased overlap from Session Three to Session Four. Because

these two sessions are contiguous, it is not likely that changing competence in either the

clinicians or the IWA were the cause of these increases. However, there is the possibility of

the specific topics employed in those sessions became a contributing factor to overlap. An

additional possible variable is that of the member – clinician relationship where we see

Althea demonstrating a surge on overlap which could have resulted in a "jockeying" for the

next turn-at-talk that is often accomplished through overlap. Just as multiple forces act on

conversation behaviors such as overlap, the behavior itself provides evidence of the various

components of group cohesiveness. There are multiple types of overlap that are oriented to

by the conversation participants as not problematic (Schegloff, 2000) and these overlaps

demonstrate the participants orientation to engagement, connectedness, and working

together. The overlaps required engagement in the conversation to the point that the

participants employed terminal overlaps where they anticipate the closing of the previous

speaker's turn in order to self-select a next turn-at-talk just before the transition relevance

place. This implies that all parties to the conversation were attendant not only to how

something was said in terms of the content, but they also were aware of the grammar and the

intonation that so often triggers anticipation of an approaching TRP (Jefferson, 1986; Lerner,

1996; Schegloff, 1987). Overlaps in the form of continuers demonstrated the participant's

connectedness to the group as the continuers served the function of acknowledging or

agreeing with another's talk while encouraging them to continue their turn-at-talk. Further,

overlaps that are referred to as "conditional access to the turn" demonstrated an orientation to

working together as participants and clinicians collaboratively repaired breakdowns in conversation such as word finding problems.

 Shared Laughter. Laughter shared by two or more people became an additional powerful indicator of group cohesiveness that was demonstrated by all participants. Instances of shared laughter increased for all participants from the earlier conversations to the latter ones and a visual representation of this can be seen below in Figure 5.2.
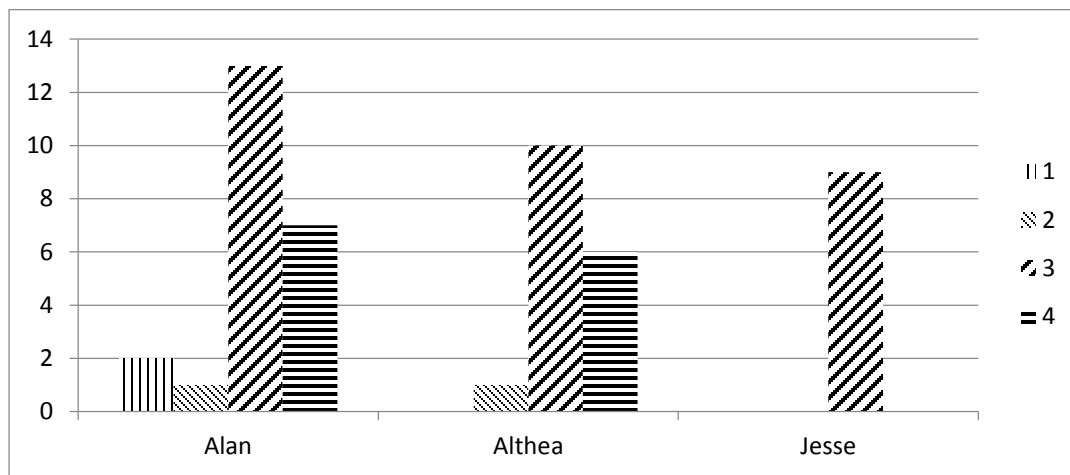
Figure 5.2. Instances of Shared Laughter across Conversations by Participant

 The above chart depicts how both Alan and Althea dramatically increased the occurrences of shared laughter. While Jesse demonstrates shared laughter only in Session Three, this is significant because he is less inclined than the others to engage in shared laughter due to both his functional domain of disability and personal factors within the contextual domain. The increased instances of shared laughter in the latter sessions provide evidence of not only engagement, but connectedness and an open, trusting attitude as people not only affiliated with each other as a group, they signified their trust in the form of laughing at themselves and each other (Jefferson, Sacks, Schegloff, 1987; Pomeroy, 2013).

 Gaze. If the saying "the eyes are the window to the soul" is true, then gaze is the window to the person's affiliation for others. Through gaze direction toward the speaker or

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referent, anticipatory gaze shift, and inclusive gaze shift the members demonstrated their

orientation toward or away from developing group cohesiveness.

Gaze Direction. Due to the limitations of the camera, little to no information on eye

gaze could be ascertained for Alan. However, both Althea and Jesse demonstrated increasing

gaze direction toward the speaker or conversation referent (i.e., another interactant or a

referenced object). The steady increase in the percentage of other turns where their gaze was

engaged can be seen below in Figure 5.3.
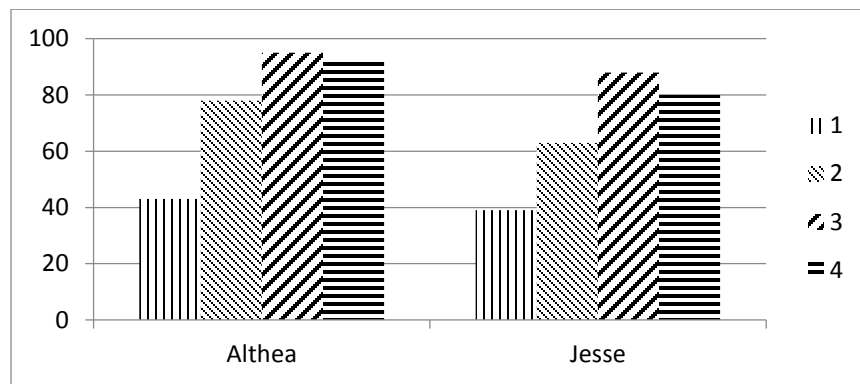
Figure 5.3. Gaze Engagement by Participants

As noted in this figure, initial conversations were characterized by approximately

60% of the gaze occurrences not directed at all to the speaker or referent; instead, the gaze

was continually directed at the table, in Althea's case, or the door, window, clock, watch, and

a non-specific mid-distance gaze, in the case of Jesse. They effectively demonstrated their

engagement in the later conversations through their gaze at the clinician, another member,

shared drawings, and photos with appropriate timing during both their own and another's

conversation turn. Althea demonstrated gazed engagement during the turn construction units

of another only 43% of the time in the first session analyzed and steadily increased her gaze

across sessions to demonstrate 93% engagement in the final conversation. Jesse, who overall

was less oriented to group cohesiveness, did demonstrate an increase from 39% gaze

direction at speaker or referent to 80% engagement in the final conversation, and 88% in the third conversation. There is clearly a relationship between speaker/referent directed gaze and engagement in the conversation and it is likely that the two events act upon each other in a synergistic fashion.

Anticipatory Gaze Shift. Anticipatory gaze describes when a listener shifts his gaze to the next speaker before the current speaker has completed their turn-at-talk. While Alan's gaze could not be determined, Althea and Jesse both increasingly employed anticipatory gaze shift and this increase is illustrated below in Figure 5.4.
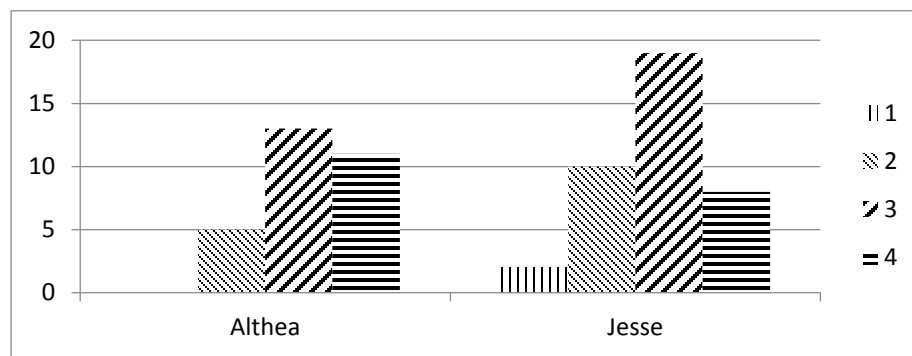
Figure 5.4. Occurrences of Anticipatory Gaze Shift by Participants

Althea never anticipated another's turn-at-talk in Session One but did so five times in the second conversation and 24 times in the third and fourth conversations combined (13 and 11 times respectively). Like Althea, Jesse demonstrated increased anticipatory gaze shift; from 12 over the first two sessions to 27 across the latter ones. What was surprising, however, given Jesse's reduced gaze directed at speaker or referent as compared to Althea, was that Jesse demonstrated more frequent occurrence of anticipatory gaze shift. This can likely be attributed to a functional factor; Jesse's auditory comprehension is the weakest in the group being in the severe range. Therefore, he must rely on more visual cues than the other participants. It is possible that he utilized the gaze direction and paralinguistic signals

demonstrated by the current speaker to supplement his auditory comprehension in order to follow the ongoing talk. This consistent employment of anticipatory gaze shift by both participants provides evidence of this behavior as an indicator of engagement in conversation as well as working together since it requires an orientation toward the collaborative coordination of talk to anticipate a next speaker.

Inclusive Gaze. As is apparent from the above behaviors, a significant amount of conversation work is accomplished through gaze and for the participants whose gaze could be reliably viewed on the video, affiliating work was done through inclusive gaze. Both participants, whose gaze could be viewed, demonstrated increased use of inclusive gaze over the course of the semester and this can be seen below in Figure 5.5.
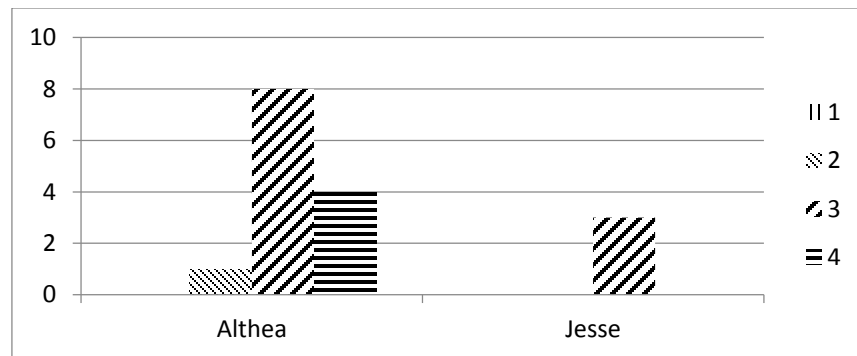
Figure 5.5. Occurrences of Inclusive Gaze Shift by Participant

Just as our gaze when directed at the speaker or a shared referent can indicate that we are attentive and engaged in the conversation, when we direct our gaze serially to all conversation partners we are either monitoring the receipt of our message or inviting Group-Level connectedness (Argyle & Dean, 1965; Argyle & Cook, 1976; Bavelas, Coates, & Johnson, 2002; Krantz, George, & Hursh, 1983). Althea increased her use of inclusive gaze shift from one instance in Session Two to 12 instances combined for Sessions Three and Four while Jesse increased his inclusive gaze from zero instances to three instances.

Although the number of instances of inclusive gaze for Jesse is small, it is significant due to the personal factors described in Chapters Three and Four that demonstrate that he had less of an orientation toward group cohesiveness. For both participants, the use of inclusive eye gaze was performed for the purposes of connecting with others and working together. During moments of shared laughter inclusive eye gaze demonstrated the participant's feelings of connectedness and working together that form the "esprit de corps" of the group. During their conversation turn, inclusive gaze was used to monitor listener understanding and engagement for the need to make adjustments such as recycling a turn or turn termination to work together.

Agreement. It has been established that agreement tokens reliably demonstrate structural affiliation (Lerner, 1996; Conroy, 1999) and the participants uniformly demonstrated the employment of agreement tokens in their turns–at-talk for each session. Their unique patterns of occurrence for the use of agreement tokens is presented below in Figure, 5.6.

Figure 5.6. Occurrences of Agreement across Participants

Where Althea demonstrates increased instances of agreement in general with a large increase for the third conversation and Jesse similarly evidences increased agreements, the source of their agreements vary. Althea demonstrates agreements as part of affiliation and consensus with another speaker's talk while instances of agreement from Jesse relate to collaborative repair of a conversation breakdown and not for affiliative purposes. Alan

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demonstrates a gradual decline in agreement tokens but this must be interpreted within the context of varying number of turns-at-talk among additional factors. For each participant, their occurrences of agreement must be interpreted with regard to a functional domain, their degree and profile of language impairment, and personal factors such as their proclivity toward group interaction and affiliation or away from it. While Althea's social history and actions designate her as more affiliative in nature, Alan's and Jesse's personal factors, actions, and even statements indicate they are not joiners. This then would enforce the above reported frequency of occurrence for agreement tokens, making it a reliable indicator of group cohesiveness; that Althea operated more as part of a group than did Alan and Jesse.

Affiliation tokens. Similar to agreements, affiliation tokens indicate positive reactions to other's turns-at-talk and have been demonstrated to indicate Group-Level affiliation (Burlingame et al., 2001; Greatbatch & Clark, 2003; Lepper & Mergenthaler, 2005; Dinger and Schauenburg, 2010). In this study, affiliation tokens were restricted to those positive relating actions other than agreement and positive assessment; they included continuers, facial expressions, and gestures. It is likely due to this restricted designation that there did not occur consistent demonstrations of affiliation tokens from Alan. His face was often obscured from view and he was a less animated communicator than Althea and Jesse. The occurrences of affiliation tokens for each of the participants can be viewed in Figure 5.7.
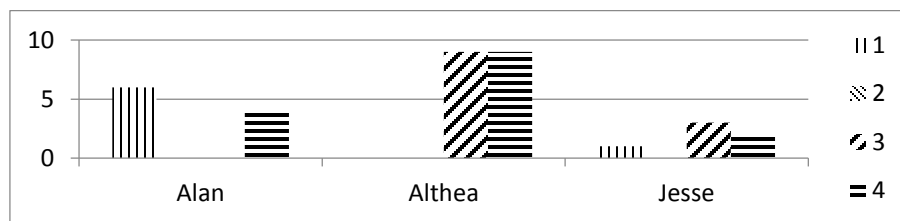
Figure 5.7. Occurrence of Affiliation Tokens across Participants

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In the above figure we can see that in the first and final conversation, Alan demonstrated affiliation toward the clinician or another member but not on conversations two and three. Althea demonstrated no instances of affiliation for Sessions One and Two, the beginning of the semester, but nine instances each for Sessions Three and Four. This is most likely related to similar patterns for gaze, laughter, and overlap. As she became more engaged and connected to the group she demonstrated affiliation through her facial expressions and continuers. Jesse likely used affiliative tokens as a resource to support his limited verbal output as tokens such as smiling increased for both Althea and Jesse.

Increasing negative assessment with positive affiliation. Althea and Jesse also both demonstrated increasing negative assessments that accomplished positive affiliation. As previously discussed, this occurs when another speaker has oriented to their own talk as being a negative assessment (e.g. when Clinician One stated in Session Four "Well it smells terrible" and another conversation participant said, "Ugh"). While Alan did employ this device in Sessions Two and Three, he did not consistently demonstrate this behavioral index across the other sessions. The pattern of negative assessment with positive affiliation can be seen below in Figure 5.8.
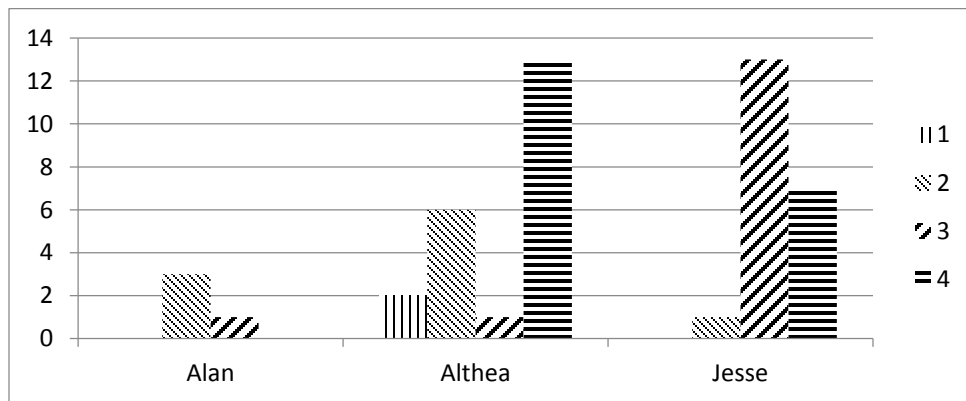
Figure 5.8. Occurrences of Negative Assessment with Positive Affiliation

What is apparent from the above chart is that negative assessments that accomplish positive affiliation are context dependent and so while a general trend of increasing occurrence is likely attributed to growing group cohesiveness, the influence of topic and clinician action cannot be extricated. Jesse demonstrated his largest share of this behavior in Session Three but as will be discussed later, he also received a greater number of other-initiated turn allocations by the clinicians. Further, the topic of conversation being travel places and experiences was one of familiarity to Jesse. This topic was not at all familiar to Althea, who has never left the state of her birth, and we see very few instances of negative assessment with positive affiliation. In other words, she did not relate to the topic at hand and that impacted how she demonstrated connectedness. Conversely, the Session Four conversation centered around family events, a wedding, and cooking with which she was very familiar and this likely resulted in her significant demonstration of negative assessments with positive affiliation. In sum, both demonstrated greater occurrences in the latter half of the semester than in the initial sessions and this provides evidence of not only their connectedness but their feelings of an open, trusting attitude where they felt comfortable making a negative assessment to support their conversation partner.

Humor. Humor is somewhat related to shared laughter but requires greater linguistic resources to accomplish. It is this condition of humor that is the most likely reason for Jesse's diminished instances of humor. The next most likely is Jesse's decreased feelings of connectedness to the group as reported in his post-semester interview. Alan, while professing that he did not identify himself as part of the group has the greatest amount of linguistic currency and does demonstrate connectedness through humor that was initially directed toward the clinicians and later included member-directed humor. Althea's linguistic ability,

though not as impaired as Jesse, still impedes her ability to initiate humor. So again, an

interaction between the functional domain and contextual domain in the form of personal

factors conspires to influence how a person uses humor to demonstrate group cohesiveness.

The patterns for the use of humor for each participant are illustrated below in Figure 5.9.
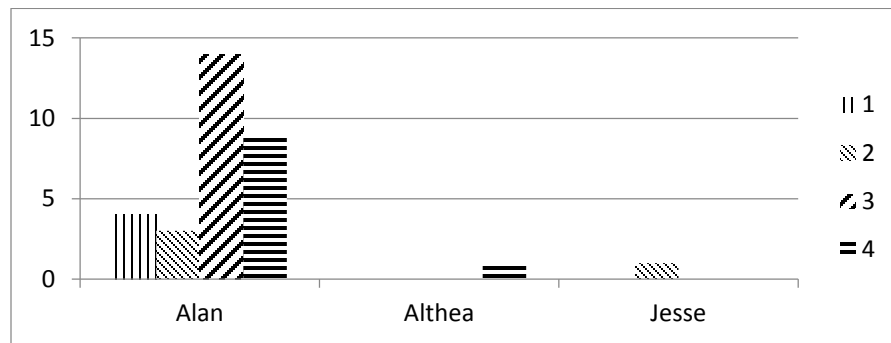

Figure 5.9. Occurrences of Humor across Participants

As this figure indicates, Alan employs humor consistently across all sessions and the

frequency of humor initiated by him significantly increases by the end of the semester.

However, Althea and Jesse, with diminished verbal ability, must rely on the context to

support any attempt at humor. For Althea, the context surrounding her use of humor in the

third session involve relating a familiar funny story that has been built upon the previous

turns of others and supported with recurrent gesture. For Jesse, the context is the agreement

with the clinician's negative self talk which, as a transgression of social protocol, becomes

funny to all participants, even the clinician; when the clinician commented that her

supportive drawing was horrible, Jesse replied "I know."

Approaching balanced turn taking. This index was so named because similar to the

differential effects of cohesion related to pre-group personality ratings in the study of Dinger

et al (2010), differing profiles of conversational turn taking result in differing displays of

group cohesiveness. For Althea, an increasing share of the turns-at-talk represented increased

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engagement, connectedness, and working together. Perhaps more notable is Alan's decreasing share in the turns-at-talk, particularly in the final session. Although these changes to conversation will be discussed in greater detail later in this chapter, it is quite possible that Alan's reduced self-selected turn taking contributed to a more balanced conversation for the members with greater language impairment.

Assessments. Assessments are those turns-at-talk in which people make negative or positive value judgments regarding someone or thing, such as Clinician One's statement, "Well, it smells terrible." In order to accomplish a first assessment of an assessment adjacency pair, a speaker must possess the language ability to perform self-initiated expression. Jesse's limited verbal expression precluded his demonstration of this index. Alan and Althea demonstrated this index in at least two of the four sessions with Althea demonstrating it for the final two sessions only. It is through the use of assessments that both Althea and Alan demonstrated their developing trust and openness within the group conversation as well as their desire to affiliate by inviting second assessments or agreements (Pomerantz, 1975; 1984).

Participant unique conversational behaviors of significance. As stated previously, an individual's communicative profile within the functional and contextual domains, which include environmental and personal factors, creates a response to aphasia and to intervention that is often as unique as the individual themselves. Therefore while some conversation behaviors were represented by a single individual, their effect was powerful enough to deserve attention. Interestingly, it was Althea who demonstrated several conversational behaviors that, while providing evidence of a growing orientation to group cohesiveness, were unique to her. They likely resulted from her level of impairment in the functional

domain, which was moderate to severe, and her personal factor of being a highly social person and who was oriented to group cohesiveness. Because Althea had limited verbal ability she frequently employed the conversation devices that would allow for maximal participation and affiliation with minimal verbal processing demands. It is most likely for this reason that she exclusively relied on continuers such as "oh", "mHm", and "ooh" to demonstrate her engagement and connectedness to the group conversation. Althea also was the participant who most exemplified an orientation toward affiliation at the Group-Level and as such she was the only one who demonstrated an open trusting attitude through the increased use of disaffiliating devices and negative assessments in later sessions when she felt comfortable enough to voice her opinion, even if it was not popular.

   Clinician-participant interaction for group cohesiveness. Participant demonstrations of group cohesiveness cannot be interpreted in a vacuum but must be viewed within the context of the conversational group treatment and the multiplicity of relationships inherent in this process. Burlingame et al. (2001) described these relationships as member-to-leader, member-to-member, and member-to-group which is why the behaviors of the clinicians that fostered group cohesiveness must be addressed; specifically, the techniques and conversational devices employed by clinicians. Modelling is perhaps the most powerful technique that a clinician can use to promote a therapeutic effect in her clients. The clinicians recurrently modelled many of the conversation devices demonstrated by the participants. Without previous exposure to the principles of group cohesiveness, their demonstration of these conversation behaviors represents their innate orientation toward group cohesiveness as opposed to an intentional display; regardless of the nature of their demonstrations, however, the modelling effect likely influenced the behaviors of the participants to varying degrees.

Some clinician behaviors were intentional and directed toward achieving a balanced conversation which likely influenced how participants demonstrated group cohesiveness. This discussion will be organized into two sections, naturally occurring indices of group cohesiveness and intentional indices of group cohesiveness.

Naturally Occurring Demonstrations of Group Cohesiveness. As participants in conversation, we are conditioned to orient toward the presentation of the best possible self and the maintenance of the projections of other's best possible self (Goffman, 1967; Lerner, 1996). It is this inherent motivation that results in the displays of group cohesiveness for which the clinicians employed conversation devices without intention. Those behaviors that occurred consistently across at least three of the four sessions are reported below in Table 5.2 along with their frequency of occurrence.

Table 5.2. Unintentional Demonstrations of Group Cohesiveness across Sessions

Behaviors of Group Cohesiveness	1-31-12	2-7-12	3-29-12	4-3-12
Acknowledgments	12	6	2	14
Agreements	8	8	18	11
Assessments	5	5	9	7
Humor	3	5	11	12
Positive Contingents	11	20	20	13

Descriptions and examples of these behaviors were reported in greater detail in Chapter Four, but how the behaviors demonstrated by the clinicians may have influenced demonstrations of group cohesiveness among the participants will be discussed in this section.

Acknowledgments. Clinicians demonstrated engagement in the conversation through their placement of acknowledgment tokens at potential terminal junctures, transition relevance places, in a participant's turn-at-talk. This served to encourage them to continued talking as well as providing verification that the participant's turn-at-talk was understood. As

discussed by Burlingame et al. (2001), these acknowledgments facilitated the responsiveness of others. The consistent use of this device for Sessions One, Two, and Four likely promoted the evidence of working together with an open, trusting attitude from the clinicians that would impact the participants increasing demonstrations of acknowledgment, most notably Althea.

Agreements. Like the participants use of acknowledgment, the clinicians demonstrated engagement, connectedness, and working together through agreement tokens. They employed gestural agreements, through nodding, that signified their engagement in the conversation and their connectedness to the speaker. Nods also served the function of encouraging the client to continue their turn-at-talk within a new turn construction unit or with repair of a conversation breakdown within the current turn-at-talk. They used verbal agreements to show their connectedness and affiliation with the speaker's proposition. Further, they used agreement as a device to expand the previous turn, thus working together with the prior speaker to contribute a richer and more descriptive turn to the conversation. These clinician actions are in keeping with the principle of "deriving shared meaning of each member's contribution" as outlined by Burlingame et al. (2001). The use of agreements increased from the beginning of the semester to the end of the semester which suggests a possible interaction between clinician and client demonstrations of group cohesiveness through agreement as Althea likewise increased her demonstration of agreements.

Assessments. According to Burlingame et al. (2001), one principle involved in creating a group that is highly cohesive is that of facilitating a group members' emotional expression and this requires that the group leader display an open, trusting attitude through sharing her attitudes and emotions through assessments. This was present across all sessions

through the clinicians assessing participation in prior activities (Lindstrom & Mondada, 2009; Pomerantz, 1975). Further, there occurred an increase in the demonstration of assessments by the clinicians from the beginning to the end of the semester. This conversation behavior was established early by Clinician Zero who made an assessment on five occasions for Sessions One and Two. By modeling assessments, the clinician established an expectation or, at minimum, an opportunity for the IWAs to similarly display an open, trusting attitude in conversation. There appeared to be a group effect upon Clinicians One and Two who increasingly assessed the prior weekend's activities, usually negatively; achieving intimacy through "Troubles Talk" (Jefferson, 1988). As they felt more connected with the group and the group demonstrated being open and trusting with them, they in turn became more open and trusting. This idea was best expressed by Clinician Two during a conversation about what was the "best" thing about the conversation treatment group when she said, "I think that bringing- finding something in common, just being real and open."

Humor. Clinician Zero employed humor that was directed at self in the earlier sessions to establish a feeling of connectedness as well as an open, trusting attitude. By using self-deprecating humor she established a more egalitarian relationship for treatment which contributed to establishing the feel of discourse equality (Simmons-Mackie et al., 2003). Her willingness to appear flawed, and her humor surrounding this, encouraged Alan to use humor in the form of jokes and teasing which was directed at her and then Clinicians One and Two. In the later sessions, Clinicians One and Two employed not only self-deprecating humor but directed teasing and joking toward Alan and the group in general. Alan in turn directed jokes toward other members in later sessions. Instances of humor increased over the course of the semester for both the clinicians and Alan. In addition, Althea's single incident of humor

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occurred in the later sessions. Humor then appears to be a reliable index of group cohesiveness and forms a reciprocal relationship with it; humor encourages group cohesiveness and group cohesiveness provides greater opportunity for humor.

Positive Contingents. The use of positive contingents remained consistent across the four sessions analyzed and was frequently employed in each. These positive reactions to the talk of the IWAs demonstrated the clinicians' engagement in the conversation and their feelings of connectedness to the speakers. Like agreements, the clinician's responses that formed positive contingents encouraged working together for continued turn taking and for collaborative repair. Positive contingents assist in creating positive post-stroke identities for the IWA which relates to the development of an open, trusting attitude which aided in facilitating the responsiveness of others (Burlingame et al., 2001). This likely contributed to the increased ability for self-repair demonstrated by Alan and Althea which will be discussed more in depth later in this chapter.

Intentionally occurring demonstrations of group cohesiveness. While, as stated previously, the clinicians were likely not consciously orienting to group cohesiveness, they were orienting to improved conversation ability for each participant and this was accomplished through the intentional employment of the conversation devices listed in Table 5.3.

Table 5.3. Intentional Demonstrations of Group Cohesiveness across Sessions

Behaviors of Group Cohesiveness	1-31-12	2-7-12	3-29-12	4-3-12
Increasing Participation				
Verbal turn invitation	6	11	6	8
Gestural turn invitation	3	2	4	5
Continuers	9	3	1	1
Supporting Turn Success				
Proxy turns	8	23	7	1
Mimic / recast	1	9	5	2
Anticipatory completions	8	3	1	8
Face saving repair				
Embedded correction	4	2	1	2
Rephrase	1	6	3	7 (4)
Verifications	4	6	1	3

These conversation devices were intended to increase the participation of each member and to support communicative success for each participant's turn-at-talk which involved doing repair work that did not cause a client to lose face. Therefore the conversation devices and techniques used by the clinicians centered on increasing participation through both turn taking and turn length, supporting the success of the persons turn, and face saving repair work that also moved the conversation forward.

Increasing participation. The work done by clinicians to increase participation in conversation also satisfied many of the principles that embody a highly cohesive group (Burlingame et al., 2001) and well-managed discourse (Simmons-Mackie et al., 2007). The clinicians demonstrated through their turn invitations and continuers that they valued each member's contribution to the conversation which established clarity regarding the group treatment process, facilitated the responsiveness of group members, as well as helped establish the feeling of discourse equality.

Verbal turn invitation. Perhaps the most consistent technique used by the clinicians to increase participation in the conversation, the clinician's verbal turn allocations provided the

opportunity for the participants to demonstrate engagement, connectedness, and working together as other group members responded to and built turns upon the invited speaker's contribution. This technique occurred 6, 11, 6, and 8 times for Sessions One through Four, respectively. It is likely that verbal turn invitation was influenced by topic with more interesting or familiar topics requiring less turn invitation than those topics that did not hold mutual interest for all members.

Gestural turn invitation. Gestural invitation occurred less often than verbal invitation but remained consistent across Sessions One through Four at 3, 2, 4, and 5 occurrences, respectively. Clinicians sometimes paired gesture with a verbal invite but often it encouraged a participant to self-select a turn while another participant completed their turn-at-talk. This provided not only for a smoother conversation but facilitated the responsiveness of group members.

Continuers. Used by all clinicians, this device was used most by Clinician Zero and largely in the first session that was analyzed. Continuers took the form of nods and "mHm" and, being placed at or near a transition relevance place, were designed to encourage the speaker to continue their turn-at-talk which aided in facilitating member's expression as well as establishing the feel of discourse equality.

Supporting Turn Success. Clinicians demonstrated their orientation to group cohesiveness and encouraged similar orientations from the group members when they used devices that supported the turn success of the participants. By assisting other's in "saving face" (Goffman, 1967), they encouraged other member's to do likewise which resulted in increased working together with an open, trusting attitude.

Proxy turns. Through the use of proxy turns, they facilitated both the derived self meaning and responsiveness of others for participants experiencing conversation breakdown during their turn-at-talk (Burlingame et al., 2001). These proxy turns were performed in such a way as to preserve the authorship of the conversation turn for the participant experiencing the breakdown; an example of this can be found in the discussion of clinician conversation behaviors in Chapter Four. Clinicians Zero and Two used this device with Clinician Zero demonstrating this 31 times and Clinician Two using it eight times. Not only was the use of the device intentional, it required therapeutic skill to attach the intonation patterns, gaze, and tags that would clearly indicate their construction as a proxy turn, not their own. Further, there was a decrease in the use of proxy turns from the initial sessions which could be clinician specific or relate to a decreased need for proxy talk as the participants increased their percentage of self-initiated turns for the conversation.

Mimicry and Recast. The clinicians consistently demonstrated mimicry of the IWA's conversational behaviors. In other words, they often copied the facial displays, gestures, or verbal expressions of the participants. Similar to this, was the use of recasting where the clinicians used part or all of a participants prior turn to form the content of their own. These actions aligned the conversation participants, demonstrating the feelings of connectedness in the speaker who performed the mimicked or recasted utterance, gesture, or facial display. These actions served to aid "in the construction of meaning as well as shaping the relationship between the participants" (Ruusuvuori & Peräkylä, 2009 p. 392).

Anticipatory completions. Lerner (1996) and Conroy(1999) both identified anticipatory completions as devices that achieved affiliation in the talk of non-impaired individuals with Lerner describing an additional function as converting a dispreferred action

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into a preferred one. The actions of the clinicians in completing the utterances of the group members served similar functions that oriented toward group cohesiveness. When the clinicians completed an ongoing utterance in overlap, they communicated engagement and connectedness. They performed agreements and assessments with their anticipatory completions; saying basically, "I know what you are going to say and I agree." For participant turns that experienced conversation breakdown in the form of a hesitation or a word finding problem, the anticipatory completion by the clinician demonstrated connectedness in addition to working together. By completing a stalled utterance, the clinician mediated the group communication (Simmons-Mackie et al., 2007) in such a way as to preserve a more competent identity for the participant and facilitate the derived shared meaning of the member's contribution (Burlingame et al., 2001). The completion moved the conversation forward which also contributed to the "feel of discourse equality" (Simmons-Mackie et al., 2007).

Face-Saving Repair. While an anticipatory completion was employed by clinicians to pre-empt a conversation breakdown to ensure success, it was also employed after the breakdown to "save face" for a participant. Additional devices that accomplished this were embedded correction and verification of a participant's utterance as well as rephrasing of the clinician's utterance.

Embedded corrections. The occurrence of paraphasias and word finding problems become a constant source of breakdown in conversation for IWA; this often halts the ongoing construction of meaning and threatens the identity of the speaker as a competent communicator. The attempts, in the form of correction, by the clinician to move the conversation forward can further erode the speaker's sense of competence unless done

delicately. Corrections that are overt and bring attention to the conversation breakdown are aptly named exposed corrections; they expose the breakdown and the individual's incompetence. Conversely, embedded corrections complete a repair without bringing attention to the error and thus preserve the individual's identity as a competent communicator. This has vast implications for group cohesiveness where members are developing connectedness and working together with an open, trusting attitude. This conversation behavior on the part of the clinicians was integral to maintaining group cohesiveness through "timing and delivery of feedback" (Burlingame et al., 2001) and as one of seven therapist behaviors that characterize well-managed discourse therapy (Simmons-Mackie et al., 2007). The use of embedded corrections does require some therapeutic finesse and it is likely for this reason that Clinician Zero employed this strategy six times while Clinician Two used embedded correction three times and Clinician One did not use this at all, instead committing exposed correction on occasion.

 <u>Rephrase</u>. Conversation breakdown sometimes occurred when a clinician's turn construction was misunderstood, either due to decreased auditory comprehension or lack of clinician specificity. By rephrasing her initial turn construction, the clinician demonstrated working together to construct meaning, on one occasion rephrasing the original message 3 times. While rephrasing was present in all conversations the frequency with which it occurred varied across Sessions One through Four with 1, 6, 3, and 7 instances, respectively. The need for rephrase cannot be reliably attached to a single aspect of conversation but the presence of rephrasing supported the principle of "facilitating derived shared meaning of each member's contribution" (Burlingame et al., 2007) and characterized a well-managed discourse therapy through "mediating group communication."

Verifications. Related to embedded correction is the use of verifications by the clinicians to maintain the construction of meaning by ensuring that the speaker's turn faithfully expressed their intended message. Verifications are similar to embedded corrections in that if not done correctly, they can pose a threat to a person's presentation as a competent communicator. Therefore, like embedded correction there emerged a pattern where Clinician Zero used a greater amount of verifications than Clinicians One and Two with 10 and 4, respectively. However, the impact of both common ground and group cohesiveness can be explanatory factors. In the initial conversations for the semester, the group had little knowledge of one another and so there was a greater burden to frame their talk around new information. Through the use of verification statements the clinician facilitated the responsiveness of others and derived shared meaning of each member's contribution (Burlingame et al., 2007) which contributed to growing common ground and group cohesiveness. Therefore, at the end of the semester when the group had achieved improved levels of common ground and cohesiveness, the use of verifications was no longer as necessary.

Strategic Conversational Behaviors

The goal of conversation based therapy is to improve the communication ability of an IWA for conversation which is the most commonly occurring communication activity among all speakers whether they have language impairment or not. To accomplish this, conversation is approached as a co-constructed meaning-making endeavor that employs all modalities as appropriate and the strategic deployment of conversation moves within those modalities.

Over the course of the semester, the participants who have varying profiles of aphasic impairment demonstrated strategies to support and compensate for limited verbal abilities. In

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this section, the participant's shared conversation strategies will be described as well as how

the use changed over the course of a semester of treatment. This cannot be discussed without

consideration of the impact of contextual variables and so when applicable the effect of topic,

environment, and common ground will be interwoven into the discussion. The interaction

between participant and facilitating clinician likewise contributes to which strategies are

demonstrated and how they are employed. Therefore, the clinician behaviors that resulted in

a change in the conversation strategies employed by the participants, such as strategies

modelled and conversation devices used, will be discussed.

Participant's shared conversation strategies. While each participant did

demonstrate strategies that were unique to them and these were described in Chapter Four,

many strategies were deployed by at least two of the three participants. These strategies and

which participants employed them are listed below in Table 5.4 and they are discussed with

reference to purpose and contextual variables following this table.

Table 5.4. Conversation Strategy Use across Participants

Conversation Strategy	**Alan**	**Althea**	**Jesse**
Clarification Questions	√	√	√
Multiple modality turns	√	√	√
Facial Displays		√	√
Gesture	√	√	√
Drawing and Writing		√	√
Laughter	√	√	√
Recasting	√	√	
Recycling own turn	√	√	

Clarification questions. While each participant requested clarification of a clinician's

turn-at-talk at least once, only Althea and Alan employed this strategy with consistency. Alan

routinely employed clarification questions when other's turn-at-talk referenced information

that was shared with only a few of the conversation members. This occurred when Aud used

a non-specific pronoun, "we" to refer to herself and her husband. Alan also requested clarification when information was implied but not fully described such as when Clinician Three held up her braced hand and reported that if she won the lottery she would "buy me a new bone" in reference to the broken bone in her hand. Althea's use of clarification question related more to her reduced auditory comprehension as when during her anecdote about her love birds that kept making "some more babies" Alan replied "gumbo." She used a clarification question twice before Clinicians One and Two, using anticipatory completion for each other, explained that Alan intended for the birds to be cooked in a gumbo. While both increased their use of clarification questions for the latter sessions, Alan demonstrated more frequent occasions of use. Clarification questions were carried verbally for both participants and it is likely that Alan's superior verbal ability resulted in his increased demonstrations of clarification questions. Jesse who possessed very poor verbal ability, used a clarification question, "uh what?" during the very first session to aid in auditory comprehension of Clinician Zero's talk for which she repaired by adding gestural support.

  Multiple modality turn construction. The use of additional modalities is perhaps the strongest resource a person with aphasia can depend upon to compensate for impairment in language expression; these included facial displays, gestures, and writing or drawing. All three participants employed multiple modalities in the construction of their turns with Alan and Althea exploiting this strategy more frequently than Jesse. It is quite possible that Jesse's severe auditory comprehension, 46th percentile, resulted in decreased comprehension of the conversation which would limit the amount of initiated turns and then the employment of multiple modalities. When looking at the use of multiple modalities as a percentage of his turns, Jesse employed this strategy most often, between 52% and 100% of conversation turns.

While Jesse would use either a gesture or writing / drawing singly to support his turn-at-talk, Alan and Althea often combined modalities which, for Althea, included facial expression. Modalities were combined singly or multiply as in the case when Althea, during her anecdote about the runaway reproductive behaviors of her birds used both gesture and facial display to support her verbal message.

Facial displays. Due to the visual constraints of the camera angle, no reliable information on facial displays could be noted for Alan, but both Althea and Jesse employed facial display either with their talk or as an alternate modality to communicate agreement, disagreement, and affiliation. Jesse was the most consistent user of facial display as a strategy, demonstrating this behavior between one and seven times per session. However, Althea employed this strategy 14 times in the fourth session alone. These two participants employed facial display both in response to other's talk and during their own talk as a way of demonstrating a self-assessment of their talk. Like the findings of Chovil (1989), participant's facial displays served the purposes of personal reaction, portrayal, as a facial shrug, and as a yes. Also similar were the participants, namely Althea's, use of facial expression when in the listener role as a backchannel or affiliating device.

Gesture. All three participants employed gesture to either take the place of their turn or to supplement meaning construction. There was a general trend of increased gesture use which will be discussed in the section of this chapter that focuses on conversation changes. Gestures served the purpose of increasing the saliency of their turn-at-talk, especially during the use of repetitive gestures (Schegloff, 1984). Gestures were co-opted by participants in sequential turns-at-talk which eased their formulation burden (Chawla and Krauss, 1994), supported the comprehensibility of their message for the recipient (Clark, 1996; Kendon,

2004; Bavelas and Chovil, 2001), and also demonstrated affiliation with the prior speaker (Cheng, 2003; Stel, 2010). There existed a relationship between the percentage of turns employing gesture and the verbal ability of each participant with greater verbal ability being associated with less gestural expression. Alan who demonstrated the greatest verbal ability used gesture in the fewest percentage of conversation turns while Jesse having the greatest verbal impairment employed them in the most utterances and Althea whose language falls between the others also gestured at a rate that was between them. The data supporting this assertion can be viewed in Table 5.6 which is in the section on conversation changes.

Drawing and writing. While the use of drawing and/or writing with speech was employed by both Althea and Jesse in the pursuit of conversation repair, it was used only in Session Two. Much of this is likely related to environmental constraints. While Clinician Zero modelled the use of drawing for conversation repair, she also both provided the writing materials necessary and encouraged the use of writing and drawing by the participants. It is likely that if Clinicians One and Two had similarly encouraged the modality, it would have been used more frequently. As such, the success of writing as a strategy was limited. In Althea's only attempt to use writing, she was not able to repair her message. In contrast, Jesse used writing /drawing successfully on 4 separate occasions within the same conversation to collaboratively communicate 7 different ideas. He was able to use first letters in addition to topic to communicate his favorite basketball team, Miami Heat, and he used drawing to share his enjoyment of travelling to Wyoming, Montana, and even Montreal, Canada.

Laughter. Laughter has been shown to be used strategically by both non-brain injured individuals (Jefferson, Sacks, Schegloff, 1987; Lerner, 1996; Conroy, 1999) and brain

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injured persons (Madden, Oelschlager, & Damico, 2002; Simmons-Mackie & Schulz, 2003) alike and it serves the functions of building rapport, maintaining face, and building solidarity. All three participants used laughter to demonstrate their appreciation of another's talk as well as to minimize a dispreferred status (Lerner, 1996). Instances of laughter for Althea served the purposes of taking a turn-at-talk, connecting with the group, and minimizing an identity of "the fool" such as when Alan teased her about cooking her birds. Jesse used laughter as a marker of participation and a signal that he got the joke. However, he was not a person who laughed often or easily and, in fact, instances of laughter occurred only for the third conversation but with great frequency, nine times. This anomalous occurrence of laughter may have been topic related as well as comprehension related. Laughter occurred around two conversations, advances in television that lead to the DVR and winning the lottery, both of which were accompanied by a high number of gestures which would have aided his comprehension. Further, the conversation regarding television was mediated by his therapist writing down key phrases. Alan demonstrated the highest occurrence of laughter which can not only be related to his relatively superior language ability but to his frequent initiations of humor; in effect, he was laughing at his own jokes.

 Recasting. Recasting is unlike mimicry in that the function of the gesture or the words that have been repeated is modified to suit the next speaker's needs (Simmons-Mackie and Damico, 1997). However it is like verbal other-repetition in that is satisfies many of the same functions. It supports conversational discourse by allowing a speaker to produce their conversation turn with greater efficiency and fluency (Oelschlager & Damico, 1998; Tannen, 2007; Hengst, Duff, & Dettmer, 2010), to manage turn-taking (Tannen, 2007), and to create humor (Tannen, 2007; Hengst et al., 2010). Both Alan and Althea demonstrated the use of

recasting. Recasting does require enough verbal ability to co-opt your own or the turn construction of another and then make it your own which likely influenced the lack of Jesse's use of this strategy. Alan and Althea both used recasting to ease formulation burdens in their turns-at-talk. They incorporated the talk of the clinicians' question in their responses and they used another speaker's talk to form self-initiated turns-at-talk. Alan additionally employed the recasting of part of the clinician's prior turn construction to manage turn taking. Though done only once, he repeated part of the clinician's prior talk to reclaim the speaking turn in overlap through which he signaled to the clinician that although he had paused, he had not intended to complete his turn. An instance of delayed repetition, or recasting, was performed by Alan for humor. In this instance he also mimicked the intonation of the clinician when during a discussion about software applications he said "it's ↑free" to chide her sense of frugality.

   Recycling own turn. This strategy was used with great frequency by both Alan and Althea; Jesse's greatly diminished verbal capacity precluded his use of verbal self- repetition. While Alan's self-repetition remained relatively constant at a rate of 4.6% to 10% of his turn constructions, Althea's self-repetitions varied in the rate at which she used this strategy with a dramatic increase in the use of self-repetition for the later sessions. Althea did not use self-repetitions during the first conversation analyzed which is not surprising since she participated in only nine turns, of which 7 were allocated to her by the clinician. For the remaining sessions, two through four, she demonstrated self-repetition 6%, 23%, and 19%, respectively. Self repetition served multiple functions for both Alan and Althea. This behavior allowed them to manage turn-taking, repair conversation breakdown, and impose affective meanings on their talk (Leiwo & Klippi, 2000). Alan's use of self-repetition served

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to manage overlap to secure a next turn-at-talk as well as keep his speaking turn and these functions are similar to those reported by Leiwo & Klippi. Also, similar to their findings on the use of self-repetition in the talk of aphasics, was Alan's recycling of his turn construction unit to negotiate meaning in production problems which allowed him to self-repair. However, dissimilar to the findings of earlier studies, Alan also used repetition as a source of humor in three instances in such a way that would not be considered expressing emphasis and affect such as repeating "one dollar" several times during a discussion about playing and winning the lottery. Althea's pattern of self-repetition did demonstrate a reliance on self-repetition for emphasis and affect; in fact, 53% of her self-repetitions served this purpose. Additionally, Althea employed self-repetition for self-repair, to manage overlap, and as a placeholder to take a turn-at-talk.

Clinician-participant interaction for conversation strategy usage. The above strategies used by participants did not occur in a vacuum but rather grew out of the conversational context which included the topics, the repeated opportunities for strategy usage, the communication partners' behaviors, and the clinicians' behaviors. This section will attempt to relate the clinicians' behaviors to those participant strategies for which they may have contributed to the development or maintenance. While causality is difficult to prove, relationships between clinician behaviors and the participants' employment of strategies will be described in reference to sequentiality (Wilkinson, 1999). In other words, in determining whether a clinician behavior demonstrated influence, the subsequent turns-at-talk were examined for the participants' conversation strategies. These behaviors and the conversation strategies they are hypothesized to influence are reported in Table 5.5 and then explicated below.

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Table 5.5. Clinician Behaviors Relating to Participant Conversation Strategies

Clinician Behaviors	Participant Strategies	1-31-12	2-7-12	3-29-12	4-3-12
Acknowledgments	*Recycle own turn multi-modality*	12	6	2	14
Agreements	*recycle own turn recast*	8	8	18	11
Embedded corrections		4	2	1	2
Anticipatory completions	*Recasting recycle own turn*	8	3	1	8
Verifications	*Recasting recycle own turn*	4	6	3	3
Assessments	*recycle own turn multi-modality laughter*	5	5	9	7
Humor	*laughter*	3	5	11	12
Inviting turn: verbal	*multi-modality laughter recasting*	6	11	6	8
Mimic / recast	*recasting*	1	9	5	2
Multiple modality turn construction	*multi-modality*	22	43	13	49
Positive contingent	*multi-modality*	11	20	20	13
Proxy turn	*recasting*	8	23	7	1

Acknowledgments. The clinicians used acknowledgments with regularity in Sessions One, Two, and Four. Many instances of acknowledgment served to manage topic and turn taking which may explain the decreased occurrence of acknowledgments in Conversation Three where the topics were of interest to the entire group who then took on more of the topic and turn management. The clinician's use of acknowledgments often preceded the participants' use of multiple or alternate modalities as well as verbal self-repetition to construct a turn-at-talk. The acknowledgment, though often in the form of a backchannel, became a first part of an adjacency pair that resulted in several conversation members providing similar acknowledgments. The participants often used recasting of the clinician's

acknowledgment token "yeah" or recycled their prior comment in response to the clinician's acknowledgment tokens.

Agreements. The clinicians engaged in agreement consistently across all sessions with an increase for the later sessions. Contiguous to their agreements in the form of nods, "yes", and full turn constructions, were the recycled turn constructions for emphasis and recasting part of the clinician's agreement turn to expand their prior turn as when Alan co-opted part of the clinician's response to expand on why Face Time® is a better application than Skype® for video chats.

Embedded corrections. Clinicians overwhelmingly embedded their corrections, as opposed to using exposed correction, orienting to the social, cultural constructs that favor preferred actions over dispreferred to support the "face" of each conversation member. As such, clinician's used embedded corrections for the talk of each other in addition to the talk of the participants. Embedded corrections took on only three forms which were anticipatory completions, clarification questions, and verification statements. Therefore while embedded correction is an important technique in establishing and maintaining the connectedness and trusting attitude that support group cohesiveness, it is the ways in which it is accomplished that most influence the strategy use of the participants. Therefore, discussion will center on the use of anticipatory completion and verification statements used by the clinicians.

Anticipatory completions. Anticipatory completion was used most often by Clinician Zero followed by Clinician One as both display personal styles that are more verbose. However, the use of anticipatory completion formed a pattern that was strategic; the primary uses being to demonstrate agreement or to embed correction of another's turn that had stalled or experienced word finding difficulty. Clinicians completed the utterances of other

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clinicians in addition to those of the members with aphasia. The appearance of an anticipatory completion often resulted in the use of other and self-repetition by the participants that took the forms of recasting for agreement, recasting for expansion, recycling a TCU to keep one's turn, recycling own turn for emphasis, and recycling own turn for self-repair.

Verifications. Similar to the pattern of use for anticipatory completion, it was Clinician Zero who most often employed verification statements. This may relate to personal communication style, but more likely is a technique developed over many years working as a clinician. Verification statements by the clinicians served the purpose of agreement, affiliation, and embedded correction. They were most often followed by an increase in the use of multiple modalities for the responses of the participants. Further, the participants often demonstrated recycled turn construction units for emphasis and for repair as well as recasted turn construction units to demonstrate agreement.

Assessments. While clinicians demonstrated assessments consistently across the sessions, it was not as frequently associated with conversation strategy use by the participants. There appeared to be a pattern of context influencing the participants' conversation strategies more than the clinician's assessments. Although, first assessments often invite second assessments, these did not occur with regularity among the participants. Their assessments related to either their participation in ongoing joint production or in a prior participation that they related to the group (Pomerantz, 1984). When instances of assessments occurred within multi-party conversation that was already tightly aligned with shorter turns and increased latching and overlaps, assessments were often associated with the use of multiple modalities and laughter, particularly when the conversation partners disagreed as in

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the discussion of the pros versus cons of high definition television. Only one case assessment resulted in a subsequent recycling of a participant's own turn to emphasize a point.

Humor. The clinicians increasingly employed humor over the course of the semester and this was likely an interactive relationship between itself and group cohesiveness; humor aiding in the establishing of group cohesiveness (Elman, 2007) and group cohesiveness resulting in increased occasions for humor (Greatbatch & Clark, 2003; Rothwell et al., 2011). However, like the use of assessments the effect of humor while demonstrable for establishing and maintaining group cohesiveness, becomes more elusive in creating opportunities for the demonstration of conversation strategies by participants. As expected, laughter was associated with humor in every session and on most occasions but served a compensatory purpose of turn taking only for Althea and another member of the group, who was not a research participant. The use of multiple modalities occurred sequentially to humor with increased frequency for conversation in Session Three where humor heightened participant engagement and resulted in quicker and shorter turns-at-talk. It could be the fast pace of talk and the suitability of the topic to visual displays that resulted in the increased use of multiple modalities, specifically facial displays and gestures. In only one instance did humor result in a participant using recasting of another's statement to agree.

Inviting turns. In an effort to establish the feel of discourse equality (Simmons-Mackie et al., 2007), the clinicians consistently used turn invitations through verbal, gestural, and gaze modalities. These invitations influenced the use of conversation strategies by providing opportunities for turn-taking. Invitations, also referred to as turn allocations, resulted in an increase in the use of multiple modalities as the participants marshalled their

resources to construct a meaningful turn in the conversation. It is likely that the multiple

modalities used in the construction of the turn invitation by the clinicians resulted in a similar

turn construction by the participants and other conversation members. Participants also

incorporated units of the clinician's talk from their turn invitation and recasted it to construct

their response. An additionally, but much less frequently, used strategy following turn

invitations was that of laughter as a turn taking device (Glenn, 1989; Madden et al., 2002).

Althea used this strategy appropriately in response to a proxy talk that also acted as a turn

invitation. By laughing she signified her agreement with the clinician's assessment of her

stance toward the necessity of owning a digital video recording device.

> *Multiple Modality Turn Construction.* Research has demonstrated that we engage in

gesture more often when our listener can see us (Clark, 1996; Kendon, 2004; Bavelas and

Chovil, 2001) and that we are likely to mirror and incorporate the gestures of another in an

authentic face to face context (Cheng, 2003; Stel, 2010). Just as clinicians employed multiple

modalities in the construction of their invitations, or turn allocations, they constructed their

self-selecting and self-continuing turns-at-talk with multiple modalities. The participants

employed multiple modalities in a similar fashion and for the same purposes. The clinician's

employed gesture, drawing, writing, and facial expression to support the participant's

comprehension but also to depict visual information that would supplement their talk as

when Clinician One used pantomime and facial display to recreate the shooting of a

champagne cork that hit him in the eye. They used repetitive gesture to highlight information

in their message as when Clinician Two demonstrated the throwing of paint or the pattern of

falling fireworks to relate her experiences at a cultural fair. The participants similarly

employed gesture and facial display to represent visual aspects of their talk and to take over

the primary mode of communication in conversation repair. On occasion group members reflected back identical gestures from not only the clinicians but each other, as when Althea incorporated Alan's gesture of holding up three fingers to indicate that television had only three channels when they were younger.

Mimicry and Recasting. Mimicry and recasting were used sporadically by the clinicians with the bulk of these behaviors occurring in sessions two and three. These related devices served the purposes of agreeing with the previous speaker, as a verification tool, and for humor. While the participants and clinicians often employed multiple modalities in their subsequent turns, it did not occur with enough consistency to attribute this clinician behavior to the expansion of that strategy. What is a more likely consequence of the clinician's use of mimicry and recasting is the adoption of the same practices by the participants but this cannot be definitively demonstrated.

Positive Contingent Response. One of the most frequently used techniques across the sessions analyzed, positive contingent responses by the clinicians, took the form of assessments, appreciative laughter, follow up questions, and agreements. The most interesting relationship occurred between positive contingent responses as assessments and the self-selected turns of the participants. The frequently occurring self-initiated turn selections by the participants were most often constructed through the use of multiple modalities and recycling their own speech. This pattern was apparent for both Althea and Alan who self-selected turns-at-talk just after the clinician's positive assessment of their prior talk, using multiple modalities to construct the subsequent turn. Positive contingent responses in the form of laughter functioned more as continuers during the ongoing talk of a participant or they marked the transition between speakers. As expected, the positive contingent

responses that formed follow up questions resulted in other-initiated turns-at-talk and while it was unanticipated, a pattern emerged where self-selected turns employed multiple modalities more often than other-allocated turns. It is likely that the follow-up question provided a linguistic resource for the verbal construction of the participants' turn-at-talk.

Proxy Turns. Proxy turns were employed by the clinicians to support the conversation turns of Althea and Jesse. While proxy turns were occasionally performed with reference to Alan, they were done so for humor, specifically teasing. The responses of the participants were often strategic with most responses employing multiple modalities. Althea often paired her verbal affirmation of the clinicians proxy turn with gesture and facial expression, while Jesse most often employed head nods and shakes with a yes, no, or "Hhh." Althea additionally employed recycling of her own turn construction units to emphasize her agreement with the proxy turn as well as recasting part of the talk in the clinician's proxy turn as agreement. Because the purpose of proxy turn for Alan was a humorous one, his responses were either "hah" or to ignore the talk.

So while it is apparent that both the participants and the clinicians used conversation devices strategically, the relationship between these co-occurring behaviors cannot be firmly delineated. Like conversation itself, the deployment of conversation strategies involves a myriad of variables acting on a dynamic event which makes establishing a causative relationship more problematic than a correlative one. Regardless of the relationship, the established group cohesiveness and the conversation strategy use did result in conversation changes over the course of the semester.

Conversational Changes

If the goal of conversation based therapy is to improve the functional communication abilities for persons with aphasia that allow them to engage in conversation more successfully, then it is particularly rewarding when those changes become apparent. This section will describe those patterns of change that occurred during group conversation therapy over the course of the semester. This will involve a discussion of the changes in how conversation was accomplished and the overall efficiency of conversation with regard to breakdowns and repairs. Because multiple interacting forces shape the trajectories of a conversation, this discussion will be situated within a discussion of the reciprocal influences of clinician on conversation and conversation upon clinician, clinician upon participant and participant upon clinician, as well as contextual factors.

Accomplishing conversation. As each of the participants oriented themselves toward the group as a valued member, they demonstrated a greater commitment and greater self-agency in constructing their turns-at-talk. This was largely accomplished by supplementing or repairing their talk with an additional or an alternate modality. They demonstrated additional resourcefulness, or creativity in their employment of laughter as a turn taking device and the verbal repetition.

Multiple modality turn construction. The use of multiple modalities in the turn construction of clinicians and participants alike showed a pattern of increasing occurrence over the course of the semester. The increased multiple modality turn constructions of participants resulted in fewer turns-at-talk requiring repair as well as a shift from other repair to self-repair, which will be described when talking about the changing shape of conversation. When looking at the use of multiple modalities as any combination of verbal,

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gestural, and facial display for participants and clinicians, there formed a general pattern of increased usage which is displayed in Figure 5.10.
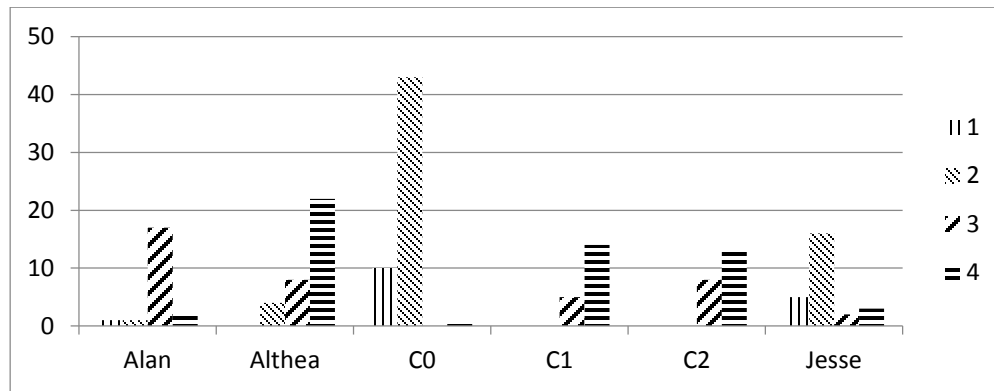

Figure 5.10. Multiple Modality Use across Clinicians and Participants

While Clinicians One and Two were present only in Sessions Three and Four, Clinician Zero facilitated Sessions One and Two and made a brief appearance in Session Four which accounts for the small number of multiple modality turns. The increased number of turns for Clinicians One and Two over consecutive sessions most likely relates to both learning to incorporate this facilitation strategy into their conversation turns as well as influences of increased comfort as a facilitator and the topics discussed. The participants likewise increased in the flexible use of multiple modalities. However, because the conversations analyzed contained differing number of turns-at-talk, the frequency for the use of multiple modalities is better expressed as a percentage of the total turn construction units. The pattern of gesture use, as well as facial display, for the participants is presented below in Table 5.6.

Table 5.6. Patterns for the Use of Gesture and Facial Display across Participants

Conversation Behavior	Alan				Althea				Jesse			
Dates	1.31	2.7	3.29	4.3	1.31	2.7	3.29	4.3	1.31	2.7	3.29	4.3
% turns gestured	0	1	19	2	0	28	16.3	30	52	58	33	100
facial displays	-	-	-	-	6	12	13	21	7	5	25	7

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Gestural usage. The use of gesture often supported conversation which preempted a conversation breakdown but when breakdown did occur, gesture often did the work of self-repair. Similar to persons with no brain injury, gestures were often used as the primary vehicle of meaning where in the participant cut off a speaking turn to complete the utterance with a gesture that more succinctly demonstrated a more complex and visually oriented idea (Schegloff (1984). While Jesse took so few turns that discerning a reliable pattern is problematic, Alan and Althea demonstrated increased use of gesturing with Alan's use of gesture forming a topic specific relationship. As the participant with the superior verbal ability it was expected that he would rely the least upon gesture, however when the topic of his talk oriented to visual content such as pets and television watching he dramatically increased his reliance upon gesture. However, the pattern of increased gesture use must be considered not only in terms of contextual influences but as related to functional factors as each participant demonstrated a change in modality specific processing from the beginning of the semester to the end of the semester; increasing in their raw score by at least one level on the *Porch Index of Communicative Ability* (PICA). The scores before and after group conversation treatment are listed in Table 5.7 for each participant.

Table 5.7. PICA Scores for the Gestural Modality across Participants

PICA percentile (score)	Althea	Alan	Jesse
Pre-treatment	18% (7.1)	47% (10.65)	65% (11.55)
Post-treatment	43% (10.4)	74% (13.425)	82% (12.65)

Similar to the findings for a study of group treatment for chronically aphasic persons reported by Bollinger et al. (1993), all participants in this study demonstrated significant improvement in processing for the gestural modality which may have influenced their

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increasing use of gesture to the same degree as the clinician's use of gesture, the other

member's use of gesture, and the developing group cohesiveness. If group cohesiveness

entails the relationships attendant to the group, namely client-clinician, client-client, and

client to group, then these same relationships may also influence the use of strategy by the

participants. Further, it is possible that conversation treatment improved gestural usage which

resulted in improved processing in the gestural modality and which then contributed to

increasing gesture use, in a reciprocal fashion.

Facial display. As can be seen in Table 5.6, both Althea and Jesse increasingly

employed facial display in the conversations during group treatment. Facial display served to

increase their participation through performing assessments and doing affiliation work

separate from its employment as a device for supporting speech in turn construction.

Therefore, there occurred a greater number of facial displays than turns in many cases. This

use as an alternative affiliating and identity shaping device was particularly important for

Jesse whose severely impaired language required him to orient to more visual modes of

communication. By pairing facial displays with non-speech utterances such as "pfff, ˜nhhh",

and "Hhhh", Jesse was able to convey affiliation through positive assessments and

agreements as well as disaffiliation through negative assessment and disagreement. He was

able to effectively use a non-speech production as a turn because of the meaning he attached

to it through his use of facial display. Additionally both employed facial display in repair of

conversation breakdown (Chovil, 1989), particularly when the repair was collaborated with

the clinician.

Creative turn taking. The participants demonstrated an overall increase in both using

laugher as a resource and using verbal repetitions in the form of other-repetitions, or

recasting, and self-repetitions, or recycling own turn construction units. The rate at which

verbal repetitions comprised their turns-at-talk as well as rate of laughter as a function of the

total turns taken in a conversation are reported in Table 5.8.

Table 5.8. Laughter and Verbal Repetitions across Participants

Conversation Behavior	Alan				Althea				Jesse			
Date of Conversations	1.31	2.7	3.29	4.3	1.31	2.7	3.29	4.3	1.31	2.7	3.29	4.3
Rate of laughter	.50	.20	2.56	.56	--	.22	1.95	.84	--	--	1.75	--
% Verbal Repetitions:	11%	4%	8%	10%	--	11%	25%	22%	5%	11%	33%	--
Recycled TCU	5	2	6	4	0	1	11	18	0	2	4	0
Recasting	2	0	1	0	0	1	1	3	1	2	0	0

Laughter as a resource. There occurred a significant increase in the instances of

shared laughter from the initial sessions compared to the later sessions. As was reported

earlier, this shared laughter served as an index of the growing engagement (Kovarsky et al.,

2009) as well as connectedness and trust (Simmons-Mackie & Damico, 2009) of the group.

The increased instances of shared laughter can be visualized below in Figure 5.11.
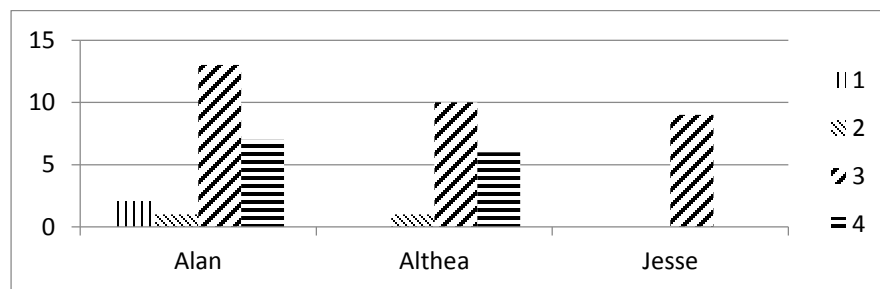
Figure 5.11. Instances of Laughter across Participants

However, the conversations did vary in length and number of turns taken so that in

order to compare the occurrence of laughter across conversations of differing length, the

number of instances for laughter was divided by the total number of turn construction units in

a conversation. For this reason, the rate of laughter ranged anywhere from 0.2 % to 2.56% of

the total turn construction units comprising a conversation; the specific rate for each participant in each conversation can be seen in Table 5.8. For all participants, an increased rate of shared laughter was apparent for the latter sessions representing the end of the semester. While it must be interpreted as related to the context in the form of conversation topic, laughter became a reliable index of growing group cohesiveness.

Verbal repetitions. A similar process was applied to the instances of verbal repetitions to allow fair comparison across sessions. While instances for the type of verbal repetition, recasted or recycled, is reported Table 5.8, the row above provides a percentage of verbal repetitions from the total of turn construction units for each participant. The increased employment of verbal repetitions, like laughter, will be influenced by topic but provides a general indicator of improved resourcefulness to accomplish conversation and reflects growing affiliation and commitment to working together among participants in the group (Simmons-Mackie et al., 2007; Simmons-Mackie & Damico, 2009).

Changing shape of conversation. Over the course of a semester of group conversation treatment, the shape of conversation changed with regard to turn-taking and repair of breakdowns. There occurred a progressive shift in who initiated the participant turns, who initiated and completed the repair of conversation breakdown, and how efficiently the conversation was repaired. The data supporting this pattern is presented below in Table 5.9 with an explanatory discussion to follow.

Approaching balanced turn taking. While it is true that the distribution of turns in a conversation is not fixed and should not necessarily be equal (Sacks et al., 1974), the excessive talking of one set of individuals over another may, at times, be considered problematic and this was discussed by Sacks et al. (1974) when they wrote:

When one member speaks, it takes time and attention from all other members of the group, some of whom may want to speak themselves. To take up time speaking in a small group is to exercise power over the other members for at least the duration of the time taken, regardless of the content. It is an exercise of power that may not coincide at all with the status position of the individual based on outside criteria, or even on special criteria developed within the group … (p. 711)

Table 5.9. Distribution of Turns and Repairs across Participants

Conversation Behavior	Alan				Althea				Jesse			
Total Turns	62	43	83	40	9	17	47	93	17*	34*	12	7
Turn Allocation Type												
TCU- Other initiated	12	9	8	13	7	13	12	15	6	27	8	2
% turns other initiated	19%	20%	9%	32%	77%	76%	25%	16%	35%	79%	66%	28%
TCU-self initiated	27	11	27	6	0	0	3	25	1 (1)	3	1	0
% turns self-initiated	80%	79%	90%	77%	22%	23%	74%	83%	64%	20%	33%	71%
Repair Type												
RT1	15	6	16	5	7	0	1	9	0	0	0	0
RT2	2	0	0	0	0	0	0	0	0	0	0	0
RT3	0	0	0	0	1	0	1	0	0	0	0	0
% repairs self-initiated and self-completed	70%	66%	100%	80%	100%	--	100%	90%	0%	0%	0%	--
RT4	0	0	0	0	0	0	0	0	0	1	1	0
RT5	0	1	0	0	0	0	0	0	0	3	0	0
RT6	4	1	0	1	0	0	0	1	1	2	2	0
NR	3	1	0	0	0	0	0	0	0	0	0	0
Total repairs	24	9	16	6	8	0	2	9	1	6	3	0
% turns requiring repair	38%	20%	19%	14%	88%	0%	4%	10%	11%	17%	25%	0%

For Jesse and Althea, who demonstrated the least turn taking of the participants, the clinicians brought them into the conversation initially through other-initiated turn allocations. Specifically, the clinicians employed proxy turns and direct questions to involve them in the conversation. Alan never required such facilitation and on occasion the clinician would need to insert a conversational turn to reduce Alan's continued self-selection as a speaker so that more members with aphasia could be involved in the conversation. For Alan, a decrease in the proportion of turns, specifically self-continuing turns, became a positive indicator of group cohesiveness. An illustration of the percentage of turns that were self-initiated is presented in Figure 5.12 with a discussion of turn initiation to follow.
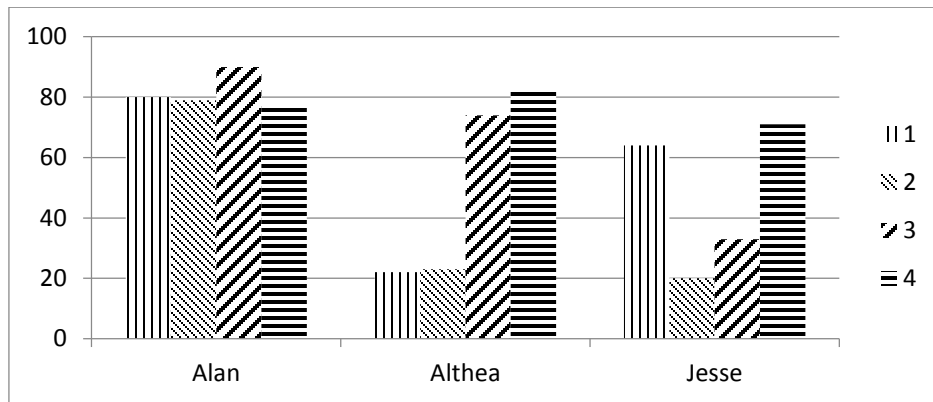
Figure 5.12. Percentages of Turns that were Self-Initiated

Althea's increased self-initiation. As can be seen in Table 5.9 and depicted in Figure 5.12, Althea demonstrated the most dramatic increase in conversation turns that were self-selected. This included turns to claim speakership subsequent to another speaker which is called self-initiated turns as well as turn construction units designed to continue her turn-at-talk. In addition, Althea increasingly used continuers which while not acting as a turn-at-talk allowed her to comment on the ongoing talk of another as well as demonstrate affiliation toward the speaker. We can see that as Althea increased the percentage of self-initiated

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utterances, she required less conversation support from the clinicians in the form of other-initiated turn allocations.

Jesse and self-initiation. Because Jesse took few turns, it is not possible to derive a pattern from his turns. However, the chart above would suggest that he increased the initiation of talk. The high number of self-selected turns in Session One reflects that 7 of his self-selecting turns, which are noted by parentheses, grew out of a ritualized introduction sequence. Jesse used gaze and gesture to regulate the order in which members introduced themselves to him. In Sessions Three and Four, Jesse used verbal and gestural means to initiate new information in his turn-at-talk. However, as stated before, because Jesse contributed few turns for each session and these turns were heavily supported by the clinician a conclusion of increased self-initiation while likely, cannot be stated with certainty.

Alan's decreased self-initiation. Alan who had no difficulty initiating a turn-at-talk demonstrated a shift in how much of the conversation was monopolized by him. Alan reduced the total number of turns he took in conversations while the rate at which clinicians allocated a turn to him through a question or a comment that was directed toward him remained steady. This demonstrated his orientation toward giving others an opportunity to talk. Alan further began to employ questions to direct turns to others.

Shifting conversation responsibility. As Alan was doing more conversation work through his turn allocations to others, the clinicians were doing less conversation work, shifting the responsibility for successful communication to the participants and other members with aphasia. Table 5.10 provides the data that supports the decreasing clinician facilitation in the form of turn taking.

Table 5.10. Distribution of Turns across Participants and Clinicians

Participant	1.31.12	2.7.12	Avg. Turn proportion	3.29.12	4.3.12	Avg. Turn proportion
Althea	2.2%	3%	2.7%	9.6%	13%	11.6%
Alan	16%	13%	14.3%	20%	6%	11.6%
Jesse	5%	7.6%	6.1%	2.3%	1%	1.5%
Total individuals with aphasia	58%	41%	48%	48%	52%	50%
Clinician Leader(s)	42%	49%	45%	35%	36%	36%

The initial sessions required increased clinician mediation in the form of turn allocations, verbal and gestural turn invitations, as well as turns used to either pre-empt conversation breakdown in the form of anticipatory completions, agreements, and proxy turns. Clinician turns also were necessary for collaborating in the repair of conversation during times of breakdown through the use of embedded correction. The result of this however, was a less balanced conversation where the clinician exerted more power through her increased rate of turn taking. This made the increasing use of humor essential to encourage the shift from a clinician centered conversation to a more egalitarian one. As clients increased their rate of self-selected turn taking and ability to self-repair, the clinicians were able to approach a more balanced rate of turn taking which created the feel of discourse equality (Simmons-Mackie et al., 2007). The shift in conversation from clinician centered is apparent in the decreasing percentage of turns taken by the clinicians and the percentage of clinician free dyads between the first session and the final session which is presented in Table 5.11.

Table 5.11. Rate and Length of Clinician Free Dyads for Turn-Taking

Session Date	1-31-12	4-3-12
Rate of clinician free turns	15.1%	23.6%
Average Turns in a Sequence	2.16	2.62

By the end of the semester the percentage of turns in the conversation that were not clinician dependent increased significantly. By saying the turns were clinician free, it is meant that they were not initiated nor responded to by the clinician, involving only members with aphasia. In addition to this the number of turns in a sequence that did not involve the clinician increased. Both indices demonstrate a decreasing reliance upon the clinician for a successful conversation.

Increasing client self-agency. The largest reason for the decreased reliance on the clinician for turn taking was the increased self agency of the clients through their turn initiations, turn allocations, and through their increasing facility with regard to conversation breakdowns. Althea and Allen demonstrated decreased breakdowns as well as increased self-repair. Because most of Jesse's turns were either automatic speech or non-speech sounds supported through gesture and facial display, fewer turns required repair. However, all repairs that were required were completed by the clinicians.

Decreasing breakdowns. It is apparent from Table 5.9 and Figure 5.13 that both Alan and Althea showed reduced communication breakdown in their conversation. Alan demonstrated a decline in conversation breakdown from 38% of turns in Session One to 14% in Session Four. Althea also demonstrated a decrease where in Session One 88% of her responses required repair compared to only 10% in Session Four. However, in Session One she contributed only nine turns so the need for repair in eight of them resulted in a very high percentage. In Session Two, where Althea did not experience breakdown in conversation 13 of her 17 turns were allocated to her by the clinician and this action supported her linguistic formulation as evidenced by her use of recasting the clinicians talk. The fact that Sessions Three and Four show decreased breakdowns in conversation and that most of her

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conversation turns were self-initiated, requiring greater linguistic ability, is quite significant. While Jesse appears to have increased the rate of conversation breakdown, he also increased the rate of self-initiated turns-at-talk which, as previously stated, require greater linguistic resources.
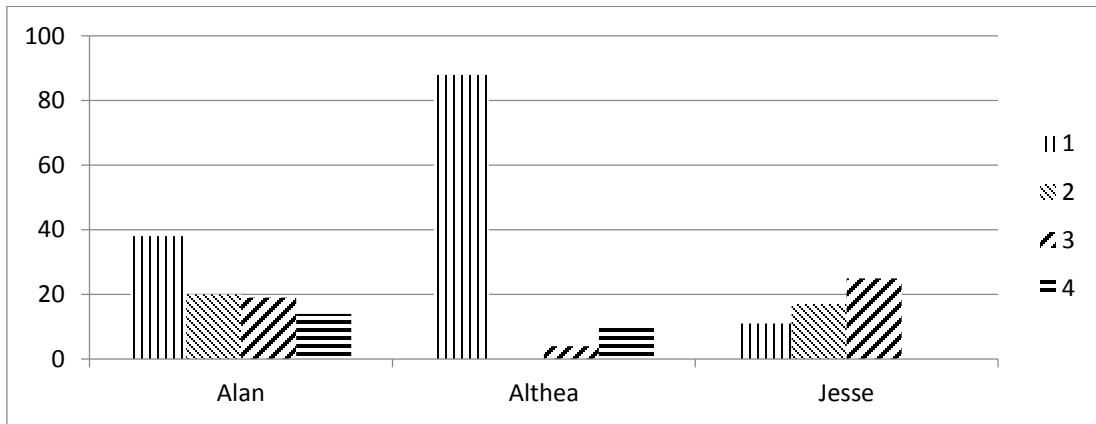

Figure 5.13. Rate of Conversation Breakdown across Participants

Improved self-repair. While all of the conversation breakdowns experienced by Jesse required clinician repair, Alan demonstrated increased self-repair; Althea's pattern of self-repair remained consistent. The visual representation of this can be seen in Figure 5.14. This is significant for both Alan and Althea because while Althea's rate of self repair did not appear to change, the types of turns she was taking did change. With increased self-selecting turns for gaining and continuing speakership, she had increased linguistic demands to construct her turn-at-talk. She initiated self-repair for all of her breakdowns, with only one requiring clinician completion. Alan not only increased his percentage of self-repair, he relied increasingly less on the clinician and he completed his self-repairs more quickly. Borrowing from Van Lier (1988), the conversation repairs were categorized according to who initiated and who completed the repair, as well as how quickly a self-repair was performed. In the first conversation, Alan's turns-at-talk required a total of 24 repairs for

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which 70% were initiated and completed by him. He completed his repairs within the same turn construction unit (RT1) for 15 of them and just following the turn construction unit (RT2) for two. However, he requested assistance for four breakdowns and no repair (RT6) occurred for three breakdowns; although the context sometimes supported meaning construction despite the breakdown. Analysis of the final conversation revealed that all of his self-initiated and self-completed repairs occurred at the most expedient position in the turn construction unit (RT1) and that he requested assistance (RT6) only once. Further, there were no instances where a breakdown was left unrepaired.
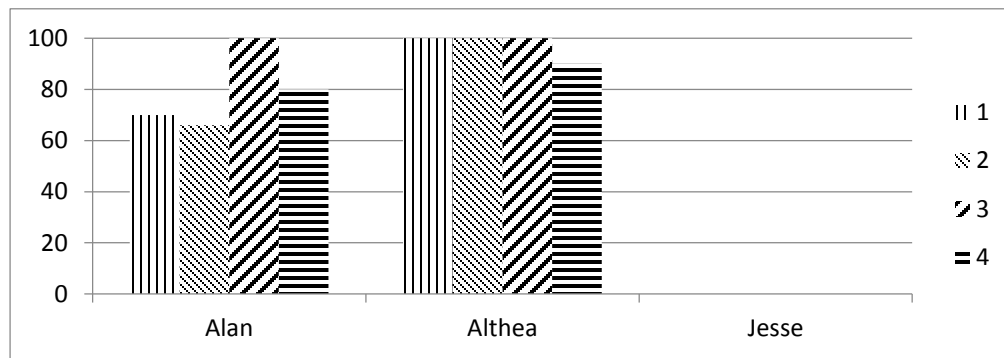
Figure 5.14. Percentage of Self-Repair across Participants

It is apparent from the conversation changes detailed above that the participants were able to assume greater responsibility for the achievement of conversation, they oriented to a feel of discourse equality, and they were able to more independently repair conversation when things went awry.

Summary of Group-Level Findings

This chapter distilled the behaviors related to group cohesiveness in conversation that were shared by participants and presented them as situated within a greater context of clinician influence, conversation topic influence, and personal factors such as language ability and orientation toward group affiliation.

Findings across participants indicated that all participants and the clinicians oriented to group cohesiveness in differing degrees and in differing capacities. Althea demonstrated the greatest orientation toward group cohesiveness; through both interpersonal liking and through task commitment. Jesse represented the extreme opposite end of the continuum with much less behaviors that indicated group cohesiveness; he was far less affiliative and less engaged in the conversation than Althea. Alan's demonstrations of group cohesiveness fell between the two.

Participants also demonstrated conversation strategies that helped them accomplish group cohesiveness. Many behaviors such as shared laughter, humor, agreement, and overlap formed uniform strategies for accomplishing group cohesiveness while other behaviors such as affiliation tokens were used by the two participants that demonstrated decreased verbal facility. There emerged a relationship between language facility and the strategies employed to achieve group cohesiveness.

However, all participants experienced conversational changes. Some of these changes reflected more balanced turn-taking among the participants while other changes resulted in shifting of the conversational responsibility. The participants, namely Althea and Alan, increased their percentage of turns-at-talk relative to all turns in a conversation and this related to decreased clinician turn taking. Further, Althea and Alan demonstrated increased self-agency and efficiency in their conversation through the reduction of conversation repairs needed in their turns-at-talk and the positioning of their repair more contiguous to the site of conversation breakdown.

The chapter to follow, Chapter Six, will explicate these findings in terms of the research question and its attendant sub-questions. Further, implications of the findings related to the manifestation of group cohesiveness in conversation therapy will be addressed.

CHAPTER SIX: Conclusion

This idea for an investigation of the manifestation of group cohesiveness in group conversation treatment arose out of decades of working with persons with aphasia and years of using conversation as the primary therapy vehicle. The researcher's experience in the treatment of individuals with aphasia, which included family training and counseling as an important component of communication rehabilitation, helped shape the questions of interest that this research strove to answer. As the result of practical experience and reading relevant research, the researcher acknowledged that, like therapeutic alliance, group cohesiveness was integral to achieving the best possible outcomes in group treatment. Therefore, with a vague notion of how group cohesiveness might be achieved and with less awareness of how one might recognize it in conversation, an odyssey of what felt like Herculean proportions was begun. The findings were sometimes surprising, often validating, and always interesting. The results reported in this chapter should contribute to a growing body of research into how conversation as a therapy vehicle holds the greatest promise for out-of-clinic functional gains in communicative ability and provide new insight into how the exploitation of group cohesiveness contributes to the achievement of improved quality of life through communication. By adapting the marketing slogan of BASF®, it could be said that group cohesiveness doesn't make for therapeutic outcomes, it makes therapeutic outcomes better.

As described in Chapter Three, this research project investigated the conversation of three individuals with aphasia situated within group conversation treatment facilitated by clinicians. This investigation relied upon an orientation toward qualitative methodology as the most appropriate line of inquiry, with its attendant tools, to answer the questions of how group cohesiveness is manifested and accomplished in conversation. The tools to accomplish

this inquiry included videotaping of contextualized conversation treatment with subsequent analysis using Conversation Analysis, administration of standardized aphasia evaluations, and review of archival documents. In addition, and as lamination, the participants and the facilitating clinicians were interviewed to obtain their perceptions of group cohesiveness and group conversation treatment as related to their communication.

It is hoped that the chapters leading to this final one have presented a clear and detailed picture of the related concepts of aphasia treatment, group treatment, group cohesiveness, and how those concepts united in the semester of conversation treatment for the participants upon which this investigation is based. This chapter, then, will attempt to extend those findings to not only conclusively answer those specific questions posed at the outset of this endeavor but also to address issues of how we conceptualize and achieve group conversation treatment and the resultant implications for the field of aphasiology. True to qualitative methodological assumptions, these findings will be also viewed in light of the potential limitations inherent in the study of a complex phenomenon and directions for future research will be suggested.

Group Cohesiveness Manifested in Conversation

An in-depth examination of the conversation of the participants who demonstrated varying profiles of aphasia resulted in the finding that there exist multiple ways to demonstrate group cohesiveness, which can also be considered group affiliation and group engagement. Further, it was found that the conversation behaviors demonstrated by IWAs are the same used by non-impaired persons in a conversation. One question guiding the research was, *how do IWAs demonstrate group cohesiveness?* The simple answer is that there occur some behaviors that universally indicate the participants increasing group cohesiveness while

other systematic behaviors arise from an individual's unique interaction between personal and contextual factors. To expand on this, those behaviors that universally demonstrated group cohesiveness will be discussed first.

Universal indicators of group cohesiveness. There are many behaviors in conversation that occur reflexively with no planning or conscious effort on the part of the interlocutors; *eye gaze* appears to be one of these. For the participants whose gaze could be consistently viewed on the video-recording, gaze pattern became a reliable indicator of their relative engagement in the conversation. For Althea it was the absence of gaze as she sat with her head bowed and eyes fixed upon the table or closed that indicated her lack of engagement. Jesse demonstrated a strong pattern of disengagement with his gaze focused on the window, the table or, more frequently, the door or his watch. His gaze communicated a preference to end the group conversation and walk out the door. Over the course of the semester both demonstrated a significant shift in gaze direction; now occasionally directing their gaze toward the speaker or a shared referent. Their gaze demonstrated increased engagement with the increasing occurrence of anticipatory gaze shift which indicated that they were following and interested in the conversation as they looked to another member in anticipation of their taking the next turn-at-talk. Further, affiliation or liking for the group was demonstrated by both through inclusive gaze where they shifted gaze from speaker to at least two other members in quick succession.

An additional reflexive conversation behavior, and one that was unanticipated by the researcher, was the increase in the *overlapping of turns-at- talk*. All three participants demonstrated an increased rate of occurrence for initiating talk prior to the current speaker's termination of talk. Overlap is a common occurrence in the conversation of non-impaired

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individuals and while it occurs frequently it is a brief event, with one party or another repairing through the cessation of their turn (Sacks, Schegloff, & Jefferson, 1974). Attending to both characteristics of turn-taking in non-impaired conversation, overlaps in the conversation of IWAs were also brief and similar devices for managing overlap were apparent with the use of cut offs, recycled turn beginnings, and elongated words forming the bulk of repair devices used by the participants. It is likely that with increased group cohesiveness, increased topic interest and linguistic alignment occurred which resulted in the shrinking gaps between turns and the jockeying for self-initiated turns-at-talk. The occurrence of overlap, then, when demonstrated by a majority of individuals in a group becomes a positive indicator of group cohesiveness.

Inherent in group cohesiveness is social affiliation and this is frequently evidenced through *tokens of agreement* that can be performed verbally or through visual channels. Agreement tokens were demonstrated by all individuals, even in earlier sessions, but the rate of their employment increased over the semester and for Althea and Alan a shift in the proportion of nodding versus verbal agreements occurred with these affiliative actions becoming increasingly demonstrated through spoken word. Agreement with the talk of another person provides evidence of agreement with another's stance and, as such, implies affiliation for the person and their talk. The affiliating quality of agreement makes it a reliable indicator of group cohesiveness, not only for the participants in this study but for members of task-based small groups (Haughton, 2009).

Humor and its associated shared laughter formed one of the strongest indicators of an increasing orientation to group cohesiveness with significantly increased demonstrations of both for all participants for the latter sessions. Shared laughter and humor have both been

shown to provide evidence for growing affiliation among various groups. In previous research, for example, students and city councilman both demonstrated cohesiveness through their increasing shared laughter (Haughton, 2009). Among stoke survivors, humor acts as a curative influence to ameliorate stress and frustration by "re-asserting autonomy and self-esteem and maneuvering social distance by pointing to boundaries and creating, confirming, or denying allegiances" (Heath & Blonder, 2003, p. 104).

The above behaviors that universally indicated an orientation to group cohesiveness shared an overriding common feature; they could be *accomplished either verbally or non-verbally*. It is the flexibility in how the behaviors could be demonstrated that created their strong utility. Some of these behaviors were less dependent upon linguistic prowess as eye gaze required no verbal production and agreement could easily be performed with a nod or a wink. Humor while produced most often by the participant with the greatest verbal skill could also be accomplished non-verbally with a gesture or facial expression and could be accomplished with minimal verbal formulation such as in imitation or through the use of automatic speech.

Group cohesiveness manifested through participant-specific demonstrations. Individuals with aphasia do vary in their profile of ability and disability. Further the impact of this disability varies across and within individuals based upon the contextual forces surrounding the communication event. The International Classification of Functioning, Disability, and Health, the World Health Care Organization (2001) aptly conceptualizes this complex amalgam of forces to create individual barriers and compensations that result in a participant's unique demonstration of group cohesiveness when they state "an individual's

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functioning in a specific domain is an interaction or complex relationship between the health condition and contextual factors (i.e. environmental and personal factors) (p.19).

Interaction between language impairment and personal factors. Chapter Five described how personal factors such as a person's verbal facility or inclination toward social interaction contributed to the devices used to demonstrate group cohesiveness. While Althea and Jesse relied more on facial expression and head gestures to demonstrate group cohesiveness through an increasing occurrence of affiliation tokens and negative assessments that were positively affiliating, Alan demonstrated few to none of these indicators; instead relying on agreements and humor that were accomplished verbally . Personal factors such as personality and attraction to social ties interacted with Althea's improving communication ability to result in the increased demonstrations of assessments (both positive and negative) and continuers while Alan and Jesse who reported themselves to be more solitary demonstrated very few or none of these behaviors.

Few studies have examined how the constructs of aphasia as an impairment of "functioning and disability" and the personal and environmental factors that form the "contextual factors" interact to result in an individual's quality of life but the findings of these studies largely reflect the methodology applied to the research. An investigation into relationships between the language disability and quality of life for chronically aphasic adults that employed formal assessments and checklists to investigate both impairment and quality of life did not yield significant findings (Ross & Wertz, 2002). An earlier study that investigated the consequences of aphasia on chronically aphasic persons and their relatives and friends found interactions between an aphasic person's disability, their personal factors such as coping strategies, and environmental factors relative to their quality of life (Le Dorze

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& Brassard, 1995). These disparate findings afford an excellent example of the effect a researcher's methodology can have upon their findings. Whereas Ross & Wertz (2002) can only, with credibility, assert that their subjects did not demonstrate a relationship between decontextualized language ability and pre-conceived indices of quality of life, Le Dorze & Brassard (1995) can claim that from the perspectives of individuals with aphasia, and those persons that form their social network, there exists a relationship between language impairment and the contextual domain of personal factors and environmental factors, that results in differential quality of life. To use their own words,

> aphasic participants' language disabilities are the major cause of handicaps; in fact they negatively influence situations involving communication, alter interpersonal relationships, provoke a loss of autonomy, restrict activities and trigger stigmatization. (p.329)

In the present investigation there appears to be a similar interaction between the participants' language impairment and personal factors in the selection of behaviors as well as the frequency for which these behaviors occur to demonstrate group cohesiveness. Alan's relative facility with the verbal modality afforded him more flexible and demonstrable ways to indicate group cohesiveness. Althea, who possessed a large social network and a desire to affiliate and was more oriented toward interpersonal relationships, demonstrated greater frequency of affiliating actions, particularly those actions that were not as dependent upon linguistic prowess. In Jesse, severe language disability as well as personal factors conspired to present an individual who demonstrated the fewest indices of group cohesiveness.

Interaction of environmental factors with personal factors and disability. While an individual's profile of language impairment with its relative strengths and weaknesses across

modalities (along with personal factors such as their premorbid level of sociability) conspire to determine communicative success, the environment in which these factors are situated forms, perhaps, the greatest constraint or support for successful communication. The environment, as described in Chapter Three, was that of a large treatment room with a window, door, clock, camera, and table around which the group members and facilitating clinicians were seated and these all worked to support communication through co-presence and as references for directionality and temporality. Of the aforementioned environmental factors, the impact of the facilitating clinicians yielded the most influence upon the participant's demonstrations of group cohesiveness which informs the research question, *how does the behavior of the clinicians foster group cohesiveness?*

As discussed in Chapter Five, the demonstrations of cohesiveness by the clinicians were examined with reference to sequentiality and local negotiation; this means that the subsequent participant behaviors were analyzed along with the clinician behaviors as part of the local context to determine what if any impact the clinician's demonstration of group cohesiveness had upon the behaviors of the participants. Many of the demonstrations of group cohesiveness by the clinicians were the result of their adherence to socio-cultural norms of conversation that promote positive identity for self and others (Goffman, 1967; Lerner G. , 1996). Overwhelmingly the occurrences of these indices resulted in similar demonstrations by the participants in subsequent turns-at-talk. The clinician's demonstration of acknowledgment tokens resulted in participant affiliation through these tokens and their use of assessments was related to the participants increased use of the various strategies that advanced this function. Some clinician behaviors that evidenced group cohesiveness resulted in the occurrence and increased usage of other indices of group cohesiveness demonstrated

subsequently. For example, as has been reported in other research, humor and laughter formed an adjacency pair (Heath & Blonder, 2003). The clinician's humor, in all but one case of poor taste, resulted in shared laughter by at least two of the three participants. However, the interaction between clinicians and participants in the evolving group cohesiveness is not a unidirectional one and so the effect of the participant's demonstrations of group cohesiveness upon the clinician's behaviors must be considered as should the relationship between the behaviors themselves and group cohesiveness. In the case of humor, it was clear that while humor aided in the establishment of group cohesiveness, group cohesiveness supported the increasing opportunity and deployment of humor which was then appreciated through shared laughter.

Topic as an environmental factor. Conversation is conceptualized as a free exchange of turns for a mutually agreed upon topic in which each party has equal rights for turn-taking. However, the term conversation is also used flexibly and "can accommodate a wide range of situations, interactions in which persons in varieties (or varieties of groups) of identities are operating" (Sacks, Schegloff, & Jefferson, 1974, p. 699). This opens up a Pandora's box allowing multiple events to use the descriptor of conversation; storytelling, teasing, interviewing, ordering, to name a few. Conversational context and environment do constrain the form that a conversation will assume and which rules of conversation are followed more literally, such as the participants rights to equal opportunity of turn-taking and that what participants say is not specified in advance (Wilson, 1987). It became apparent through the analysis of the four conversations that *topic* similarly influences conversation and the manifestation of group cohesiveness within conversation; that it interacts with the socially constructed norms of conversation. In other words, it is through topic initiations and

responses that participants often construct their identities and establish intimacy or distance. Additionally, it is an accepted socio-cultural norm that new topical talk is introduced systematically and sequentially and is responded to as such with repercussions for violation of this expectation (Goffman, 1967; Grice, 1975; Maynard & Zimmerman, 1984; Wilson, 1987).

In the early sessions where participants were only acquaintances, much of the conversation was spent in the pursuit of initiating topics through the use of pre-topical sequences (Schegloff & Sacks, 1973). The result was minimal turn initiation on the part of the participants as they contributed short responses that demonstrated short-from replies without return questions (Maynard, 1980). This afforded little demonstrations of group cohesiveness as would be expected. Therefore, in the final sessions, by which time the participants had amassed a significant amount of shared knowledge and contributed a large amount of identity shaping discourse, a stark contrast became apparent between mutually interesting topics that emerged naturally and sequentially and those topics whose initiations were more explicit. The topics, initiated by the clinicians, for which there was less mutual interest, were short lived being characterized by decreased self-initiation of turns by the participants, short responses, and decreased use of gesture or facial display. The topics that extended several turns and involved more participants were those that emerged as a transition from the pre-topical sequences of the clinicians where a member with aphasia produced the topicalizer, taking advantage of the content of the clinician's proposition but focusing on a different element of the turn-at-talk (Wilson, 1987). This supported both the tenet that what a person will say is not specified a priori and the equal rights to conversation for all participants.

While some pre-topic sequences led to satisfying conversation, others resulted in stilted and awkward transactions of information. When the clinicians oriented to mutually shared knowledge and accumulating common ground while preserving the sequentiality or adjacency of the new topic initiation, however, a more balanced and equitable appearing conversation occurred and was marked by facial expression and gesture as indicators of engagement. This pattern objectively elucidates the need to consider topic as a contextual variable to be accounted for in both research and rehabilitation of individuals with aphasia.

Group cohesiveness as a multi-dimensional construct. The patterns for the demonstration of group cohesiveness that were unique to an individual participant brought into focus the short-comings of an all-inclusive definition of group cohesiveness.   As was described in Chapter Two, researchers have predominantly characterized group cohesiveness as the resultant forces that act upon an individual to be attracted to and remain in a group, as the "espirit de corps" of a group, as involving all relationships in a group, and as the Group-Level equivalent of therapeutic alliance. The commonality shared by these conceptions of group cohesiveness is the lack of flexibility in the framework to account for individual differences. It was clear from the conversational demonstrations of affiliation and engagement -- and then verified through her post-semester interview -- that Althea differed from Jesse and Alan in her level of interpersonal attraction to the group. Multiple studies of group cohesiveness contrast interpersonal cohesiveness and task cohesiveness through the design of their studies (Dinger & Schauenburg, 2010; Goette, Huffman, & Meier, 2006; Zaccaro & Lowe, 1988) but it was Zaccaro (1991) that contrasted task cohesion with interpersonal cohesion and found that task cohesion drove group processes to a higher degree and was more positively correlated with role certainty and negatively correlated with

absenteeism. Since that time additional researchers have incorporated tasks and goals of both members and the group as a whole into their conceptualization of group cohesiveness (Johnson, Burlingame, Olsen, Davies, & Gleave, 2005; Schechtman & Katz, 2007) and the primacy of task cohesion as driving interpersonal cohesion has been reported (Mullen & Copper, 1994). The participants in this study demonstrated equal attendance which is consistent with the primacy of the commitment to task that is inherent in task cohesion. They demonstrated differences in both how often and through which means they demonstrated affiliation and engagement which implies that they differed in their levels of interpersonal cohesion. So while we were dealing with a whole phenomenon of group cohesiveness, as a construct it can be divided into at least two varieties: those that are mediated by the task and those that are mediated by interpersonal factors. It is problematic to separate the two but there appears to be enough differentiation in the data to suggest that the division seems to be sustainable. Zaccaro has talked about this extensively within the field of psychotherapy; however in aphasia treatment we are not dealing with individuals whose concern centers on emotional and thought processes but, rather, we are dealing with established goals for improved communication that uses a collaborative task, conversation, as the vehicle so the construct of group cohesiveness may look different.

Conversation Changes Related to Group Cohesiveness

Over the course of a semester's group therapy participants both evidenced growing group cohesiveness and changes in conversation for each of the participants. The findings of this research then answered the research question, *what are the possible conversational changes that occur over the course of a semester?* Additionally they informed the related

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question, *how does the pattern and distribution of conversation strategies used by participants change over a semester of treatment?*

Increasing self-agency. The participants uniformly demonstrated some *increase in their self-agency* as competent members of conversation. Through their resourceful use of additional or alternate modalities and their creativity in the employment of laughter or verbal repetition as a turn taking device, they increased their self-initiated turns-at-talk. They increasingly oriented to strategies to construct meaningful turns-at-talk and to self-repair problematic turns-at-talk with the utmost efficiency. The resultant increase in participation for the group conversation formed an indicator of increasing group cohesiveness (Haughton, 2009). The participants, particularly Althea and Alan, took more responsibility for initiating, transitioning, and maintaining topic; they performed a greater amount of conversational work. As participants in conversation construct their identity through discourse (Maynard & Zimmerman, 1984; Schenkein, 1978), the increased agency with which the conversation turns were created and repaired resulted in the formation of improved identities as competent communicators. In turn, this increasing self-confidence in conversation begets a positive cycle by which the participants take greater risks in the constructions of turns-at-talk and reap the rewards of successful communication which inherently rewards the effort, thus encouraging the cycle to continue.

Decreasing clinician mediation. Conversation is constructed turn-by-turn and with the additional principles of which party talks next as well as what they say never being specified in advance (Sacks, Schegloff, & Jefferson, 1974). Consequently, the logical extension of the participant's increased self-agency is the decreasing need for clinician mediation. Initial sessions required extensive clinician work to establish topic, maintain

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topic, and to include participants to the extent they were able to participate. Further, the clinicians had to sensitively navigate problematic talk by engaging in collaborative repair that would maintain the participant's competence as well as ownership of their turn-at-talk. The clinicians accomplished this through their demonstration of conversation strategies such as multiple modality turn construction, self- and other-repetition, and inviting assistance. As the participants increased their self-initiated turns and self-repair of problematic turns, the clinicians were able to assume less of a facilitator role and more of a conversation member role; they reduced their mediation of topic and talk. This has huge implications for the clinician-client relationship which is often grounded in disequilibrium of power. The initial topic work that had to be performed by the clinicians contributed to a power differential in which the clinicians through topic initiation, or choice, constrained what parties would say and who would speak next. When the participants were able to initiate, maintain, and close topics the previous power inequity was diminished. This along with the use of humor created a sense of togetherness and equality that supported the identity construction of participants through their conversation turns.

Related to the decrease in turn taking for topic management and or conversation repair, clinicians decreased the use of mediational techniques. Initial sessions were characterized by increased usage of techniques such as embedded corrections, anticipatory completions, verifications, turn invitations, and proxy turns. The participants became more adept at initiating, constructing, and repairing their turns-at-talk through the use of strategies such as multiple and alternate modalities, self- and other-repetition and laughter as a turn and this mitigated the necessity of clinician mediation for successful conversation. These

clinician actions and the resulting participant behaviors inform the research question, *how does the behavior of the clinicians result in a change in conversational strategies?*

Expanding Our Definition of Authenticity in Therapeutic Tasks

Through the review of the literature in Chapter Two, it was demonstrated that the field of aphasiology has become increasingly oriented to the positioning of assessment and treatment of aphasia within an authentic context. Researchers have demonstrated the impact of context upon the communicative behaviors of individuals with aphasia through natural conversation therapy (Basso, 2010), training supportive communication partners (Kagan, 1998; Kagan et al., 2001; Lyon et al., 1997), the impact of "aphasia friendly" reading materials (Brennan, Worral, & McKenna, 2005), and specific conversation training (Booth & Perkins, 1999; Wilkinson et al., 2010). However, with the wide variety of forms that conversation can take (Sacks, Schegloff, & Jefferson, 1974) determining what constitutes an "authentic" conversation becomes an exercise in semantics. There are multiple forces that shape conversation and influence its form; the opportunities and limitations for turn-taking, the devices for social intimacy or distance, and the strategies that an individual with aphasia can deploy for the successful construction of a turn. A general framework of what constitutes an authentic conversation then needs to be formulated that takes into account some of these forces. Through the course of this investigation and the analysis of both the primary data (the transcripts of video-taped conversation) and the secondary data (the post-semester interviews and artifacts) it became clear that conversation in a group looked different than conversation in a one-to-one dyad. Further, by looking at the confounding influence of topic it became clear that group conversation sessions were characterized by moments of contrived conversation as islands within authentic conversation.

One-to-one conversation compared to group conversation. The most obvious difference between the one-to-one conversation that occurred during individual treatment sessions and the multi-party conversation that comprised the group treatment sessions was that of turn-taking. The socio-linguistic climate of an individual session dictates who will speak next as conversation takes an alternating order that begins with the first part of an adjacency pair. This is not to say that self-initiation doesn't occur, it can in the form of interruptions and gaps in conversation, but the climate of the individual treatment session does not support the same frequency of self-initiation that a group treatment session affords. However, for the occasions of self-initiation by individuals with aphasia, the one-to-one context is much less competitive and for persons with limited verbal ability, like Jesse, the two-person dyad facilitated verbal, gestural, and written initiations for turns-at-talk.

Another difference appeared in the linguistic devices and compensatory strategies for participants that predominated one setting over another. While the use of multiple modalities as a compensatory strategy was stressed in both contexts, it was in the individual session that Jesse would routinely rely on writing and drawing to successfully construct a conversation turn. Alan relied on the strategy of "requesting assistance" routinely in the individual session as he oriented to the principle of least collaborative effort. The one-to-one conversation resulted in a quicker exchange of turns and quicker amassing of common ground through shared bases which afforded Alan the strategy of requesting assistance through using facial expression and intonation which resulted in a repair that was situated within his continuing turn-at-talk. Clarification questions were more predominant for all participants in the one-to-one conversation where the action would be less stigmatizing to the participant as a potential demonstration of conversational incompetence. Linguistic devices demonstrating Alan's

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affiliation toward the talk of the clinician were plentiful in the post-semester interview where he repeatedly demonstrated agreements, acknowledgement tokens, and anticipatory completions of the clinician's turns-at-talk. These affiliatory devices were greatly reduced for the group conversation where the turn-taking was not as tightly coordinated.

However, in group, all participants demonstrated increased use of self- and other-repetitions in the construction of their turn-at-talk. It is likely that the collaborative nature of group conversation with the multiple models of strategy use and varied turns-at-talk formed a linguistic resource for accomplishing verbal repetition that was situated within the context of the ongoing talk. A demonstration of affiliation that occurred more often in group than individual treatment was that of humor. This is not surprising because of the relationship between humor and shared laughter that forms an adjacency pair (Hay, 2001). Without a sufficient audience to appreciate the performance of humor, it becomes less socially rewarding.

It has been demonstrated by persons with aphasia that strategy use is flexible and context sensitive (Simmons, 1993; Simmons-Mackie & Damico, 1995). The impact of the conversational context then constrained the decision of which strategies and indices of group cohesiveness could and would be demonstrated with one-to-one and multi-party conversation contexts providing differing environments for the preference of some compensatory strategies and affiliatory devices over others.

Achieving authentic conversation in group treatment. The influence of topic on the authenticity of conversation has already been discussed as it relates to how the clinician's influenced group cohesiveness and conversation strategy usage. It was asserted that how topics are initiated constrains the direction the conversation will take (Maynard &

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Zimmerman, 1984; Wilson, 1987) and this contributes to the feeling of authenticity within the conversation. The responses to pre-topical sequences and topic initiators provide the most reliable barometer as to whether a conversation has naturally emerged as an agreed upon topic of mutual interest or a contrived transaction of information.

In conversation group therapy the vehicle for improved communication is conversation; that is the task set before all members of the conversation group. Therefore, from the outset of group conversation treatment an expectation of conversation participation was present which violates, to some degree, the principle of equal rights in conversation where which parties shall talk is not specified in advance. This expectation of conversation is reinforced by the turn allocation techniques employed by the facilitating clinicians to encourage the participation and identity shaping discourse required to achieve improved communication and group cohesiveness. This characteristic of the group conversation treatment was brought to the researcher's attention by the participant with the greatest verbal facility and who, not surprisingly, was not oriented to interpersonal affiliation. It was during the post-semester interview that Alan brought this important distinction to light when he said

> whereas you try to say something in this group- you try to say- I don't think I ever
>
> with that attitude with with the group(.) where as I- in real life I would probably (1) d-
>
> … In the group, there there- it's understood that you will make that commitment to
>
> saying what you want to say (Appendix B-I at 1:04:51).

Because conversation can take a variety of forms, then the group conversation treatment constitutes one form on the continuum of informal to formal speech (Schegloff, 1968; Wilson, 1987). By recognizing the expectations of participation and the constraints of topic initiation among groups who initially have little common experiences (Maynard &

Zimmerman, 1984), the alternating conversational talk and more stilted, awkward talk becomes inherent in this speech genre. However, as clinicians pursue group cohesiveness through conversation, they amass the common ground in the form of shared experiences and joint knowledge (Clark, 1996) which decreases the need for the often times awkward pre-topical sequences and topical initializers that mark conversation as contrived (Maynard & Zimmerman, 1984).

The pursuit of common ground by the facilitating clinicians emerges as its own factor in the authenticity of conversation. The clinicians in this study relied on a series of pre-topical sequences in their search for topics of common interest. This pursuit, performed out of necessity, will initially make a conversation appear less authentic but over time and with consistent flexible topic management, the clinician can reduce the time in conversation spent in pursuing mutually agreed upon topics. This flexibility requires that the clinician understand what conversation is and how it works as well as employ ecologically valid discourse management techniques (Simmons-Mackie, Elman, Holland, & Damico, 2007). The clinician must practice a linguistic flexibility that allows her to capitalize on the multiple propositions within a prior speaker's turn-at-talk to maintain or transition a topic to achieve engagement by the group members (Wilson, 1987).

Implications for the Field of Aphasiology

While acknowledging the limitations for uniformly generalizing findings that come from a study of three participants, the principles of qualitative methodology for accountability and verifiability instill in this investigator a confidence in the conclusions that have been reported above and the extension of those conclusions as implications for the management and research of aphasia.

By looking at group cohesiveness as a construct inherent in a successful conversation therapy group, where success is defined as improved ability for self-initiation, decreased problematic talk, and increased self-repair along with participant perceptions of improvement, the researcher was able to locate the practices of the clinicians that supported increasing group cohesiveness. She was able to identify the demonstrations of affiliation that acted as indices of group cohesiveness and recognize the influence of language ability and personal factors upon how group cohesiveness was displayed. These findings proved useful to this investigator as a clinician and as a researcher.

Clinical implications. Although it has been years since students were exposed to training in behavioristic methods and attitudes in the department wherein this investigation occurred, many master degree students still operate under the assumption that there should exist a "professional detachment" in the therapeutic relationship. This researcher herself once held these ideas until her first clinical experience where she was supervised by Dr. L. L. Schendel and was instructed to become a "love object" for a 5 year old boy with difficulty making his "r"s. While the terminology applied could have used a little, pardon the pun, massaging, the advice was sage and sound. Dr. Schendel went on to explain that by establishing an optimal relationship with the child, he would work very hard to please and make more progress. So, in 1988 I received my first lesson on the power of the therapeutic alliance. The longer I practice speech pathology the more salient that first lesson became. This research endeavor into the effect of group cohesiveness on the conversation devices and strategies used by participants and clinicians made it clear that this Group-Level alliance should be pursued at the earliest moment of clinical contact. This revelation has significant implications for how clinicians work with individuals with aphasia to improve their

communication and the re-shaping of their identity as a part of their community. Most importantly, there appear to be specific strategies and behaviors – detailed by Conversation Analysis and other qualitative methodologies – that can systematically enable a clinician to achieve the desired level of alliance.

Implications for assessment. Assessment of the manifestation of aphasia within an individual and their social system most appropriately begins with an interview. Luck and Rose (2007) described how clinicians make linguistic adjustments to accommodate an individual's unique aphasia, however, if we clinicians are going to create a relationship that achieves the best possible outcomes then we need to adjust our attitudes and ideas about what an interview should look like. By using the conversation behaviors that promote group cohesiveness (therapeutic alliance) we establish a level of connectedness that promotes the clients' confidence in their ability to make improvement and a more equitable power relationship that promotes the clients' confidence in their competence as both a communicator and an agent of change in their own rehabilitation. By sharing personal information, using positive contingent responses and embedded verification, the clinician assists the client in their construction of a more positive post-stroke identity; one of self-agency that focuses on their remaining abilities to compensate for impairment. When the clinician includes humor, especially self-directed, with its related shared laughter, she creates a positive context for therapy where the individual with aphasia can similarly laugh at their own mistakes and begin the work of self-correcting. The findings related to group cohesiveness in conversation make it clear that the very term "interview" needs to be re-conceptualized or perhaps dropped from our core vocabulary due to its strong associations with question and answer sequences and a clinician – client power difference that promotes

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an identity of incompetence. Typically, a client will expect to engage in this commonly practiced clinical event and so work must be done by the clinician to help the client adjust to a more conversational method of exchanging information. By recognizing and naming the elephant in the room, the clinician can explicitly alter the communication event by which client and clinician share information.

The second important implication for assessment involves the demonstrated power of conversational mechanisms, devices, behaviors and/or strategies that enable individuals to accomplish social action through conversation. Rather than focus primarily on the employment of aphasia test batteries and normative measures alone, the practicing clinician should always obtain conversational data that is authentic and then engage in fine-grained analysis to determine what conversational strategies and behaviors are employed and for what reasons during conversation. Such a focus may mean that assessment becomes more formative and progressive, with initial data collected and then continuous assessment occurring over time to better understand the conversational strategies and behaviors. Since the data in this investigation and numerous others of recency in the area of clinical aphasiology have documented the comprehensive power of conversation, anything less is not sufficient.

Implications for treatment. The discovery that group cohesiveness is most likely a multi-factor construct with task cohesiveness being the primary force that drives interpersonal cohesiveness (Bonito & Meyers, 2011; Schechtman & Katz, 2007; Zaccaro, 1991), the selection of tasks within a group treatment session becomes a serious consideration and the therapist should orient to those tasks that are authentic, socially constructed ones that promote both forms of cohesiveness for which conversation is well

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suited to accomplish. Our individual and collective identity is established through discourse; we build the self we want others to see turn-by-turn in conversation. However, as it has been discussed in the results, having a conversation is not a simple matter and requires pre-group preparation to include topics that will be of interest to all parties in the conversation. By beginning the therapeutic process with conversations, rather than interviews, the clinician will have a better idea of each member's interests and then identify possible topics that will intersect these interests. Therapists will also consider the types of conversations and topics of conversations they have day to day; recognizing that the ordinary and mundane can provide a foundation upon which the shared experiences that create common ground result in group cohesiveness. Because individuals with aphasia demonstrate successful communication through the support of the environmental context and their self-created compensatory strategies, clinicians should also consider the selection of topics that lend themselves to the use of multiple modalities and environment exploitation to achieve successful and positive interactions. However, because in an authentic conversation "what parties say is not specified in advance" (Sacks, Schegloff, & Jefferson, 1974, p. 701) the clinician will keep these topics in reserve; opting for those conversations that emerge sequentially, from a previous turn, to take priority and then transitioning to them as the propositional content in a prior turn supports the topic transition (Basso, 2010; Wilson, 1987).

The clinician will reap the benefits of group cohesiveness in achieving successful outcomes best if she considers the impact of the relationships that are attendant to group cohesiveness, being clinician to member, member to member, and member to group. By intentionally employing conversation behaviors that demonstrate affiliation the clinician

serves as a model of group cohesiveness for the IWAs to follow suit. While the personal factors that conspire within an individual to create their unique aphasia also determine their inclination toward or away from group cohesiveness, the lack of clinician demonstrations of affiliation would effectively delimit any demonstrations by group members. The clinician must similarly orient to those successful compensatory strategies that are member generated in addition to strategies that their profile of language ability might suggest.

The effect of one member upon another must also be recognized with each member having the power to encourage or discourage demonstrations of affiliation from another. For instance, Jesse's reduced displays of affiliation were taken by Althea to imply that he did not like her and therefore she did not demonstrate an affiliative stance for his talk where she frequently responded to the clinicians and other members with shows of interest which encouraged their continued turns-at-talk or similar demonstrations of affiliation. However, members can have tremendous positive influence upon other members as Alan supported Althea through turn allocations and his turns and talk and gestures, which she co-opted in the construction of her sequential turns-at-talk. As a benefit of group treatment, which is heightened by the established group cohesiveness, members observe other member's successful deployment of compensatory strategies and they selectively incorporate those compensations into their own inventory to be enacted immediately or delayed as supported by the context.

Clinicians must also recognize the effect that a member can have upon the entire group and Alan was a tremendous example of this with his use of teasing that was most often directed toward the clinicians. Alan's relative affiliation or disaffiliation became such a

strong influencer that one of the clinicians reported this influence, unsolicited, in the post-semester interview when he said

> and to say this is weird but, Alan. how well he took the story and I think that that was
>
> kinda the direction that conversation would go in, who was gonna get teased and
>
> that kinda thing. (Appendix D-C1-I at 0:11:59)

 Groups where one member dominates the conversation or attention of the group diminish the opportunities for others in the pursuit of group cohesiveness and strategic conversation. However, a member that routinely asks questions to invite others into the conversation has a positive impact on the turn by turn construction of conversation that leads to growing group cohesiveness.

An additional implication of the findings that group cohesiveness builds over the course of a semester, can be reliably identified through conversation behaviors, and interacts with conversation strategies to promote increased self-agency on the part of the individual with aphasia influences how clinicians educate and train families for improved communication. The clinicians should raise the awareness of family and friends of the IWA for the ameliorating effects of group cohesiveness for successful communication. It is through the framing of conversation according to the principles of group cohesiveness as affiliation, engagement, and collaboration that we may be able to create a paradigm shift within the preconceptions of caregivers as to what constitutes a good conversation partner. Many spouses and caregivers engage in the task of "therapizing" their loved one to the detriment of a satisfying and ultimately communication enhancing conversation. They expose the individual's problematic talk by engaging in unnecessary repair which they accomplish through explicit naming of the problematic talk and then often requiring the

individual with aphasia to repeat it over and over (Booth & Perkins, 1999; Lindsay & Wilkinson, 1999). By situating the training of conversation partners within the social construct of group cohesiveness the clinician can advocate conversation as an interaction over a transaction where the focus is on the jointly constructed meaning and the social and emotional benefits for all parties involved.

Implications for research. This body of work took 2 years from its inception to its completion and many lessons were learned along the way that guided the research effort and will shape future research activities. That group cohesiveness is demonstrated through the conversation practices of group members became an important discovery; especially the discovery that the indices of group cohesiveness that were performed universally by all three participants were similar to those demonstrated by non-impaired conversation participants (Haughton, 2009).

These indices will serve as verification of the cohesiveness of conversation therapy groups in future research into the therapeutic effect of group conversation in the treatment of individuals with aphasia. The recognition that clinicians systematically employ conversation behaviors that model group cohesiveness, both unintentional and deliberate, will inform future research into the impact of clinicians on aphasia treatment through conversation. The discovery that topic impacted group cohesiveness and that its effect could be reliably identified through the sequential turns-at-talk will inform research into what constitutes authentic conversation as well as research into clinical practices that support effective, functional improvement in communication for persons with aphasia. While there are a multitude of implications from the results of this research upon any future investigative endeavors, the aforementioned significations will likely contribute more significantly to

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future work in the area of group cohesiveness as an appreciating force for improved conversation ability.

Implications for Conversation Analysis Relative to the Field of Aphasiology

This study was not the first to employ Conversation Analysis (CA) to the study of aphasic talk; in fact, there are a multitude of studies that examine the conversation of individuals with aphasia in a variety of contexts, settings and partners. This study was not the first to apply CA to multi-party conversations where the conversation turns of several participants jointly construct topic and collaboratively achieve socio-communicative events such as humor, forgetting and remembering, troubles talk, and the building of discourse identities. However, this is one of the few that looked at the conversation of a group of persons with aphasia interacting with each other and their therapist over time and collaboratively through multiple modalities. Without the context-sensitive and context-free properties of CA, many of the behaviors that informed this research would have passed undetected. The use of repetition, both self and other, only became apparent through the meticulous transcription. The appearance of individual specific as well as uniform indices of group cohesiveness only emerged as the data was examined for its local negotiation and sequentiality and then, in keeping with the context-free principle of CA, examined within and across participants. An additional and significant finding that only emerged as results were compared and contrasted was the influence of the topic on conversation and only through the meticulous transcription that is requisite for CA, was this able to be verified.

What became apparent from the outset of the investigation was the necessity to treat conversation as an interactional event achieved through a multitude of communication channels. Through the transcription of facial expression, gesture, writing, and gaze in

addition to what was said, the researcher was able to capture a detailed snapshot of the communication event and reliably represent it throughout the investigation (Mondada, 2008). Certainly for persons whose verbal ability has been limited through the devastating effects of aphasia, it is essential that CA routinely involve all channels of communication and systematically represent those modes of communication to represent what and how meaning is constructed.

Directions for Future Research

As the first investigation into group cohesiveness as a progressive achievement over the course of a semester that is manifested in the conversation behaviors of a group of persons with aphasia, this endeavor became one more of breadth than depth. To adequately describe and discuss the related phenomenon of conversation and group cohesiveness and then to layer the constraints of language impairment might require a multi-volume encyclopedia. It is for this reason that the opportunities for and responsibilities of continued research are vast but a few of the more visible issues that emerged during the investigation will be presented.

1. The interaction between an individual's profile of language impairment and personal factors to influence their displays of group cohesiveness is dynamic and complex and thus deserves more attention than could be given in this investigation. Future research should employ the framework presented by the World Health Organization (2001) along with those frameworks that allow the contrastive treatment of communication events (Hymes, 1974) and group context (Bonito & Meyers, 2011) to create a picture of how these forces conspire to shape an individual's conversation behaviors.

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2. The impact of conversation therapy, as a functional and authentic, contextualized treatment vehicle, upon linguistic processing. When comparing the results across participants, the investigator noted scores for gestural processing that improved by 1 to 3 points on the multi-dimensional scoring system (Porch, 1981) for each participant. This finding instilled a curiosity that led the examiner back to the literature where she found that in a study by Bollinger, Musson, & Holland (1993) of group communication intervention with chronically aphasic persons, there occurred a consistent improvement in gesural processing. Additional studies with increasing numbers of participants are warranted to determine if this is a consistent and natural consequence of a conversation based therapy that supports the authentic use of gesture for communication purposes.

3. An inventory of clinician techniques to foster group cohesiveness. As the initial study of its kind, this investigation was not able to comprehensively identify all clinician behaviors that promote group affiliation. Further, the clinicians that served as facilitators of the latter sessions were students in a speech pathology training program. By analyzing videotaped conversation treatment sessions that are conducted by experienced clinicians and where the objective indices of group cohesiveness for the IWAs are present, an inventory of beneficial clinician practices can be developed.

4. The interaction between topic and conversation. It became clear that topic heavily influenced conversation and future research should examine this relationship more closely through the number of turns required to establish a topic, rate of alternate modality use, rate of self-initiated turns, and trajectory of

conversation repair across differing topics. By gaining additional information on how topic shapes conversation in persons with aphasia, clinical management techniques can be refined to maximize outcomes.

Concluding Statements

While it was suspected that group cohesiveness existed among persons with aphasia in a group therapy setting, it was verified through the conversation behaviors of the individuals with aphasia and the facilitating clinicians. Moreover, many of the behaviors of aphasic individuals that served as indices of group cohesiveness were identical to non-impaired individuals. Those shared indices of group cohesiveness were the behaviors that were demonstrated uniformly across participants namely acknowledgements, agreements, and shared laughter. The additional indices shared by all participants reflected the contextual forces that shaped the conversation where "reduced capabilities and loss of social support were frequent subjects of conversational humor" (Heath & Blonder, 2003, p. 97) and gaze was easily exploited to manage conversation by persons who possessed less verbal ability to perform that function (Goodwin, 1995). Conversation served as the vehicle for establishing group cohesiveness but a reciprocal relationship between group cohesiveness emerged, with group cohesiveness influencing conversation strategies and participation. Participants evidenced the growing group cohesiveness through their increasing displays of affiliation and engagement and as their orientation toward group cohesiveness increased there occurred an increase in strategy use, self-initiated turn-taking, and efficiency for self-repair with a corresponding decrease on conversation breakdowns requiring repair. While it is difficult to dissect the relationship between group cohesiveness, conversation changes and the change in compensatory strategies that accomplish conversation, it is apparent that as a messy and

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complex whole they work together to create positive outcomes for individuals with aphasia. It is situated within an individual with aphasia that the therapeutic benefits of social cohesiveness for conversation in group therapy become most apparent. As one of the participants stated,

So what it is, they listen to me what I say but I, I, I stutter sometime (2) but they, they help me. (Althea, Appendix A-I at 1:39:42)

BIBLIOGRAPHY

Abramovitch, R., & Daly, E. (1978). Children's use of head orientation and eye contact in making attributions of affiliation. *Child Development*, 519-522.

Argyle, M., & Cook, M. (1976). *Gaze and Mutual Gaze.* New York: Cambridge University Press.

Argyle, M., & Dean, J. (1965). Eye Contact, Distance, and Affiliation. *Sociometry, 28*(3), 289-304.

Armstrong, E., & Ulatowska, H. (2007). Making stories: Evaluative langauge and the aphasia experience. *Aphasiology, 21*(6-8), 763-774.

Atkinson, J., & Heritage, J. (1984). *Structures of Social Action.* Cambridge, MA: Cambridge University Press.

Avent, J. (1997). *Manual of Cooperative Group Treatment for Aphasia.* Boston, MA: Butterworth-Heinemann Medical.

Bandur, S. a. (1986). *Treatment of Aphasia: A Language-oriented Approach.* London: Taylor & Francis.

Basso, A. (2010). "Natural" conversation: A treatment for severe aphasia. *Aphasiology, 24*(4), 466-479.

Basso, A. (2010). "Natural" conversation: A treatment for severe aphasia. *Aphasiology, 24*(4), 466-479.

Bavelas, J., & Chovil, N. (2000). Visible acts of meaning: An integrated message model of language in face-to-face dialogue. *Journal of Language and Social Psychology, 19*(2), 163-194.

Bavelas, J., Coates, L., & Johnson, T. (2002). Listener responses as a collaborative process: The role of gaze. *Journal of Communication, 52*(3), 566-580.

Beeke, S., Wilkinson, R., & Maxim, J. (2009). Prosody as a compensatory strategy in the conversation of people with agrammatism. *Clinical Linguistics & Phonetics*, 133-155.

Beeke, S., Wilkinson, R., & Maxim, J. (2009). Prosody as a compensatory strategy in the conversations of people with agrammatism. *Clinical Linguistics & Phonetics, 23*(2), 133-155.

Bickmore, T. W. (2004). Unspoken rules of spoken interaction. *Communications of the ACM, 47*(4), 38-44.

Bloch, S., & Beeke, S. (2008). Co-constructed talk in the conversations of people with dysarthria and aphasia. *Clinical Linguistics and Phonetics, 22*(12), 974-990.

Bloom, L. (1962). A rationale for group treatment of aphasic patients. *Journal of Speech and Hearing Disorders, 27*(1), 11-16.

Boas, F. (1911). *The Mind of Primitive Man.* New York: MacMillan.

Bollinger, R., & Stout, C. (1976). Response-contingent small-step treatment: Performance-based communicaiton intervention. *The Journal of Speech and Hearing Disorders, 41*(1), 40-51.

Bollinger, R., Musson, N., & Holland, A. (1993). A study of group communication intervention with chronically aphasic persons. *Aphasiology, 7*(3), 301-313.

Bonito, J., & Meyers, R. (2011). Examining functional communication as egocentric of group-centric: Application of a latent group model. *Communication Monographs, 78*(4), 463-485.

Booth, S., & Perkins, L. (1999). The use of Conversation Analysis to guide individualized advice to carers and evaluate change in aphasia: A case study. *Aphasiology, 13*, 283-303.

Breasted, J. (1930). *The Edwin Smith Surgical Papyrus* (Vol. I). Chicago, IL: University of Chicago Press.

Brennan, A., Worral, L., & McKenna, K. (2005). The relationship between specific features of aphasia-friendly written material and conprehension of written material for people with aphasia: An exploratory study. *Aphasiology, 18*(8), 345-363.

Bucholtz, M. (2000). The politics of transcription. *Journal of Pragmatics, 32*, 1439-1465.

Budman, S., Demby, A., Feldstein, M., Redondo, J., Scherz, B., Bennet, M., . . . Ellis, J. (1987). Preliminary findings on a new instrument to measure cohesion in group psychotherapy. *International Journal of Group Psychotherapy, 37*, 75-94.

Budman, S., Soldz, S., D. A., Feldstein, M., Springer, T., & Davis, M. (1989). Cohesion, alliance and outcome in group psychotherapy. *Psychiatry, 52*, 339-350.

Burlingame, G., Fuhriman, A., & Johnson, J. (2001). Cohesion in Group Psychotherapy. *Psychotherapy: Theroy, Research, Practice, Training, 38*, 373-379.

Butler, R. (1982). A personal account of dysphasia. In L. Sies (Ed.), *Aphasia theory and therapy: Selected lectures and papers of Hildred Schuell.* Baltimore, MD: University Park Press.

Camras, L. (1977). Facial expressions used by children in a conflict situation. *Child Development*, 1431-1435.

Casillas, M., & Frank, M. (2013). The development of predictive processes in children's discourse understanding. *Proceedings of the 35th Annual Meeting of the Cognitive Science Society.*

Chapey, R., Duchan, J., Elman, R., Garcia, L., Kagan, A., Lyon, J., & Simmons-Mackie, N. (2001). Life participation approach to aphasia: A statement of values for the future. In R. Chapey (Ed.), *Language Intervention Strategies in Aphasia and Related Neurogenic Communication Disorders* (pp. 235-245). Baltimore, MD: Lippincott, Williams, & Wilkins.

Cheng, C., & Chartrand, T. (2003). Self-monitoring without awareness: Using mimicry as a nonconscious affiliation strategy. *Journal of Personality and Social Psychology, 85*(6), 1170-1179.

Chovil, N. (1989). *Communicative functions of facial displays in conversation.* Victoria, British Columbia, Canada: unpublished dissertation, Department of Psychology, University of Victoria.

Clark, H. (1996). *Using Language.* Cambridge, MA: Cambridge University Press.

Coelho, C., & Duffy, J. (1987). The relationship of the acquisition of manual signs to severity of aphasia: A training study. *Brain and Language, 31*(2), 328-345.

Conroy, T. (1999). "I don't want to burst your bubble": Affiliation and disaffiliation in a joint accounting by affiliated pair partners. *Human Studies, 22*, 339-359.

Croteau, C., Vychytil, A.-M., Lafeuil, C., & LeDorze, G. (2004). "Speaking for" behaviors in spouses of people with aphasia: A descriptive study of six couples in an interview situation. *Aphasiology, 18*(4), 291-312.

Cruice, M. (2007). Issues of access and inclusion with aphasia. *Aphasiology, 21*, 3-8.

Cutler, A., & Pearson, M. (1986). On the analysis of prosodic turn-taking cues. In K. Johns-Lewis, *Intonation and Discourse* (pp. 139-155). London: Croom-Helm.

Damico, J. S., Wilson, B., Simmons-Mackie, N., & Tetnowski, J. (2008). Overcoming unintelligibility in aphasia: The impact of non-verbal interactive strategies. *Clinical Linguistics & Phonetics, 22*(10-11), 775-782.

Damico, J., & Simmons-Mackie, N. (2002). The base layer and the gaze/gesture layer of transcription. *Aphasiology, 16*(5), 317-327.

Damico, J., Simmons-Mackie, N., Oelschlaeger, M., Elman, R., & Armstrong, E. (1999). Qualitative methods in aphasia research: Basic issues. *Aphasiology, 13*(9), 651-665.

Davidson, B., Worral, L., & Hickson, L. (2003). Identifying the communication activities of older people with aphasia: Evidence from naturalistic observation. *Aphasiology, 17*(3), 243-264.

Davis, G. A. (2000). *Aphasiology: Disorders and Clinical Practice.* Needham Heights, MA: Allyn & Bacon.

Davis, G., & Wilcox, M. (1985). *Adult Aphasia Rehabilitation.* San Diego, CA: College-Hill.

Dinger, U., & Schauenburg, H. (2010). Effects of individual cohesion and patient interpersonal style on outcome in psychodynamically oriented inpatient group psychotherapy. *Psychotherapy Research, 20*(1), 22-29.

Eisenson, J. (1973). *Adult Aphasia: Assessment and Treatment.* New York: Appleton.

Ekman, P. (1979). About brows: Emotional and conversation signals. In J. Aschoof, M. von Cranach, K. Foppa, W. Lepenies, & D. Ploog (Eds.), *Human Ethology* (pp. 169-202). Cambridge, UK: Cambridge University Press.

Ekman, P., & Rosenberg, E. (1997). *What the Face reveals: Basic and Applied Studies of Spontaneous Expression Using the Facial Action Coding System (FACS).* (P. Ekman, & E. Rosenberg, Eds.) New York: Oxford University Press.

Elliot, R., Fischer, C., & Rennie, D. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*, 215-229.

Elman, R. (2007). *Group Treatment of Neurogenic Communication Disorders.* San Diego, CA: Plural Publishing.

Elman, R., & Bernstein-Ellis, E. (1999a). Psychosocial aspects of group communication treatment- Preliminary findings. *Seminars in Speech and Language, 20,* 65-72

Elman, R., & Bernstein-Ellis, E. (1999b). The efficacy of group communication treatment in adultswith chronic aphasia. *Journal of Speech, Language, and Hearing Research, 42*, 411-419.

Ferguson, A. (1994). The influence of aphasia, familiarity, and activity on conversational repair. *Aphasiology, 8*(2), 143-158.

Ferrara, K. (1992). The interactive achievement of a sentence: joint productions in therapeutic discourse. *Discourse Processes, 15*, 207-228.

Festinger, L., Schachter, S., & Back, K. (1950). *Social pressures in informal groups: A study of human factors in housing.* Stanford, CA: Stanford University Press.

Ford, C., & Thompson, S. (1996). Interactional units in conversation: Suntactic, intonational, and pragmatic resources for the management of turns. In S. E. A., & S. Thompson, *Interaction and Grammar.* Cambridge: Cambridge University Press.

Frattali, C. (1992). Functional assessment of communication: Merging public policy with clinical views. *Aphasiology, 6*(1), 63-83.

Fridlund, A. (1991). Sociality or solitatry smiling:Potentiation by an implicit audience. *Journal of Personality and Social Psychology*, 229-240.

Frymark, T., Schooling, T., Mullen, R., Wheeler-Hegland, K., Ashford, J., McCabe, D., . . . Smith-Hammond, C. (2009). Evidence-based systematic review: Oropharyngeal dysphagia behavioral treatments. Part I--background and methodology. *Journal of Rehabilitation Research & Development, 46*(2).

Gardner, H. (1973). The contribution of operativity to naming capacity in aphasic patients. *Neuropsychologia, 11*, 213-220.

Garfinkle, H. (1967). *Studies in Ethnomethodology.* Englewood Cliffs, NJ: Prentice-Hall.

Gerwing, J., & Bavelas, J. (2004). Linguistic influences on gesture's form. *Gesture, 4*(2), 157-195.

Glenn, P. (1989). Initiating shared laughter in multi-party conversations. *Western Journal of Communication, 53*(2), 127-149.

Godfrey, C., & Douglas, E. (1959). Recovery in aphasia. *Canadian Medical Association Journal, 80*, 618-624.

Goette, L., Huffman, D., & Meier, S. (2006). The impact of group membership on cooperation and norm enforcement: Evidence using random assignment to real social groups. *Teh American Economic Review, 96*(2), 212-216.

Goffman, E. (1963). *Stigma. Notes on the Management of Spoiled Identity.* Englewood Cliffs, NJ: Prentice-Hall.

Goffman, E. (1967). On face-work. In *Interaction ritual: Essays on face-to-face behavior.* Garden City, NY: Anchor Books.

Goodglass, H., & Kaplan, E. (1972). *The Assessment of Aphasia and Related Disorders.* Philadelphia, PA: Lea & Febiger.

Goodwin, C. (1980). Restarts, pauses, and the achievement of a state of mutual gaze at turn-beginning. *Sociological Inquiry, 50*(3-4), 272-302.

Goodwin, C. (1980). Restarts, pauses, and the achievement of a state of mutual gaze at turn-beginning. *Sociological Inquiry, 50*(3-4), 272-302.

Goodwin, C. (1986). Between and within: Alternate sequential treatments of continuers and assessments. *Human Studies, 9*, 205-217.

Goodwin, C. (1995). Co-constructing meaning in conversations with an aphasic man. *Research on Language and Social Interaction, 28*, 233-260.

Goodwin, C. (2000). Gesture, aphasia and interaction. In D. McNeill (Ed.), *Language and Gesture* (Vol. 28, pp. 84-98). New York: Cambridge University Press.

Goodwin, C. (2000). Gesture, aphasia, and interaction. In D. McNeil (Ed.), *Language and Gesture 2* (pp. 84-98). Cambridge, UK: Cambridge University Press.

Goodwin, C., & Heritage, J. (1990). Conversation Analysis. *Annual Review of Anthropology*, 283-307.

Goodwin, M. (1980). Processes of mutual monitoring implicated in the production of description sequences. *Sociological Inquiry, 50*(3-4), 303-317.

Goodwin, M., & Goodwin, C. (1986). Gesture and coparticipation in the activity of searching for a word. *Semiotica, 62*(1-2), 51-76.

Greatbatch, D., & Clark, T. (2003). Displaying group cohesiveness: Humour and laughter in the public lectures of management gurus. *Human Relations, 56*, 1515-1544.

Grice, H. (1975). Logic and conversation. In P. Cole & J. Morgan (Eds.), *Syntax and Semantics Volume 3: Speech Acts* (pp. 41-48). New York: Academic Press.

Haugh, M. (2010). Jocular mockery, (dis)affiliation, and face. *Journal of Pragmatics, 42*(8), 2106-2119.

Haughton, B. (2009). Identifying diversity and cohesion in small group interaction. *The International Journal of Diversity in Organisations, Communities, and Nations, 8*(6), 57-66.

Hay, J. (2001). The pragmatics of humor support. *Humor, 14*(1), 55-82.

Heath, R., & Blonder, L. (2003). Conversational humor among stroke survivors. *Humor, 16*(1), 91-106.

Heeschen, C., & Schegloff, E. A. (1999). Agrammatism, adaption theory, Conversation Analysis: On the role of so-called telegraphic style in talk-in-interaction. *Aphasiology, 13*(4-5), 365-405.

Helm-Estabrooks, N., Fitzpatrick, P., & Barresi, B. (1982). Visual action therapy for global aphasia. *Journal of Speech and Hearing Disorders, 47*(4), 385-389.

Hengst, J., Frame, S., Neuman-Stritzel, T., & Gannaway, R. (2005). Using others' words: Conversational use of reported speech by individuals with aphasia and their communication partners. *Journal of Speech, Language, and Hearing Research, 48*, 137-156.

Heritage, J. (1984). *Garfinkel and Ethnomethodology.* Cambridge, MA: Polity Press.

Hoen, B., Thelander, M., & and Worsley, J. (1997). Improvement in psychological well-being of people with aphasi and their families: evaluation of a community-based programme. *Aphasiology, 11*(7), 681-691.

Holland, A. (1977). Some practical considerations in aphasia rehabilitation. In M. Sullivan & M. Kommers (Eds.), *Rationale for adult aphasia therapy* (pp. 167-180). Omaha: University of Nebraska Press.

Holland, A. (1980). *Communicative activities in daily living: A test of funcitonal communication for aphasic adults.* Baltimore, MD: University Park Press.

Holland, A. (1991). Pragmatic aspects of intervention in aphasia. *Journal of Neurolinguistics, 6*, 197-211.

Holland, A. L. (1971). *Psycholinguistics and Behavioral Variables Underlying Recovery from Aphasia.* Social and Rehabilitative Services, DHEW.

Holler, J., & Wilkin, K. (2011). Co-speech gesture mimicry in the process of collaborative referring during face-to-face dialogue. *Journal of Nonverbal Behavior, 35*, 133-153.

Hopper, T., & Holland, A. (1998). Situation Specific Training. *Aphasiology, 12*(10), 933-944.

Howe, T. J., Worral, L. E., & Hickson, L. M. (2008). Interviews with people with aphasia: Wnvironmental factors athat influence their community participation. *Aphasiology, 22*, 618-643.

Hunston, S., & Thompson, G. (2003). Evluation: An introduction. In S. Hunston & G. Thompson (Eds.), *Evaluation in Text: Authorial Stance and the Construction of Discourse* (pp. 1-27). Oxford, UK: Oxford University Press.

Hymes, D. (1974). *Foundations in Sociolinguistics: An Ethnographic Approach.* Philadelphia, PA: University of Pennsylvania Press.

Jefferson, G. (1973). A case of precision timing in ordinary conversation: Overlapped tag-positioned address turns in closing sequences. *Semiotica, 9*(1), 47-96.

Jefferson, G. (1983). Notes on the systematic deployment of the acknowledgement tokens "yeah" and "mm hm." *Tilburg Papers in Language and Literature. 28.* The Netherlands: Tilburg University.

Jefferson, G. (1984). On the organization of laugther in the talk about troubles. In J. Atkinson & J. Heritage (Eds.), *Structures of Social Action: Studies in Conversation Analysis* (pp. 346-369). Cambridge, UK: Cambridge University Press.

Jefferson, G. (1985). On the interational unpackaging of a 'gloss'. *Language in Society, 14,* 435-466.

Jefferson, G. (1988). On the sequential organization of troubles-talk in ordinary conversation. *Social Problems, 35*(4), 418-441.

Jefferson, G. (2004). A sketch of some orderly aspects of overlap in natural conversation. In G. Lerner (Ed.), *Conversation Analysis: Studies from the First Generation* (Vol. 125, pp. 43-62). Philadelphia, PA: John Benjamins.

Jefferson, G., Sacks, H., & Schegloff, E. (1987). Notes on the laughter in the pursuit of intimacy. In G. Button & J. Lee (Eds.), *Talk and Social Organization* (pp. 152-205). Clevedon: Multilingual Matters.

Johannsen-Hornbach, H., Cegla, B., Mager, U., Schempp, B., & Wallesch, C. (1985). Treatment of chronic global aphasia with a nonverbal communication system. *Brain and Language, 24*(1), 74-82.

Johnson, J., Burlingame, G., Strauss, B., & Borman, B. (2008). Therapeutic relationships in group psychotherapy. *Group Psychotherapy and Group Dynamics, 44*, 52-89.

Jucker, A. H. (1993). The discourse marker well: A relevance-theoretical account. *Journal of pragmatics, 19*(5), 435-452.

Kagan, A. (1998). Supported communication for adults. *Aphasiology, 12*(9), 816-830.

Kagan, A., Black, S. E., Duchan, J. F., Simmons-Mackie, N., & Square, P. (2001). Training volunteers as conversation partners using "supported conversation for adults with aphasia" (SCA): A controlled trial. *Journal of Speech, Language, and Hearing Research, 44*, 624-638.

Kaplan, E., Goodglass, H., & Weintraub, S. (1983). *The Bostson Naming Test.* Philadelphia, PA: Lea & Febiger.

Kendon, A. (1980). Gesticulation and speech: Two aspects of the process of utterance. In M. Key (Ed.), *Relationship of Verbal and Nonverbal Communication* (pp. 207-227). Amsterdam: Mouton de Gruyter.

Kendon, A. (1996). An agenda for gesture studies. *Semiotic review of books, 7*(3), 8-12.

Kendon, A. (2004). *Gesture: Visible Action as Utterance.* Cambridge, MA: Cambridge University Press.

Kertesz, A. (1982). *The Western Aphasia Battery.* New York: Grune & Stratton.

Kitzing, P., Ahlsen, E., & Jonsson, B. (2005). Communication aids for people with aphasia. *Logopedics Phoniatrics Vocology, 30*, 41-46.

Kotthoff, H. (1993). Disagreement and concession in disputes: On the context sensitivity of preference structures. *Language in Society, 22*(2), 193-216.

Kovarsky, D., Curran, M., & Nichols, N. (2009). Laughter and communicative engagement in interaction. *Seminars in Speech and Language, 30*(1), 27-36.

Kovarsky, D., Shaw, A., & Andingono-Smith, M. (2007). The construction of identity during group therapy among adults with traumatic brain injury. *Communication and Medicine, 4*(1), 53-66.

Krantz, M., George, S., & Hursh, K. (1983). Gaze and mutual gaze of preschool children in conversation. *The Journal of Psychology, 113*(1), 9-15.

Kraut, R., & Johnston, R. (1979). Social and emotional messages of smiling: An ethological approach. *Journal of Personality and Social Psychology, 37*, 1539-1553.

Laakso, M. (1997). *Self-initiated Repair by Fluent Speakers in Conversation.* Helsinki, Finland: Finnish Literature Society.

LaPointe, L., & Horner, J. (1998). *Reading Comprehension Battery for Aphasia.* Austin, TX: Pro-Ed.

Le Dorze, G., & Brassard, C. (1995). A description of the consequences of aphasia on aphasic persons and their relatives and friends, based on the WHO model of chronic diseases. *Aphasiology, 9*(3), 239-255.

Leiwo, M., & Klippi, A. (2000). Lexical repetition as a communicative strategy in Broca's aphasia. *Aphasiology, 14*(2), 203-224.

Lerner, G. (1996). Finding "face" in the preference structures of talk-in-interaction. *Social Psychology Quarterly, 59*(4), 303-321.

Lerner, G. H. (2002). Turn sharing: the choral co-production of talk-in-interaction. In C. Ford, B. Fox, & S. Thompson (Eds.), *The Language of Turn and Sequence* (pp. 238-271). Oxford, UK: Oxford University Press.

Levinson, S. (1983). *Pragmatics*. Cambridge, MA: Cambridge University Press.

Levi-Strauss, C. (1966). *The Savage Mind* (2nd ed.). Chicago: University of Chicago.

Lindsay, J., & Wilkinson, R. (1999). Repair sequences in aphasic talk: A comparision of aphasic-speech and language therapist and aphasic-spouse conversations. *Aphasiology, 13*(4), 305-325.

Lindsay, J., & Wilkinson, R. (1999). Repair sequences in aphasic talk: A comparison of aphasic-speech and language therapist and aphasic-spouse conversations. *Aphasiology, 13*(4-5), 305-325.

Lindstrom, A., & Mondada, L. (2009). Assessments in social interaction: Introduction to the special issue. *Research on Language and Social Interaction, 42*(4), 299-308.

Luborsky, L. (1976). Helping alliances in psychotherapy: The groundwork for a study of their relationship to its outcome. In J. Claghorn (Ed.), *Successful Psychotherapy* (pp. 92-116). New York: Brunner/Mazel.

Luck, A., & Rose, M. (2007). Interviewing people with aphasia: Insights into method adjustments from a pilot study. *Aphasiology, 21*(2), 208-224.

Lyon, J. (1992). Communication use and participation in life for adults with aphasia in natural settings: The scope of the problem. *American Journal of Speech-Language Pathology, 3*(1), 7-14.

MacKay, R. (2003). "Tell them who I was": the social construction of aphasia. *Disability & Society, 16*, 811-826.

Madden, M., Oelschlager, M., & Damico, J. (2002). The conversational value of laughter for a person with aphasia. *Aphasiology, 16*(12), 1199-1212.

Mandelbaum, J. (1989). Interpersonal Activities in Storytelling. *Western Journal of Speech Communication, 53*, 114-126.

Martin, J., & White, P. (2005). *The Language of Evaluation: Appraisal in English.* London: Palgrave.

Maxwell, M. (1993). Conflict talk in a professional meeting. In D. Kovarsky, M. Maxwell, & J. Damico (Eds.), *Language Interactions in Clinical and Educational Settings. ASHA Monograph* (Vol. 30, pp. 68-91). Rockville, MD: ASHA.

Maynard, D. (1980). Placement of topic changes in conversation. *Semiotica, 30*(3-4), 263-290.

Maynard, D., & Zimmerman, D. (1984). Topical talk, ritual, and the social organization of relationships. *Social Psychology Quarterly, 47*(4), 301-316.

McCarthy, M. (2003). Talking back: "Small" interactional response tokens in everyday conversation. *Research on Language and Social Interaction, 36*(1), 33-63.

McNeill, D. (1985). So you think gestures are nonverbal? *Psychological Review, 92*(3), 350-371.

McNeill, D. (1992). *Hand and Mind: What Gestures Reveal About Thought.* Chicago, IL: University of Chicago Press.

Mol, L., Krahmer, E., & van de Sandt-Koenderman, M. (2013). Gesturing by speakers with aphasia: How does it compare. *Journal of Speech, Language, and Hearing Research, 56*, 1224-1236.

Mondada, L. (2008). Using video for a sequential and multimodal analysis of social interaction: Videotaping institutional telephone calls. *Forum: Qualitative Social*

Research, 9(3). Retrieved May 14, 2013, from http://www.qualitative-research.net/fqs/

Mullen, B., & Copper, C. (1994). The relations between cohesiveness and performance: An integration. *Psychological Bulletin, 115*, 210-227.

Norrick, N. (1993). *Conversational Joking: Humor in Everyday Talk.* Bloomington, IL: Indiana University Press.

Norrick, N. R. (2007). Conversational story telling. *The Cambridge Companion to Narrative*, 127-141.

Norrick, N. R. (2008). Using large corpora of conversation to investigate narrative: The case of interjections in conversational storytelling. *International Journal of Corups Linguistics, 13*(4), 438-464.

Norrick, N. R., & Sptiz, A. (2010). The interplay of humor and conflict in conversation and scripted humorous performance. *Humor: International Journal of Humor Research, 23*(1), 83-111.

Oelschlager, M. L., & Damico, J. S. (1998). Joint productions as a conversational strategy in aphasia. *Clinical Linguistics & Phonetics, 12*(6), 459-480.

Oelshlager, M.L., & Damico, J.S. (1998). Spontaneous verbal repetition: A social strategy in aphasic conversation. *Aphasiology, 12*(11), 971-988.

Office of Communications and Public Liaison. (2014, Feburary 14). *NINDS Aphasia Information Page*. Retrieved from National Institute of Neurological Disorders and Stroke: http://www.ninds.nih.gov/disorders/aphasia/aphasia.htm

Pachalska, M. (1991). Group therapy for aphasia patients. *Aphasiology, 5*(6), 541-554.

Parr, S. (2007). Living with severe aphasia: Tracking social exclusion. *Aphasiology, 21*, 98-123.

Perkins, L. (2003). Negotiating repair in aphasic conversation. In C. Goodwin (Ed.), *Conversation and Brain Damage* (pp. 147-162). Oxford: Oxford University Press.

Pickering, M., & Garrod, S. (2006). Alignment as the basis for successful communication. *Research on Language and Computation, 4*(2-3), 203-228.

Pomerantz, A. (1984). Agreeing and disagreeing with assesments: Some features of preferred/ dispreferred turn shapes. In J. Atkinson, & J. Heritage (Eds.), *Stuctures of Social Action* (pp. 57-101). New York: Cambridge University Press.

Porch, B. (1981). *Porch Index of Communicative Ability.* Austin, TX: Pro-Ed.

Porch, B. (2001). Therapy subsequent to the Porch Index of Communicative Ability. In R. Chapey (Ed.), *Language Intervention Strategies in Aphasia and Related Neurogenic Communication Disorders* (4th ed., pp. 663-674). Baltimore, MD: Lippincott Williams & Wilkins.

Priego-Valverde, B. (2009). Failed humor in conversation. In D. Chiaro, & N. Norrick, *Humor in Interaction* (pp. 165-183). Philadelphia, PA: John Benjamins North America.

Robey, R. R. (1998). A meta-analysis of clinical outcomes in the treatment of aphasia. *Journal of Speech, Language, and Hearing Research, 41*(1), 172-187.

Ross, A., Winslow, I., Marchant, P., & Brumfitt, S. (2006). Evaluation of communication, life participation and psychological well-being in chronic aphasia: The influence of group intervention. *Aphasiology, 20*(5), 427-448.

Ross, K., & Wertz, R. (2002). Relationships between language-based disability and quality of life in chronically aphasic adults. *Aphasiology, 16*(8), 791-800.

Rothwell, E., Siharath, K., Bell, S., Nguyen, K., & Baker, C. (2011). Joking culture: The role of repeated humorous interactions on group processes during challenge course experiences. *Journal of Experiential Education, 33*(4), 338-353.

Russel, J. A., & Fernández-Dols, J. (1997). *The Psychology of Facial Expression.* Cambridge, UK: Cambridge University Press.

Ruusuvuori, J. (2001). Looking menas listening: Coordinating displays of engagement in doctor-patient interaction. *Social Science & Medicine, 52*(7), 1093-1108.

Ruusuvuori, J., & Peräkylä, A. (2009). Facial and verbal expressions in assessing stories and topics. *Research on Language and Social Interaction, 42*(2), 377-394.

Ryff, C. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of personality and social psychology, 57*(6), 1069-1081.

Sacks, H. (1987). On the preferences for agreement and contiguity in sequences in conversation. In G. Button & J. Lee (Eds.), *Talk and Social Organisation* (pp. 54-69). Clevedon, Avon, England: Multilingual Matters.

Sacks, H. (1992). *Lectures on Conversation* (Vol. I; II). (G. Jefferson, Ed.) Oxford, United Kingdom: Blackwell.

Sacks, H., Schegloff, E., & Jefferson, G. (1974). Simplest systematics for the organization of turn-taking for conversation. *Language, 50*, 696-735.

Schectman, Z., & Katz, E. (2007). Therapeutic bonding in group as an explanatory variable of progress in the social competence of students with learning disabilities. *Group Dynamics: Theory, Research, and Practice, 11*(2), 117-128.

Schegloff. (1968). Sequencing in conversational openings. *American Anthropologist, 70*(6), 1075-1095.

Schegloff, E. (1987). Recycled turn beginnings: A precise repair mechanism in conversation's turn taking. In G. Button, & J. Lee, *Talk and Social Organization* (pp. 70-85). Clevedon, Avon: Multilingual Matters.

Schegloff, E. A. (1982). Discourse as an interactional achievement: Some uses of 'uh huh' and other things that come between sentences. In D. Tannen (Ed.), *Georgetown University Roundtable on languages and linquistics.* Washington, D.C.: Georgetown University Press.

Schegloff, E. A. (2000). Overlapping talk and the organization of turn-taking for conversation. *Language in Society, 29*, 1-63.

Schegloff, E., & Sacks, H. (1973). Opening up closings. *Semiotica, VIII*(4), 289-327.

Schegloff, E., Jefferson, G., & Sacks, H. (1977). The preference for self-correction in the organization of repair in conversation. *Language, 53*, 361-382.

Schein, E. (1985). *Organizational Culture and Leadership.* San Francisco: Jossey-Bass.

Schenkein, J. (1978). Identity negotiations in conversation. In J. Schenkein (Ed.), *Studies in the Organization of Conversational Interaction* (pp. 57-78). New York: Academic Press.

Schiffrin, D. (1987). *Discourse Markers.* New York: Cambridge University Press.

Schuell, H., Jenkins, J., & Jimenez-Pabon, E. (1964). *Aphasia in Adults.* New York: Harper & Row.

Shadden, B. (2005). Aphasia as identity theft: Theory and practice. *Aphasiology, 19*(3/4/5), 211-223.

Shadden, B., & Agan, J. (2004). Renegotiation of identity: The social context of aphasia support groups. *Topics in Language Disorders, 24*(3), 174-186.

Simmons, N. N. (1993). *An ethnographic investigation of compensatory strategies in aphasia.* The Lousiana State University, The Department of Communication Sciences and Disorders. Baton Rouge: ProQuest Dissertations and Theses.

Simmons-Macki, N., & Damico, J. (1999). Communicaiton strategies used by 'good' versus 'poor' speaking partners of individuals with aphasia. *Aphasiology, 13*(9-11), 807-820.

Simmons-Mackie, N. N., & Damico, J. S. (1995). Communicative competence in aphasia: Evidence from compensary strategies. *Clinical Aphasiology, 23*, 95-105.

Simmons-Mackie, N., & Damico, J. (1997). Reformulating the definition of compensatory strategies in aphasia. *Aphasiology, 11*(8), 761-781.

Simmons-Mackie, N., & Damico, J. (2009). Engagement in group therapy for aphasia. *Seminars in Speech and Language, 30*(1), 18-26.

Simmons-Mackie, N., & Damico, J. S. (1999). Social role negotiation in aphasia therapy: Competence, incompetence and conflict. In D. Kovarsky, M. Maxwell, & J. Duchan (Eds.), *Constructing (in)competence: Disabling evaluations in clinical and social interaction* (pp. 313-341). Hillside, NJ: Erlbaum.

Simmons-Mackie, N., & Kagan, A. (1999). Communication strategies used by 'good' versus 'poor' speaking partners of individuals with aphasia. *Aphasiology, 13*(9-11), 807-820.

Simmons-Mackie, N., & Schultz, M. (2003). The role of humour in therapy for aphasia. *Aphasiology, 17*(8), 751-766.

Simmons-Mackie, N., & Schultz, M. (2004). "Speaking for another": The management of participant frames in aphasia. *American Journal of Speech-Language Pathology, 13*, 114-127.

Simmons-Mackie, N., Elman, R., Holland, A., & Damico, J. (2007). Management of discourse in group therapy for aphasia. *Topics in Language Disorders, 27*, 5-23.

Skinner, B. (1974). *About Behaviorism.* New York: Alfred A. Knopf.

Smith, J., & Osborn, M. (2008). Interpretative phenomenological analysis. In J. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods* (pp. 53-80). London: Sage.

Spradley, J. (1979). *The Ethnographic Interview.* New York: Holt, Rinehart and Winston.

Stivers, T. (2008). Stance, alignment, and affiliation during storytelling: When nodding is a token of affiliation. *Research on Language & Social Interaction, 41*(1), 31-57.

Sutton, B. (1993). The rationale for qualitative research: A review of principles and theoretical foundations. *The Library Quarterly, 63*(4), 411-430.

Tannen, D. (1984). *Conversational Style: Analyzing Talk Among Friends.* Norwood, NJ: Ablex.

Tannen, D. (1987). Repetition in conversation: Toward a poetics of talk. *Language, 63*(3), 574-605.

Thompson, C. (1989). Generalization in the treatment of aphasia. In VV. Mc Reynolds & J. Spradlin (Eds.), *Generalization Strategies in the Treatment of Communicative Disorders* (pp. 82-115). St. Louis, MO: B.C. Decker.

Tice, M., & Henetz, T. (2011). Turn-boundary projection: Looking ahead. *Proceedings of the 33rd annual meeting of the Cognitive Science Society.*

van der Gaag, A. (2005). Therapy and support services for people with long-term strokeand aphasia and their relatives: A six month follow-up study. *Clinical Rehabilitation, 19*, 372-380.

Wertz, R., Collins, M., Weiss, D., Kurtzke, J., Friden, T., & Brookshire, R. (1981). Veterans Administration cooperative study on aphasia: A comparison of individual and group treatment. *Journal of Speech and Hearing Research, 24*(4), 580-594.

Wilkinson, R., Bryan, K., Lock, S., & Sage, K. (2010). Implementing and evaluating aphasia therapy targeted at couples' conversations: A single case study. *Aphasiology, 24*(6), 869-886.

Wilkinson, S., & Kitzinger, C. (2006). Surprise as an interactional achievement: Reaction tokens in conversation. *Social Psychology Quarterly, 2*, 150-182.

Wilson, J. (1987). On the topic of conversation as a speech event. *Research on Language & Social Interaction, 21*(1-4), 93-1114.

World Health Organization. (2001). *International Classification of Functioning, Disability, and Health.* Geneva: World Health Organization.

World Health Organization. (2001). *International classification of impairment, activity and participation.* Geneva: World Health Organization.

Yalom, I. (1995). *The Theory and Practice of Group Psychotherapy* (4th ed.). New York: Basic Books.

Zaccaro, S. J. (1991). Nonequivalent Associations between forms of cohesiveness and group-related outcomes: Evidence for multidimensionality. *The Journal of Social Psychology, 131*(3), 387-399.

Zaccaro, S., & Lowe, C. (1988). Cohesiveness and Performance on an additive tak: Evidence for multi-dimensionality. *Journal of Social Psychology, 128*(4), 547-558.

Appendices

Appendices are formatted to a compact disk that is attached to this dissertation's back cover.

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ABSTRACT

This dissertation focused on how the affiliation and engagement practices that
contribute to social cohesiveness result in changes to conversation for three individuals with
aphasia who were part of group therapy that targeted improved communication through
conversation. It revealed how those changes were made manifest by employing a qualitative
research design which allowed the researcher to discover *how* social cohesiveness is
demonstrated in conversation. This design included the administration of aphasia batteries
that are widely used in the area of aphasiology and were administered prior to and
subsequent to the period of conversation treatment. The design further included medical and
clinical records that informed the researcher of the participants' physical and communicative
abilities. The primary research tool was Conversation Analysis, which, by virtue of its dual
characteristics of being context-sensitive yet context-free, allowed the researcher to examine
behaviors in an authentic context and observe patterns within and across participants.
Additionally, post-semester interviews served as a lamination tool that, along with the
primary and other secondary data sources, would verify or refute the patterns of conversation
changes.

The resulting data were then analyzed for patterns of conversation change and formed
three areas of interest: patterns of conversation changes that revealed the member's growing
orientation toward group cohesiveness, patterns of changing compensatory strategy use, and

changing patterns of turn-taking. The results of this study demonstrate the importance of social cohesiveness as an integral part of group conversation treatment and its effect, as a catalyst, upon improving conversation ability. Additionally, it illustrates group cohesiveness as a multi-dimensional construct that involves an orientation to task and interpersonal cohesiveness. Further, it explicates the relationship between an individual's functioning, personal factors, and context as influencers of the aphasic's demonstration of social cohesiveness. This study proffers important implications concerning the value of a qualitative research design for studying communication changes in aphasia and the essential employment of constructivist approaches to communication therapy for individuals with aphasia. These clinical implications shape the assessment and intervention practices of clinicians who recognize the transformative power of a constructivist approach that requires the situation of treatment in an authentic context.

BIOGRAPHICAL SKETCH

Born in Mt. Airy, NC, and raised in Miami, FL, Jennifer Tetnowski is a clinical supervisor and researcher at the University of Louisiana at Lafayette. She maintains the Certificate of Clinical Competence from the American Speech, Language, and Hearing Association and has been a practicing Speech Language Pathologist for 24 years. She has worked with aphasic individuals in a variety of settings that include rehabilitation, acute care, nursing facilities, and home health. She obtained both her Bachelor of Science and Master of Science degrees in Communicative Sciences and Disorders from the Florida State University, graduating in 1988 and 1990, respectively.