

# Negotiation of identity in group therapy for aphasia: the Aphasia Café

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## Abstract

*Background:* There has been increasing interest in ensuring that aphasia intervention includes attention to the negotiation of a robust identity after the life-altering changes that often accompany the onset of aphasia. But how does one go about simultaneously improving communication and positive identity development within aphasia therapy? Socially oriented group therapy for aphasia has been touted as one means of addressing both psychosocial and communicative goals in aphasia.

*Aims:* This article describes the results of a sociolinguistic analysis of group therapy for aphasia in which positive personal and group identity are skillfully negotiated.

*Methods & Procedures:* Sociolinguistic microanalysis of discourse in a group therapy session was undertaken. The session, described as group conversation therapy, included eight adults with aphasia, a speech–language pathologist and an assistant. The session was videotaped and transcribed, and the data were analysed to identify ‘indices of identity’ within the discourse. This included discourse that exposed members’ roles, values or beliefs about themselves or others. The data were further analysed to identify ‘patterns’ of discourse associated with identity. The result is a detailed description of identity-enhancing discourse within group therapy for aphasia.

*Outcomes & Results:* The findings included several categories associated with the negotiation of identity in therapy including: (1) discourse demonstrating that group members were ‘being heard’, (2) that the competence of group members was assumed, (3) that ‘solidarity’ existed in the group, (4) that saving face and promoting positive personal identity was important, and (5) that markers of group identity were made visible via discourse that referenced both member inclusion as well as non-member exclusion.

*Conclusions & Implications:* The results suggest that it is possible to create identity-enhancing interactions as part of therapy for aphasia; the analysis demonstrates the potential role of the group leader/clinician in managing identity negotiation in aphasia therapy.

*Keywords:* adults, aphasia, self-esteem, identity, speech and language therapy.

## What this paper adds

This paper argues for the importance of addressing identity as part of speech–language therapy for aphasia and offers both a method of analyzing identity negotiation in aphasia therapy as well as insight into behaviors during social interaction that support robust identity development for people with aphasia.

## Introduction

Not only does the aphasic person suffer a cerebral infarction, but also an ‘ego’ infarction—the lesion also has an impact on the ‘self’ of the patient.

(Wahrborg 1991: 3)

The most salient characteristic of aphasia is the reduced ability to communicate. A less obvious, though certainly no less important, characteristic is the potential damage to the sense of self—the identity (Shadden 2005). With

the onset of aphasia ‘Who I am now’ often does not reconcile with ‘who I was’ (Mackay 2003). Consequently, an important issue faced by individuals after the onset of aphasia is the renegotiation of identity—the search for a sense of self that is consistent with the sudden and life changing presence of aphasia.

## Definitions of identity

Shadden and Agan (2004) define identity as ‘a composite of roles, values and beliefs that are acquired

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and maintained through social interaction' (p 175). Individuals project identities to others during interactions and others in turn confirm or disaffirm the presented identity. Moreover, identity is intricately tied to communication since we use language to shape our own experience and create an image for others. Individual social interactions create positive or negative assessments of identity. When social relationships and the resulting discourse provide for a negative sense of self, then identity is weakened and self-esteem suffers. Conversely, social relationships and communicative interactions that support autonomy and self-esteem help foster a robust identity. A strong or robust identity tends to be associated with 'well-being' and a higher quality of life (Cooney *et al.* 2009).

The literature identifies several types or aspects of identity. '*Personal identity* concerns the development, establishment and maintenance of a person's sense of self' (Pound *et al.* 2000: 178; emphasis added). This involves internal beliefs about who we are and what we wish to present to others. '*Social identity* is often defined as an identity constructed outside of the person by society based on preconceived ideas and specific attributes (Tajfel and Turner 1979). For example, people might hold preconceived notions of 'political conservatives' or 'people with brain damage'. Group or '*collective identity* refers to shared traits and values associated with social or cultural groups or communities. Collective identity often involves 'a sense of group unity, parity and action' (Pound *et al.* 2000: 178). For example, disability rights groups sometimes frame political agendas based on aspects of shared collective identity. Aspects of personal, social and collective identity interact to contribute to one's sense of self.

In order to arrive at a coherent sense of self, individuals engage in communicative interactions through which identities are established and modified. Goodwin (1987) refers to '*discourse identities* that are established within co-constructed talk. These are 'invoked' relationships that help establish particular identities within the conversation and also help speakers and listeners interpret what is being said. In other words, 'people design communication in such a way as to bring into play selected identity relationships among the conversational participants' (Goodwin 1987: 118). One's choice of wording, topic, or discourse organization provides insights into the identities in play. For example, the name or title one uses to introduce oneself helps mark the aspect of self that the speaker wishes to convey (for example, Dr Jones, Bernard Jones, Bernie). The speech-language pathologist invokes her 'expert' identity when she instructs patients and families regarding the consequences of stroke. Yet, her identity as a mother is invoked when she commiserates with her aphasic client about the difficulty of finding good

childcare. Thus, communication is a primary vehicle through which identity and the sense of self are negotiated (Armstrong and Ulatowska 2007; Shadden and Koski 2007; Simmons-Mackie and Damico 1999).

### *Identity and aphasia*

With the onset of aphasia, multiple assaults to identity are possible. People with aphasia experience changes in abilities, roles, relationships and community life. Reactions and attitudes of others as well as personal experiences are no longer consistent with the pre-aphasia identity. After the onset of aphasia, interactions with family and healthcare providers are two predominant experiences that might influence identity construction. Healthcare provides an immediate and often disturbing introduction to the 'new self' (for example, Mackay 2003; and Shadden and Agan 2004). The disempowerment experienced by patients in healthcare is exacerbated by the inability to communicate. Patients with aphasia are often forced into dependent roles and excluded from healthcare decisions (Simmons-Mackie and Damico 1999). The 'medicalization' of interactions is apparent within aphasia therapy also. For example, researchers describe 'therapist centred' interactions in which the clinician exerts control over the goals, activities, discourse structures and meanings negotiated within sessions (Horton 2007; Kovarsky *et al.* 2007; Simmons-Mackie and Damico 1999, 2010; Simmons-Mackie *et al.* 1999). A dependent and disempowering therapy role of the client with aphasia can inhibit positive identity development. Thus, the healthcare system, including speech-language therapy, plays an important role in the construction of identity after the onset of aphasia. Although the aim of healthcare is to promote recovery, the traditional 'medicalized' social context is not likely to support reconstruction of a robust identity with aphasia.

In addition to the marginalizing interactions in healthcare, people with aphasia often experience marginalizing interactions with family, friends, acquaintances and the general public. Due to lack of knowledge of aphasia, others might orient to people with aphasia as though they are intellectually incompetent, childlike or emotionally disturbed. Thus, a negative externally constructed identity is invoked within interactions. Shadden (2005) describes this diminishment of the sense of self that is associated with the onset of aphasia as 'identity theft'.

### *Renegotiating identity after the onset of aphasia*

How does a person with aphasia renegotiate positive identity after the onset of aphasia? One way to negotiate a robust identity after aphasia is to develop social connections that are coherent with a positive sense

of self. Since social connections are largely established and maintained through communication, people with aphasia face a marked disadvantage. The professional most concerned with communication, the speech–language pathologist, is part of this process of identity reconstruction. Traditionally, clinicians have either ignored the role of ‘self’ in therapy, assumed that improved language or communication (by virtue of aphasia therapy) would bolster the developing sense of self, or assumed that ‘being supportive and helpful’ contributes to a healthy identity. Unfortunately, an emerging literature suggests that these assumptions are erroneous (for example, Aujoulat *et al.* 2007). It is likely that some types of therapy interactions improve language, yet impair a healthy identity. Yet, one’s identity, confidence and sense of social membership are integral to effective and successful communication. Thus, aphasia therapy must focus on both improved communication and enhanced identity in order to maximize outcomes. But how does one go about simultaneously improving communication and positive identity development?

#### *Group therapy: A context for identity negotiation*

Group conversation therapy has emerged as one method of altering the dynamics of traditional therapy so that psychosocial goals (for example, self-esteem, identity, confidence) are addressed along with linguistic and communicative goals (Elman 2007a, 2007b; Elman and Bernstein-Ellis 1999; Pound *et al.* 2000; Shadden and Agan 2004; Simmons-Mackie 2008). When managed correctly, such aphasia groups provide a social context that can support the dynamic construction of identity along with improvement in communication (Simmons-Mackie *et al.* 2007). However, detailed information is needed on how clinicians actually negotiate ‘identity-enhancing’ interactions. Without information on how discourse contributes to identity construction, it is difficult to insure that our aphasia interventions are identity-enhancing. Therefore, this paper presents an example of group therapy discourse designed to support a robust identity with aphasia. The aim is to describe identity-relevant interactions in a group aphasia therapy session and identify explanatory themes associated with positive identity negotiation in order to contribute to the process of ‘unpacking’ identity negotiation as an interactive phenomenon in aphasia.

#### **Method**

Schiffrin (1996) describes how discourse serves as a ‘linguistic lens’ to help us discover peoples’ views of themselves and others as situated in a social structure. For this study, indices of identity were identified using

the ‘linguistic lens’ of discourse. Specifically, sociolinguistic interactional analysis (Gumperz 1982; Schiffrin 1996) was employed to investigate identity in group therapy for aphasia. Sociolinguistic interactional analysis involves the microanalysis of discourse and social interaction as a means of understanding how people create meaning: linguistic, personal and social meaning. Like conversation analysis (Atkinson and Heritage 1984), sociolinguistic interactional analysis focuses on the sequential and structural organization and content of discourse. However, sociolinguistic interactional analysis is more concerned with how discourse relates to aspects of the self and society such as social structure, social roles and identity. While the analytic processes of conversation analysis and interactional sociolinguistics are similar, the perspectives and explanations of participants as well as knowledge of non-local context and experience are often accessed in sociolinguistic interactional analysis in order to illuminate motives, perspectives or feelings involved in a particular discourse event or segment. Sociolinguistic investigation is well suited to the present study since the relationship between language, discourse and identity has always been a major area of sociolinguistic investigation (De Fina *et al.* 2006).

#### *Data collection*

Qualitative data were drawn from one video taped session that was identified as a ‘conversation group’ for adults with aphasia; the session was further classified as a social approach to intervention in aphasia (Simmons-Mackie 2008; Simmons-Mackie and Damico 2010; Simmons-Mackie *et al.* 2007). The session under study was drawn from routine, ongoing therapy sessions that occurred once per week in an outpatient setting. The session lasted ninety minutes. The session was videotaped using a stationary camera that captured all participants. Video segments of interest were orthographically transcribed using conventions adapted from Sacks *et al.* (1974) (see Appendix A for notations).

#### *Participants and setting*

There were ten participants in the group including eight individuals with aphasia, a group ‘leader’ and a non-aphasic assistant. The group leader was a female speech–language pathologist with over 20 years of experience working with aphasia. The group assistant was also female. Participants with aphasia included seven males and one female ranging in age from 48 to 70 years with a range of aphasia severity from mild to moderately severe. Characteristics of participants with aphasia are presented in table 1. All group members with aphasia were greater than six months post onset of aphasia. Although there had been some change

**Table 1. Characteristics of group members with aphasia**

Name	Gender	Age (years)	Aetiology	Aphasia type	Severity	Associated diagnoses
John	Male	58	CVA	Broca's	Moderate to severe	Apraxia of speech, left hemiparesis, left visual field cut
Dennis	Male	63	CVA	Conduction	Moderate	
Pat	Male	48	CVA	Broca's	Moderate to severe	Apraxia of speech, right hemiparesis
Ben	Male	48	CVA	Conduction	Moderate	
Dean	Male	40	CVA	Broca's	Moderate to severe	Apraxia of speech
Lil	Female	65	CVA	Broca's	Moderate to severe	Apraxia of speech
Bernie	Male	65	CVA	Wernicke's	Moderate	
Mike	Male	70	Anoxia	Mild anomic	Mild	Memory deficit

Note: CVA, cerebral vascular accident.

in group composition over the lifespan of the group, several core members of the group had participated in the group therapy programme for more than one year.

Participants were seated around a large table. There were beverages, papers, notepads, newsletters, writing implements and other materials on the table. The atmosphere would best be described as 'informal'. The group leader was seated closest to the camera and to her left participants were seated in a circular pattern in the following order: John, Dennis, Pat, Ben, Dean, Gail (the assistant), Lil, Bernie and Mike. The primary topic of discussion was 'favourite restaurants'. According to the speech-language pathologist, the session was focused on promoting and improving conversational skill, self-confidence and participation within and outside of the group therapy environment.

#### *Data analysis*

In order to identify 'indices of identity' within the group therapy session, the primary investigator cycled through the videotape and transcript to identify discourse sequences that exposed members' roles, values or beliefs about themselves and others. There was no a priori designation of the length or number of turns or propositions required for identified segments or sequences; the only requirement was that the sequence of turns represented an aspect of identity negotiation. For example, segments ranged from as little as two consecutive speaking turns to multiple turns related to a particular topic. Once segments were identified, they were further reviewed to analyse similarities and contrasts across segments. In this way, identified 'patterns' became the focal point for investigation. By analysing what goes on immediately before, during and after identified segments it was possible to determine the function(s) of these discourse behaviours. Thus, discourse sequences associated with 'identity' within the group session were categorized and described. The final stage of interpretive analysis involved identifying explanatory themes that appropriately described the categories. Thus, the results of this

study include examples of actual identity segments as well as discussion of the explanatory themes derived.

#### *Validation of analysis*

Once the data were analysed and interpreted, the primary investigator cycled back through the session videotape and transcript to identify evidence of behaviours that verified or disputed the interpretations; no conflicts with final interpretations were identified. In order to further confirm the findings the data and preliminary results were presented to three qualitative researchers and to the aphasia group leader for comments and feedback. For example, identified segments were reviewed by researchers not involved in the project and they commented on whether findings were consistent with the data. The group leader was asked to read preliminary findings, review the videotape and confirm or refute findings based on her experiences. In this way, the findings and conclusions of the analysis were validated.

#### **Results and discussion**

The discourse analysis of a group therapy session for aphasia revealed several findings potentially important to 'identity' work in aphasia including (1) discourse demonstrating that group members were 'being heard', (2) that competence of group members was assumed, (3) that 'solidarity' existed in the group, (4) that saving face and promoting positive personal identity was important, and (5) that markers of group identity were made visible via discourse that referenced both member inclusion as well as 'non-member' exclusion. The following sections provide examples of each of these markers of identity negotiation within the group therapy session.

#### *Being heard*

The first and most obvious discourse behaviour that pervaded this session was the focus on providing a context in which the 'voices' of people with aphasia are heard. Rather than focus on practising elements

of linguistic skill such as forming grammatical sentences, the focus of this session was on 'having a say'. The session was oriented towards sharing of experiences, information, opinions and humour. In order to insure that each group member's contribution to the conversation was 'heard' and understood by others, the group leader modelled various approaches to communicative support such as using spoken elaborations, written key words, props (for example, menus, newsletters), gestures or drawing (Kagan 1998). Thus, the clinician served as a *mediator* of interpersonal communication (Simmons-Mackie *et al.* 2007). Importantly, this was achieved without raising the disability of aphasia to the surface of communication and without exerting authority as an expert. Although the session provided a context for learning *methods* of communicating successfully, there was equal emphasis on *doing* communication. Thus, contributions of each member were considered maximally important. This ability to make one's opinions and ideas visible to others and display one's intelligence and personality is an important element of positive identity construction. In order for this to occur, the leader facilitated the expression of opinions and ideas of group members, and insured that communicative offerings were recognized, heard and understood while avoiding foregrounding 'the disability' of aphasia.

In the following example, two group members have talked about restaurants that they like. The group leader has facilitated the discussion and, in closing this line of talk, she highlights the importance of their offerings by asking if they can bring in menus from the restaurants.

- (1) Clinician: Will you bring us the menu where you can get breakfast for 3 bucks?  
((leaning forward gazing at Dean))  
...  
(8) Clinician: And you ((looking at Ben)) can bring us the one from Oley's?

By asking the group members to bring more information about the restaurants, the leader has acknowledged that their descriptions were heard, were interesting and warrant further investigation by the group. Such affirmation of the value of one's talk/opinions can increase feelings of worth and importance and contribute to a positive sense of self.

*Assumption of competence: 'So who's gonna open a restaurant?'*

A basic tenet of identity-enhancing interactions is the assumption of competence and realization of mutual respect (Shadden and Agan 2004; Simmons-Mackie and Kagan 1999; Simmons-Mackie *et al.* 2004). During group interaction, the group leader crafted

questions and comments that projected her 'belief' that group members were competent, interesting and 'worth' conversing with.

In the following example, the clinician orients to group members as competent communicators. Several group members have brought menus from favourite restaurants and the group is talking about these restaurants (for example, where they are located, type of restaurant, food items, cost of items). The segment of interest starts after one participant has raised a complaint that the restaurants are too expensive. He has pointed out, as a case in point, that the restaurant sells French toast for US\$6.50. While the group continues to talk about restaurant prices, two members (Pat and Ben) figure out on paper that French toast costs only 50 cents to make. The clinician notes that at US\$6.50 the restaurant is making a US\$6 profit and comments as follows:

- (1) Clinician: Pretty good  
(2) So who's gonna open a restaurant?  
(3) Group: ((Laughter))

The group laughs at the clinician's question ('So who's gonna open a restaurant?') because they interpret the question as a joke. The question is funny because of the big leap from making French toast to opening a restaurant. In other words, the proposal vastly exceeds conversational expectations. The question is, in fact, a 'mock proposal' that flouts the conversational maxim that we express only what we believe to be true and possible. Not only is the clinician's proposal a joke, but also the group 'gets' the joke as evidenced in their shared laughter (Glenn 2003; Goodwin 1996). Offering a joke carries the implication that the clinician believes that group members are competent enough to get the joke. Thus, the proffered joke and the fact that the group understands the joke is an affirmation of the 'competence' of group members—an identity-enhancing experience.

Consider how the clinician might respond to Pat and Ben's assertion regarding French toast within a more didactic, traditional session. The clinician would probably call attention to the success of communication or of using written supports (for example, 'good, you got that idea across,' 'good, you used writing to show us'). The focus would be on the *performance* of people with aphasia—notable since they are communicatively impaired. In other words, the focus in a didactic session shifts from really communicating, to highlighting an aspect of incompetence or disability (that is, people with aphasia might not be able to get the idea across). In contrast, during the above segment the clinician responded to the *content* (for example, 'pretty good' to make a US\$6 profit). By responding to the meaning communicated, rather than to the method of commu-

nicating, the clinician has reinforced the value of Pat and Ben's opinions and insights, and carried their contribution forward into a joke for the group. The clinician projects her belief that group members are competent communicators. While this might seem like 'splitting hairs,' such subtle variations in talk cumulatively construct or deconstruct a robust identity.

*Group solidarity: 'Should we open an Aphasia Center Café?'*

Not only does the clinician's joke evidence her appreciation of the competence of group members, but also the opportunity for the group to share in humour reinforces the solidarity or 'togetherness' of the group. Mutual laughter displays a multi-party consensus about how something is to be interpreted (Goodwin 1996). In effect, the group is collaborating to share the experience of humour. Such examples of sharing within the group suggest the existence of a group identity at some level (that is, we are alike in our appreciation of this joke). This shared experience of humour is carried forward as the clinician expands the joke.

- (1) Clinician: ((Leans forward towards Lil))
- (2) Lil, should we open an Aphasia Center Café?
- (3) Group: ((All laugh including Lil))
- (4) Lil: ((Lil's laughter escalates)) No no

Here the clinician words her question inclusively: 'Should we open an Aphasia Center Café? 'We' is a marker of group identity. The entire group is included in the joke. Also, notice how the clinician directs her question to Lil. This member has relatively severe aphasia and does not always take an active role in this discussion. By asking for her opinion, the clinician engages Lil in the discussion. Lil responds by increasing her laughter and uttering a warning 'no no,' indicating that she also gets the joke and is in on the fun. This individual is given the opportunity to add to the joke and be an important part of the group in spite of her aphasia. Being included as part of the group is identity-enhancing.

*Reinforcing personal identity: 'Would you make the French toast for us?'*

Following upon the above example, the clinician continues the joke by addressing Dean as follows:

- (1) Clinician: ((laughing)) Dean, would you make the French toast for us?
- (2) Dean: Right ... easy, easy

Dean is known in the group as an excellent cook—a positive aspect of his personal identity. The clinician pulls Dean into the centre of the joke while highlighting his expertise as a chef. Thus, his personal identity as a cook is affirmed and he is included as an important part of the group via the joke. It is also notable that the clinician's reference to the 'French toast' (the origin

of the joking sequence) reintroduces Pat and Ben's interesting calculation regarding the cost of French toast. Thus, in the course of a joke, Pat and Ben's clever math regarding the price of French toast, Lil's opinion about the Aphasia Center Café and Dean's expertise as a chef have been foregrounded. In other words, the clinician has provided a discourse context in which group members are oriented to as 'contributors'. These subtle interactions provide opportunities for positive affirmation of personal identity.

*Face-saving repair: 'Who's gonna be the waitress?'*

People with aphasia are faced with frequent communicative breakdowns and errors. When communicative breakdowns or errors occur in conversation, the person who made the error runs the risk of 'losing face' or of appearing less competent, particularly if the error is made obvious to others (Jefferson 1987). For example, errors might be exposed when another participant points out the error, visibly corrects the error or requests clarification or repair. When errors are repeatedly exposed, the speaker begins to view him/herself as an incompetent communicator; the sense of self begins to suffer.

In the following segment, the group has continued to escalate the joke initiated by the clinician. As the joke escalates and group members take ownership of the joke, the clinician is faced with a potential communicative error (from Simmons-Mackie and Damico 2008).

- (1) Pat: Hey ((gestures with left arm as though mixing))
- (2) ((points towards John))
- (3) John: ((Lifts arm))
- (4) Pat: ((looks at pad and begins to draw))
- (5) John: Waitress waitress ((points to Pat))
- (6) Clinician: Waitress? ((looking at John))
- (7) John: ((Laughs)) Yea
- (8) ((Turns to clinician and holds hand out and shrugs)): Hey
- (9) Clinician: Who's gonna be the waitress? ((looking around group))
- (10) John: yea yea ((points to Ben, Dean, then around the table, shrugs))
- (11) Clinician: Dennis, can you be the waiter? ((leans towards and points to Dennis))
- (12) Dennis: [yea yea ((nodding and laughing)) right
- (13) John: [yea ((pointing to Dennis))
- (14) Clinician: Or Mike ((looks at Mike))
- (15) Mike: Yep

Pat seems to be suggesting via gestures that John can do some cooking when they open a restaurant. John retorts that Pat can be the waitress for the restaurant. The clinician seems unsure whether to interpret John's offering as a mock insult (that is, the wrong gender) or whether to ascribe John's wording to an aphasic error. She initially signals a possible trouble spot by casually repeating 'waitress?' while gazing at John. When John

stands by his choice, the clinician carries on the idea with ‘Who’s gonna be the waitress? Since this question is addressed to the whole group (as evident from eye gaze and body orientation), it is apparent that the clinician is carrying forward the discussion, rather than asking John to confirm a correction. Thus, the clinician creates a hidden repair by opening the invitation to all group members (including two females). In this way she acknowledges John’s idea of needing a waitress as a good one, but deflects the issue of whether the gender choice was a joke or an aphasic error. The clinician furthers the repair by asking Dennis if he can be the waiter. These embedded repairs are produced without emphasis on the offending words (Jefferson 1987). Thus, the clinician delicately negotiates John’s offering to fit it appropriately into the conversation, rather than making the potential error explicit. Traditional therapy focuses explicitly on errors in order to ‘fix’ the errors. The goal of this group is to maximize natural communicative interactions, reinforce strategies and enhance self-confidence and identity. Minimizing errors in circumstances such as the example is consistent with these goals.

#### *Markers of shared and group identity*

##### *Exclusion and group identity: ‘Poor Gail’*

While the group discussion of restaurants has moved forward, Pat has been drawing a picture that relates back to the discussion of the ‘Aphasia Center Café’. When Pat completes his drawing, the group attempts to figure out what he is trying to communicate with this drawing. Group members have guessed that he is talking about food and cooking, but Pat has something additional to say as evident in his ‘Okay but ...’ as follows:

- (1) Pat: Okay but ... we can all ((points around the table))  
...
- (2) Dit dit dit ((points to Ben, Dean, Gail the non-aphasic assistant))
- (3) ((Hesitates, points to Gail again))
- (4) Oh, no. ((shakes his hand as in waving off))
- (5) Group: ((Laughter))
- (6) Pat: [((points to Dennis, himself, and Ben))
- (7) Ben: [((imitates [the wave off of Gail])
- (8) Clinician: [Poor Gail
- (9) Group: ((continuing laughter escalates))
- (10) Clinician: Are you talking about your cooking after your stroke?
- (11) Pat: Yea ((points to clinician)) THAT’S RIGHT!
- (12) Clinician: Okay. So some of you have trouble with ...
- (13) ((points to her own left arm then right arm with arm hanging))
- (14) Pat: Right

Pat points around inclusively to each group member, then exaggeratedly ‘eliminates’ Gail, the group assistant,

from being included in the group (lines 2 and 3). This purposeful exclusion is mirrored by Ben (line 7). As evident in the clinician’s later clarification (lines 10 and 12), Pat is counting off those who have suffered a stroke (that is, hemiparesis). The assistant has not had a stroke and is not aphasic or hemiplegic. The tone of the group as Pat counts off the included members is not serious or gloomy. Rather, members are laughing and agreeing. Hemiplegia is oriented to as a marker of group inclusion; Gail is excluded from this group. Pat’s surface intention is to communicate the concept of cooking with hemiplegia. To get his point across he highlights hemiplegia as a marker of shared group identity. The overlay of humour diffuses the negativity of hemiplegia by casting it as ‘something we can laugh about’. The group is addressing a problem which no doubt has serious impacts on their daily lives. However, the sharing of this problem and the ability to make light of it in conversation creates a strong mechanism for coping. Moreover, the laughter, the good-natured ‘exclusion’ and the clinician’s mock sympathy (‘Poor Gail’) implies a ‘status’ and shared experience associated with this aspect of group membership.

We also see in this excerpt another example of the clinician facilitating a member ‘being heard’ by giving voice to the intended meaning. Here the clinician asks ‘Are you talking about your cooking after your stroke?’ (line 10) to verify that she understands Pat’s point, then she demonstrates (using gesture) the concept of hemiplegia to the group (line 12 and 13). Thus, she speaks for or translates Pat’s proposition (similar to the ‘speaking for another’ behaviour described by Simmons-Mackie *et al.* 2004). The clinician’s seamless and matter-of-fact use of these strategies to support and mediate talk not only improve the actual message transfer within the group, but also demonstrates to members that someone who uses such strategies (for example, gesture, drawing) can be respected by others.

##### *Shared identity: ‘We’re together in our artistic ability’*

Recall that in the prior excerpt Pat has introduced the idea of ‘hemiplegia’ and its affect on cooking. The clinician identifies an opportunity to ‘educate’ the group about hemiplegia as it relates to stroke and aphasia. Certainly, one role of a clinician is to insure that people with aphasia have an accurate understanding regarding the disorder and associated issues. However, by ‘lecturing’ to the group, the clinician runs the risk of destabilizing the egalitarian structure of the group interaction and undermining the delicate power balance by adopting the role of ‘expert’. In this example the clinician picks up a tablet to draw a picture to support her explanation about the consequences of stroke (from Simmons-Mackie *et al.* 2007).

- (1) Clinician: Okay. So I might draw a picture ((drawing 'hemiplegia'))
- (2) Well ((looking up)) ... Dennis don't laugh at my picture
- (3) Group: (((laughter)))
- (4) John: [Watch out for her ((laughing))]
- (5) Clinician: ((looks up at John))
- (6) Alri::ght ((touches John's arm and they lean towards each other))
- (7) We're together in our artistic ability.
- (8) John and clinician: ((face each other laughing))
- (9) Group: ((laughter))

The clinician's implied insult to her own drawing ability ('Well ... Dennis don't laugh at my picture') suggests to the group that she is 'not perfect'. Thus, the humour serves an equalizing function within the group. The clinician is an expert on the consequences of stroke, but she is not an artist. The contrast between her poor drawing and her knowledge of stroke diminishes any potential display of superiority or power over the group. Furthermore, her disclosure of her drawing 'disability' communicates that a robust identity encompasses both strengths and weaknesses. John escalates the humour with a mock insult ('watch out for her') suggesting that indeed the clinician cannot draw. The clinician returns with a counter mock insult by including John in the 'bad drawing' category with her. These insults are interpreted as joking based on the laughter, body language (for example, reaching out, leaning) and use of solidarity markers (that is, we, together). It is interesting that the joke focuses on artistic ability, a personal characteristic that is 'outside of' aphasia or stroke. The clinician and John share and disclose this part of their personal and shared identity—they are alike in their weakness and likeable in spite of their weakness.

It is interesting that both the clinician and the group make jokes about themselves and about each other. The distribution of 'who jokes' in this therapy session is different than that found by Simmons-Mackie and Schultz (2003) in traditional individual therapy for aphasia. In the study of traditional individual therapy the overwhelming majority of instances of 'humour' were clinician generated. Clearly this group feels very comfortable initiating humour, and even in poking fun at their therapist. This even distribution of humour could be further evidence of a more equalized power distribution within the group. The group members can laugh and offer mock insults because 'we know each other well enough' and 'we trust each other'. This positive aspect of the relationships within the group is identity-enhancing (for example, I am good enough for these people to know and trust and joke with).

#### *Within group identity—the Aphasia Café:*

The group has continued to talk about hemiplegia, cooking and opening a restaurant. Pat has been trying to get an idea across, and group members have taken turns guessing Pat's intent. Dennis offers a guess in the form of a drawing.

- (1) Clinician: ((looking at Dennis's paper)) What's that?
- (2) Did you draw a pizza?
- (3) Dennis: Right.
- (4) Clinician: Hold it up to the camera so they can see how we draw pizzas here.
- (5) Dennis: ((Exaggerated act of holding pad towards camera))
- (6) Group: (((laughter)))
- (7) Pat: A::PHA::SIA:: CA::FÉ ((punctuates each syllable with a gesture))
- (8) Group: ((laughter))
- (9) Clinician: Oh I like that.
- (10) Group: ((laughter continues))
- (11) Ben: ((places hand on Dean's shoulder and shakes him;))
- (12) ((both Ben and Dean laughing and leaning towards each other))
- (13) Clinician: Now you got it out!
- (14) So ... and all and all of you would work in it?
- (15) John, Dennis, Pat, Ben: Yes ((all speak in unison))

Here Pat finally gets out his idea of the 'Aphasia Café'. The 'cooking with hemiplegia' drawing and the pizza were ideas subsumed within the concept of an Aphasia Café. Thus, the café embodies the collective identity of group members that share certain characteristics (for example, have disabilities such as hemiplegia, eat fast food). Although the idea is a 'joke' it is a context for sharing a collective identity. Notice that Pat has changed the clinician's original proffered idea of the Aphasia Center Café to the Aphasia Café. The clinician's idea might be considered more 'politically correct' in that she identified the café with the facility, rather than with the disability. Pat, on the other hand, deletes the word 'centre' and creates a name that focuses on the people with aphasia rather than on the facility. He appears to focus purposefully on the correlates of aphasia (for example, hemiplegia). We might wonder if the truncated title was created because of his difficulty communicating (that is, difficulty with the word 'Center'). While we cannot rule out this interpretation, his production of Aphasia Café is remarkably exacting. He carefully pronounces each word and gesturally punctuates each syllable with great deliberation. Furthermore the massive response of the group suggests that they have embraced this altered name. Furthermore, notice that the clinician attributes the idea to Pat ('Oh, I like that'). In other words, she treats his suggestion as a 'new idea' and compliments him on the idea. Again, this is a subtle means of building self-esteem and acquiescing to group ideas.

A less sensitive clinician might have said something like ‘oh you like my idea for an Aphasia Center café’. The clinician also follows Pat’s lead by asking ‘all of you would work in it?’ This allows the talk to continue on the unifying topic of the Aphasia Café. Interestingly, the clinician has recognized that the ‘Aphasia Café’ has been renegotiated by the group. The Aphasia Café is made up of and for the aphasic members of the group (as evidenced by the repeated use of within group identity markers). Recall that in an earlier question the clinician included herself in the restaurant plan (‘Should we open an Aphasia Center Café?’). Now, the clinician eliminates herself in the question ‘all of you would work in it?’

After the above segment, the group continues to talk about the Aphasia Café. After discussing various menu options, the group identity is vividly displayed in their portrayal of their Aphasia Café.

- (1) Dennis: ((Holds out left arm and partly lifts right paretic arm))
- (2) Get somebody on this side and get this one over here.
- (3) So you have two of em ((still holding out arms))
- (4) Pat: Yea! That’s great ((gestures with his right hand cooking))
- (5) Clinician: So people with problems on one side could help each other.
- (6) Dennis: [Yea! ((gesturing with good arm))
- (7) Pat: [((gesturing with his good arm in unison with C))
- (8) Clinician: I think it could work!
- (9) John: ((holding up his left hand; laughing))
- (10) Ben and Dean: [((looking at each other and laughing))
- (11) John: [((Puts hand over his left eye, then moves head around as though trying to see))
- (12) OH!
- (13) ((gestures outward and pretends surprise at seeing on left))
- (14) Clinician: You wouldn’t see what’s going on on that side.
- (15) Group: ((laughing))
- (16) John: ((nods yes and waves hand in air, turns head))
- (17) HEY! ((waves hand))
- (18) Group: ((continues laughing))
- (19) Clinician: Might work!
- (20) ((holds up pad with Aphasia Café written on it))
- (21) People would remember the name.
- (22) They’d remember us.
- (23) John: [((nods vigorously)) Yes::
- (24) Pat: [((punches air)) Yes
- (25) Ben: [Yes

The group has returned to the discussion of one handed cooking due to hemiplegia. Dennis creatively suggests that by pairing two group members—one with a good right arm and one with a good left arm—they could cook! Pat and John join in the humour by agreeing and demonstrating with their ‘good arms’. Ben and Dean join with laughter and mutual body orientation. John

adds to the image of the Aphasia Café by showing that visual field deficits will also be a factor. His humorous pantomime of being surprized by objects on his ‘blind side’ escalates the humour. So the group humorously depicts ‘deficits’ of group members and creates an image of a wacky, fun restaurant staffed and run by people with aphasia. These group members appear to feel comfortable joking about their own deficits. And in fact, the deficits appear to serve as markers of group inclusion. The humour literature suggests that joking about problems tends to make them less painful or negative (for example, Dupre 1998) and, in fact, absurdity helps us focus our self-reflection and gain insight into our selves. However, joking about disability is a delicate operation. Notice how this clinician mediates the talk (for example, ‘So people with problems on one side could help each other’), but she does not contribute to the list of deficits or add to the jokes. It would be inappropriate for the clinician to joke openly about deficits, because she is not included within the group—she does not have joking rights.

Furthermore, group members raise aphasia and related disabilities to the surface of the talk in a manner that does not shift the power balance or marginalize the members. Instead, the orientation to markers of group inclusion raises the status of group members with aphasia. This line of talk is controlled by the aphasic participants and has joined several group members in social action. John, Dennis, Pat and Ben respond in unison when the clinician asks if they will all work in the café. Ben and Dean seem to have a ‘group within a group’. They relate to the larger group, but also affiliate directly with each other as evidenced in exchanges of gaze and body leans. Such interpersonal interactions highlight the solidarity of group members and sharing of identity-enhancing friendships.

It is interesting that the clinician continues to interact in the group, but her role is to voice the messages of group members in a subtle and non-evaluative manner. For example, she verbalizes Dennis’s idea of two-person cooking and John’s contribution of visual problems without adding evaluations or her own contributions. Thus, the group members line of talk is voiced without reference to the joke. She narrates the wording, but allows the group members to project the humour—a subtle operation that appears to succeed. Also, as the discussion nears its finale, the clinician slightly shifts the direction of the talk by holding up a pad with Aphasia Café written on it. This action ends the ‘litany of funny deficits’ and the group is reoriented to the name. Again there is no attempt by the clinician to evaluate the humour. Rather, she reorients the discussion to the name of the Café and states ‘People would remember the name’. This comment relates back to an ongoing topic of building awareness and

understanding of aphasia in the general public. John, Pat and Ben respond with obvious strong emotion and enthusiasm to this prediction. The escalation of humour and successful social interaction and affiliation has increased the emotional key of the group; they are 'spun up'. The clinician orients this heightened emotion towards a positive issue—advocacy in aphasia. Thus, the Aphasia Café is not just a collection of disabled people, but a mechanism for helping others to understand 'us'. Here she inserts herself back into the group as an advocate and ends the interactive sequence with a shared 'purpose'.

### Conclusions

Pound *et al.* (2000: 199) suggested several strategies for aiding identity negotiation including: raising awareness of personal strengths, skills and knowledge, improving awareness of rights and acceptability of accommodations, situating barriers external to the self (for example, a problem is due to poor signage versus I cannot read), identifying with other people with similar disabilities, advocating for reducing public barriers, and building public awareness. Interestingly these suggestions have been deftly incorporated into this group therapy session via skilful discourse management by the clinician. Moreover, analysis of the discourse details that created the identity-enhancing interaction provides support for a dual focus on communication and psychosocial issues.

### *Benefits and limitations of the research*

Sociolinguistic interactional analysis proved to be a useful method of studying identity negotiation within this group therapy session. The combination of rigorous attention to the structure and organization of discourse along with consideration of the perspectives, experiences and context of participants allowed the researchers to gain insight into identity as a 'process' that is embedded in social action (De Fina *et al.* 2006). Thus, utterances within the group discourse provided a window into 'extra-linguistic' reality—who participants are and how they wish to project their 'selves'. By analysing the social interaction the researchers were able to view the interaction between linguistic acts and social and cultural worlds, and view the process of identity creation. The analysis heightens our awareness of identity negotiation and possible methods of creating identity-enhancing interactions as part of therapy for aphasia.

However, this paper presents a microanalysis of one group aphasia therapy session conducted by an expert clinician. We do not propose that the clinician and client behaviours and strategies described are representative of 'group aphasia therapy' in general. Nor are we suggesting that clinicians attempt to replicate aspects

of this session (for example, talk about an aphasia café, make jokes about disability). Rather, the results are meant to sensitize the reader to the potential for identity-enhancing interactions during therapy and the need for clinicians to develop skill in managing group dynamics that not only enhance communication skills, but also enhance identity and self-esteem. Thus, the specific results are not 'generalizable' in the traditional sense of applying 'what this clinician said or did' to other group sessions. However, explanatory themes from multiple examples of behaviours within this session are applicable to group therapy for aphasia. Moreover, the themes derived from analysis of this session are coherent with and further elucidate suggestions that exist in the literature (for example, Pound *et al.* 2000; and Simmons-Mackie *et al.* 2007). Further research aimed at analysing identity-relevant interactions in diverse group therapy sessions with therapists of various skill levels will expand our understanding of this clinically important topic.

While these examples of identity negotiation are drawn from one group therapy session, there are overriding themes that orient us to discourse experiences that influence identity construction in general. Active listening and mediation of meanings appear to be important methods of reinforcing the identity of 'competent communicator' among group members. In effect, the clinician played a role in translating meanings for group members with aphasia, and in doing so reinforced the value of each person's opinions, ideas and contributions. When contributions are valued, a positive sense of self is reinforced. Simmons-Mackie *et al.* (2007) have described 'mediation' in group therapy as a strategy for the clinician to act as a 'voice' while group members are recognized as the source of the ideas. However, serving as 'mediator' of meanings is a sensitive manoeuvre in a group. It involves restating to the group the content of a communicative attempt while insuring that the contribution is attributed to the original speaker without 'taking over' the floor, without foregrounding the disability and without presenting the restatement in the form of a request for repair (Simmons-Mackie *et al.* 2007).

A second theme was the focus on building relationships versus overtly practising language. By sharing opinions and exposing personal identities, group members were able to develop a shared history which provided an excellent basis for conversation (Goodwin 1987). The role of the therapist in such interactions is to listen, clarify, question and support the member's utterances. Thus, the interaction is more conversational than 'instructive' (as in traditional therapy). This experience of successful conversation and relationships promotes a positive sense of self.

Another characteristic evident in this group session was the collaborative creation of alternative conceptions of disabilities. Pound *et al.* (2000) suggest that the goal of identity work is to ‘incorporate’ disability into a healthy, robust sense of self, rather than deny disability or make disability *equal to the self* (that is, ‘I am my disability’). In the group session studied group members appeared to project a sense of their own power and worth and a sense of pride in group membership. Members were able to explore their own experiences and perspectives on living with disability. As the jokes about the Aphasia Café evolved, members could re-evaluate their own conceptions of disability. For example, the jokes served to reorient members to think of hemiplegia as ‘something they share with friends,’ rather than merely a regrettable consequence of stroke. Thus, the group allowed members to redefine aspects of identity.

With the growing emphasis on creating interventions that not only improve communicative skill, but also enhance quality of life, it is imperative that we do not overlook the importance of a healthy sense of self. Future research should be directed at analysing additional therapy sessions, both individual and group, in order to continue cataloguing the discourse management strategies that enhance both communication and identity negotiation in aphasia.

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### Appendix A: Transcription notations

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