Paying Attention to Therapy Discourse: Identifying Therapy Processes and Practice in Talk about Talk

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ABSTRACT

Therapy discourse between the client and clinician has specific objectives to ameliorate problems associated with communication and swallowing disorders and is highly specialized. Analysis of this interaction that is the essence of therapy demonstrates the roles played by participants, revealing layers of meaning and assisting clinicians to redefine and refine their ideas about therapy. In this article, the authors analyze a series of extracts of therapy interaction to explore how therapy rapport is coconstructed by participants through talking and how roles are negotiated during the process of problem solving in therapy.

KEYWORDS: Clinical discourse analysis, therapy processes, therapy roles, language

Learning Outcomes: As a result of this activity, the reader will be able to discuss the layers of meaning in clinical interaction, including the different kinds of roles played by those involved and how these roles are negotiated during the process of therapy.

The conversational interaction between a client and clinician in the speech and language clinical context is specific and specialized. This context is uniquely designed for in-depth talking about problems in communication and swallowing disorders—problems affecting some of our most basic human characteristics. Working with people with communication and swallowing disorders is the clinician's central focus, with the ultimate objective of problem resolution or, where this is not possible, of helping the client achieve a good quality of life. The clinician is aware that the client with communication and swallowing disorders is vulnerable and is experiencing problems that may have several adverse consequences. These include how we feel about ourselves as individuals, how we socialize, and how we identify ourselves. The duty of care of the client is the clinician's central concern, and this concern is

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reflected in the ethical perspectives of the profession.

The rationale for paying attention to therapy discourse is compelling. For the reflective clinician, there is the opportunity to increase awareness of the roles played by each of the participants in the therapeutic interaction. How these roles are defined and how they are negotiated in the therapy discourse are issues to be addressed. Clinical discourse analysis will reveal at least some the layers of meaning in the interaction between client and clinician and will help clinicians to redefine and refine their ideas about therapy. Analyzing discourse suggests that we look closely and in detail at the interaction that takes place, asking "What is going on here?"[1]

We focus here on examples of discourse that provide some light and interest about how therapy is coconstructed by the participants and demonstrate how the roles of client and clinician are developed and are negotiated. We look at the primary exchange structure and follow through some of the stages of therapy to show how paying attention to therapy discourse can be beneficial. Conversely, however, clinical interaction analysis may disclose problems in communication between the client and clinician. Some examples will be presented, along with some suggestions about constructing resolutions.

Panagos and Bliss[2] point out that formal knowledge of the kind acquired in professional education is rooted in preintellectual experience—in other words, that the clinician as native speaker is using language that she or he learned tacitly in childhood. "Everything a clinician learns about language and culture becomes a part of therapy . . . almost a theatrical style of personal expression" (p. 20). This notion of "theater" is evident when one becomes aware of how the clinician's accent, intonation patterns, articulation precision may change when he or she takes on the clinician role. Examples include the volume and intonation exaggeration used in giving feedback to clients when the clinician is in instruction mode: "Very good!"; "Excellent!" "Good talking!"

The similarity in discourse patterns observed in student speech-language pathology clinical discourse is described by Panagos and Bliss[2] as "honing of discourse skills," which is "so exacting that lesson transcripts appear scripted and interchangeable from one clinician to another." Some explanation for this may be provided by the structure of recognized procedures in shaping treatment sessions according to planned objectives and needs. Conformity within clinical exchanges has the obvious implications of reducing therapy to impersonal routine activities, thereby ignoring both individual roles and exchanges. However, elements of conformity serve to confirm the notion of the unique social and cultural formation in the speech-language clinical context, which invites close scrutiny and analysis.[3]

The talk-about-talk in the clinic combines elements of art and of science, both essential elements of therapy. In their day-to-day work, clinicians and student clinicians perform complex tasks, engaging in therapeutic processes at many levels. Among these is the development of satisfactory rapport with the client that will develop and change over time as a central aspect of therapy, which is often thought to be a necessity to achieve therapy goals. The rapport between therapist and client is what largely composes the *art* of therapy, a creative, individual, and distinctive means of negotiating roles between the two parties in a relationship formed to engage in problem resolution. How rapport is developed and maintained is one element that becomes clear though the analysis of clinical discourse.

Another key therapeutic process is identifying and finding solutions to communication dilemmas, that is, problems and concerns arising from speech, language, and communication impairments. Therapy goals include the assessment and evaluation of behaviors to identify, analyze, and classify disabilities and functioning, and the provision of therapy to assist remediation and develop the potential of clients to become more effective communicators. Ultimately, it may be necessary for clients and clinicians to move beyond the impairment and to consider how best to manage the disability, in such a way that facilitates clients to have a good quality of life.

Both of these key therapeutic processes—rapport building and identifying and finding

solutions—that reflect the art and science of therapy will be discussed in this article. The discourse management strategies that help illuminate these processes in talk will be described through analysis of extracts from a range of clinical interactions. However, before focusing on these processes in particular, an examination of a typical exchange structure in discourse that helps define therapy roles and that pervades clinical interactions is necessary.

ESTABLISHING THERAPY ROLES: EXCHANGE STRUCTURE

In the following discussion of the basic exchange structure used in therapy, the context is provided, describing some characteristics of the participants (C = client; T = therapist), and the focus of talk (for conventions, see Appendix A).

Extract A. Context: third session with experienced speech-language therapist (50+ years old) with male client (17 years old) who stutters

A1. T: So, K, how have you been since last time?

A2. C: Fine. I tried out a few things.

A3. T: Great, let's look at what you did.

Extract B. Context: second session speech-language pathologist (SLP) with adult male client with dysphagia

B1. T: So how is the coughing this week then John? (1.0)

B2. C: None =.

B3. T: =None? – ex:cellent [excellent that's].

B4. C: [there's been none].

B5. T: Brilliant ((2.0 S puts on gloves)). OK, we'll get started.

In both extracts A and B, the clinician (T) initiates the interaction with a request, client (C) responds, and T comments, positively evaluating the response, giving an evaluation of the content of what the client said. This request-response-evaluation (RRE) exchange structure is pervasive in institutional talk, for example, between teachers and pupils[4] and between doctors and patients,[5] and it has been described frequently in the speech-language pathology context.[2,6,7] In initiating interaction and then commenting on the client's response, the therapist has encapsulated the client's talk, dominating the exchange and retaining control. Furthermore, the evaluation element—although it serves as encouragement and may help in the development of building rapport—represents the authority of the therapist, who is in a position to evaluate the other speaker's response.[8] However, the evaluative function within the RRE exchange format has also been shown to extend beyond having meaning within situations, ignoring important messages. A stark example of this appears in a report from the director of a British radio documentary entitled *The Simulated Patient*, on training junior doctors. The actor who is simulating the patient role reports:

> A classic is when they take your history and they say, "How's your parents?" and you reply, "My dad's OK but my mum died of horrible cancer yesterday," and they say, "Great," and you realise they've been so busy writing things down they have forgotten to listen."[9]

The dominance of the RRE routine is augmented by the therapist's use of specific markers (e.g., "so," "now," "OK," "right," "well," "good") and the use of back-channeling ("mmmm," "ahmm"), described by Kovarsky[10] as having a regulatory function. Most clients rarely initiate the interaction and they rarely use such markers, except occasionally when agreeing with instructions or showing understanding ("right," "OK").

Further illustrations of the RRE routine are drawn from interactions with a female client (Yvette) as she talks about her difficul-

ties with communication, particularly her tendency to say "things which are out of context." These examples also illustrate how the use of questions structure and manage the exchanges.

Extract C. Context: experienced therapist (aged approximately 45 years) with client with chronic schizophrenia (Yvette, aged approximately 45 years)

C1. T: You'd been thinking about it= =.

C2. C: = =I found that I say certain things which are out of context and em.

C3. —I find that everything I wanted to say I say it out before anything

C4. else could happen I say it out and I find that this is the reason—that

C5. this is one of the ways why I say those things I'm thinking too fast.

C6. T: Yeah and it has to come straight out ==.

Talk continues and the following occurs later in the same session.

C25. T: And does it happen?

C26. C: It () in the crowd.

C27. T: In where?

C28. C: In the crowd.

C29. T: In the crowd, yeah yeah . . . it's almost involuntary isn't it.

The interaction with C is characterized by comments ("You'd been thinking about it") and questions ("And does it happen?") about her concerns in relation to her speech, which structure and manage talk within the interaction. The therapist (T) is in control of the unfolding talk in the interaction, asking the questions, prompting responses, and evaluating or commenting on C's contributions, showing listening and understanding.

Extract D. Context: experienced therapist (aged 45+ years) talking with a 13-year-old female client who stutters, following approximately 20 minutes of interaction in the session.

In this extract, the client (C) demonstrates initiative by moving away from the technique focus and introducing a sociorelational context; however, the therapist (T) retains control of the session by paying attention to the manner of how C's question was uttered, emphasizing C's use of speech technique on two occasions in this extract.

D274. C: Do you live round here?

D 275. T: OK could you make that just a little bit softer?

D276. C: Do you live round here?

D277. T: Em, I live about four miles away. Em, you told me last time that you were

D278. going to America this summer. Can you tell me a bit about the way

D279. you're going?

D280. C: I'm not sure well what's going to happen there.

D281. T: OK can you say it again?

Coupland et al[5] summarize the type of interactions in Extracts C and D as having some of the following characteristics:

1. Question asking is dispreferred when done by patients.
2. Question structure is often restrictive, allowing for only short factual answers.
3. Question sequences often come in three-part structures, allowing the doctor to initiate the topic-question, hear the patient's answer, and maintain control of the floor with a third-position "assessment."

4. Third-position assessments, such as "uh-huh," "mm-hm," and "right," do not clearly signal to patients the force of doctors' evaluations but simply act as conversational continuers.
5. Doctors rarely give accounts for asking particular questions and shifting topics (p. 91).

In Extract C, the talk of the therapist largely conforms to the criteria described by Coupland et al[5] except for criterion 4: in C6 and C29, the therapist is providing a third-position assessment, agreeing with C, elaborating on what has been described, and in Shriffrin's[11] terms, "chipping in." In this way, the force of T's evaluations are that empathy is expressed, helping to build rapport. Similarly, in extract D, the therapist's talk restricts the client's attempt to shift the focus of talk, although she does respond to C's question (D277) briefly, but returns to a third-position assessment in D 281, indirectly evaluating C's use of speech technique.

BUILDING RAPPORT

The importance of building rapport and developing a working relationship between therapist and client cannot be taken for granted, and it is among the first elements of therapy interaction that students learn. The word *rapport* derives from the French verb *rapporter*—to bring (or to carry) back—however, the concept has been extended to a psychological context, meaning "intense harmonious accord," as between therapist and patient.[12] Rapport is the means through which ease in therapy exchanges is fostered, a means to create mutual understanding, of developing mutual trust and respect upon which therapeutic relationships are built. Rapport building is usually sociorelational talk and often occurs at openings or closings of sessions, but as will be demonstrated, it is not tied exclusively to these. Most obvious examples occur at particular junctions of talk (e.g., transition between therapy tasks) or within RRE sequences as demonstrated earlier. Without rapport, the working relationship is likely to be restricted to practice of technique routines that may have limited therapeutic effect. Corcoran and Stewart[13] indicate that an understanding and supportive relationship is necessary for clients to "feel safe" in recounting their story, so that in therapy elements of that story may change meaning. An example of how rapport may be developed is provided through analyzing the following extract.

Extract E. Van Riper (aged approximately 70 years) with client who stutters (C) (aged 18 years); stage 3 of video-recorded action therapy,[14] focus on desensitization

Following an introduction, the session with the client opens with the clinician, VR, referring to the previous week's focus:

E1. VR: Well, C, here we are again eh a moment ago I felt your pulse and

E2. it was racing, em, but you've had a hard = week.

E3. C: = Yes.

E4. VR: Having to identify your stuttering

E5. I guess and I'd like to know if the thing has happened to you

E6. that usually happens (. . .) after they begin

E7. to explore their stuttering to catalogue it to examine it to take a look

E8. at it to feel it a lot of emotion usually rises up, any in you?

E9. C: Yes I find it very hard to (. . .) to elauelauelauelauelau look

E10. at my stuttering, em (. . .) I've been (+t) stuttering

E11. a lot more more severely.

E12. VR: And I did that to you didn't I? Eh the dirty dog.

E13. C: (laughs).

In this extract, one of the major contributors to the study of stuttering in the 20th century, Charles Van Riper (designated as VR in the extract), is demonstrating his desensitization phase of therapy with a young male client (C). VR opens the session with a medical reference (C's "racing" pulse), that serves to establish his authoritative role as therapist. However, he begins to build rapport, immediately referring to C's "hard week" in identifying stuttering, to which C immediately responds (C3), overlapping with VR. VR describes some of the work done by C, and asks about emotional responses (C8), to which C replies, stuttering severely, indicating that one of the effects is that his stutter has deteriorated (C11). VR's evaluating response is to use humor in assuming responsibility for the deterioration. By calling himself "the dirty dog," VR is expressing what C might well be thinking (i.e., negative evaluative words about VR that usually would not be expressed openly by a client). The sequence shows VR's rapport building, first in recognition and understanding of the hard week, and then, in the humorous self-deprecating remark, which help to put C at ease. Leahy[15] suggests that this instance of VR speaking for C (in C12) demonstrates an affiliative manner, saying words that C could not in the context, nevertheless allowing C's voice to be heard. This instance of speaking foranother can be interpreted positively; however, speaking for another can also have negative implications (e.g., when "butting in"[11]).

A further level of analysis of this exchange draws on Goffman's[16] speaker roles, which he categorized under the heading of *footing*. Goffman observed that a person who plays a social role (e.g., brother, father, therapist, teacher) assumes additional speaker roles: those of animator, author, and principal. The *animator* is the speaking machine; the *author* is the person who selected the sentiments being expressed, as well the words used; the *principal* is someone active in some social identity or role, whose position is established by the words spoken. In the extract, VR confers the principal role to C as VR (as animator) says the words that C could probably say in the context. C's acceptance of the humor expressed provides support for this. The use of humor in therapy helps to build rapport and affiliation between the therapist and the client and can solicit cooperation.[17] Although VR has established himself as the expert in the initial exchange, through his use of humor he presents a warm, understanding voice to C, thus continuing to augment the rapport between therapist and client.

However, rapport building is not a process that occurs in discrete moments of an interaction but is an ongoing, jointly constructed process that permeates clinical talk as it unfolds. The analysis of rapport building can be informed by issues regarding power in discourse management strategies[18] and by politeness strategies as outlined by Brown and Levinson.[19] An interesting discourse site for the investigation of rapport building is "How are you?" (HAY?)-type sequences, as discussed by Coupland and colleagues[20] in the context of doctor-patient interaction. HAY?-type sequences can include inquiries as to family members, about recent activities or experiences, that is, general "state of play" enquiries. Their occurrence within and outside of clinical interactions may differ considerably, primarily in terms of who is "permitted" by the rules of engagement to ask the HAY?-type question (similar to the characteristics of doctor-patient interactions as previously outlined).

The following extracts illustrate typical HAY?-type sequences in nonclinical settings interactions (e.g., hairdressing salon) where the prerogative to initiate the HAY? sequence is *equally* available to both participants, although some "power" differential is present given the hairdresser (HD)–customer(C) context. In the first example, the hairdresser initiates the HAY? sequence, and in the second, the customer does so.

Extract F. Context: hairdresser (HD), male, addressing customer (C), female

F1. HD: How's your Mum? [lower voice]

F2. C: Yerra great aha.

F3. HD: She's great is she?

F4. C: Not bad.

F5. HD: That's good.

Extract G. Context: hairdresser (HD), male, with client (C), female, talking about the hairdresser's daughter

G1. C: How is she?

G2. HD: She's great!

G3. C: Is she enjoying school?

G4. HD: Yeah she loves the new teacher.

Showing concern for the other(s) is highlighted in HAR-type sequences. This is a positive politeness strategy, in that it represents being seen to show interest in the other[19] and not just around the task at hand. In typical HAY? sequences, there is a tendency to respond in a positive way (see above). The tendency toward positive responses may be seen as a feature of positive politeness at work, where enhancing each other's face (i.e., being thought well of by the other and not complaining) is at issue. This is joint rapport building at its best where participants are using such strategies as "social accelerators" in the interaction.[19]

However, when we begin to look at the occurrence of HAY? sequences in clinical interactions, we can see that the tendency to respond in positive ways (initially at least) is such that it casts this type of question more into the role of a greeting, with a possible "unpackaging" of relevant health issues at a later stage in the sequence, depending on the context and level of familiarity with the hearer (see Coupland et al[20]). Hence, positive rapport-building talk can give way to, or trigger, "troubles telling," that is, a sharing of concerns of important clinical relevance; that rapport had been established facilitates this troubles telling to emerge. Consider the initial and subsequent gloss of the following troubles-telling sequence between a therapist and client with communication difficulties associated with schizophrenia:

EXAMPLE INITIAL GLOSS

Extract H

H1. T: How's the weekend?

[4]

H2. C: Eh [3] wasn't too bad

[4]

H3. T: Did you stay in or go out?

[5]

H5. C: I was at home for a few hours . . THE USUAL.

Extract I: Later in the same session, unpackaging of troubles-telling following a period of language testing and occurring many turns later

I61. T: Ha? All those FIDDLY bits of things==.

I62. C: ==I was going to SIGN MYSELF INTO HOSPITAL.

I63. T: Were you?

I64. C: Yeah, I feel a bit better now.

I65. T: WHEN were you going to sign yourself into hospital?

I66. C: . . . I was going to mention it to YOU T==.

I67. T: ==Were you?

I68. C: Yeah.

I69. T: THIS MORNING?

In the earlier part of the session, the client responds to the therapists' HAY?-type question ("How's the weekend?") with the common formulaic phrase *not too bad* ("wasn't too bad"), a response type typically used to

HAY?-type requests/greetings. This use of a qualified initial negative appraisal[20] in this context may be said to function to "orient to a negative appraisal or circumstance but deny its full force to varying extents (p. 223)." The "wasn't too bad" response in the above example serves an important positive politeness function, that of avoiding bald on-record appraisals,[19] and in doing so mitigates any possible negativity that may threaten rapport.

Although the initial response to the HAY?-type request mitigates negativity, troubles telling is apparent at later stages in the interaction (when the client says "I was going to sign myself into hospital"). Jefferson's (1985) analysis of how troubles tellers "unpackage" their troubles (as discussed by Coupland et al[5]) is applicable here. Jefferson describes how troubles tellers provide initial glosses (which may be of the above form and usually positive) and subsequently unpackage the troubles through a second more negative gloss, at various stages in the ensuing interaction. This notion is akin to the "good news/bad news formats," as discussed by Coupland et al[5] and described as "beginning with a relatively positive formulation then proceeding to detail specific difficulties or discomfort (p. 112)." The period between the initial gloss and the subsequent unpackaging of the troubles varies from context to context.

The example above sees the "not too bad" utterance occurring early in the session with the subsequent unpackaging of troubles many turns later and after some language testing. Interestingly, troubles telling is followed by the more positive statement ("Yeah, I feel a bit better now"), thereby reducing the negative impact of troubles telling. This pattern of delayed troubles telling is significant in the consideration of sociorelational concerns and joint rapport building. C's holding back of the "bad news" can be considered a phatically oriented discourse process taking his listener—the therapist—into account relationally.

Exploring rapport building in this way has several benefits. Analysis of the above clinical extract shows how (1) rapport is coconstructed by both therapist and client; (2) troubles telling is facilitated as emerges naturally with the talk and considered within a HAY?–type structure; and (3) although the client involved in these extracts is thought to be communication disordered, he demonstrates some discourse management strategies (e.g., politeness work) not picked up by SLPs' assessments alone.

IDENTIFYING AND FINDING SOLUTIONS

Exploring extracts of talk can also help illuminate the science of therapy in terms of assessment and intervention. The overriding concern in therapy is the identification and discovery of solutions to problems or dilemmas in speech, language, communication, and swallowing. Extract J is taken from an interaction between a client with dysphagia and an SLP.

Extract J. Context: therapy session involving SLP with adult male client with dysphagia

J1. T: So how've you been this week?

J2. C: (2.0) Alright except this morning my cough was bad.

J3. T: Was it?

J4. C: Yeah.

J5. T: O::kay:: (3.0) and was that after breakfast?

J6. C: (2.0) Before breakfast.

J7. T: Before breakfast okay—and is it . . .

J8. C: (2.0) And during

J9. T: And during breakfast as well (1.0) a::nd emm emm (2.0) did you get up any drinks::? [or?]

J10. C: [yeah] Yeah.

J11. T: So some of the drinks came back up?

J12. C: Not drinks.

J13. T: Ohh right OK OK (1.0) [and].

J14. C: [drinks] Came out the normal place.

J15. T: Y::eah ((laughs)) and tell me John emm (1.0) was the phlegm coloured?

J16. C: (1.0) No=.

J17. T: = No, OK (1.0) and was there a lot of it?

J18. C: A good dose=.

J19. T: = Mm OK.

J20. C: Two tissues an and a bit of a napkin.

J21. T: OK and do you think emm you cleared what was there?

J22. C: Yeah.

J23. T: Yeah?

J24. C: Yeah.

J25. T: O::kay (2.0).

The discourse management strategies at work reflect the RRE sequence discussed earlier. In fact, Extract J is characterized by a repeated RRE cycle as the therapist is trying to establish how the client has been progressing since last seen. Here, she is collecting important assessment information, while at the same time establishing rapport (i.e., making humorous comments in relation to regurgitation of fluids e.g., "Came out the normal place") and identifying problems that may be subsequently dealt with in therapy. The information-gathering process, so crucial to the assessment process and in setting therapy goals, is seen here to be coconstructed: both therapist and client are building a picture of the client's status at the start of a session.

INTRODUCTION TO SOME OF FAIRCLOUGH'S IDEAS ABOUT POWER

An analysis of discourse using some of Fairclough's[18] ideas regarding power in discourse allows for a consideration of how we as SLPs identify problems and find solutions for those problems. Finding solutions, as in rapport building, is often a jointly constructed and negotiated process between therapist and client that can be mapped through discourse. Considering who is holding power in talk can help in this regard.

The context of the following extract is talk around the client's (C) concern in relation to her tendency to blurt out inappropriate (often obscene) comments, a tendency she feels she has no control over and has asked the SLP for help with.

Extract K: Context: experienced therapist (aged approximately 45 years) with client with chronic schizophrenia (Yvette, aged approximately 45 years)

K1. T: As I said, I do think I'm not so sure that we can help the

K2. other part of you blurting out things but I do

K3. think that it's tied into your speech and how rushed your speech

K4. comes out and how unclear your speech comes out sometimes.

K5. C: Yeah.

K6. T: I do think it's tied into that.

K7. C: Yeah.

K8. T: So if we can work on the clarity.

K9. C: Right.

K10. T: And the speed or the rate==.

K11. C: ==Right.

K12. T: That might help the other.

K13. C: Yeah it might.

K14. T: Well it might we can only try but you'll have to work very hard

K15. to be more conscious of your speech and slow down—even the

K16. girls do you remember you said to me the first part of the

K17. video you said "Oh I can't understand what they're saying"

K18. then you got into it, didn't you?

K19. C: Yeah.

In this extract, the therapist (T) takes control of the talk about the client's (C) speech rate, outlining possible causes of and suggesting solutions to the reported difficulty (see opening lines). Meanwhile, the client uses several back-channel devices to maintain her presence in talk (e.g., "Yeah," "Right," "Yeah it might"). An interesting by-product of the therapist's endeavor to identify the client's problem is her reinforcement of the client's position as "error maker" in the opening lines (K1 to K4).[2] Being cast as "error maker" is mitigated later in the extract as the T talks about how well the client did on reviewing the conversational skills of people on a video clip as part of a therapy session (K16 to K18).

As expected, in most instances of clinical discourse, the therapist exerts control and power over speech or communication-related issues. However, the shifting nature of "power" is particularly obvious in the next extract, involving the same client as above.

Extract L. Context: experienced therapist (aged approximately 45 years) with client with chronic schizophrenia (Yvette, aged approximately 45 years)

L1. T: But you were saying to me the last day that those things are related,

L2. you were explaining to me and you know best, you're the expert on

L3. this not me—you're the expert that when your rate speeds up you're

L4. more inclined to blurt out those things.

L5. C: Yeah.

L6. T: Isn't that ==what you explained to me?

L7. C: ==That is true, that is true.

L8. T: So it makes sense then if you try and slow your rate down . . .

L9. C: Because I'll tell you what, it's so fast it comes out so fast I haven't it in my mind to think about it first you know . . .

L10. T: Mm (. . .).

L11. C: You know when you are going to say something you say it in

L12. your mind==.

L13. T: ==Yes, you do==.

L14. C: =Well, this you don't say it in your mind it just comes out==.

L15. T: ==It just comes out without any warning==.

L16. C:==No, no warning, nothing.

L17. T: So there's kind of no rehearsal.

L18. C: Nothing [laughs] I could write a science book.

L19. T: You could what?

L20. C: I could write a science book [laughs].

L21. T: You could write science books [laughs].

L22. C: The Guinness Book of Records.

L23. T: The Guinness Book of Records.

L24. C: [laughs].

The therapist is very much in control of the talk in the opening lines of this extract, identifying what she thinks the problem is. The therapist then relinquishes control to the client after several turns (L9), indicating that she is listening by back-channeling (L12) and then agreeing with C (L13). The client, having given the therapist detailed information regarding the nature of her difficulty, thereby identifying her difficulties more clearly, then concludes jokingly, that in the context of her knowing so much about her difficulties, she "could write a science book" (L20) or go into the *Guinness Book of Records* (L22), implying that her knowledge is so extensive, that it is of record-breaking proportions. The identification of the problem is thus shown to be a jointly constructed process with the therapist initially paraphrasing for the client (L1), and later, empowering the client to elaborate on her account, reinforcing her by echoing her assertions (L21; L23) and joining in the humor initiated in this instance by the client C.

The negotiation of a solution is also a jointly constructed process and is evident in the previous extract as the therapist brings the fact that a fast rate of speech can precipitate the client's tendency to blurt out irrelevancies. The client initially agrees with this possible solution (L7). Further work on negotiating a solution continues into a subsequent session with this client as follows.

Extract M. Context: experienced therapist (aged approximately 45 years) with client with chronic schizophrenia (Yvette, aged approximately 45 years)

M1. T: About YOUR RATE . . . remember ?

M2. C: Yeah.

M3. T: Remember you just said you were going to say something about

M4. your rate of speech, you'd something to tell me.

M5. C: Right.

M6. T: About your rate.

M7. C: Right.

M8. T: You'd been thinking about it= =.

M9. C: = =I found that I say certain things which are out of context and

M10. em I find that everything I wanted to say I say it out before

M11. anything else could happen I say it out and I find that this is

M12. the reason—that this is one of the ways why I say those things,

M13. I'm thinking too fast.

M14. T: Yeah and it has to come straight out ==.

M15. C: = =It has to come straight out and this is what makes me say things that are corrupt () and I have no control of.

M16. T: Yeah and = =.

M17. C: = =Some of the things I say I do not have = =control of.

M18. T: = =Any control of, yeah right and you're sure about that?

M19. C: I'm positive . . . it's not something that I want to say.

M20. T: Right, right—and have your any ideas of how you can help that?

M21. C: () I'd say by speaking slowly.

Following a reiteration of the problem and a reminder of what was talked about in the previous session, the therapist invites the client to talk about her rate of speech (i.e., T: "Remember you just said you were going to say something about your rate of speech, you'd something to tell me"). It is established through this, and on the basis of previous interactions, that the problem is out of the client's control (i.e., C: "I have no control of") and comes about by thinking and speaking too fast (C: "I'm thinking too fast"). A solution, though referred to before by the therapist in a previous interaction (see Extract L8, T: "So it makes sense then if you try and slow your rate down") is eventually voiced by the client (C: "I'd say by speaking slowly").

The concept of power is defined by Hutchby[21] (p. 586, following Foucault[22]), as "a set of potentials which, while always present can be variably exercised, resisted, shifted around and struggled over by social agents." He goes on to explain that according to Foucault, power is not something that one participant *has* and the other *has not*. Rather, it is created within a network of possibilities, removed from the static predetermined roles in the interaction. From the example discussed, it can be seen that like rapport building, identifying problems and coming up with solutions can be a negotiated process that is easily mapped through discourse. Power is at times held by the therapist as she dominates the talk and manages the discourse, but there are other times when the client is holding the power casting herself as "expert" in her own detailed accounts of her difficulty. Power in talk is a shifting potential in the hands of neither participant, but negotiated by them on a moment-by-moment basis.

A consideration of discourse management strategies within the context of power relations may help clarify the jointly negotiated processes of identifying problems and finding solutions in speech-language pathology contexts.

CONCLUSION

This article has focused on two main processes in SLP practice: rapport building and the identification and discovery of solutions. These processes can be exemplified in talk, as therapist and client are seen to negotiate meaning and structure through the discourse management strategies discussed in this article (e.g., RREs and HAY? sequences). Therapy processes such as these may be illuminated through analysis of discourse, revealing not only useful insights for how therapists interact with clients, but also how the elusive concept of "therapy" is itself coconstructed, negotiated, and realized in talk. Reflection on therapy practice as an integration of "art" and "science" is facilitated by paying attention to therapy discourse, analyzing the talk about talk within clinical exchanges that comprises the essence of therapy practice.

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APPENDIX A Transcription Conventions

.	certainty, completion (typically falling tone)
no end of turn punctuation	implies non-termination (no final intonation)
,	parcelling of talk; breathing time
?	uncertainty (rising tone or wh-interrogative)
!	''surprised'' intonation (rising falling tone)
WORDS IN CAPITALS	emphatic stress and/or increased volume
" "	change in voice quality in reported speech
( )	untranscribable talk
(words within parentheses)	nonverbal information
[words in square brackets]	transcriber's guess
= =	overlap (contiguity, simultaniety)
...	short hesitation within a turn (less than 3 seconds)
[4]	indication of inter-turn pause length
dash, then talk	false start/restart

Adapted from: Eggins S, Slade D. Analysing Casual Conversation. London, United Kingdom: Cassell; 1997