Top Lang Disorders
Vol. 27, No. 1, pp. 37–49

Clinicians as Communication Partners

Developing a Mediated Discourse Elicitation Protocol

Julie A. Hengst, PhD; Melissa C. Duff, PhD

This article presents the development and piloting of a *mediated discourse elicitation protocol*. Grounded in situated theories of communication and informed by *mediated discourse analysis,* this protocol selectively samples familiar discourse types in a manner designed to preserve interactional aspects of communication. Critically, the mediated discourse elicitation protocol conceptualizes the entire session (not just targeted tasks) and both client and clinician talk (not just client monologues) as clinical/research data. Using situated discourse analysis techniques, we present two pilot sessions. Surprisingly, in the first session the clinician had difficulty shifting from a clinical stance (e.g., offering prompts, directing talk) to a reciprocal conversational stance during target communicative activities (e.g., being an audience to client narratives). Thus, we revised the protocol to better specify the clinician's dynamic role and conducted a second pilot session with strikingly different results. Broadly, these findings reveal that complex interactional discourse can be elicited in clinical settings and that mediated discourse analysis provides rich theoretical and methodological resources to empower clinicians in examining, accounting for, and flexibly shifting their discourse roles in order to better achieve clinical goals. **Key words:** *adult neurogenics*, *clinical discourse*, *discourse analysis*, *discourse elicitation tasks*, *mediated activity*

THE role of the speech–language pathologist (SLP) in discourse elicitation procedures is broadly grounded in issues of clinical discourse. Researchers (e.g., Leahy, 2004) have identified ways that prevailing clinical discourse practices limit opportunities for, and patterns of, participation for clinicians and clients alike. In traditional clinical contexts, the clinician assumes the role of expert or person-in-charge, whereas clients are offered the role of novice or person-seeking-help. As an expert-in-charge, clinicians assume the rights and responsibilities for initiating, managing, and evaluating the content and form of client talk. To control the discourse, clinicians use imperatives, interview-style questions, task prompts, and initiation–response–evaluation routines (Leahy, 2004; Simmons-Mackie & Damico, 1999), which are also a hallmark of instructional discourse in schools (see Mehan, 1979).

In her study of SLP feedback during sessions with aphasic clients, Simmons-Mackie, Damico, and Damico (1999) found that negative evaluations were frequently indirect (e.g., asking for a repetition rather than explicitly critiquing a response) and that feedback was often vague, with its success dependent on the client interpreting it within a clinician–client framework (e.g., clinician silence after client utterance indicates inadequate response and need for client to try again). In a study of group sessions with brain-injured adults, Kovarsky, Kimbarow, and Kastner (1999) reported that SLPs focused attention on clients' cognitive-linguistic

From the Department of Speech and Hearing Science, University of Illinois at Urbana-Champaign (Dr Hengst); and the Department of Neurology, Division of Cognitive Neuroscience, University of Iowa College of Medicine, Iowa City (Dr Duff).

Corresponding author: Julie A. Hengst, PhD, Department of Speech and Hearing Science, University of Illinois, 901 S Sixth St, Champaign, IL 61820 (e-mail: Hengst@uiuc.edu).

abilities by offering frequent evaluations of the form of client productions while minimizing response to content, and by keeping activities focused on therapeutic topics and goals. This growing body of research on clinical discourse practices of SLPs points to ways that these practices in effect suppress the competencies of the client and limit the role of the clinician.

Holland (1998), in a response to Kagen's (1998) article on supported conversation, argued that clinical training approaches may actually make it harder for SLPs to carry on meaningful conversations with aphasic adults. Kagen documented that laypeople were able to successfully adopt supported conversation techniques to improve their interactions with aphasic adults, whereas SLPs found such strategies difficult to implement. Holland suggested that the SLPs' poor performance could (in part) be accounted for by the way the field of speech–language pathology pulls clinicians away from the business of being effective communicators in conversational interactions. Theoretical and methodological traditions define conversational interactions as nontherapeutic, focusing instead on isolated linguistic units produced by individual speakers. Thus, clinicians are trained to focus attention on client talk by adopting an impersonal, distanced stance. Indeed, according to Holland, the common sentiment among clinicians seems to be that although conversation with clients may be important for building rapport, it is not an integral part of therapeutic procedures.

The two main approaches to obtaining discourse samples from individuals with neurogenic cognitive-linguistic communication disorders focus on attenuating the presence of the clinician. Traditional linguistic approaches to discourse elicitation (see Cherney, Shadden, & Coelho, 1998) focus on discourse as a multisentence linguistic unit produced by individual speakers. Discourse level tasks are designed to focus on a client's ability to organize and produce different types of discourse (e.g., narrative, descriptive, procedural) under controlled task conditions. During elicitation, the clinician presents the client with appropriate prompts (e.g., "tell me everything you see happening in this picture") and limits her own contributions to follow-up prompts (e.g., "Is that all you see?").

As an alternative to eliciting controlled client monologues, researchers and clinicians interested in interactional dimensions of discourse (see Damico, Oelschlaeger, & Simmons-Mackie, 1999; Lesser & Perkins, 1999) have drawn on conversational analysis (CA) to argue for the importance of recording conversations that occur in the course of everyday activities to meet the routine needs of the participants. CA approaches argue that to capture more "natural" samples for analysis, ideally the clinician should not participate in the conversations. The clinician's role is limited to identifying communication partners and situations appropriate for analysis, facilitating recording, and analyzing the samples. While traditional linguistic approaches seek the controlled conditions of a clinical setting to isolate client competence, the CA-based approach rejects clinical spaces as artificial. The CA approach seeks the authenticity of everyday, nonclinical settings in order to capture the communicative work of coparticipants in an interaction. Yet, each approach in its own way sees clinician talk as a source of interference and positions the clinician as an outsider to, rather than a direct participant in, the discourse being sampled.

The alternative we take here is *mediated discourse analysis* (Norris & Jones, 2005; Scollon, 2001; Wertsch, 1998). It conceptualizes discourse within a broader unit of analysis—*mediated action*. It insists on careful attention to concrete, situated action and the cultural resources (whether languages or tools, other people, or long-established and taught routines) that mediate action. It focuses clinicians' attention on (1) all participants (not just speakers) as active collaborators in an interaction; (2) all communicative resources (not just language) as the relevant mediational tools; and (3) goal-directed activity (not accurate production of discourse

forms) as the motives for communicative interactions. Mediated discourse analysis assumes that we must consider chains of activity that are longer than the immediate sequences of a given interaction, including histories of interactions between particular people, or in specific situations, social identities, genres, and so on. Taking a mediated approach to discourse elicitation shifts attention away from who is in charge (e.g., clinician or client) or where the interactions take place (e.g., clinic, home). It focuses instead on what activities participants are engaged in and how mediational means (e.g., social/communicative histories and resources) are being deployed in and around these activities. This perspective allows professionals to imagine and begin to describe alternative clinical stances, including that of the clinician as a communication partner in the discourse being sampled.

Several years ago we began a line of research exploring the interrelationship of language and memory by studying the *discourse practices* of adults with anterograde amnesia. We were particularly interested in how profound, isolated memory deficits might impact the interactional elements of discourse. Our access to these participants, set by the terms of a broader study, was limited to sessions in a clinical-research setting. Therefore, we wanted to structure a protocol that would allow us to systematically collect meaningful, interactional data in a clinical context. In this institutional setting, which by convention foregrounded clinician-controlled discourse, the challenge we faced was to implement an elicitation protocol that fostered a more symmetrical communicative relationship between the clinician and the client.

Drawing on theories of communication as mediated action, we designed a *mediated discourse elicitation protocol* and piloted it with a woman with amnesia. Reviewing that session, we concluded that our protocol had underspecified key interactional elements of the target discourse and that routine clinician discourse practices were surprisingly resistant to change.

In this article, we narrate how our initial protocol was designed theoretically, how the pilot revealed problems implementing it, how we revised the protocol to better specify discursive reception roles of the clinician in the target activities, and how striking changes in the discourse were observed during the second piloting.

DEVELOPING A MEDIATED DISCOURSE ELICITATION PROTOCOL

The mediated discourse elicitation protocol was designed to selectively target a range of familiar discourse types relevant to exploring the interrelationships of language use and memory impairments, yet to do so in a manner sensitive to its interactional complexities. Critically, the mediated discourse elicitation protocol conceptualized the whole session (as opposed to only the targeted tasks) as the elicitation protocol. It focused on specific, or targeted, discourse types as conversationally shaped (as opposed to isolated client monologues). Research on discourse abilities of adult neurogenic populations focuses on four discourse types (narrative, descriptive, procedural, and conversational) and has suggested that cognitive and linguistic demands vary considerably with discourse type, the nature of discourse tasks, and familiarity of prompts (see Cherney et al., 1998). Thus, the protocol targeted multiple samples of these four discourse types.

Conversational discourse was elicited first, in part because it was the most open-ended of the discourse types and also to help establish the conversational frame critical for the remainder of the protocol. The goal was to obtain a 10-min conversation between the client and clinician covering multiple topics of mutual interest (e.g., sharing experiences, discussing current events). The protocol did not specify a set of topics, or interview-style questions. Instead, the clinician was to draw on her own repertoire of appropriate topics for a casual conversation between acquaintances, as well as to follow up on topics offered by the client.

Narrative discourse was targeted second using three story-generating prompts (frightening experience, historical event,

personal/family story) designed to elicit personal narratives in a conversational framework. We chose story generation because it was assumed to be more demanding than tasks in which clients describe story sequences using picture prompts or retell stories from verbal models. We focused on personal narratives because they were a well-documented communicative practice in everyday talk across social and professional settings (e.g., Ochs & Capps, 2001), and thus would be more consistent with everyday discourse practices.

Descriptive discourse was targeted third using three visual prompts, two that were selected for their clinical relevance (cookie thief drawing, Norman Rockwell painting) and one of a salient event (World Trade Center attack).

Procedural discourse was targeted fourth with three prompts based on daily activities (making a sandwich, grocery shopping, changing a tire). In order to frame the client as an expert on the requested topic, the clinician personalized the prompts (e.g., tell me how to make *your* favorite sandwich) and displayed interest in the client's expertise (e.g., taking notes).

Finally, by conceiving of the entire session as the protocol, we treated discourse obtained throughout the session (between as well as during target tasks) as data, allowing for systematic analysis of interactional discourse elements (e.g., client following/taking conversational lead) and creating opportunities for unplanned target discourse samples (e.g., conversational stories).

Defining discourse as mediated action made it critical to specify the clinician's role in its production. In our initial protocol, we identified two interactional frames—a clinician-directed frame and a reciprocal frame—and called for the clinician to shift her communicative stance, or footing (see Goffman, 1981), between these two frames at appropriate times throughout the session. During the clinician-directed frame, which was used for pretask and posttask interactions, the clinician was the expert-in-charge managing clinical business, providing task instructions and prompts, and moving the session forward. During the reciprocal frame, which was used during targeted discourse tasks and to create opportunities for spontaneous conversation between tasks, the clinician adopted the stance of communication partner by providing appropriate interactional responses (e.g., being a good audience for storytelling). The reciprocal frame called for the clinician to focus on the content of the client's utterances; to be an active interactional partner (e.g., provide meaningful verbal/nonverbal backchannel supports); and to avoid passing judgment on the quantity, quality, or form of client talk. Written out, the mediated discourse elicitation protocol listed the three prompts for each of the four target discourse types with notations reminding the clinician to shift her stance between the two interactional frames.

PARTICIPANTS

Melissa Duff (second author) served as the clinician-researcher in charge of data collection. At the time, she was a doctoral student and a licensed SLP with 5 years of experience working in medical settings. Melissa was comfortable working with adults with acquired brain injuries and had extensive experience with various formal and informal assessment techniques. In addition, she had been working for 2 years in the Amnesia Research Lab, serving as clinical coordinator, handling scheduling and neuropsychological testing for amnesic participants.

We selected "Susan" (a pseudonym) to pilot the mediated discourse elicitation protocol. Susan was a 54-year-old wife, mother, and retired hairdresser with a 4-year history of profound amnesia due to bilateral hippocampal damage from an anoxic episode. Formal testing documented her language and intellectual abilities to be within normal limits, while scores on memory tasks indicated that her memory was severely impaired. Susan was friendly and outgoing, and had been a regular participant in the Amnesia Research Lab. It was, in fact, Susan's easy conversational manner, comfort in this setting, and history with

Melissa that made her perfect for piloting the protocol.

Piloting the protocol—The first session

The first pilot session took place during one of Susan's regular visits to the lab. Melissa scheduled it for the first hour of Susan's 4-hr testing schedule in an attempt to limit the influence of the controlled clinician–client roles that were typical of the standardized paper-and-pencil testing and computer experiments conducted in the lab. On this day, Susan was in good spirits. As was typical, Melissa reintroduced herself (Susan does not explicitly remember Melissa from session to session) and reviewed the day's schedule with Susan.

If viewed as a traditional discourse elicitation task focusing on client performance in isolation from the broader communicative context, the results of this first session would have certainly been successful—Melissa moved the session through all target tasks, Susan responded to all prompts, and the 19-min session yielded clean data with roughly equal amounts of time devoted to each of the four discourse types. However, as an initial attempt to implement the mediated discourse elicitation protocol, the session was disappointing. Melissa reported that throughout the session she was conflicted as to what she, as the clinician, was allowed to say. Consequently, she felt she had relied on the clinician-directed frame and had not adopted the role of communication partner for the target discourse. She felt that her attempts at small talk were too scripted (e.g., she limited herself to predetermined topics) and could not recall following up on topics introduced by Susan. In effect, her interactions with Susan felt stiff and Susan's discourse on the target tasks seemed flat and disengaged—a pattern not representative of interactions Melissa had witnessed with Susan on other occasions, even earlier that day.

Reviewing the tape, we identified several ways that Melissa had maintained an authoritative (though friendly) clinical stance during the session. Melissa minimized her own contributions while maximizing opportunities for Susan to make comments, express opinions, and tell stories. Melissa directed Susan to talk, introducing topics and tasks almost exclusively with imperatives (e.g., "tell me about your wedding day") or questions ("Do you garden or anything?"). Even during the target conversation, Melissa maintained control of the discourse by providing topics for Susan to talk about, while offering few opinions, stories, or comments of her own. In fact, Melissa introduced all 10 of the topics and did so by asking Susan questions ("Wow, so what do you think of the weather we've been having?").

Throughout the session, Melissa's feedback, particularly at the end of tasks, was usually brief and carried a general evaluation of Susan's production or compliance (e.g., "okay"; "that was a fine story"). Very little interaction occurred between target tasks, and Susan made almost no offers of topics outside of the ones introduced by Melissa.

In addition, there was evidence that Susan aligned to the role of client or research subject—she demonstrated little conversational initiative, generally waiting to be directed to talk and limiting herself to topics introduced by Melissa. She also focused on the adequacy of her responses, commenting on her memory deficits ("I don't remember any of that"), and seeking reassurance that she was performing the tasks adequately ("Did I mess that one up?"). Melissa interpreted these comments to indicate that Susan, in the absence of other explanations, was construing the target discourse tasks as activities designed to assess her memory impairment.

The impact of Melissa's clinical stance on the discourse samples obtained can be seen nicely in the narrative discourse. The narrative discourse task, including all three prompts, was 46 turns long. Melissa's instructions to Susan were minimal ("Now I'm going to have you just . . .tell me some stories") and did little to motivate the task, to indicate how the task was related to research or clinical goals, or to clarify what aspects of storytelling (e.g., accuracy, performance) were important here. The excerpt presented in Example 1 begins four turns into the narrative

discourse tasks, immediately after Melissa has given the first story prompt—"Can you tell me the most frightening experience. . .that you've had in your life?"

Example 1: Excerpt from response to frightening story prompt in session one. (see Appendix for Transcription Key):

4 S: hm. . . . . 10. . . . . the only thing that comes to mind is going on this silly roller coaster and [shakes head "no"] and I couldn't hardly get out [laughs]

5 M: Well tell me about that.

6 S: It was just so scary that..2.. my knees just buckled when I tried to get out of it in the car [laughs] when it was over with,..2.. that's about it, *I never had any* major . . . .4. . . . *burglars or robbers or anything like that.* [shakes head "no"]

7 M: Well tell me more about this roller coaster.

8 S: Just . . . ..5. . . .. I'm sacred of heights . . . 3. . . and (uh) . . . 3. . . that was probably my big thing, going through loops and everything, it was a great huge big roller coaster, the scariest thing ever happen in my life is this..2..this problem [laughs & nods head "yes"]

9 M: What problem is that?

10 S: No memory [shakes head "no"]

11 M: No memory.

12 S: No memory, . . . 3. . . yeah, . . . 3. . . like . . . being stranded somewhere and..2.. not having a clue how to get home or..2.. remembering telephone [shakes head "no"] numbers or, . . . *you know* . . . . . 6. . . . . .

13 M: So these things have happened . . . to you or you're afraid they're going to.

14 S: No::::, I'm- I've- [nods head "yes" then shakes head "no"] my family's been wonderful.

15 M: Mhm

16 S: They . . . don't want me out their sight [laughs and shakes head "no"]. They have just absolutely *been wonderful*, . . . but I'm always scared that it's going to happen you know? Ronald caught me one time, . . . I just stood where I was supposed to stay and wait for him you know and he was late, and when he came up I had a little tear in my eye and he felt so bad [laughs] yeah, but I know if I just stood there he would be there you know?

In the turns that follow, Susan rules out potentially frightening experiences such as burglaries or robberies (turn 6) and offers descriptions of two possible stories that could be considered frightening. The first story (turns 4–8) is about how she was scared during a roller coaster ride, and the second story (turns 8–16) was about fears related to her amnesia and one particular time when she was left waiting. Melissa did not follow up on the details of these narratives or respond to their emotional tones. That is, she did not display the kind of active listenership expected from a conversational partner truly interested in the story being told. Instead, Melissa maintained a clinical stance (turns 5, 7, 9, 11, 13), instructing Susan to say more and clarifying story topics. For her part, Susan never broke into a full-bodied performance of either story by setting the scene, narrating a detailed sequence of events, or using engaging storytelling elements (e.g., changing speaking prosody, including gestures, using reported speech).

REFINING THE MEDIATED DISCOURSE SAMPLING PROTOCOL—TARGETING MULTIPLE FRAMES

Because we had expected that our protocol would be relatively easy to administer, we were both quite surprised by this initial outcome. Melissa was an experienced clinician highly familiar with this population and was a skilled communicator. In addition, Susan, despite her amnesia, was outgoing and capable of participating in conversations, and she and Melissa had engaged in many conversations prior to this session. So, what went wrong? Why was it so difficult for both Melissa and Susan to draw on and display their conversational skills within this clinical context?

As a communication partner outside of the clinical context, Melissa would have felt

free to share her own stories, offer her own opinions, and generally comment on and respond to what Susan had said. However, in the clinical context, where the focus was on getting a sample of Susan's discourse, Melissa's history with controlled clinical tasks and well-established clinical discourse practices worked to limit her participation, as she kept her opinions to herself and her speaking turns brief. Consequently, Susan took up a stance consistent with the traditional client role in a typical clinical setting. Collaboratively their patterns of interaction throughout the session worked against their functioning as more reciprocal communication partners. Clearly, the interactional components of our original protocol, which primarily stated *when* the clinician should shift her stance between the reciprocal and clinician-directed frames, were insufficient to guide moment-by-moment clinical decisions.

To better specify the clinician's dynamic role in the elicitation process, we revised the protocol to focus on goal-directed activities instead of the two interactional frames. Our aim was to allow the clinician to make interactional choices at any point throughout the session by asking herself: *What is the current activity? What clinical goals does this activity address? How should I collaborate with the client to accomplish this activity?* Table 1 lists the three goal-directed activities (clinical management, target discourse sampling, and transitioning) and the clinical goals and collaborative role of the clinician during each of these three activities.

The first activity is *clinical management.* This acknowledges that the clinician carries a professional responsibility to display and use her position of authority in ways that serve clinical, institutional, and research goals. In this position, the clinician is expected to take charge of the overall session and provide expert judgments. However, unlike the often assumed, vague, and indirect ways of displaying clinical control and expertise that have been documented in traditional clinical practices (see literature review), the mediated discourse elicitation protocol calls for overt and direct clinical discourse practices. In this way, the clinician is expected to clearly display, through verbal and nonverbal means, when she is exercising her control of the session and fulfilling her role of communication expert. Specifically, this includes explicitly stating, establishing, and negotiating clinical goals; clearly explaining, motivating, presenting, and managing materials for target tasks; openly taking responsibility for institutional management issues; and providing direct and specific evaluations of client's performance as needed.

The purpose of adopting overt clinical discourse practices here is twofold. First, logistically, a clear display of a managerial stance allows both parties to more easily differentiate clinical management activities from other session activities (see below). Second, instrumentally, an overt and direct explanation of clinical (or research) goals provides an opportunity to motivate the tasks. During our evaluation of the first protocol session, it appeared that Susan misinterpreted the discourse tasks as memory assessments, and thus worked to shape her narratives as memory displays (e.g., recalling story details) instead of as conversational stories. Overt discussion of clinical goals should keep the client from having to guess about task motivations and facilitate client and clinician collaboration. Finally, such an explicit focus reflects the emphasis in theories of mediated action on the centrality of motives and goals to all situated activity.

The second activity, *target discourse sampling,* focuses on obtaining conversationally produced discourse samples. In this activity, the clinician adopts an important supporting role within the target discourse by serving as an appropriate communicative partner. The goal of the conversational task is to obtain a 10-min *reciprocal* conversational exchange. By focusing on swapping stories and opinions, as is typical of causal conversation, the clinician's role includes making conversational offers and responding conversationally to offers made by the client. The goal of the narrative discourse task is to obtain a conversational

Table 1. The interactional elements of mediated discourse analysis protocol, focusing on the activity frames of the session and the different clinical goals and collaborative roles for the clinician for each activity frame

Activity frame	Clinical goals addressed in activity	Clinician's collaborative role in accomplishing activity
Clinical management	1. Set research/session goals 2. Present task instructions and prompts 3. Evaluate client responses, progress 4. Provide clinical expertise 5. Respond to client questions and concerns 6. Obtain recordings of interactionally produced discourse samples	Clinician-controlled discourse marked by 1. Clinician provides overt, explicit, instructions, directions and feedback. 2. Topics discussed focus on session goals, form and content of client utterances, and explanations of communication, communication disorders, diagnosis, and treatment. 3. Clinician works with client to develop shared understanding of, and motives for, activities in the session.
Target discourse sampling	Four target discourse types: 1. Conversational 2. Personal narratives 3. Picture descriptions 4. Procedural	Clinician in communication partner role, marked by 1. Clinician responds to content of client talk and provides appropriate reception (e.g., conversation partner; narrative audience; listening to client picture description; taking notes on procedural expertise). 2. Topics discussed are personal and social in nature. 3. Clinician provides interactional support and follows client's lead.
Transitioning	1. Make shifts in activities visible 2. Create opportunities for nonprompted talk 3. Create and maintain conversational framework for session through use of small talk	Clinician has fluid role—shifting between clinician-controlled and communication partner: 1. Formally marks end of current target task 2. Makes conversational small talk 3. Responds to conversational offers by client 4. Introduces next task/prompt

telling, or performance, of a personal narrative. The clinician's role as audience is critical in encouraging the client to break into a narrative performance. To do this, the clinician needs to be engaged with, and responsive to, the content and emotion of the story event. The goal of the descriptive discourse task is to solicit the client's opinion or observation about the target picture. The clinician's role in this context is to listen attentively, allowing the client to have the first say, and follow up with an observation of her own. Finally, the procedural discourse task creates opportunities for the client to display expertise by outlining or describing a procedure. Procedural discourse occurs in everyday

conversational settings, such as getting a recipe from a friend or explaining how to use a new piece of equipment. Speakers often recite the procedure in a manner that allows the listener to accomplish, or write, the steps, and listeners often seek confirmation of the procedure by restating the steps. Thus, the clinician's collaborative role in the protocol includes writing down the procedures presented by the client and reading them back to the client for confirmation.

The third activity, *transitioning*, highlights the importance of attending to the work of, and opportunities for, shifting activities throughout the session. During transitioning, the clinician overtly marks the shift in activities both verbally (e.g., "okay, now we need to move on to the next task") and nonverbally (e.g., picking up a clipboard, changing posture). Opportunities for unplanned interactions are created by initiating conversational small talk and following the client's conversational leads. Transitioning is not limited to the moments between targeted tasks, but may be initiated by the client (or clinician) at any time during the session. For example, in the first session when Susan commented on her poor memory or the adequacy of her responses to task prompts ("I don't know if I'm doing this right"),Melissa could have identified such utterances as transitioning activity by ratifying the shift to clinical management and overtly restating the goals of the task (e.g., "Remember this is not a memory test").

Piloting the protocol—The second session

Working with an amnesic client provided an opportunity to conduct the second pilot session with minimal concern for how learning might impact the results. The second session occurred approximately 10 months after the initial one. As in the first session, Susan was in good spirits and Melissa (re)introduced herself and reviewed the schedule, which began with the revised protocol. The pilot session that followed, however, was quite different from the first one.

During the second session, which lasted 45 min, Susan and Melissa produced more than double the turns and words than they did the first session, and talk time (estimated by total number of words produced) was more evenly distributed between them. Indeed, during the first session, in which Melissa worked to limit her talk time, Susan produced twice as many words as Melissa (1432 and 730, respectively). In the second session, however, Melissa actually produced more words (3315) than did Susan (2602). Melissa's increased talk time included more discussion of research and task goals as well as more side conversations during which both Melissa and Susan made comments and offered stories.

Compared to the first session, Melissa felt that their interactions throughout this second session had "loosened up." The session flowed easily from task-to-task and topic-to-topic. At various times both Melissa and Susan took the conversational lead. As the conversational partner in the target discourse, Melissa confidently took on diverse interactional roles. Overall, Melissa reported that their interactions during this second session were more consistent with Susan's conversational engagement outside of the clinic room.

In reviewing the videotape, there was clear evidence that Melissa shifted her stance to accomplish target activities. As the clinician in charge, Melissa took on a directive and open stance, clarifying what she was, and was not, looking for (e.g., "There are no wrong answers here, all I am interested in ... is to see how you communicate").Melissa returned to this overt directive stance at the beginning and end of each target task, resuming her role as session manager, moving them forward through the protocol, and clarifying the goals of the various tasks. The length and content of Melissa's turns varied across activities. Within the conversational task, Melissa used her own comments, opinions, and stories to shape the discourse into a back-and-forth, or swapping, pattern. She introduced topics by sharing her own experiences (e.g., "My dad

uhm.1. he had a truck, he didn't have to go . . . you know cross-country, he pretty much stayed in the Midwest"), by reintroducing past topics (e.g., "one of these past times when you were in you told me that you used to work in a . . . salon"), and by following up on emerging topics. Susan's talk was also more varied. She responded to topics Melissa raised, initiated topics of her own, and made fewer comments about her memory impairment or the accuracy of her responses. On the few occasions when Susan did mention her memory deficit, Melissa shifted to a clinical frame to overtly restate the research goals.

The difference in these two sessions is displayed nicely in the narrative samples. This time Susan and Melissa devoted more than four times as many turns (199 turns) to the narrative discourse tasks than in the first session (46 turns). In addition, Melissa clarified the task goals by telling Susan that she wanted to hear her tell stories, not test her memory. She focused Susan's attention on what it meant to be a good storyteller by asking her who the good storytellers were in her family. Example 2 begins with Susan's turn right after Melissa had given the frightening story prompt: "the first story I want you to tell me is about your most frightening experience."

Example 2: Response to frightening story prompt in session two (see Transcription Key in Appendix 1).

14 S: *Frightening experience* . . . 3 . . . *frightening experience* . . . 3. . . have I had one of those. . . .4. . . . okay..2..it was no- not too frightening, but uhm, I was working at the beauty shop..2..

15 M: Mhm

16 S: a:::nd everybody had gone to leave and there was about nine of us . . . that worked in there

17 M: Mhm

18 S: and everybody had gone and I was there with keys to close up and I was working on my last customer

19 M: Uhm

20 S: and it was like . . . nine o'c lock at night, . . . a::nd there was a door at both ends . . . [gestures as if pointing at doors] of the shop, that went straight through [moves hands side to side] the shop again, a::nd when I look up . . . and there was a man standing there and the door was locked you and it was like..2.. "Can I help you?" you know

21M: Oh my gosh!

22 S: It was like "Ohhh! Gosh what is this!" . . . and we had already had the cash door open a::nd . . . [moves hand as if opening drawer] yeah

23 M: Mhm

24 S: everything opened and you could see there was no money

25 M: Right

26 S: You could see that from the outside even but uh..2.. he's standing there and he's he's really nervous you could tell he was shaking and and I was . . . a little alarmed and my customer was very alarmed you know and . . .

27 M: Oh well, at least there was someone else there.

28 S: Yeah [nods head "yes"]

29 M: For a minute I was thinking it was just you.

30 S: Yeah, but she was like a hundred years old so [laughs::::::::::]

31 M: [laughs] So she was useless to you?

32 S: Yes, mh [nods head "yes"] and finally I ge- I- you know . . . "Can I help you?" . . . Uhm, . . . very nervously he says "Yeah I need uh change for the vending machine." I said "Okay [nods head "yes"] I can do that you know" I said "that's all I got is change."

33 M: Mhm

34 S: I said "I don't have any bills you know." So I- I gave it to him and..2.. and I let him out cause I had to unlock the door you know and uh . . . 3. . . my customer immediately got up and called her husband and told him what happened you know . . . he came straight down . . . with his handgun [laughs]

35 M: Oh wow!

Throughout the 37 turns of this storytelling, Melissa displayed her engagement in Susan's emerging conversational narrative. While Susan settled on a frightening story to tell, presented a description of the scene, and set up the story events to follow (turns 14, 16, 18), Melissa provided backchannel responses to signal her involvement in the unfolding narrative (turns 15, 17, 19). In turn 20, Susan presented the initial frightening event ("a man standing there"), and dramatized the telling with use of gestures (pointing to imaginary doors, moving hands side to side) and direct reported speech ("'Can I help you?"). In turn 21, Melissa's response ("Oh my gosh!") marked her continued affective involvement in the story. Susan highlighted Melissa's response by recasting it as her own response within the story to the stranger's sudden appearance: "Ohhh! Gosh what is this!" For the remainder of the storytelling, Melissa continued to respond to the narrative by reflecting story emotions and clarifying story details. At the end, she not only agreed that it was a scary story but even offered a more dramatic setting for the tale ("I picture it being a dark night"). Throughout the telling, Susan capitalized on Melissa's affective audience displays of involvement to construct a successful, dramatic narrative.

CONCLUSIONS—THEORETICAL AND CLINICAL IMPLICATIONS

We have presented this account of our development of a mediated discourse analysis protocol because we found the process of working through it quite striking. It was striking to both of us that the initial protocol—although theoretically grounded, explicitly talked through and written up, implemented by an experienced clinician-researcher, and piloted with a client who had good communication skills—had failed to achieve its goals. It was striking, too, that the revised protocol, grounded in an analysis of what went wrong and why, took such a different approach from the first. Finally, it was striking how quantitatively and qualitatively different the discourse produced in the second session was from that of the first session. In short, we found that this process of protocol development and piloting clarified for us both the challenges and the means of enacting a mediated discourse approach in a clinical setting.

When discussing these findings with others, we are often met with the response that some clinicians are simply better communicators than others. The implication seems to be that effective communication in clinical settings is a mystery, perhaps a natural gift for some, but in any case beyond serious analysis or instruction. For a field constituted on the premise of clinical intervention to improve linguistic and communicative abilities, such a view is decidedly odd.

We suspect, in addition to prevailing clinical training practices suggested by Holland (1998), that it is precisely the asymmetrical power relations, the ideology of authority (see Kovarsky et al., 1999), that has kept clinician discourse outside the circle of analysis and intervention. Even conversational analysts, who have detailed and critiqued the effects of the traditional forms in clinical settings, seem to have accepted their manifestations as inevitable (hence the need to collect samples outside of any clinical influence). As we presented here, although we found the combined weight of dominant theories of language as individual competence, of ideologies of professional expertise and authority, and of histories of socialization into clinical practices to be stronger than anticipated, we also found them amenable to our interventions. In short, in the microcosm of this story, we see dynamics and forces we believe to be widely present in our field.

Broadly, these results reveal that SLPs' expertise in communicative analysis can effectively be applied to reshaping clinical practices. Discourse elicitation procedures should aim to sample monitor, and sustain specific types of interaction and goal-directed discourse. Such procedures call on clinicians to reject the conventional wisdom that sampling procedures should be simplified and clinician "interference" should be minimized.

Clinicians cannot rely on the assumption either that a task prompt will simply produce the desired discourse type or that collecting discourse samples at home or in community settings will guarantee a more meaningful or collaborative interaction. This analysis (along with our experience using the revised protocol in more than 40 sessions) makes it clear that complex interactional discourse can be elicited between clinicians and clients in clinical settings. Finally, this experience reinforces our perception that theories of mediated action and mediated discourse analysis offer rich resources for reconceptualizing communication as situated, sociocultural practice. This reconceptualization focuses on how activities are shifted, sustained, and juggled; on how communication is collaboratively supported not only by co-present participants but also by histories of use; and on how personal and social motives and goals infuse and animate communicative activity. This new focus strikes us as productive grounds for empowering clinicians to reimagine their roles in clinical contexts and to flexibly wield their discourse to achieve clinical goals.

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Appendix

Transcription Key

Symbol	Meaning
S:	Susan speaking
M:	Melissa speaking
. (period)	Turn final intonation
, (comma)	Turn continuation intonation
? (question mark)	Questioning intonation
: (colon)	Prolonged sounds
! (exclamation mark)	Excited intonation
- (dash)	Abrupt stop in speaking
" " (quotation marks)	Shift in voicing to match quoted speaker
italics	Quiet voice
underlining	Simultaneous talk across speakers (e.g., overlapping turns) or simultaneous talk/gesture (e.g., laughing while speaking)
... (ellipses)	Pauses of less than a second
...3...	Longer pauses indicated in number of seconds
[ ]	Descriptions of gestures