# THE ACHIEVED COHERENCE OF APHASIC NARRATIVE

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## ABSTRACT

This paper addresses what can be called "the problem of coherence in aphasic discourse." Most research on aphasic discourse analytically strips it from the context of its *in situ* production, and then paradoxically finds language deficits at the sentence level, but intact discourse abilities. This paper argues that conversation analytic methods can solve this problem by analyzing the data without desocializing and detemporalizing it. We then argue that sequences of social action, not individuals, are the locus of conversational competence and coherence.

*The stylistic shaping of an utterance is shaping of a social kind, and the very verbal stream of utterances, which is what the reality of language actually amounts to, is a social stream. Each drop of that stream is social, and the entire dynamics of its generation is social.*

—(Volosinov 1973, pp. 93-94)

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## INTRODUCTION: APHASIC DISCOURSE AS A HEALTH PROBLEM

As people age, their chances of having a stroke increase (but strokes are not limited to the elderly). As life expectancy increases and the U.S. population (on average) gets older, strokes are becoming a health problem that most people will experience (directly or through affected family members and friends). As a result, the outcomes of stroke (such as aphasia) are health problems with which large numbers of people will have to deal.

When a person survives a stroke, he or she may be left aphasic. Aphasia involves

> ...a disturbance of language function...[usually resulting]...from damage to the left cerebral hemisphere. In its mildest form, it may simply involve the inability to name objects such as a table, clock, or pen....In the worst cases, the patient has almost complete loss of the ability to comprehend language, and cannot speak, though happily, the problem is rarely so severe (Gregory 1987, p. 751).

There are two types of aphasia: Nonfluent (Broca's aphasia) and fluent (Wernicke's aphasia). The patient we will discuss in this paper has nonfluent aphasia, which means that he has difficulty finding words, even extremely common ones, and therefore talks in a slow, halting, fragmented manner, as displayed in the following data excerpt, wherein the patient has been asked to tell the interviewer "How did you know you were having a stroke?"[1]

[Aphasia 1]
42 P: Bathroo:m,
43 (0.8)
44 W: *alr:i:ght,*
45 (.)
46 L: Hm hmm,
47 P: O::h o::h
48 (4.4)
49 s:ome thin wrong
50 (0.8)
51 may be (0.4) STROKE.
52 (1.2)
53 L: Ah huh,
54 (1.0)
55 P: Got up,
56 (0.6)

How does the interviewer understand this patient? How can the patient make himself understood? Managing interactions, either as an aphasic patient or as someone talking with one, is a real, palpable problem for many people, and yet they routinely manage this problem. How do they do it?

We know from the social problems literature that any health problem can also be studied as a *social* phenomenon, (e.g., Conrad 1975; Emerson and Pollner 1978; Hilbert 1984). Furthermore, this social respecification can help us better understand the foundations on which our knowledge and experience of health and illness are built. Health problems do not occur in a vacuum, and people do not respond to them in a vacuum; rather, social conditions and processes are highly relevant to (indeed, in a technical sense, constitutive of) the emergence, detection, and management of health problems (Hilbert, 1984; Halkowski, forthcoming).

## Coherence in Aphasic Discourse

This paper will address what can be called "the problem of coherence in aphasic discourse." While "coherence" is defined as a "logical or aesthetic consistency," there is a related sense which is more relevant for our discussion. That second, related sense refers to the way that something "holds together firmly, as parts of the same mass" (*Webster's Ninth New Collegiate Dictionary*).

In research on aphasia, an interesting problem has been posed, namely, given the inventoried language deficits of aphasic patients, the fact that they can produce narratives *seems* remarkable.[2] As Ulatowska and Freedman-Stern argue, there is:

> preservation of narrative structure and of the cohesiveness of connected language in the presence of the severe disruption of language at the sentence level. The dissociation between functioning at these two different levels of language was so striking that it has kept us working in the area of discourse ever since (Ulatowska et al. 1983, p. 319).

In addition, Ulatowska and colleagues make reference to:

> clinical impressions of a discrepancy between aphasics' performance on standardized tests and their communicative functioning in natural environments (Ulatowska et al. 1981, p. 346).

This observation is also noted in research that takes a sociolinguistic approach to aphasic discourse, as in Burns and colleagues:

> Sociolinguistic analysis of the speech of aphasic patients suggests that communicative competence is often present even when linguistic competence appears to be lacking (Burns et al. 1991, p. 166).

Both Ulatowska and colleagues, and Burns and colleagues note a "dissociation between functioning at these two different levels of language," and this difference leads to a specification of the problem of aphasic discourse, namely: given the noted deficits of aphasic speakers at the sentence level, *how* are they able to produce cohesive discourse?

After a review of the literature on aphasic language abilities at the level of discourse, Ulatowska and colleagues, propose that:

> ...all the above investigations of discourse point to the relative preservation of discourse structure in the aphasics studied. The selective disruption of certain elements of discourse, although lowering cohesiveness of discourse, does not destroy it (Ulatowska et al. 1983, p. 319).

The problem of how aphasics are able to produce coherent discourse is answered by arguing that "discourse structure" in aphasics, while somewhat lowered, is not disrupted as much as other language abilities. Thus some "preinjury" ability remains, and this native ability can still be drawn upon, despite language deficits at the sentence level. We might characterize this answer as an "appeal to preserved native ability."

Burns and colleagues, have a more specific approach to this question. They argue that:

> ...phonological, lexico-semantic, and grammatical errors in the speech of aphasic patients makes conversations with them arduous and difficult to follow, but, as we hope to show, attention to conversational cohesion can overcome these disturbed speaking strategies used by aphasic patients. In particular, "illocutionary force" (Searle 1969), or the speaker's explicit or implicit intention to communicate, present in normal conversation, can be discerned in the speech of aphasic patients (Burns et al. 1991, p. 166).

Moving beyond an appeal to preserved native ability, Burns et al. address the question of how aphasics produce cohesive discourse by arguing that the "illocutionary force" of utterances by aphasics can be "discerned." Thus, being able to see what actions one's interlocutor is "explicit[ly] or implicit[ly] inten[ding] to communicate" with his or her talk provides the hearer with a way to find coherence in aphasic discourse. If Ulatowska's solution is an appeal to preserved native ability, Burns and colleagues answer might be characterized as an appeal to speech act theory.

We need to address one more aspect of the problem of coherence in aphasic discourse, namely, is there such a thing as aphasic discourse? While the discourse produced by people diagnosed as aphasic might reasonably be called "aphasic discourse," this question gets at a deeper analytic issue. That is, what specific warrant do we (as researchers) have for characterizing talk produced by aphasic patients as something *analytically* distinct from "ordinary" talk?

In the conversation analytic literature, this question is that of the "relevant" categorization of analytic phenomena, and it has been discussed at great length and depth (cf. Sacks 1972, 1992; Schegloff 1991; Wilson 1991; Zimmerman and Boden 1991).

Until it has been shown otherwise, we ought not presume that aphasic discourse is something analytically distinct from "ordinary" talk. That distinction must be demonstrated, not assumed.

In contrast with the extant literature on "aphasic discourse," we shall propose that:

(1) *how* aphasics produce coherent discourse is entirely graspable, once one accurately reformulates the question; and (2) the "problem of coherence in aphasic

discourse" is largely a measurement artifact that has been exacerbated by a fundamental misunderstanding of what discourse (and more specifically, narrative) is.

That is to say, the finding of a "disparity" between aphasic language ability at the sentence and discourse level, and the resultant "problem of coherence in aphasic discourse" tells us more about *research* on "aphasic narrative" than it does about aphasia, narrative, or aphasic narrative.

To foreshadow our argument, "discourse" has been conceived of (in most research on aphasia) as the sole product of an individual's speech. As such it has been both desocialized and detemporalized. Furthermore, "aphasic discourse" has been studied almost exclusively via experimental methods, rather than naturalistic data. These *reductions* of the phenomenon have created a research artifact which is quite distinct from discourse in its natural contexts of use.[3]

## COHERENCE IN SITU

In their research, Ulatowska and colleagues treat coherence as purely psychological and linguistic. For example, consider the following:

> Many discourse studies have investigated the coherence and cohesion of texts and their relation to thought....Both coherence and cohesion relate to the well-formedness of text: coherence, in terms of the plausibility, conventionality and conclusiveness of text, is a general cognitive concept, while cohesion refers to linguistic devices such as anaphora and reference, which produce coherence (1981, pp. 346-347).

First, note that in their analysis of the coherence and cohesion of aphasic narratives, that evaluation is being made *ex cathedra* by researchers. However, in everyday talk (by aphasics and others), the coherence and cohesion of narratives is attended to, as a practical matter, by the interlocutors themselves (Sacks et al. 1974).

Secondly, consider that interlocutors attend to the coherence and cohesion of each others talk on a *moment by moment* basis (Sacks et al. 1974; Sacks 1992). They do this, for example, not simply at the end of a person's story in a summative evaluation, but all the way through the story, verbally and nonverbally registering understanding, confusion, agreement or disagreement, amazement, and so on (Sacks 1992, 1974; Goodwin 1984). There are a host of ways that a narrator can detect and repair misunderstandings of a story by hearers in the midst of a narrative (Sacks 1992, 1974).

Thus researchers could study narrative coherence by looking at how interlocutors deal with these concerns *in the midst* of the talk in question. This would provide researchers with a measurement of these phenomena that is both reliable and valid, because it is the way that interactants themselves attend to these issues.

## Narrative Discourse as Interactional

In their research, Ulatowska and colleagues have defined "discourse" as "connected speech," beyond the level of "simple sentences" (1981, p. 346). Note that this definition treats discourse as the product of an individual's work. Focusing more specifically on "narrative," Ulatowska and colleagues (1981 pp. 350-351) use the Labov model, which defines narrative as consisting of five defined components. They also cite Labov (1972) for his analysis of the "internal organization" of narrative (Ulatowska et al. 1981, p. 348). Yet Labov's analysis of narrative also treats it as the product of an individual.

In addition, the use of researchers' notions of what constitutes a narrative, such as some definition of its internal components (Labov 1972), may not be as valid as looking at what interactants treat as narratives in actual interactions (Sacks 1992). When Ulatowska and colleagues (1983, p. 320) use the notion of a "narrative superstructure" (Labov's model), as a way to evaluate the narratives, they commit a fundamental error; they treat narrative superstructure as a reified individual product (a solitary block of talk), rather than as an interactive (i.e., social) process (Sacks 1974, 1992). Indeed, narratives are social not simply in content; the *very form* of narratives are social/interactive (Goodwin 1981; Sacks 1992).

## Narrative Discourse as Sequential

By failing to recognize that narratives are interactional productions, we lose sight of crucial abilities that speakers (aphasic or not) make use of in talk with one another. These abilities rely on the sequentiality of human interaction. Because narratives are routinely produced for (and in response to) others, they need to be understood, analyzed and evaluated with these features of their production in mind.

For example, in their research, Ulatowska and colleagues (1983, p. 321) report that, as a part of their data collection methodology, they deleted repetitions and false starts from their tape recorded aphasic discourse data. This sort of "data cleaning" is typical of research done on aphasic discourse, and discourse in general. In addition, the silences (within and between turns of talk) are usually not timed or transcribed, and are not treated as relevant data. With these deletions, what is (inadvertently) stripped from the data are almost all the bits of concrete evidence for the thoroughly interactional character of narrative discourse (Sacks et al. 1974; Sacks 1992).

Work in conversation analysis (Sacks et al. 1974; Goodwin 1981; Sacks 1992; Schegloff 1987) has shown that silences, hesitations, repetitions, and false starts, are orderly phenomena in natural talk-in-interaction, and should not be *presumed* to be disorderly in the talk of aphasics. When one considers narratives by aphasic individuals where the data are not "cleaned up," the evidence for their interactional constitution is overwhelming.

## ANALYSIS

In this paper we will analyze some ways that a fundamental aspect of human interaction, that is, the sequentiality of talk, is used by aphasics and others to produce and understand narratives. The data for this paper consist of a videotaped, semistructured interview with an aphasic male and his wife.[4]

[Aphasia:1][5]
L: *Okay.*
(.hh)
I'd like ta just begin by asking you if you can
tell us a little bit about thuh stroke.=
=when it first happened.
Ha-how'j you know you were having ah stroke
what-what happened.
(0.6)
Kin you remember?
(8.4)
W: What happened thuh day you had thuh stroke.
(.)
in Wildwood.
(0.6)
when you were in thuh trailer,
[Aphasia:1][5]
(1.1)
P: (d)Right.
(2.5)
Mony:: (0.6) STROKE (0.3) Diff'rent Strokes
diffrent stroke
(0.8)
Me:
(1.0)
got me
hhmm.
W: you-no,
(.)
W: [what ]
L: [(No/ah)]
(.)
W: they didn't ask you (.) (h:)how come you had thuh
stroke
(0.4)
What h(h)appened thuh day that you (were-) had thuh
stroke.
(.)
How did you know you were having ah stroke.

38 (1.2)
39 Tell them a[bout] when you were in thuh trailer,
40 →P: [O::h]
41 (0.7)
42 →P:Bathroo:m,
43 (0.8)
44 W: *alr:i:ght,*
45 (.)
46 L: Hm hmm,
47 →P:O::h o::h
48 (4.4)
49 s:ome thin wrong
50 (0.8)
51 may be (0.4) STROKE.
52 (1.2)
53 L: Ah huh,

Near the very beginning of the interview, the interviewer (L) asks the patient (P) if he can "tell us a little bit about the stroke" (lines 1-10). After a series of clarifications (lines 11-39), the patient tells the story of how he discovered that he was having a stroke (lines 42-51). As "telegraphic" as the patient's story is, I take it that its basic contour is evident: the patient was in the bathroom (line 42), noticed something wrong (lines 47-49), and thought that it might be a stroke (line 51). At this point the interviewer produces a "continuer" (line 53), thereby indicating that while she heard this "slot" in the patient's talk as a possible completion point, she would like the patient to continue speaking (Schegloff 1982).

In this analysis, I will demonstrate two basic points: first, the process of clarifying the interviewer's initial question (lines 1-39) so as to elicit an appropriate answer from the patient is a demonstration of the coherence of "aphasic" discourse; second, when the patient produces the requested narrative (lines 42-51), its coherence is provided via its sequential structure (Schegloff 1992).

## Eliciting a Narrative

One of the most important aspects of narratives is that they are interactionally initiated (Sacks 1974, 1992). One offers up a story (after ascertaining that one has an audience for it) or one is asked for one. In our data example, a narrative is elicited by the interviewer (L).

[Aphasia:1]
1 L: *Okay.*
2 (.hh)
3 I'd like ta just begin by asking you if you can
4 tell us a little bit about thuh stroke.=
5 =when it first happened.

6 Ha-how'j you know you were having ah stroke
7 what-what happened.
8 (0.6)
9 Kin you remember?
10 (8.4)
11 W: What happened thuh day you had thuh stroke.
12 (.)
13 in Wildwood.
14 (0.6)
15 when you were in thuh trailer,
16 (1.1)
17 P: (d)Right.
18 (2.5)
19 mony:: (0.6) STROKE (0.3) diff'rent strokes
20 diffrent stroke
21 (0.8)
22 Me:
23 (1.0)
24 got me
25 hhmm.
26 W: you- no,
27 (.)
28 W: [what ]
29 L: [(No/ah)]
30 (.)
31 W: they didn't ask you (.) (h:)how come you had thuh
32 stroke
33 (0.4)
34 What h(h)appened thuh day that you (were-) had thuh
35 stroke.
36 (.)
37 How did you know you were having ah stroke.
38 (1.2)
39 Tell them a[bout] when you were in thuh trailer,
40 →P: [O::h]

Note a few simple features of this story elicitation. First, L sets a context for her question (lines 3-5). Then she asks her question (line 6-7) and waits for a response (line 8). Getting no response, L issues an answer prompt which provides a possible account for P's lack of answer so-far ("Kin you remember?," line 9).

After a long 8.4 second silence, the wife of the aphasic patient (W) produces a recycled reformulation of the story elicitor (lines 11-15). Her reformulation of the question seems designed to elicit a story from her husband, P. Specifically, she asks about the events on the day he had the stroke, then adds the location, (line 13), and a more specific temporal and spatial formulation of P's location (line 15).

These specifications ask P to focus on a specific day, location, and event, and tell what happened then.

P acknowledges his wife's reformulation of the question (line 17), and then produces a candidate answer (lines 19-25). This answer seems to state that he had different strokes, but does not know why ("got me"). Note that his turn appears to offer a candidate *answer* or account, rather than a story.

Indeed, W starts to respond in a way that rejects P's answer (line 26-28), as does the interviewer (line 29). W then goes on to issue a recycled reformulation of the story elicitor (lines 31-39). Again, W's turn seems designed to elicit a story from P. She does this first by rejecting P's prior answer, and specifying why it is rejected ("they didn't ask you (.) (h:)how come you had thuh stroke"; lines 31-32). Second, she re-asks her initial question (lines 34-35). Third, she recycles one of L's initial questions (line 37: "How did you know you were having ah stroke"; cf. line 6). In the midst of the next portion of her question recycling (line 39), the patient starts to respond (line 40).

The specific form of P's response in line 40 is a "change of state token" (Heritage 1984), which is a claim of understanding ("O::h"). Via this turn, P claims to now know what is being asked of him. By its specific sequential placement within W's talk, P indicates that the immediately prior portion of W's turn (line 37 and the start of line 38) gives him what he needs to appropriately address the question. We can note that this question by W (line 37) is one that patients in primary care visits with their doctors routinely address, (via a "narrative of symptom discovery"), that is, a story of what I noticed that made me realize I need to consult a physician (Halkowski, forthcoming).[6] There is evidence then, that P may now see that what he is being asked for is such a narrative.

As a result of the ways that both L and W reformulate their questions, based on P's initial response (lines 17-25), they demonstrate that they see his response *as* an understandable response, just not the one they we're asking for (as W puts it, "they didn't ask you (.) (h:)how come you had thuh stroke"; lines 31-32). Therefore, even in this preliminary part of the interview, both L and W treat P's talk as coherent. In the next portion of the analysis, we'll consider how P's next few turns are hearable as a coherent narrative.

## Achieved Coherence in Aphasic Narrative

[Aphasia:1]
37 W: How did you know you were having ah stroke.
38 (1.2)
39 Tell them a[bout] when you were in thuh trailer,
40 P: [O::h]
41 (0.7)
42→P: Bathroo:m,
43 (0.8)

44 W: *alr:i:ght,*
45 (.)
46 L: Hm hmm,
47→P: O::h o::h
48 (4.4)
49 → s:ome thin wrong
50 (0.8)
51 → may be (0.4) STROKE.
52 (1.2)
53 L: Ah huh,

As discussed above, W's question in line 37 operates as a particular kind of story elicitor question, tha is, an elicitation of the patient's practical epistemology (e.g., "how did you know [or find out] 'X'?") (cf. Whalen and Zimmerman 1990; Bergmann 1993). It works to elicit what can be called a "narrative of discovery" (Halkowski, forthcoming).

At line 41, both W and L withhold speech. By these actions, the "floor" is turned over to P. A crucial aspect of the production of a narrative is that it requires more than one turn to complete (Sacks et al. 1974; Sacks 1992). Thus it requires the cooperation of the interlocutors, and this handing over of the "floor" is partially constitutive of the narrative. Thus this seemingly brief silence (0.7 seconds) is an illustration of one of the ways that narratives are thoroughly interactional productions.

In line 42, the patient begins his story with a one word utterance:

P: Bathroo:m,

The utterance is spoken with a slight upward intonation (signified by the comma) and is slightly stretched in its production (marked by the colon). The continuation intonation of this utterance allows the others to hear the turn as an initiation of a longer turn (i.e.,they can expect that more is to come).

This turn provides an initial location, but also does more. As Schegloff (1972) noted, sets of activities are "bound" to different locales, so much so that some location terms become euphemisms for certain *activities* (e.g., "going to the bathroom" or "going to bed with someone"). Thus, this turn gives a location, but also may suggest a set of possible activities P was engaged in at the time. This is important because narratives of discovery typically start with an "ordinary" activity, into which the storyable event intrudes (e.g., "I was just shaving, when I happened to notice that...") (cf. Zimmerman 1992; Sacks 1992).

Next there is a silence (line 43), during which the patient declines to continue, and no one else self-selects to speak. When W and L do elect to speak (lines 44 and 46), they do so only to produce acknowledgments of the turn-in-progress. In other words, both of their turns acknowledge what the patient said, but specifically treat it as turn-*initial*, rather than a complete turn. In this way they help to elicit and

sustain the patient's telling. We should note as well that the wife's turn has the sense of a third turn receipt such as a teacher might employ, after asking a quiz question—it seems to function as a validator of the prior turn (cf. Meehan 1979.).

[Aphasia:1]
37 How did you know you were having ah stroke.
38 (1.2)
39 Tell them a[bout] when you were in thuh trailer,
40 →P: [O::h]
41 (0.7)
42 →P:Bathroo:m,
43 (0.8)
44 W: *alr:i:ght,*
45 (.)
46 L: Hm hmm,
47→P: O::h o::h
48 (4.4)
49 s:ome thin wrong
50 (0.8)
51 may be (0.4) STROKE.
52 (1.2)
53 L: Ah huh,

In line 47 the patient produces an utterance which marks a negative discovery. Its understandability as such is derived from its "parasitic" relationship to the "change of state" token (Heritage 1984). That is to say, since "oh" is often used in talk to claim a "change of state" (e.g., to claim that one just *now* has noticed or understood something), the utterance "*oh* oh" (spoken with falling intonation) is routinely used and heard as a marker of negative discovery.[7]

Note the long silence in line 48, yet another display of the interactional nature of narrative. The patient has just produced an utterance (line 47), which is not yet hearable as a complete turn, so W and L withhold talk, thus helping to constitute this silence as a "pause within the narrative" (as opposed to a silence at the end of a turn of talk). Having heard the marker of negative discovery, (which forecasts a negative event), the hearers wait for the completion of the turn, wherein the negative event might be announced.

In line 49, P produces a turn which marks a negative event, further forecasting the bad event to come. After the silence on line 50 (about which we can make the same observations we did regarding the silence on line 48), the patient produces a proposed problem label ("maybe stroke"). Note that the proposed problem label allows the patient to use the word about which both L and W requested the story (L: "tell us a little bit about thuh stroke"; W: "How did you know you were having ah stroke"). Schegloff (1992) has argued that words from a question can be used in an answer as a way to mark possible completion of the turn.

After this utterance there is a silence (line 52), following which L issues a continuer (line 53). By issuing the continuer, L treats the prior talk as a possibly complete story, but requests that P continue his turn (Schegloff, 1982).

As we have seen, in order to achieve a narrative the normal turn taking rules for conversation are adjusted by the participants (Sacks et al. 1974; Sacks 1974, 1992). As opposed to ordinary conversational turn-taking, the storyteller gets more than one turn, and the interlocutors use the places where P was *possibly* done talking (i.e., "transition relevance places," Sacks et al. 1974) to either abstain from speech, or produce continuers, thus eliciting more talk from P. By doing this, L and W co-construct P's ongoing narrative.

In this data excerpt, the patient is able to produce highly economical utterances (e.g., "bathroom") which are treated by L and W as complete turns. This sort of turn also serves narrative functions, such as setting the initial scene and establishing the course of action P was engaged in when the story event happened. This allows L and W to treat some of the silences as silences "within P's ongoing turn of talk" (where speech should be withheld), and others as "between turn" silences (where continuers should occur) in the story. By producing continuers in the appropriate "slots," W and L are able to display an understanding of the narrative during its ongoing production (Sacks and Moerman 1971). But those continuers and moments of withheld speech are *also* co-constitutive of the story (cf. Schegloff 1982).

## CONCLUSION

It is not remarkable that people diagnosed as aphasic can produce coherent narrative discourse. This is graspable once we recognize that narrative coherence does not reside in the skills (linguistic or otherwise) of a solitary speaker. Rather, narrative coherence is interactionally achieved, with all parties to the talk working to achieve and sustain it.

Once we look at actual narratives in all of their detail, we see many ways that they are interactionally organized and produced. There are interactional procedures that elicit or announce a narrative, such as story-requests, and story-prefaces, (Sacks 1974, 1992), encourage its continuation (Schegloff 1982), and mark its conclusion and upshot, such as response sequences and second-stories (Sacks 1992).

The coherence of narratives is sustained through sequential procedures such as those discussed above. But these procedures are interactional phenomena; they are not the doings of solitary individuals, but of *interactants*. Thus the source of narrative coherence is in the interaction itself, not in any particular interactant (aphasic or not).

In their study, Burns and colleagues state:

> What can be learned from this brief discussion of the texts of aphasic patients? First of all, the reliance on phonological, syntactic, and semantic analysis is not sufficient for understanding the effects of brain damage on language behavior or the interaction of brain, language and thought. Language occurs though interaction, and analysis of natural, or as in this case, open-ended interview texts shows that aphasic patients are much more successful talkers than would be predicted from traditional diagnosis. This is because their ability to process human speech is naturally found in supportive social contexts where a person's speech is usually given every opportunity to succeed (Burns et al. 1990, p. 175).

In this report of ongoing research on narratives of people diagnosed as aphasic, we have further specified some aspects of the "supportive social contexts" noted above. Primarily, it is the sequentiality of discourse that makes coherence achievable, even when linguistic "deficits" are diagnosed.

This paper's argument is of a piece with other conversation analytic studies that look at issues of "competence" and presumed incompetence or disabilities (Goodwin 1995, 1998; Holstein 1988; Marlaire 1990). The findings of this paper add to the growing number of studies that find conversational competence to be more a feature of interactions than interactants (i.e., it is located at a "higher" level of analysis, and fundamentally *social*). It is found that sequences of social actions are the locus of conversational competence and coherence. It is from these materials that competence and coherence will be found, if it can be.

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## NOTES

1. P = patient, W= wife of patient, and L = interviewer.

2. An important exception to the vast majority of studies of aphasic discourse is the exemplary recent work by Charles Goodwin (1995, 1998). This paper is an attempt to follow the path defined by his work.

3. These same criticisms can be leveled at research on "aphasic language" at the sentence level, because there, as well, language is *fundamentally* social in its production (see, e.g., Volosinov 1973; Sacks 1992; and Goodwin 1981).

4. See Schegloff and Sacks (1973, n. 4) on the analytic status of lay characterizations of the interactants.

5. In an attempt to render on the page as much of the detail of spoken language as possible, I use standard conversation analytic transcription conventions, as originally developed by Gail Jefferson (Atkinson and Heritage 1984; Drew and Heritage, 1992).

> Asterisks indicate *quiet* speech.
> Inbreaths are indicated by (.hh).
> Intonational stress is marked by underlining.
> Latched speech is marked by =
> Brackets indicate overlapping speech, as in the following:
> A: I just don't think it would be [in keeping with] the situation.
> B: [a PPROpriate.]
> Cut off speech is marked by- (as in "wha-").
> Colons indicate elongated speech, as in "ho:::ld o::n."
> Punctuation is used to mark intonational contour. Periods mark falling intonation, commas mark slightly rising intonation, and question marks indicate strongly rising intonation.
> Numbers in parentheses are silences timed in tenths of seconds.
> (.) indicates a micropause (approximately 0.1 second).
> Text in parentheses indicates uncertain hearing, e.g., (was).

6. Indeed these narratives of discovery appear to be a generic feature of interaction, occuring as they do in medical visits, gossip (Bergmann 1993), and 911 emergency calls (Whalen and Zimmerman 1990).

7. Children learn to use "oh oh" at a very young age, and it is not surprising that they would. By mastering this simple "device," children then have a tool for claiming competence even when they make physical "errors" (e.g., dropping a glass of milk). Even if one cannot appropriately handle a glass of milk, one can at least demonstrate that one knows it was a physical "error" (cf. Goffman 1981).

## REFERENCES


Atkinson, J.M., and J. Heritage (eds.). 1984. *Structures of Social Action.* Cambridge: Cambridge University Press.

Bergmann, J. 1993. *Discreet Indiscretions: The SocialOrganization of Gossip.* Hawthorne, NY: Aldine De Gruyter.

Burns, A., L. Blonder, and K. Heilman. 1991. "Sociolinguistics and Aphasia." *Journal of Linguistic Anthropology* 1(2): 165-177.

Conrad, P. 1975. "The Discovery of Hyperkinesis: Notes on the Medicalization of Deviant Behavior. *Social Problems* 23: 12-21.

Drew, P., and J. Heritage (eds.). 1992. *Talk at Work.* Cambridge: Cambridge University Press.

Emerson R., and M. Pollner. 1978. "Policies and Practices of Psychiatric Case Selection. *Sociology of Work and Occupations* 5: 75-95.

Goffman, E. 1981. *Forms of Talk.* Oxford: Basil Blackwell.

Goodwin, C. 1981. *Conversational Organization.* New York: Academic Press.

_____. 1984. "Notes on Story Structure and the organization of participation." Pp. 225-246, in *Structure of Social Action,* edited by J.M. Atkisson and J. Heritage. Cambridge: Cambridge University Press.

_____. 1995. Co-constructing Meaning in Conversation with an Aphasic Man. *Research on Language and Social Interaction* 28(3): 233-260.

_____. 1998. Pointing as Situated Practice. A paper presented at the annual meeting of the American Sociological Association, August, San Francisco, CA.

Gregory, R. (ed.). 1987. *The Oxford Companion to the Mind.* Oxford: Oxford University Press.

Halkowski, T. *Forthcoming.* "Realizing the Illness: Patients' Narratives of Symptom Discovery. In appear in Practicing Medicine: *Talk and Action in Primary Care,* edited by J. Heritage and D. Maynard. Cambridge: Cambridge University Press.

Heritage, J. 1984. "A Change-of-State Token and Aspects of Its Sequential Placement. Pp. 299-345 in *Structures of Social Action*, edited by J.M. Atkinson and J. Heritage. Cambridge: Cambridge University Press.

Hilbert, R. 1984. "The Acultural Dimensions of Chronic Pain: Flawed Reality Construction and the Problem of Meaning. *Social Problems* 31: 365-78.

Holstein, J. 1988. "Court Ordered Incompetence: Conversational Organization in Involuntary Commitment Hearings. *Social Problems* 35(4): 458-473.

Labov, W. 1972. *Language in the Inner City*. Philadelphia: University of Pennsylvania Press.

Marlaire, C. 1990. "On Questions, Communication, and Bias: Educational Testing as 'Invisible' Collaboration. Pp. 233-260 in *Perspectives on Social Problems*, Vol. 2, edited by G. Miller and J. Holstein. Greenwich, CT: JAI Press.

Meehan, H. 1979. *Learning Lessons*. Cambridge: Cambridge University Press.

Sacks, H. 1972. "An Initial Investigation into the Usability of Conversation for the Doing of Sociology." Pp. 31-74 in *Studies in Social Interaction*, edited by D. Sudnow. New York: Free Press.

_____. 1974. "An Analysis of the Course of a Joke's Telling in Conversation. Pp. 337-353 In *Explorations in the Ethnography of Speaking*, edited by R. Bauman and J. Sherzer. Cambridge: Cambridge University Press.

_____. 1992. *Lectures on Conversation*, Vols. 1 and 2. Oxford: Basil Blackwell.

Sacks, H., and M. Moerman. 1988. "On Understanding in Natural Conversation." Pp. 180-186 in *Talking Culture*, edited by M. Moerman. Philadelphia: University of Pennsylvania Press.

Sacks, H., E. Schegloff, and G. Jefferson. 1974. "A Simplest Systematics for the Organization of Turn-Taking for Conversation. *Language* 50: 696-735.

Schegloff, E. 1972. "Notes on a Conversational Practice: Formulating Places." Pp. 75-119 in *Studies in Social Interaction*, edited by D. Sudnow. New York: Free Press.

_____. 1982. "Discourse as an Interactional Achievement: Some Uses of "Uh huh" and Other Things That Come Between Sentences. Pp. 71-93 in *Georgetown University Roundtable on Language and Linguistics. Analyzing Discourse: Text and Talk*, edited by D. Tannen. Washington, DC: Georgetown University Press.

_____. 1987. "Recycled Turn Beginnings." Pp. 70-85 in *Talk and Social Organization*, edited by G. Button and J. Lee. Philadelphia: Multilingual Matters.

_____. 1991. "Reflections on Talk and Social Structure." Pp. 44-70, in *Talk and Social Structure*, edited by D. Boden and D. Zimmerman. Berkeley: University of California Press.

_____. 1992. "On the Organization of Sequences as a Source of 'Coherence' in Talk-in-Interaction." Pp. 51-77 in Conversational *Coherence in Developmental Perspective*, edited by B. Dorval. Norwood, NJ: Ablezx.

Schegloff, E., and H. Sacks. 1973. "Opening Up Closings." *Semiotica* 7: 289-327.

Searle, J. 1969. *Speech Acts: An Essay in the Philosophy of Language*. London: Cambridge University Press.

Ulatowska, H., L. Allard, and S. B. Chapman. 1990. "Narrative and Procedural Discourse in Aphasia." Pp. 180-198 in*Discourse Ability and Brain Damage: Theoretical and Empirical Perspectives*, edited by Y. Joanette and H. H. Brownell. New York: Springer-Verlag.

Ulatowska, H., R. Freedman-Stern, A. Weiss Doyel, S. Macaluso-Haynes, and A. North. 1983. "Production of Narrative Discourse in Aphasia," *Brain and Language* 19: 317-334.

Ulatowska, H., A. North, and S. Macaluso-Haynes. 1981. "Production of Narrative and Procedural Discourse in Aphasia," *Brain and Language* 13: 345-371.

Volosinov, V. N. 1973. *Marxism and the Philosophy of Language*. Cambridge, MA: Harvard University Press.

Whalen, M., and D. Zimmerman. 1990. "Describing Trouble: Practical Epistemology in Citizen Calls to the Police. *Language in Society* 19: 465-492.

Wilson, T. 1991. "Social Structure and the Sequential Organization of Interaction." Pp. 22-43, in *Talk and Social Structure*, edited by D. Boden and D. Zimmerman. Berkeley: University of California Press.

Zimmerman, D. 1992. "The Interactional Organization of Calls for Emergency Assistance. Pp. 418-469 in *Talk at Work*, edited by P. Drew and J. Heritage. Cambridge: Cambridge University Press.

Zimmerman, D., and D. Boden. 1991. "Structure-in-action." Pp. 3-21 in *Talk and Social Structure*, edited by D. Boden and D. Zimmerman. Berkeley: University of California Press.

# PART IV

## SOCIAL PROBLEMS AND DIVERSITY