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**Bionote**

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Abstract

This article focuses on what can be labelled ‘trouble-talk’: how it is initiated and responded to in therapist-resident encounters. It adopts the perspective of the individual with acquired brain injury. The study is based on a video ethnography of interaction, targeted at identifying trouble-talk and its interactional consequences. The study was carried out in a Danish care home facility for residents with severe acquired brain injury. Encounters involving a case resident, an occupational therapist, a pedagogue and participant researchers were video-recorded (totaling 30 hours), including fieldwork over one year, between 2012 and 2013. The dataset has been analyzed through a combination of discourse analysis and ethnomethodological conversation analysis.

The findings show that when the resident takes initiatives and/or addresses criticisms, this may be heard by the occupational therapist as complaints about institutional life and/or talking gibberish. Such perceived trouble-talk is responded to by the occupational therapist with misalignment and repair work. In general, trouble-talk is co-constructed; however, it is accentuated by the occupational therapist’s response, which suggests an undesired institutional ramification. In promoting awareness of the impact of impairments on interaction, I discuss how trouble-talk is emergent in the interaction itself and in what ways it can be resolved or minimized.

**Keywords**: Trouble-talk, Acquired brain injury, Repair, Alignment, Aphasia, Person-centered institutional care

1. Introduction

Increasingly, there is a need to examine the situation of vulnerable subjects and the trajectories of interaction involving individuals with severe impairments within the field of health communication. Individuals with impairments are anticipated to behave in unaccountable ways in their attempt at making themselves understood. Encounters involving participants with severe impairments such as acquired brain injury (ABI) repeatedly reveal sources of interactional trouble. Such instances can be referred to as ‘trouble-talk’, since co-participants respond to them as ‘problematic’ (Drew 1997). Trouble-talk in this article refers to more than acoustic perception and misunderstanding due to aphasic pronunciation (Wilkinson *et al.* 2020: 28).

Crucially, the psychosocial consequences of recurrent confrontation and misalignment can lead to depression and lower quality of life (QOL) (National Report 2020). A prerequisite for improving communication in encounters with individuals with impairments is to identify where trouble-talk appears, how it is initiated and responded to in processes of interaction and accomplishment of understanding. As a point of departure, this study scrutinizes a) a case resident’s initiation of talk and b) a therapist’s reception of and response to talk perceived as trouble-talk.

The paper is structured as follows: first, in Section 2, I offer a review of existing studies on trouble-talk. In Section 3, data and methodology are presented, followed by the analytical framework. The analysis examines trouble-talk and illustrates how an individual with ABI is perceived and responded to by the therapist, in Section 4. Finally, key analytical findings are discussed in Section 5 and some concluding remarks are offered in Section 6.

1. Literature review

2.1 Studies in repair of troubles

Troubles are a typical feature of talk-in-interaction. Studies in conversation analysis (CA) have identified *troubles* in the organization of talk (Schegloff *et al.* 1977). Corrective practices or *repairs* refer to the initiation of and the reception and response to trouble identified by participants. As a result, a new contribution (a repair suggestion) is produced as a response to identified trouble. Two basic types of repairs exist: 1) self-initiated; and 2) other-initiated. In ordinary conversation, there is a preference for self-initiated repair (Schegloff *et al.* 1977: 362). The outcome of the *repair work* being done is the recognition of a communication breakdown and a display of a lack of understanding (Schegloff 1992).

2.2 Aphasia studies and extended repair work

Interaction with individuals with aphasia is characterized by repair, which departs from the ordinary, since aphasia (Broca’s aphasia) demonstrates effortful speech exhibition and partial loss of speech (Nielsen *et al.* 2019), including substantial use of facial expression, hand gesturing, and pointing at resources in the material setting (Goodwin 2000, 2003). An extensive and still growing body of studies has examined encounters with individuals with ABI and aphasia. These studies describe encounters characterized by extensive interactional *repair work* (Perkins 2003; Wilkinson *et al.* 2020). Largely, the studies focus on the following topics: a) the organization of repair – whether self-initiated or other-initiated – which is frequently prolonged in the accomplishment of understanding (Goodwin 2003); b) the co-construction of talk to convey meaning (Goodwin 1979, 1995; Wilkinson 2011), and c) the use of resources such as local objects and bodily resources such as gesturing, gaze and pointing (Goodwin 2000, 2003; Klippi 2015). Studies of encounters involving aphasia are often approached through the lens of ethnomethodological conversation analysis (EMCA) (Antaki and Wilkinson 2013; Goodwin 2003; Wilkinson *et al.* 2020) to identify distinct organizational features (Perkins 2003) , supplemented by multimodal analysis of gesture and gaze activity.

2.3 Studies in troubles talk

Another definition of trouble-talk refers to practices of addressing troubles as a conversational topic labelled *troubles talk* (Jefferson 1988). This definition refers to the organization of troubles-telling and alignment. These characterizations cover 1) corrective practices with suggestions of repair and 2) talk about troubles within the CA framework; however, they operate on two different levels. Repair work occurs at the level of turn-taking, demonstrated through minimal responses such as ‘what?’ and verbal responses such as ‘do you mean?’, while troubles-telling occurs at the conversational level, demonstrated through conversational topics.

2.4 Studies in alignment and involvement

In understanding interaction as a multiparty process, Goffman (1981) links the relation between participants and their alignment. Goffman’s notion includes monitoring of self and other, which shapes not just the interaction but also the situated participants’ involvement in categorizing themselves and co-participants as ratified/unratified. Among recent discourse-oriented studies of participants’ alignment, the examination of institutional encounters has shown that the interaction is gatekept by professionals who manage categorization and involvement of the other participants, leading to a number of interactional misalignments (Tranekjær 2015). Trouble-talk involving ABI and aphasia, which is the focus of the present study, is dependent on how it is a) initiated, b) received and c) responded to (Jefferson 1988; Kupferberg and Green 2005; Schegloff *et al.* 1977), thus addressing issues of repair and specifically alignment. Participants’ changes in alignment can be approached in the investigation of trouble-talk with reference to “actions demonstrating forms of involvement performed by parties within evolving structures of talk” (Goodwin and Goodwin 2004: 222), incorporating an interactional definition of involvement, which is referred to as ‘footing’ by Goffman (1981).

2.5 Conceptualizing trouble-talk

My focus here is to approach trouble-talk with a combined approach of discourse analysis and EMCA that can elaborate on participants’ repair work at the interactional level and their alignment at the conversational level through observation of their involvement. My use of trouble-talk operates on different discursive levels referring to a) organization features and b) relations between the participants. In sum, the study of repair within CA and aphasia studies is very nuanced, while the study of trouble-talk in therapist-resident encounters is less recurrent. The relationship between the therapist and the resident and their mutual engagement in and response to trouble-talk and the consequences of professionals’ involvement in such talk constitutes the core of the empirical data analysis.

1. Methodology, data and analytical framework
   1. Single-case study of trouble-talk

The single-case design which underpins the present study examines the joint interaction between a male care resident who has functional impairment and a co-present occupational therapist. The resident needs a wheelchair to move around with help from assistant therapists (due to partial paralysis and spasticity from traumatic ABI years prior), and this resident’s speech has aphasia, characterized at the interactional level by extensive pauses, initiation of talk marked by stuttering and problems with retrieving pronunciation of first syllables following stuttering.

The interaction trajectory of this resident is under scrutiny. This idiographic approach has been chosen since this individual was involved in a range of interactional dilemmas across the dataset, demonstrating the subtleness of trouble-talk. The observed encounters never led to explicit anger or direct conflict, and the dilemmas were responded to with a gentle ease. However, in considering the often-neglected experiential perspective of the individual with impairments, the study aimed at profiling the trouble-talk-experience, regardless of this resident’s overt manners, in order to pay attention to interactional consequences involving aphasia and ABI in institutional life.

3.2 Data

Over the course of one year between 2012-2013, a series of meetings, breaks and an excursion to a shopping mall were video-recorded (totaling 30 hours), which included fieldwork at a care home facility for adult residents with severe ABI in Northern Denmark. The video ethnography forms part of a larger study on routines of everyday institutional life. The co-participants in the study included individuals who had impairments due to ABI, occupational therapists, pedagogues, students of occupational therapy and participant researchers. At the time, the care home had capacity for 22 residents. The data comes from communication training meetings held in a conference room and from an excursion to a shopping mall. Typically, communication training and recording sessions would last two to three hours. The form of the typical meeting is that the occupational therapist would lead the meeting, with help from a local pedagogue mediating the involvement of residents, as well as researchers and other visitors, e.g. students of occupational therapy. At the care home, the participant researchers video-recorded meetings with one stationary and two wearable Go-Pro-cameras; at the excursion for the shopping mall, the recordings were made with one wearable GoPro-camera. The researchers participated through dialogue with the professionals and the residents. Two residents participated in the meeting and the excursion. In the analysis, the focus is on the perspective of one resident, a male in his 40s with ABI after trauma 20 years prior. He uses a wheelchair to move around due to sensory disturbances in one side of the body, partial paralysis and spasticity. His talk has aphasic traits marked by stuttering/repetitions and he has trouble with generating words, which takes time. Furthermore, he has memory deficiency and cognitive challenges. Apart from these clinical details, the identity of the resident and the name of the residential home are protected through anonymization. Written informed consent was given by the participants, including the vulnerable participants and their legal guardians.

Data were collected using ethnography, including field notes and video recordings. This process included notetaking, audio recordings, interviews, and participant video-observation. In a combined sense, this collection forms the “core data” and supportive evidence (Ten Have 2004). The primary data source for detailed analysis are the video recordings of selected encounters between the residents and the professionals.

The extracts that have been selected for analysis stem from the first month of recording, where three days were recorded using participant video observation and ethnographical notetaking. The excerpts from two recording days, one week apart, one day from the center and another day during an excursion, are selected for analysis. Secondary, supportive data sources that inform the analysis include informal interviews with the staff, the activity plans, the clinical remarks, the local-level decision-making and the political-level decision-making.

The selection of excerpts for analysis is based on a clip collection archive accumulated while reviewing the collected data. The clips are organized into two main themes ordered under the keywords *critique of the place* and *wishes to participate*. These refer to the care resident’s situational participation, and how his contributions were received and responded to a) in one case by the co-present therapist, one other resident and the participant researchers, and b) in another case by the co-present therapist, a pedagogue, the other resident and the participant researchers.

3.3 Analytical framework

In accounting for my approach to ‘trouble-talk’, it is necessary to combine 1) discourse analysis and 2) EMCA, which would enable an extended view on troubles in interaction (including repair work, troubles talk and alignment) to examine the data on both conversational and interactional levels. For this purpose, the selected video recordings were transcribed using the protocol for transcription of talk data (Sacks *et al.* 1974: 731–733), elements of semiotic representation (Goodwin *et al.* 2012), and some detail from micro-action protocol (Mondada 2014). The transcription conventions can be found together with the original transcripts in Appendix A and Appendix B, respectively. The original Danish transcription and the English translation have been informed via data sessions and workshops. Peer assessment included presenting anonymized video excerpts and transcribed sequences of the videos. Some supplements to talk have been added to capture the multimodal details in a more fine-grained way (Jordan and Henderson 1995; Laurier 2014).

By extending the analysis beyond sequentiality, the macro context of the resident’s specific moves can be taken into consideration. In this case, the “macro” concerns the interaction trajectory of the resident across the two recording days, demonstrated by the excerpts. A discourse analytical approach which is more open than the micro-sequential analysis enables a close examination of what consequences practices can have for the individual with impairments in the context of everyday institutional life. The broader discourse analytical approach includes institutional practices as context at the conversational level. To inform this level of analysis, extra sequential knowledge and cross sequential observations support my engagement with the data.

Demonstrably, trouble-talk encompasses more than troubles in understanding within this combined approach. Management of trouble-talk and action can be studied as practices by adapting the tools from discourse analysis and EMCA. When applied, this combined approach enhances understanding of the practiced culture of trouble-talk and identifies its technicalities: the organization of repair, trouble-telling, and alignment in trouble-talk. This strategy for studying trouble-talk is to develop a two-sided focus that includes a) the interaction itself and b) a consideration of how the interaction itself is mediating discourses from other scales (Scollon and Scollon 2004).

1. Data analysis
   1. Initiation, reception and response to trouble-talk

The analysis of trouble-talk that follows has a threefold purpose: to pay attention to the a) design of the resident’s wishes to participate, b) reception of this resident’s moves, and c) response from the therapist and co-participants to examine the features of trouble-talk. These three attention points are explored in selected excerpts from two different recording days and from two different settings. Two data examples (which are extensive and thus broken down into four examples 1a, 1b and 2a, 2b) are provided to illustrate how the resident initiates telling and how these are received and responded to, mainly by the therapist who manages the course of the interaction. The first set of examples (1a and 1b) are recorded at the care home. A glimpse of the data serves to get acquainted with the resident (S) and illustrates a talk initiative, which may be perceived as an initiation of trouble-talk by the occupational therapist (OT).

Data example (1a, short extract)

087 →S: eh eh so if you. If you out in society are

to build something new

088 →S: eh then you consult the professional group

for advice who are dealing with it

089 ((right hand palm open upwards,

small headshakes, gazes at OT))

In this short extract, which is presented and analyzed at full length in Section 4.1.1, no verbal response follows from the therapist (OT), who the resident (S) is targeting with his gaze. Rather, the resident’s talk is monitored with a form of corrective disengagement in what follows. As we shall see later in the analysis, the therapist’s forms of multimodal and verbal involvement signal her alignment with the resident. This interactional management turns out to play a defining role in the construction of trouble-talk.

The second set of examples (2a and 2b) are from an excursion to a shopping mall. These demonstrate further issues of misalignment and illustrate the consequences of trouble-talk for the resident. All examples are from the fall of 2012. Interestingly, there is only one week between the two recordings; noticeably, the resident manages his participation quite differently during the two sessions. Across the excerpts the same participants feature, plus one extra health professional in examples 2a and 2b. Two weeks prior, the researchers introduced the research project to the participants.

* 1. Data examples, first set

The following extract includes two residents, two researchers and the occupational therapist. All participants are engaged in watching the video from the last visit on a computer screen two weeks prior. The therapist (OT) is at the end of the table and is not visible due to the recording angles of the camera on the table as well as the mounted camera to her right, directed towards the table center. The two researchers are standing up (C to the left of the table and P to the right); the two residents (R and S) are seated at the table. S is our focus. In the beginning of the extract, the research assistant (C) is commenting on the video.

* + 1. Data example (1a, full extract)

082 C: it is a way to improve everyday life

((opens left palm gaze towards OT

while nodding))

083 S: Yes. Yes ((gazing towards OT))

084 C: ((nods towards OT)) so that

085 S: yes yes ((gazes and nods towards OT))

086 (1.5)

087 →S: eh eh so if you. If you out in society are

to build something new

088 →S: eh then you consult the professional group

for advice who are dealing with it

089 ((right hand palm open upwards,

small headshakes, gazes at OT))

090 S: right

091 C: ((nods)) yes-

092 P: ((nods))

093 S: so so what hi hi hm ((gazes at OT))

094 C: you are right about this that would be reasonable

[Haha] to do

095 S: ((elevates coffee cup, looks downwards)).

[m ha]

------------------------------>((all participants continue

watching the video recording))

096 (1.0)

097 S: ((drinks tea, puts eyeglasses on top of head,

turns toward computer screen))

098 (5.0) --------------------------------------------------->

099 P: so-

100 C: So we cannot watch movies all day long

101 S: he ((gazes towards OT))

102 P: No. (he) no no that does not work well

(noise)

103 C: ha (ha)

104 P: ((gazes at OT, gesticulating))

we cannot go back to two weeks ago haha

105 S: [Haha]

106 C: [haha] we just wanted to show you how

(noise)

107 ((OT goes to seat, P and C find their seats))

108 S: Mm. well fine

109 (1.0)

110 S: ((puts on eyeglasses))

In turns 87 and 88, the resident S takes an initiative and comments on the research assistant C’s opening remark: “eh eh so if you. If you out in society are to build something new eh then you consult the professional group for advice who are dealing with it”. With this statement, S criticizes the lack of inclusion of individuals with impairments in the construction of the care home by pointing to an expected general standard of including the users as experts when developing care centers. By pointing to this disjunction, the construction of inclusion in society is encapsulated in the design of the care home. Repeatedly, S raises a critical voice about professionals’ lack of knowledge concerning the lived experiences of individuals with impairments. This contribution from S elaborates the prior talk about the construction of the interior design of the present care home – a recurrent theme in the dataset.

The therapist’s (OT) treatment of S’s contributions by declining to respond, regardless of S’s constant gazing at her after each contribution, demonstrates that S’s contributions do not concur with the therapist’s stance. The therapist does not respond verbally or with any audible sound to S’s gazing towards her. By observing her non-verbal response while listening to C in turns 83 and 85, and again while the resident makes contributions in turns 88 and 93, it suggests that OT may be interpreting S’s contributions as criticisms about institutional life and/or disapproving of the resident’s co-participation in this activity with the research assistant. A transitional sequence follows that contributes to a shift in alignment from the therapist towards the resident. In turn 100, C states that “so we cannot watch movies all day long”, thus initiating the end of watching video, which is followed by a noisy transition of the researchers and the therapist moving around the room (turns 102-107). Hereafter, there is a noticeable shift in OT’s response management towards S, as can be seen in extract 1b.

OT’s change of alignment in extract 1b provides a counter-example. It is exemplary in summarizing the routine courses of interaction in the recorded encounters. It demonstrates the interactional consequences of the resident’s discontinued talk with the researcher, but it also indicates the end of S’s conversational initiative. Notice the extensive break in turn119 (4.0 seconds).

* + 1. Data example (1b)

109 OT: what do you think of watching yourselves

110 S: (well that) I am fine with that and eh

111 R: (eh eh) eh eh

112 S: it is just too bad that we are from behind huh [R]

((gazes into the air))

113 R: ((gazes towards S)) (eh eh) (ha) ha

114 S: (m ha) ha ha

115 OT: then you must smile a bit to the camera (noise)

116 S: ha

117 R: ha

118 S: ((drinks of cup))

119 (4.0)

120 ((P and C talk in the background))

In turn 109, the therapist (OT) takes the floor by asking the two residents: “what do you think of watching yourselves”. S responds that he is fine with it in turn 110. Then, immediately afterwards, S initiates a joke telling in turn 112: “it is just too bad that we are from behind huh [name of R]”. The joke is about being filmed from their back in the recording watched from two weeks earlier. The therapist immediately responds to S’s joke in turn 115 with a follow-up joke: “then you must smile a bit to the camera”. As suggested in example 1a (turns 83 to 91), the resident’s recurrent gazing at OT may indicate his seeking approval or support in an attempt to avoid being responded to as someone doing trouble-talk. However, his persistent gaze at the therapist may be perceived by the latter as an indication of exactly the opposite, trouble-talk, which this therapist occasions with disregard, thus portraying S as an interactional trouble-maker.

This perception is contrasted with the therapist’s willing alignment with S’s joking about the recording angle in the last part of extract 1b (turns 109-120), where the therapist participates while involving S as a ratified participant with the camera joke (turn 115). However, there is little laughter from the two residents as response to the therapist in turns 116-117. S, then, takes a sip from his cup (118), which is something that he previously has done after being disregarded, and then the longer focal pause (4.0) follows in turn 119. Interestingly, across the dataset S demonstrates a verbally explicit interest in the research project, and several times he contributes with talk that is perceived as trouble-talk by the therapist as far as her immediate responses to S’s initiation is concerned.

In extracts 1a and 1b, a subtle discrepancy in the therapist’s perception and her change of response management to S demonstrate the workings of recurrent trouble-talk at play. The discrepancy emerges in the therapist’s remarkable change of alignment in responding to S, first, as doing trouble-talk using troubles-telling in 1a (by disregarding his gaze) and next, by orienting to him as accountable (by responding to his joking). The therapist clearly disregards the resident’s demonstration of a serious interest in participating in the research project.

* 1. Data examples, second set

The following excerpt is from an excursion to a local shopping mall approximately 30 km from the care home. This excerpt is recorded three weeks into the data collection, one week after the examples above. In the extract, the two residents ( S and R), the therapist ( OT) and a pedagogue (Pe) are present. They are having lunch in the shopping mall’s cafeteria. The two participant researchers (C and P) sit nearby, recording with a wearable GoPro camera attached to C. Roughly five minutes earlier, OT initiated talk about garden work, since they bought plant supplies (“now next week we are going to go out in the garden”, which is omitted from this extract). After a mundane conversation about planting flower onions, S takes the initiative and addresses the research assistant, C, about whether she has a garden herself. This initiative cascades a series of gazes between the co-present health professionals. However, notice how S recurrently gazes at the visible camera attached to C instead of the therapist as he did in example 1a above in seeking approval.

* + 1. Data example (2a)

061 S: te:ll me- te:ll me-

((gazes towards the camera and C))

062 (0.5)

063 S: do: yo:u↓ ha:ve a ga::rden↑ at ho:me

((gazing fixated at C))

064 Pe: ((removes hair from her forehead

and puts it behind ear))

065 OT: ((leans forward, gazes towards C))

066 C: I have a tiny one

((draws a square in the air with finger

in front of the camera))

067 S: eh yes- yes-

068 C: it↓ i:s not so big

069 S: no

070 C: perhaps from here and over to that plant

071 Pe: ((looks up, gazes at C and back down again))

072 S: well (that) I ((gazes towards Pe and OT))

073 C: [and then over to the next table

074 S: [ye:s o:k ye:s

((gazes towards C and then camera))

075 C: and then back again

((draws line in the air with index finger))

076 S: o:k- E:H- so- [so-

077 C: [ but it is (.)SO↑ ni(h)ce he hi

078 Pe: ((gaze towards C and smiles)) mm(h)m

((eats))

079 OT: ((gazes at C))

080 (0.5)

081 C: I am re:ally happy about I have got such

a small ga:rden

082 S: the:n the:n yo:u do: no:t ha:ve: to: cu:t

the: gra:ss fo:r ho:urs

083 C: yes-

084 Pe: ((gazes towards C))

085 S: [HA: ha he: he

086 C: [yes that is absolutely correct

087 OT: ((gazes at Pe))

088 Pe: ((gazes at OT)) a manageable ga:rden↑

In turn 63, S’s contribution, “do: yo:u↓ ha:ve a ga::rden↑ at ho:me”, is immediately responded to by C: “I have a tiny one” (turn 66). This cascades a series of gazes from the health professionals towards C mainly, and between them (Pe and OT), when responding multimodally to S’s initial conversation with C. The gaze exchanges could be seen as their joint anticipation of trouble-talk or as questioning S’s and C’s abilities to manage this conversation. Interestingly, S has changed his modus operandi from the first example (example 1a), where he recurrently gazed towards the OT after each contribution, to gazing towards the camera (turns 61 and 74) and C as seen in this example.

Gazing at the camera also marks his initiative to begin the dialogue in turn 61, asking whether C has a garden (turn 63). Routinely, S orients to the camera now, besides in one case, in turn 72, where he gazes both at the therapist and the pedagogue, perhaps demonstrating his ability to manage this, reassured by C having answered his question. There is, however, a sense of worry emphasized by the flickering gaze of OT and Pe towards C repetitvely, while the latter is talking with S. S’s initiative seems to impact the extra-verbal management of actions that are performed by the professionals and their activity of co-monitoring intensely the two interactants, S and C. Finally, the pedagogue joins in verbally, and contributes to the topic of garden by adding “a manageable ga:rden↑” in turn 88 as a response to the sequence concerning the tiny size of C’s garden, but also appreciating S’s joke about C not having to cut the grass for hours (turn 82).

In this extract, misalignment is found mostly in Pe’s and OT’s questioning (via gazing) S’s accountability. A joint attempt at misalignment is afforded by the series of gazes exchanged between the two professionals and C throughout this extract. The exchange of gazes occurs as “next-turn” activities to each of S’s contributions in the dialogue and can be interpreted as other-initiated repair. Recurrently, Pe and OT are seen as orienting to C, perhaps in an attempt of care for S, or in an attempt to scaffold C’s ability to manage this conversation with S. Either way, S’s accountability is questioned by the exchange of gazes indicating mistrust. Only in one case, the therapist catches the eye of the other co-present resident, in turn 91. The situation is aggravated in the next example, 2b, which is an immediate follow-up to example 2a. Importantly, Pe’s intense gaze at OT in turn 88 in example 2a is, finally, responded to by OT in example 2b as an invitation to participate; however, this turns out to have crucial consequences for S’s accountability.

* + 1. Data example (2b)

089→OT: ((looks over shoulder, turns))

I- thought you asked if [C] she had an a:pe↑

090 Pe: WELL↑ ((puts glass down)) ha ha

091 OT: ((looks around and catches eye contact with R))

hi hi

092 R: ((smiles))

093 C: he he↑ an A:pe↑ No I have a small boy

((shows height with hand))

094 S: He he ((wipes mouth with napkin and gazes towards C))

he he

095 Pe: he he ((gazes towards C and wipes mouth with napkin))

096 C: but it is almost like an a:pe↑ ha

097 S: ((gazes towards Pe))

098 Pe: ((wipes mouth with napkin and gazes at S))

099 C: he he sometimes

100→Pe: it is nice with such a small manageable ga:rden

101 S: m:m ((wipes mouth and puts down napkin))

102 C: but I am really fond of it really

In example 2b, OT orients to S’s accountability in an attempt to demonstrate that he is talking gibberish in adult conversation. After having looked over her shoulder, OT turns to the table and produces what may be called a focal other-initiated repair: “I- thought you asked if (name of C) she had an a:pe↑” (turn 89). OT may have misheard S asking about C’s “ha:ve” (ga:rden) for whether C had an “a:be” (a:pe), which leads OT to offer a repair suggestion in turn 89. However, these are two phonetically distinct words (ha:ve/a:be) in Danish with distinct pronunciation, which underpins the oddness of mistaking the voiced fricative ‘v’, pronounced labiodentally (ha:ve) for the voiceless plosive ‘b’, pronounced bilabially (a:be).

One could speculate here whether Pe joined the conversation in example 2a, turn 88, to anticipate other-initiated repair of OT’s silent misperception of S’s pronunciation of “ha:ve” (garden) as a response to OT’s ongoing flickering gaze. However, this too seems odd since C had already responded to S’s talk about garden as accountable talk throughout turns 66-86 — and with understandable pronunciation — underpinned by her continued storytelling about her tiny garden throughout example 2a, which occurred in OT’s co-presence prior to the focal turn 89 of 2b. In fact, in concert, Pe and C had already been supportive of S’s inquiry in OT’s co-presence. Alternatively, OT could have completely misunderstood the whole conversation about ‘garden’, or more likely, she could have been anticipating S to cause trouble to a degree that she deliberately chose not to pay attention to the conversation at all and, therefore, changed her alignment, grounded in the following observation.

In example 2a (turn 65), the therapist leaned forward after S’s pronunciation of “h:ave” (garden), orienting to it as a candidate correction. Seemingly for this earlier misperception in turn 64, OT explicitly responds to S’s talk about garden as trouble-talk in the focal turn 89 of example 2b. However, this reads as problematic since it reverses the other co-participants’ prior response to him as being entitled to do accountable talk about garden. Literally, OT disrupted the flow of the conversation with a ‘her getting it right’-correction –– categorizing the resident as a “non-native speaker” (Wong and Olsher 2000: 114). However, C responded to him as being proficient and accountable prior to this move.

OT’s correction is supported by Pe’s exclamatory response to OT’s disruption with “WELL↑ ((puts her glass down)) ha ha” in turn 90. In turn 91, OT vocalizes a little laughter, perhaps attempting to endorse the disruption as a joking opportunity. However, Pe’s response is pronounced with such eruption and surprise that it supports that Pe and OT are not aligning on the possible mispronunciation of ‘ha:ve’ (garden) nor on making it a joking-opportunity.

As can be seen, in the sequence that follows, the research assistant builds on OT’s joking-attempt in responding to the ape-claim with a new candidate joke – a second storytelling (Sacks 1992: 250) where she replaces ‘ape’ with ‘boy’. C continues with “he he↑ an a:pe↑ no I have a small boy” in turn 93, followed by a comparison of the two (ape/boy) “but it is almost like an a:pe↑ ha”. This attempt is responded to with smiles and laughter from first Pe and then S, who in concert pre-close this repair suggestion with silently gazing and mouth-wiping with napkins throughout turns 97 and 98. The next focal turn, turn 100, marks a new change of alignment when Pe returns to the topic of garden, supporting S’s initial contribution by stating “it is nice with such a small manageable ga:rden”, which brings closure to the topic and offers a new repair suggestion concerning the accountability of S, disregarding OT’s disruption.

In examples 2a and 2b, S is attempting to do ‘ordinary talk’, but this attempt results in him being questioned by the therapist for asking about whether the research assistant in fact had an ape at home, an inapt question for an adult to pose out of context. The response from OT to S that accuses S for talking gibberish is a candidate attempt at excluding S from the dialogue. OT, unwillingly, herself performs as trouble-talk-aggravator in these examples, perhaps from over-focusing on her anticipation of trouble-talk from S. Crucially, the intervention of OT promotes trouble-talk and repair work over several turns, resulting in S’s withdrawal from participating in the dialogue. However, OT as co-participant is expected to interact in concert with the individual with impairment as a scaffolder not as an opponent. Yet, as the examples demonstrate, the resident often has less entitlement to ‘make claims’ (Coulter 1975: 391) than his interlocutors (without impairments).

In turn 97, S gazes at Pe perhaps asking for support, since in turn 101 he affirms Pe’s remark. To avoid S’s withdrawal, OT could have chosen to ‘let it pass’ and not engage in corrective practices which promote trouble-talk (Wilkinson 2011: 39). OT could have contemplated the ongoing dialogue instead of responding to S as a trouble-maker by applying repair suggestions and other-initiated repair. Ultimately, S’s withdrawal became the consequence. Regardless of Pe’s offer of a decent exit, S’s participation ends and is hereafter reduced to minimal response in the form of gambits (“mm hm mm”, omitted from this extract) in the next sequences, after being categorized as unratified repeatedly.

1. Discussion

Based on the above analysis I provide a twofold discussion, concerned with how the therapist (OT) (mis)aligned with the resident (S) and the consequences of trouble-talk. In the analysis, I have shown *how* the resident was oriented to by the therapist as an unratified participant. In one example (2b), the resident was, furthermore, explicitly responded to as being cognitively impaired by the therapist. As a counter-example, the resident was categorized as a ratified participant in example 1b, which provided an illustration of the impact of the therapist’s choice of involvement – whether multimodal and/or verbal.

The therapist’s response to the resident’s initiation of talk included perceived trouble-talk, for instance, in the examples 1a and 2a, where she overheard the dialogue between the resident and the research participant without engaging verbally. Her responsivity to the resident concerned the resident’s commenting on the research project, which may have been perceived as a criticism (example 1a) affording gatekeeping. Similarly, in 2a and 2b gatekeeping emerged multimodally and verbally, especially in 2b where the therapist explicitly targeted the resident’s talk as gibberish. This resulted in the resident’s withdrawal from the dialogue.

As a counter-example (example 1b), the resident–– with no restrictions –– was entitled to respond to talk about watching themselves on video and participate in joking in concert with OT. Clearly, the therapist’s changes of alignment seemed to evolve around the resident’s initiatives in an attempt at gatekeeping the interaction by scaffolding trouble-talk herself. Whenever the resident took initiatives on his own, he was likely to be monitored as unratified (examples 1a, 2a and 2b), which was shown in the way that the therapist responded with corrective actions and misalignment. Hence, practices of trouble-talk were institutionally driven and managed by the therapist.

In combining discourse analysis and EMCA, trouble-talk can be seen as emergent in the interaction itself, based on the following indicators: a) the resident’s initiation of a telling, b) the therapist’s reception of a telling as trouble-talk, and c) the therapist’s response as co-constructive of trouble-talk. Typically, the resident’s indication of a wish to participate began with a sequence of stuttering. Regardless of the form of talk, his interactional initiatives were responded to by the therapist as trouble-talk. Routinely, the therapist responded to his initiatives by resorting to corrective behavior at the interactional level, by gazing disengaged and/or by offering repair suggestions and/or by disengaging at the conversational level.

The analysis demonstrates how the therapist’s involvement in scaffolding trouble-talk resulted in the resident’s resignation. In the aggravated case (2b), the resident gave in and withdrew from the dialogue, possibly to avoid further exposure to trouble-talk. In examples 1a, 2a and 2b, the construction of the resident as causing trouble-talk was afforded by OT’s monitoring of him. The therapist failed to grasp the resident’s ability and make it a basis for further elaboration and expanded conversation –– for instance, using a ‘let it pass’-strategy (Wilkinson 2011).

More generally, an awareness of the management of trouble-talk is crucial since the consequences of aggravating troubles can have further QOL-related ramifications (Goode 1994; WHO 1995). Notwithstanding the identification of trouble-talk and misalignments, this study is not intended as a critique of professionals; instead, the interpretation remains non-conclusive, necessitating the avoidance of “a ‘talking down’ model of feeding back research findings”, in the spirit of Roberts and Sarangi (1999: 498-499). The ICF (International Classification of Functioning, Disability and Health) protocol (WHO 2001, 2013) is recommended as guidelines to 1) downscale institutionally driven confrontation due to ABI and 2) consider consequences of trouble-talk.

1. Conclusion

This article examined trouble-talk in therapist-resident encounters. The analysis focused on the perspective of the individual with impairment in interaction, which afforded a deep analysis of trouble-talk. Tools from EMCA helped illustrate how the resident was monitored and how his tellings were responded to as trouble-talk, causing instances of interactional misalignment between the therapist and the resident. The trouble spots were identified whenever the resident took initiatives. These may have been heard by OT as criticisms and responded to as trouble-talk, or as gibberish, thus giving rise to repair work, which resulted in a series of explicit misalignments between the therapist and the resident. Demonstrably, misalignment leads to withdrawal from participating actively. The force of anticipated unaccountability afforded the therapist to respond to S as a person with cognitive impairment, regardless of his demonstrated proficiency in leading a conversation and in joking.

Encounters involving individuals with ABI are expected to involve trouble-talk. However, ramifications of trouble-talk can be diminished by considering the perspective of the individual with ABI analytically. Increased awareness of the consequences of trouble-talk in therapist-resident encounters can improve management of trouble-talk in promoting a person-centered QOL. Ways of monitoring co-participants’ talk without presupposing a lack of confidence in the ability of the speaker with ABI would have been helpful in this therapist-resident encounter, potentially enhancing communication.

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**Appendix A**

**Transcription key**

h[ave they] Square brackets: start/end of overlapping talk

↑ Arrow up: high tone pronunciation

↓ Arrow down: low tone pronunciation

→ Arrow forward: focal line

----> Stippled arrow with text in grey tone: ongoing activity parallelly to turn-taking

(.) Micro-pause, less than a second.

(3.0) Pause in whole seconds

small- Hyphen at the end of word: cutoff

WELL Capitals: high volume

(sound) Parenthesis: uncertain hearable

((gazes)) Double parentheses: multimodal comments

[C] Capital letter = name of participant mentioned

**Appendix B**

**Original data extracts in Danish**

Data example (1a)

082 C: det er en måde at forbedre hverdagen ((opens left palm gaze towards OT

noding))

083 S: Ja. Ja ((gazing towards OT))

084 C: ((nods towards OT)) så det

085 S: ja ja ((gazes and nods to OT))

086 (1.5)

087. S: så så hvis man. Hvis man ude i samfundet skal lave noget nyt øh så spørger man da

088 S: den faggruppe til råds som man har med at gøre ((gesticulates with hands))

((pulls up shoulders, small headshakes, gazes at OT))

089 ((right hand palm open upwards small headshakes, gazes at OT))

090 S: ikke

091 C: ((nods))

092 P: ((nods))

093 S: så så hva hi hi hm ((gazes at OT))

094 C: det kunne man (ha ha) godt gøre

095 S: ((elevates coffee cup, looks downwards))

------------------------------>((all participants continue watching the video recording))

096 (1.0)

097 S: ((drinks tea, puts spectacles on top of his head))

098 (5.0) --------------------------------------------------------------------------------------------->

099 P: så-

100 C: vi kan jo heller ikke se film hele dagen

101 S: he ((gaze towards OT))

102 P: Nej. (he) nej nej det går ikke godt (noise)

103 C: ha (ha)

104 P: ((gazes at OT gesticulating)) vi kan heller gå tilbage til for to uger siden

105 S: [Haha]

106 C: [haha] vi vil bare gerne vise jer hvordan (noise)

107 ((OT goes to her seat, P and C find their seats))

108 S: Mm. ja fint

109 (1.0)

110 S: ((puts on spectacles))

Data example (1b)

109 OT: hvad siger I til at se jer selv

110 S: (øh det) det er har jeg det fint med og øh

111 R: (øh eh) øh eh

112 S: det er bare ærgerligt at vi vender ryggen til hva [R] ((gazes into the air))

113 R: ((gazes towards S)) (øh øh) (ha) ha

((gazes towards S)) (eh eh) (ha) ha

114 S: (m ha) ha ha

115 OT: så må i smile lidt til kameraet (noice)

116 S: ha

117 R: ha

118 S: ((drinks of cup))

119 (4.0)

120 ((P and C talk in the background))

Data example (2a)

061 S: si:g mig- si:g mig- ((gazes towards the camera and C))

062 (.)

063 S: ha:r d:u:↓ e:n ha::ve↑ derhje:mme ((gazing fixated at C))

064 Pe: ((removes hair from her forehead and puts it behind ear))

065 OT: ((leans forward, gazes towards C))

066 C: jeg har en lillebitte en ((draws a square in the air with finger in front of the camera))

067 S: eh ja- ja-

068 C: den↓ e:r ikke så stor

069 S: nej

no

070 C: måske ligesom herfra og over til den plante

071 Pe: ((looks up, gazes at C and eyes back down again))

072 S: ja (det) jeg ((gazes towards Pe and OT))

073 C: [og så over til det næste bord

074 S: [ja: o:k ja: ((gazes towards C and then camera))

075 C: og så tilbage igen ((draws line in the air with index finger))

076 S: o:k- E:H- så- [så-

077 C: [ men den er (.)SÅ↑ dej(h)lig he hi

078 Pe: ((gaze towards C and smiles)) mm(h)m ((eats))

079 OT: ((gazes at C))

080 (0.5)

081 C: jeg er vi:rkelig glad for jeg har fået sådan en lille ha:ve

082 S: så: så: sli:ppe:r du:fo:r a:t sku:lle: slå: græ:s i:fle:re timer

083 C: ja-

yes-

084 Pe: ((gazes towards C))

085 S: [HA: ha he: he

086 C: [ja det er nemlig rigtigt

087 OT: ((gazes at Pe))

088 Pe: ((gazes at OT)) en overkommelig ha:ve↑

Data example (2b)

089 OT: ((looks over shoulder)) jeg- troede du spurgte om [C] hun havde en a:be↑

090 Pe: NÅ↑ ((puts her glass down)) ha ha

091 OT: ((looks around and catches eye contact with R)) hi hi

092 R: ((smiles))

093 C: he he↑ en a:be↑ nej jeg har en lille dreng ((shows how tall with hand in front of the

camera))

094 S: he he ((wipes mouth with napkin and gazes towards C)) he he

095 Pe: he he ((gazes towards C and wipes mouth with napkin))

096 C: men det er næsten ligesom en a:be↑ ha

097 S: ((gazes towards Pe))

098 Pe: ((wipes mouth with napkin and gazes at S))

099 C: he he nogle gange

100 Pe: det er dejligt med sådan en lille overskuelig ha:ve

101 S: m:m ((wipes mouth and puts down napkin))

102 C: men jeg er virkelig glad for det altså