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Commentary. Six basic principles in the communication of social identities: The special case of discourses and illness

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17 The four articles in this special theme issue demonstrate several important general points: that communication practice is finely and systematically structured; that structures in communication serve to identify people as members of some social categories rather than others; that movement among these categories is immanent in the movement of communication practices and structures; that relations among people are negotiated through such structuring of communication and identities; and that these patterns of practice are active in socially occasioned ways, from clinical scenes of interaction to the scenes of routine everyday life.

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31 The specific studies presented in this special theme issue explore in focused ways how communication practices are formative sites of identity work. For example, the article by Wilkinson, Gower, Beeke, and Maxim poses the questions: How do people construct turns in conversation? Do variations in the ways turns are constructed identify people at differing stages of recovery? Their analyses explore various discursive practices that go into the construction of a turn-at-talk, such as a search for proper wording, repairing errors, extensions to turns-in-progress, and the like. Their analyses demonstrate how variations in these practices of turn construction do indeed occur at different stages of recovery, and thus provide verbal markers of patients as more or less impaired. In other words, their study shows how communication practices such as word searches, repairs, and extensions are used to identify patients as types of people, from mild to severely impaired.

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53 I will elaborate a bit on these general points by drawing attention to each article. I will structure my remarks through six principles that are active within and across these studies. By formulating these principles,

I hope to make explicit some of the connections between communication and identity generally, while focusing on those in 'illness discourse' in particular.¹

Let us start with a first, basic principle:

1. The ubiquity principle: Identity is a dimension of all communication practices

Bokhour, Powel, and Clark's article explores ways in which explicit discursive resources are used by patients to construct a sense of identity after being treated for prostate cancer. These resources are explicitly tied to important parts of one's life such as one's profession (being an engineer), or one's stage of life (being a child of the sixties). As we see in this study, each provides specific discursive terms, metaphors, and themes for one's verbal interpretations of who one is, after the diagnosis of cancer. Enlarging the discursive concern, we find in their study a narrative form which is itself composed of various discursive resources. These re-position, or re-collage the self relative to one's earlier profession, gender, and stage of life.

Through this article, and others in this special theme issue, we find that whether intended or not, what we say and how we structure our communication says something about who we are, and who others are with whom we communicate. It is this inextricable relationship between our communication and our identities that partly animates our social practices. This process becomes particularly rich as a site for inquiry, especially during life changes, such as those brought about by traumatic brain injury, breast and prostate cancer, and aphasia. What do we say about ourselves, and with others, before, during, and after these life changes? This is a powerful site for reflections, for in these discursive moments we can generate deeper understandings of ourselves and our lives, while focused on the nature of these changes. In the

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1 process we can create deeper meanings about who we
2 (and others) are, designing ways of moving forward,
3 at times helping those involved in the process.

4 Note that studies as these are built on several
5 important assumptions: Matters of identity are im-
6 manent in communication practices in explicit (and
7 implicit) ways. Explicit claims of identity can be un-
8 derstood as occurring through communication forms
9 such as narratives, or acts-in-sequences such as the
10 construction of turns; claims to identities are also
11 made through explicit symbols such as 'being a survi-
12 vor' or a 'failure', or through words and phrases that
13 identify ones' self as a 'therapist' and others as
14 'impaired'. Implicit claims to identity can occur
15 as one talks about actions such as 'not wearing a
16 wig' or 'getting a tattoo' and thus casting a self as
17 one counter to traditional ideals of beauty (see
18 below).²

2. The principle of situated practice: Identity is an outcome of situated communication practices

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24 The accumulation of one's communicative practices,
25 in particular social scenes, creates a sense of who one
26 is. Who one is in particular social scenes, for example,
27 being a doctor during physical exams, a patient given
28 advice, or a care-giver, each is both an enactment of
29 an identity and an outcome of that enacted iden-
30 tity in particular communicative scenes. An identity,
31 then, so conceived, is an outcome of communication
32 practices in the particular scenes of social and cultural
33 life.

34 The study by Kovarsky, Shaw, and Adingono-
35 Smith nicely demonstrates how the discursive enact-
36 ment of an identity is tied to certain communication
37 practices. In their data, Monica, the speech and lan-
38 guage therapist, manages therapeutic interactions so
39 that the patients collaboratively, and explicitly, affirm
40 their deficiencies. She requires patients to comply with
41 the therapist's claim that they are injured, that they
42 suffer memory loss, or that they indeed have lapses
43 of attention. Insisting on this compliance implements
44 the widely held belief that a problem must be ex-
45 plicitly acknowledged before it can be addressed or
46 solved, and of course the therapist knows, in this
47 scene, what the relevant problems are! The therapist's
48 communication is thus guided by such a belief and
49 such practice to the extent that other conversational
50 moves are subsequently ignored, unaddressed, or de-
51 valued, such as a frame of humor introduced by the
52 patients. Note in such scenes, as in all social situa-
53 tions, some verbal actions are affirmed and sup-
54 ported, as others are devalued, deflected, or ignored.
55 In this scene of therapy, the therapist's identity, and
56 the patients', are active through a set of highly spe-
57 cific, carefully monitored, communication practices.

58 In Ucok's study, we see also how specific scenes of
59 treatment are available to survivors of breast cancer.

In each, one can be shown both who one is as a can-
cer patient, and what one can become, especially by
manipulating one's appearance in particular ways. In
these scenes, specific practices are discussed such as
wearing wigs, shaving hair, and the like. Each such
practice can be conducted in order to help oneself
become a survivor; yet also, as Ucok shows, each
can be resisted, so to enact another variation of being
a survivor. Ucok's analysis nicely widens the range of
practices available to women with breast cancer, as
well as broadens our understanding of the scenes in
which women may enact this stage of identity.

3. The salience principle: Any particular social identity is a set of communicative practices that is more salient in some scenes than in others

Kovarsky et al. nicely illustrate how the social occa-
sion of therapy sets a strong stage for the enactment
of the therapist's and patients' identities and roles.
This is done through a limited set of practices that
the therapist orchestrates such as 'stating and affirm-
ing the deficiencies' of the patients. Who the patients
are, however, generally speaking, is a much larger set
of practices, but the therapist knows little of the prior
history of those in her therapy group. This—and con-
straints the therapist sets on what proper therapy
indeed is—deflects prior knowledge from the scene,
making it much less relevant or not salient. Viewed
in this way, the scene of therapy loses discursive re-
sources about who is there, since patients' prior life
histories are unavailable to the therapist. As a result,
the therapist's communication becomes addressed less
to the specificity of clients or patients, and more to
the category of medical-person-as-deficient, specifi-
cally as brain-injured.

A second, related point is that the one in charge
of a scene, like a therapist, judge, or teacher, may
render some information that patients make available
in the conduct of therapy for example, as not salient
to it. In Kovarsky et al.'s study, when the patients
began introducing practices outside of what the
therapist deemed proper as therapy, such as playful
self-degradation or humor, difficulties arose, for the
speech language pathologist found it difficult to pro-
ductively manage these comments. The therapist evi-
dently did not deem such comments productive ones,
and began wondering whether what was getting said
in the process was indeed salient or productive in
the scene of therapy. The study nicely illustrates this
'boundary of salience' which the therapist and clients
traversed, as well as the very fact that traversing this
boundary is part of the practices of therapy, as it is
in many social scenes. How tightly the boundary
of proper communication is woven becomes part of
situated practice in such scenes, and understanding
this provides additional insights about enactments of
identity in social scenes (see Cameron 1995).

1 Ucok's study very interestingly invites readers to
 2 consider the nature of scenes in which 'being a cancer
 3 survivor' is deemed socially relevant to individuals.
 4 For some, making this a very private part of one's
 5 self is preferred, while for others making this a public
 6 part of one's self is preferred. What cues are made
 7 available, in what scenes, about being a cancer survi-
 8 vor? For each woman, a set of practices concerning
 9 this identity is created, and for each a set of scenes in
 10 which each is enacted becomes pivotal. Yet for all
 11 women, of course, there is no uniform set of practices
 12 for any given scene. A key value in Ucok's study is
 13 just this: Each identificational enactment involves ne-
 14 gotiating a range of possible practices, some of which
 15 are deemed salient in a selected set of scenes. How
 16 these are normalized, or interpreted, is part of the in-
 17 dividual negotiation of one's self during these transi-
 18 tional stages of one's life.

19 Eliciting narratives about who one is, is a particu-
 20 larly productive technique for Bokhour et al. Treat-
 21 ments of prostate cancer may create publicly invisible
 22 consequences such as incontinence and sexual dys-
 23 function, and how one renders these as a part of one-
 24 self may productively be studied through elicitations
 25 of one's story. In this sense, a particular kind of inter-
 26 view can create a conversational scene in which tell-
 27 ing one's story becomes relevant (unlike other scenes
 28 where this aspect of life may receive little, if any,
 29 discursive treatment). Note that the telling itself may
 30 present resources otherwise hidden to patients and
 31 health professionals alike. As one result, then, the
 32 patients' stories in Bokhour et al.'s research are re-
 33 sponsive to a research exigency which makes them
 34 salient, yet as such, this itself is an instructive
 35 and helpful discursive exercise, for it provides addi-
 36 tional ways of understanding who one is, who one
 37 may become in this scene, and in the process suggests
 38 further ways of helping one in the various scenes
 39 of one's social life (as discussed in the following
 40 principle).

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 43 **4. The sequential structuring principle: The**
 44 **communication of a particular identity is part of**
 45 **a social process; when enacted, it is typically**
 46 **precipitated by what came before, as a socially**
 47 **occasioned performance, just as it is also**
 48 **consequential for what happens later**
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50 The specific Traumatic Brain Injuries at play in the
 51 data presented in the Kovarsky et al. article show
 52 how relations between discursive scenes can become
 53 problematic as those with severe brain injuries have
 54 difficulties linking a present discursive scene to what
 55 came before it. Note how the disjuncture created
 56 in the social process, and its effective remedy, then,
 57 presents at once a symptom of a problem, and a site
 58 for its remedy. Indeed, building a present scene of
 59 therapy as part of this smaller problem of remedying

an interactional deficiency, and a larger social pro-
 cess of recalling now what occurred earlier, becomes
 part of the work the therapist must orchestrate, to
 some degree. Each sequence, the smaller micro-
 sequence of talk, and the larger interdiscursive scene
 of which this is a part, provide distinctive levels in
 the structuring of talk itself. Each responds to what
 came earlier; each can be consequential for what
 comes later.

Wilkinson et al.'s study demonstrates similarly
 how the ability of patients to manage the micro-
 details of conversational sequences changes over
 time. The truncated ability to construct sequences of
 talk thus demonstrates how impaired aphasic speech
 presents itself; the change in such sequential construc-
 tions shows in a highly refined way how aphasics can
 progress from a more severe to mild speech impair-
 ment. These changes are part of the interactional
 sequencing of communication practice. These occur
 locally in interactional details, and more broadly be-
 tween discursive events. By exploring the sequential
 organizations in communication practices, therapists
 are able to track and treat the conversational abilities
 which are identified as movement from a more to a
 less impaired identity.

5. The dialectical principle: The communication of
social identity can be productively considered as
part of a dialectical discourse

This principle is a way of asking: Of what is this
 specific communication practice a part? For example,
 one social identity (e.g., as a male) may occur
 discursively—and explicitly or implicitly—relative to
 another (e.g., as a female); the play between these
 two can create an eventual interactional need for a
 movement of identification to other levels such as to
 a nongendered identity (e.g., let's discuss things now
 not as 'men and women' but as 'persons' or 'individu-
 als'). Or, in another direction, the play may extend
 not away from gendered identities, but within a
 gender, to types of gendered identities (e.g., males be-
 ing discussed as 'feminist, chauvinist, and sensitive'
 types). The dialectical play of identity talk thus
 creates the possibility of alternative discourses both
 within and between levels of identification.³

The data presented in the Kovarsky et al. article
 show interactional sequences in which a therapist
 may, but did not, take up the frame suggested by pa-
 tients. One gets the sense that such play, or at other
 times, such role-playing, might creatively intervene in
 protracted patterns (of therapist and patient) while
 offering something productively different to the group
 (a transcending of traditional roles). In other words,
 if a therapist is cognizant of a dialectical form of vac-
 illating identities, including its productive potential,
 and allows it to play out a bit, new opportunities
 for intervention and learning may appear, beyond

1 the more solidified interactional sequences typically
2 available to those in that scene (e.g., of therapist and
3 patient).

4 Ucok's study is exemplary here as it explores sev-
5 eral dialectical tensions in the discourses of cancer
6 survivors. These include the play at once between vi-
7 sual and verbal images, portrayals of oneself before
8 and after treatment, including the productive play of
9 ideas about what is healthy and normal, and what is
10 not. As one becomes a 'recovering identity', one can
11 productively adopt a conventional ideal of beauty
12 and align with its conventional premises of appear-
13 ance; yet also, Ucok demonstrates alternative routes
14 of adaptation, through which different standards of
15 visual beauty come into play after treatment, assum-
16 ing other premises of value. It is this kind of deep dia-
17 lectical process that identities take shape within, play-
18 ing the before and the after, the verbal and visual
19 channels, and the different aesthetic standards that
20 are created through this process.

21 By making the dialectical play explicit, Ucok's
22 study nicely enlarges the variety of discourses avail-
23 able to women when becoming a cancer survivor,
24 with the play involving not only before and after dis-
25 courses, but different premises of beauty. Going be-
26 yond a standard offering of one treatment program,
27 she shows how reactions to physical consequences of
28 cancer treatment can indeed be varied, productive in
29 a variety of ways, and even transformative of conven-
30 tional aesthetic concerns. Various consequences, then,
31 come into play about who one is, and how one nego-
32 tiates one's identity, through communication about
33 one's bodily appearance, after treatment.

34 Bokhour et al.'s study, as Ucok's and the others,
35 do presume a dialectical play between one's former
36 self and one's current self. For Bokhour et al.'s pri-
37 mary data, this involves a play between an image
38 of a normally virile male, and one who now is not as
39 he was. Such dialectical, vacillating discourses, when
40 brought to the fore explicitly through analyses, can
41 help us understand both the standards of normalcy
42 being presumed about who one is, and the transfor-
43 mative change from those standards that are at play
44 in the discursive elaborations of self.

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47 **6. The cultural principle: The communication of**
48 **social identities always presumes and creates**
49 **some set of cultural premises**
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52 Premises for doctors are not the same as those for
53 shamans; premises for patients in the United States
54 are not the same as those for patients in Russia;
55 epilepsy in prominent US scenes of medicine is not
56 conceived and evaluated in the same way among the
57 Hmong. In sum, the communication of identities, di-
58 agnoses, and treatments, as situated social and cul-
59 tural action, always involves some cultural stance

and standard more than others. All communication
is based upon and invokes cultural premises, beliefs
about what exists, and what is valued, of what is bet-
ter or worse. Illness discourse is no exception. The be-
lief that deficiencies must be expressed prior to their
correction is one such belief, and a central belief, in a
problem-solving scene of selves (Duchan and Kovar-
sky 2005).

Bokhour et al.'s data nicely demonstrate promi-
nent premises in US discourses about being a self-
contained, responsible person, about 'being a man'
and fulfilling roles as a provider, and virile partner,
among other ideals. We are invited to ask: which are
invoked in the construction of these identities; how is
each active in the telling of one's story; which ideas
and ideals usefully help (as a liberated child of the six-
ties), or risk hindering (as a mechanical failure) one's
recovery? These inquire about common discursive re-
sources that invoke basic premises in the construction
of a life, and in a life now changed by recent medical
circumstances. While each verbal portrayal as these
provides openings and functions for such con-
structions, each also has its limits, indeed its cul-
tural limits, as Bokhour et al.'s data and analysis
demonstrate.

Ucok's study shows how traditional premises of
feminine beauty are active in images of women, and
how these are used in a treatment program. Also,
counter to these are other images more closely tied to
cancer, and more closely related to the physical lives
of some women who are cancer survivors. By the end
of Ucok's study, we are left wondering how deep our
premises are, concerning beauty, and whether these
can indeed be enlarged to serve others who are beau-
tiful also in their own way. Deep ideals are active
in discourses of health, are dialectically played, and
questioning who they serve, and who not, may open
new paths to a healthier world.

As is evident in the articles of this special theme is-
sue, the communication of social identities in illness
discourses is a complex process. I hope to have cap-
tured some of that complexity by discussing six basic
principles in the communication of identity. In sum-
mary: Illness discourses, as cultural discourses gener-
ally, involve communication in social and cultural
scenes. Who we are is an ever-present dimension, an
always retrievable part of this social and cultural pro-
cess (the ubiquity principle); who we are involves situ-
ated enactments of communication that are salient
in some scenes more than others (the principles of situ-
ated practice and salience); the enactment of identity
has its social life in sequential structures, large and
small (the sequential structuring principle); identities
are dialectically played within and across planes of
identification (the dialectical principle); and the com-
munication of identity always involves cultural prem-
ises about what exists, what is valued, about what is a
problem and how it should be treated (the cultural
principle).

Notes

- 1. See Carbaugh (1996: 24–27).
- 2. Elsewhere I have defined, demonstrated, and summarized in detail how identity is active, explicitly and implicitly, through various communication forms and symbols (Carbaugh 1996: 203–207; Brockmeier and Carbaugh 2001).
- 3. This point is developed elsewhere as both a vacillating form of identity talk, and dueling identities (Carbaugh 1996: 123–139, 157–190).

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