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

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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.

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.

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

Note that studies as these are built on several important assumptions: Matters of identity are imminent in communication practices in explicit (and implicit) ways. Explicit claims of identity can be understood as occurring through communication forms of attention. Insisting on this compliance implements such as the construction of turns; claims to identities are also made through explicit symbols such as 'being a survivor' or a 'failure', or through words and phrases that identify ones' self as a 'therapist' and others as 'impaired'. Implicit claims to identity can occur as one talks about actions such as 'not wearing a wig' or 'getting a tattoo' and thus casting a self as one counter to traditional ideals of beauty (see below).²

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

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

The study by Kovarsky, Shaw, and Adingono-Smith nicely demonstrates how the discursive enactment of an identity is tied to certain communication practices. In their data, Monica, the speech and language therapist, manages therapeutic interactions so that the patients collaboratively, and explicitly, affirm their deficiencies. She requires patients to comply with the therapist's claim that they are injured, that they suffer memory loss, or that they indeed have lapses of attention. Insisting on this compliance implements the widely held belief that a problem must be explicitly acknowledged before it can be addressed or solved, and of course the therapist knows, in this scene, what the relevant problems are! The therapist's communication is thus guided by such a belief and such practice to the extent that other conversational moves are subsequently ignored, unaddressed, or devalued, such as a frame of humor introduced by the patients. Note in such scenes, as in all social situations, some verbal actions are affirmed and supported, as others are devalued, deflected, or ignored. In this scene of therapy, the therapist's identity, and the patients', are active through a set of highly specific, carefully monitored, communication practices.

In Ucok's study, we see also how specific scenes of treatment are available to survivors of breast cancer. In each, one can be shown both who one is as a cancer 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 occasion 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 affirming 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 constrains 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 resources 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, specifically 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 productively manage these comments. The therapist evidently 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).
Ucok’s study very interestingly invites readers to consider the nature of scenes in which ‘being a cancer survivor’ is deemed socially relevant to individuals. For some, making this a very private part of one’s self is preferred, while for others making this a public part of one’s self is preferred. What cues are made available, in what scenes, about being a cancer survivor? For each woman, a set of practices concerning this identity is created, and for each a set of scenes in which each is enacted becomes pivotal. Yet for all women, of course, there is no uniform set of practices for any given scene. A key value in Ucok’s study is just this: Each identificational enactment involves negotiate a range of possible practices, some of which are deemed salient in a selected set of scenes. How these are normalized, or interpreted, is part of the individual negotiation of one’s self during these transitional stages of one’s life.

Eliciting narratives about who one is, is a particularly productive technique for Bokhour et al. Treatments of prostate cancer may create publicly invisible consequences such as incontinence and sexual dysfunction, and how one renders these as a part of oneself may productively be studied through elicitations of one’s story. In this sense, a particular kind of interview can create a conversational scene in which telling one’s story becomes relevant (unlike other scenes where this aspect of life may receive little, if any, discursive treatment). Note that the telling itself may present resources otherwise hidden to patients and health professionals alike. As one result, then, the patients’ stories in Bokhour et al.'s research are responsive to a research exigency which makes them salient, yet as such, this itself is an instructive and helpful discursive exercise, for it provides additional ways of understanding who one is, who one may become in this scene, and in the process suggests further ways of helping one in the various scenes of one’s social life (as discussed in the following principle).

4. The sequential structuring principle: The communication of a particular identity is part of a social process; when enacted, it is typically precipitated by what came before, as a socially occasioned performance, just as it is also consequential for what happens later

The specific Traumatic Brain Injuries at play in the data presented in the Kovarsky et al. article show how relations between discursive scenes can become problematic as those with severe brain injuries have difficulties linking a present discursive scene to what came before it. Note how the disjunction created in the social process, and its effective remedy, then, presents at once a symptom of a problem, and a site for its remedy. Indeed, building a present scene of therapy as part of this smaller problem of remedying an interational deficiency, and a larger social process of recalling now what occurred earlier, becomes part of the work the therapist must orchestrate, to some degree. Each sequence, the smaller microsequence 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 microdetails 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 constructions shows in a highly refined way how aphasics can progress from a more severe to mild speech impairment. These changes are part of the interational sequencing of communication practice. These occur locally in interational details, and more broadly between 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 interational 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 ‘individuals’). 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 being 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.

The data presented in the Kovarsky et al. article show interational sequences in which a therapist may, but did not, take up the frame suggested by patients. 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 vacillating identities, including its productive potential, and allows it to play out a bit, new opportunities for intervention and learning may appear, beyond
the more solidified interactional sequences typically available to those in that scene (e.g., of therapist and patient).

Ucok’s study is exemplary here as it explores several dialectical tensions in the discourses of cancer survivors. These include the play at once between visual and verbal images, portrayals of oneself before and after treatment, including the productive play of ideas about what is healthy and normal, and what is not. As one becomes a ‘recovering identity’, one can productively adopt a conventional ideal of beauty and align with its conventional premises of appearance; yet also, Ucok demonstrates alternative routes of adaptation, through which different standards of visual beauty come into play after treatment, assuming other premises of value. It is this kind of deep dialectical process that identities take shape within, playing the before and the after, the verbal and visual channels, and the different aesthetic standards that are created through this process.

By making the dialectical play explicit, Ucok’s study nicely enlarges the variety of discourses available to women when becoming a cancer survivor, with the play involving not only before and after discourses, but different premises of beauty. Going beyond a standard offering of one treatment program, she shows how reactions to physical consequences of cancer treatment can indeed be varied, productive in a variety of ways, and even transformative of conventional aesthetic concerns. Various circumstances, then, come into play about who one is, and how one negotiates one’s identity, through communication about one’s bodily appearance, after treatment.

Bokhour et al.’s study, as Ucok’s and the others, do presume a dialectical play between one’s former self and one’s current self. For Bokhour et al.’s primary data, this involves a play between an image of a normally virile male, and one who now is not as he was. Such dialectical, vacillating discourses, when brought to the fore explicitly through analyses, can help us understand both the standards of normalcy being presumed about who one is, and the transformative change from those standards that are at play in the discursive elaborations of self.

6. The cultural principle: The communication of social identities always presumes and creates some set of cultural premises

Premises for doctors are not the same as those for shamans; premises for patients in the United States are not the same as those for patients in Russia; epilepsy in prominent US scenes of medicine is not conceived and evaluated in the same way among the Hmong. In sum, the communication of identities, diagnoses, and treatments, as situated social and cultural 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 better or worse. Illness discourse is no exception. The belief 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 Kovarsky 2005).

Bokhour et al.’s data nicely demonstrate prominent 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 sixties), or risk hindering (as a mechanical failure) one’s recovery? These inquire about common discursive resources 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 constructions, each also has its limits, indeed its cultural 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 beautiful 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 issue, the communication of social identities in illness discourses is a complex process. I hope to have captured some of that complexity by discussing six basic principles in the communication of identity. In summary: Illness discourses, as cultural discourses generally, involve communication in social and cultural scenes. Who we are is an ever-present dimension, an always retrievable part of this social and cultural process (the ubiquity principle); who we are involves situated enactments of communication that are salient in scenes more than others (the principles of situated 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 communication of identity always involves cultural premises about what exists, what is valued, about what is a problem and how it should be treated (the cultural principle).
Notes

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).

References


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