Clinical Pragmatics: Expectations and Realizations

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Abstract

Pragmatic language models have had a profound impact on our thinking about language disorders. This paper reviews expectations for change and those changes that were realized in clinical practice as a result of these models.

A review of the clinical literature of the last ten years reveals that pragmatic language models (Austin, 1962; Searle, 1969; Bates, 1976) have had a major impact on our thinking about language disorders. The depth of the impact and the remarkably short time in which it was felt are remarkable characteristics of what has been referred to by some as the "pragmatics revolution" (Duchan, 1984). Both in terms of learning from our past as well as charting a course for our future it seems fitting at this time to critically examine what changes have occurred and why.

The goal of pragmatic language models is to characterize communicative competence. In general, communicative competence reflects complex interrelationships among three types of knowledge: language structural knowledge (knowledge of the language code), presuppositional knowledge (the ability to make appropriate judgments about the form an utterance must take to adequately communicate the speaker's intent), and conversational knowledge (knowledge of the discourse rules governing conversation in the speaker's society). This perspective, a functionalist perspective, focuses on language as it is used for communicative purposes. Language, within this framework, is a type of social behaviour. In addition to our own, a variety of disciplines have contributed to this literature including psychology, linguistics, anthropology, sociology, and education.

Perhaps the first question to address is why this type of model had the impact that it did on the clinical literature as early as the late 1970's. Acceptance of pragmatic models probably was enhanced by the influence of three major factors. One was the attention the model received in the normal language development literature. In a joint preface to their recent book, *From First Words to Grammar* (Bates, Bretherton, & Snyder, 1988), three primary contributors to the pragmatics literature characterized that period as follows: "In the 1970s this interactive view of language development was so popular that we were preaching among the converted." (p. ix)

A second factor was a growing frustration throughout the 1960's and early 1970's with the limitations of an almost exclusively syntactic/semantic characterization of language behaviors. This frustration resulted in part from an inability to adequately identify the depth and range of communicative problems speech-language pathologists encountered in their clients with assessments that were limited to language structural measurements, and in part from concerns clinicians had about the ecological validity of the content of language sessions and the problems encountered with their clients' generalization of learned structures in contexts other than the therapy room.

A third factor may have been an intuitive recognition that there was something basically right about the field's earliest conceptualizations of language disorder as a type of socially defined disability. In 1939 Charles VanRiper defined speech as defective, a general term encompassing both speech and language disorders, when "it deviates so far from the speech of other people in the group that it calls attention to itself, interferes with communication, or causes its possessor to be maladjusted to his environment." (p. 51) This definition, which highlights the role of language as communication and the context of language behaviour as social, is consistent with current pragmatic models. The enthusiasm with which pragmatics was received led to high levels of anticipation and expectation for pragmatically based clinical practice. For example, in 1978 Norma Rees characterized the potential contributions of pragmatic approaches to clinical practice as "limitless." (p.263) To what extent have those expectations been realized?

Major changes have occurred in the last decade. Pragmatically based clinical practice, as it has evolved, differs in some important respects from the generative grammar based clinical practice of the immediately prior decade. These differences reflect the influence of three major lines of prag-

matic research with language disordered populations that have been reported in the last 10-15 years. This research has included the study of context and the influence of contextual variables upon the language used; the study of discourse specific phenomena previously unstudied and unnoticed within a language structural perspective, for example, contingent queries and turn taking behaviors; and studies of communicative intentions using a speech act analysis system.

Pragmatically based clinical models, to greater or lesser extents, have affected all aspects of language practice. Regarding identification of language disorder, the concept of communicative disability has expanded the set of potential criteria by which children and adults can be included within service delivery systems. Some of the clients who become eligible for service given these expanded criteria may not have qualified or may have only minimally qualified for service using exclusively language structural criteria (e.g., the older school-aged child).

Assessment activities also have undergone change. Pragmatic studies of the impact of various types of communicative context (interpersonal, physical, nonlinguistic, paralinguistic, etc.) upon the language structures used by interactants have motivated changes in spontaneous language sampling procedures. The data relative to contextual variability highlighted the futility of attempts to strip context effects from language use or to neutralize their idiosyncratic influences upon interactants by identifying a "preferred" or standardized context to be used with all clients. Two recommendations have been made in response to these data, that additional information be obtained on each client prior to language sampling that would enable clinicians to individualize language sampling contextual configurations, a procedure sometimes referred to as "pre-assessment" (Gallagher, 1983; Lund & Duchan, 1988), and that language samples be obtained in more than one context.

Changes also have been recommended in the analysis procedures used once a language sample has been obtained. These changes entailed the measurement of new behaviors, both verbal and nonverbal, and the re-classification of previously noted behaviors. Examples of the former categories are clarification responses and gaze behaviour, and an example of the latter category is the inclusion of questions in the broader speech act category of requests.

Several pragmatic profiles have been proposed (Prutting & Kirchner, 1983; 1987; Roth & Spekman, 1984; Penn, 1988). Prutting and Kirchner's (1983;1987) and Penn's (1988) are the most elaborate. Prutting and Kirchner's "Pragmatic Protocol" elicits clinician appropriateness judgments of 30 client interactant behaviors representing three broad classes—verbal behaviors (e.g., the variety of speech acts used), paralinguistic behaviors (e.g., prosody), and nonverbal behaviors (e.g., physical proximity). Penn's "Profile of Communicative Appropriateness" is a five-point rating scale of 49 client behaviors that are divided into six categories—responses to interlocutors (e.g., acknowledgement), control of semantic content (e.g., topic adherence), cohesion (e.g., ellipsis), fluency (e.g., false starts), sociolinguistic sensitivity (e.g., indirect speech acts), and nonverbal communication (e.g., facial expression).

Other types of scales also have been introduced into clinical practice. Sociometric scales, social interview scales, and more informal measures of interpersonal acceptance such as the frequency with which the client is sought after as a conversational partner, the typical length of his/her conversations with peers and teachers, the frequency with which the client initiates conversations with potential interactants, the symmetry of the conversations in which they are included, and so on, all provide clinically useful information. This information can be used in identification, assessment, severity judgments, the establishment of intervention goals, the prioritization of intervention goals on the basis of social penalty, and as additional documentation indices for monitoring intervention effects.

Changes in intervention also were evident. One of these changes related to goal setting. New intervention goals targeting specific pragmatic behaviors have been added. Examples include focusing lessons on the use of communicative functions such as controlling and informing (Wood, 1977a; 1977b), requesting (Olswang, Kriegsmann, & Mastergeorge, 1982); and turn taking (Muma, 1975; Bedwinek, 1983). Another change was the suggestion that clinicians modify the feedback or evaluation phase of intervention. Within pragmatically based intervention approaches, clinical contexts were manipulated so that natural needs, desires, and consequences of communication were used as feedback mechanisms rather than specific clinician evaluations of client behavior or external rewards (e.g., Halle, 1984).

Other changes relative to intervention involved new types of clinical tasks and activities that could comprise therapy sessions. Clinical tasks and activities have been expanded to include routines, scripts, and formulaic utterances. Memorized sequences, once devalued and considered counter-productive, are being incorporated within pragmatic clinical practice models as a means of achieving productive use, or as compensatory or coping strategies for handling highly interactionally penalizing behaviors. This change has been supported in part by research suggesting that the early conversational development of young children with limited language skills is typically scaffolded by repetitive interactive games with predictable verbal and nonverbal sequences, such as "peek-a-boo" and the disappearance game (Bruner,

1974; 1975; 1977; Ratner & Bruner, 1978; Snow, 1978). In addition, Peters (1983), among others, has suggested that the units of child language may not be the same as those of adult language and that one route to language acquisition may be the incorporation of "large wholes" that are gradually analyzed and broken down into their component parts. This alternative route to language acquisition would provide further support for the potential therapeutic value of learning chunks of language. As a consequence of these changes in intervention tasks and activities, the role of the clinician has been expanded from that of facilitator to that of teacher/facilitator, as activities that are best characterized as examples of explicit instruction are being incorporated into clinical practice (Craig, 1983).

The number of potential intervention agents also has been expanded. Attempts have been made to include competent peers as intervention agents not only as a means of extending the therapy context but also as role models of peer dialects. The literature addressing code-switching has indicated that development of this skill is important to peer acceptance, particularly among older children (Donahue & Bryan, 1984).

Although this is an impressive set of new ideas, all of our expectations have not been realized. One expectation, that pragmatic developmental norms, pragmatic skill profiles, and tests of pragmatic skills would be forthcoming and would be similar in form to the language structural norms, profiles, and tests with which we had become familiar and comfortable throughout the generative grammatical period largely has not been met. Although some pragmatic tests have been developed, for example, *The Test of Pragmatic Skills* (Shulman, 1986), the *Let's Talk Inventory for Children* (Bray & Wiig, 1987), the *Interpersonal Language Skills Assessment* (Blagden & McConnell, 1985), a gap has existed between the demand for pragmatic clinical materials and their availability. Those that are available and the pragmatic skill checklists that have been published have not seemed to meet this need. Why?

The answer may relate to the assumptions underlying these expectations. There are important differences between the generative grammar theories reflected in the clinical practice of the 1960's and early 1970's, and current pragmatic models. One of the major differences relates to theoretical clarity. Unlike generative theory, pragmatic models are not characterized by an overarching, coherent, explanatory theory that leads to predictable, rigorous, and supportable hypotheses (McTear, 1985). Some of the consequences of this lack of theoretical clarity, have been terminological confusion, terminological proliferation, and a blurring of the distinctions between the identification of behaviors and their explanation. Within generative models the units of analysis were finite, clearly identifiable, and, therefore, quantifiable. Units of analysis within pragmatic models are not as well defined.

Perhaps more important, however, are the fundamental differences in the nature of the two theories. Generative theories attempted to characterize the universal aspects of grammar with models derived from mathematical logic. Pragmatic theories, on the other hand, are inherently individualistic and characterize behaviour in interactional, culturally sensitive, highly situated terms. A consequence of these differences may be that the development of unidimensional, pragmatic paper and pencil tests may be logically inconsistent with the theory itself. Pragmatic analyses, by definition, may require multi-level, multi-variate, interactive behavioral descriptions. These types of descriptions are not readily adaptable to some of the testing formats that have been used in the past, for example, delayed imitation of a model that is provided.

The limits of pragmatic models still are being tested and fundamental questions remain. Among these are whether pragmatic analyses will clarify long standing enigmas of language disorder, such as language structural inconsistencies; whether interactional difficulties exhibited by language disordered individuals are consequences of limited language structural skills or are related to other types of nonlinguistic impairments that may be cognitive or social; and whether the boundaries of pragmatics can be made sufficiently clear and delimited to support reliable clinical predictions.

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