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Responding to Uncertainty in the Context of Clinical Pragmatics and Speech and Language Therapy Practice: A Grounded Theory Study

A dissertation submitted to the School of Linguistic, Speech and Communication Sciences at Trinity College, the University of Dublin, in partial fulfilment of the requirements for the award of Doctor of Philosophy

July 2011

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Summary of the Thesis

Clinical pragmatics is a relatively young and evolving area. Clinical pragmatics involves the application of theory and constructs from the broad area of pragmatics to intervention and research in the area of communication health and disorder. While it has been suggested that the area of clinical pragmatics is marred by disparity and confusion (e.g., Cummings 2007a, 2010b, Perkins 2005b), there is little published evidence of attempts to specifically explore the concerns of the Speech and Language Therapy (SLT) community in this area. The purpose of this study was to develop insight into the concerns of members of the SLT community, with regard to clinical pragmatics and SLT practice, and to explore how these concerns were being managed.

This research was conducted using a Classic grounded theory methodology. Classic grounded theory entails utilising a set of prescribed procedures to guide the researcher in moving iteratively back and forth between data collection and analysis in order to generate data-driven theory. Thus, this thesis presents the theory of *Reshaping Remit* as a conceptual account of the ways in which *Uncertainty*, as the main concern of participants, was managed.

Multiple data sites and sources were involved in this study. Primary data sources included practising Speech and Language Therapists (SLTs) and SLT educators, while extant documents in the form of commercially available intervention resources were also included as data. Data gathering was carried out simultaneously with data analysis. Initially, data was gathered by inviting practising SLTs to complete questionnaires. Following this, further data generation was guided by theoretically purposive sampling that led to the analysis of documents and also led to focus group interviews with practising SLTs. The final phase of data generation involved conducting individual interviews with SLT educators and practising SLTs. The total data set which was analysed comprised 50 questionnaires, 6 commercially available intervention resources and the transcripts of 6 focus group interviews and 8 individual interviews.

Data analysis revealed that *Uncertainty,* as a multifaceted and distributed phenomenon, was a salient and significant concern for participants. Based on conceptual patterns uncovered during data analysis, *Reshaping Remit* emerged as a theoretical account of how members of the SLT community managed their main concern of *Uncertainty*.

Reshaping Remit comprised three main responses or strategies explicating how *Uncertainty* was dealt with vis-à-vis the participants' considerations of their role and the role of the client. *Reshaping Remit* conceptualises the participants' management of *Uncertainty* as a typology of responses or strategies. Firstly, the response of *Shrinking Remit* captured how

participants pulled back from providing intervention in the context of *Uncertainty*. *Shrinking Remit* portrayed how participants acknowledged and evoked *The Limited Impact of Intervention* and *The Limits of the Profession* in responding to *Uncertainty.*

Secondly, *Containing Uncertainty through Homogenisation* explicated patterns in the data, as responses to *Uncertainty,* which involved *Automating, Involving Norms and Normalcy*, using *Formal Pointers* and assuming a stance of *Clinician as Evaluator*.

Thirdly, *Stretching Remit* emerged as a response to *Uncertainty* which involved *Actively Accepting Variance, Being Collaborative, Expanding Remit* and *Enacting Trial-and-Error Interventions*.

In this thesis, the theory of *Reshaping Remit* is presented by explicating and illustrating the categories and properties of each of these three responses to *Uncertainty*. The theory of *Reshaping Remit* is discussed in light of the theory of clinical pragmatics and the literature on clinical uncertainty and uncertainty management. Suggestions for theory development are presented in relation to uncertainty management and clinical pragmatics, in the context of SLT practice.

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The thesis was made possible by the kind support offered to me by a number of people.

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- Thanks are also due to my colleagues, particularly Linda, Sarah and Fiona for their interest and tentative inquiries about how this thesis was progressing.
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- Various individuals affiliated with the methodology of Classic grounded theory have been more than available and approachable in supporting me to learn about this methodology over the last three years, for which I thank them.
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Glossary

This glossary presents an overview of the abbreviations, terms and notation conventions used throughout this thesis for clarity and brevity.

Direct quotes from the data will always be presented in bold typeface and within double quotation marks. The names of concepts which emerged from the data will be presented in capitalised italics throughout this thesis (e.g., *Stretching Remit* is the name of one of the main conceptual categories from the theory of *Reshaping Remit* which accounts for one way in which *Uncertainty* was responded to by participants). Italics will be also used to mark the titles of books, assessments and published intervention resources (American Psychological Association, 2010, pp. 104-105). The following abbreviations, terms and notation conventions will be used throughout this thesis:

Abbreviations

- "SLT" will be used in lieu of Speech and Language Therapy.
- "SLTs" will be used in place of Speech and Language Therapists (plural), while "Speech and Language Therapist" will be used to refer to "therapist" in the singular.
- The generic term "Speech and Language Difficulty/Difficulties" will be referred to as SLD/SLDs.

Terms

- The term "clinical pragmatics" will be used to refer to pragmatics as it has been drawn on by clinicians and researchers working with communication and communication disorders.
- Additionally, the term "mainstream pragmatics" will be used to refer to pragmatics as it is has been more generally represented in the literature of mainstream linguistics, rather than interpreting pragmatics within any one specific framework from the area of linguistics.
- The phrase "pragmatics notions" will be used with reference to concepts, theories and constructs from the subject area of mainstream pragmatics following Kamhi (2000, p. 182).
- The term "remit" will be used to capture all of the responsibilities and obligations which fall within the role of the Speech and Language Therapist. Remit pertains to all of the activities an individual carries out as a Speech and Language Therapist.
- The term "client" will be used to refer to people who access SLT inputs and interventions, whether they are children, adults, parents or teachers etc.

- The terms "uncertainty" and "clinical uncertainty" will be used interchangeably throughout this thesis. When italicised and capitalised the term *Uncertainty* will be used to refer specifically to the concept of clinical uncertainty, as it emerged from analysis.
- In this thesis, the term "clinical knowledge" will be used to refer to the external research base or general clinical literature and information environment which is accessed by clinicians via journals, electronic databases and so on.
- The term "health care" will be used to refer to the broad array of clinical services that are now offered in relation to health, illness and well-being. When a particular form of health care service is being discussed this will be specified as in "medical health care services" or "occupational therapy services".
- The term "Evidence-Based Practice", and its acronym EBP, will be used as a generic term following on from the application of evidence-based medicine (EBM) principles across a variety of health care disciplines. This usage follows a discussion of evidence based practice as "the application of the principles of evidence based medicine...to all professions associated with health care, including purchasing and management" (Straus, Richardson, Glasziou & Haynes, 2005, p. 280).
- The term "non-clinical perspectives" will be used to refer to perspectives from outside the clinical realm which have also been called "lay perspectives" following (Gabe, Bury & Elston, 2004).

Notation conventions

- For the sake of simplicity, allusions to the participating SLTs and all other clinicians will be made in the female gender, with apologies to male clinicians, while clients will be referred to in the male gender.
- [Sic] will be used to indicate that a particular grammatical or spelling error appearing in a direct quotation also appeared in the original text from which the quotation was taken.
- Unless otherwise stated, all italics which appear in a direct quotation also appear in the original text from which the quotation was taken.

CHAPTER 1. INTRODUCTION

1.1 IDENTIFYING THE STARTING POINT OF THIS STUDY

The impetus for this study was clinical and personal. When embarking on the PhD process, the author had approximately two and a half years' experience as a practising Speech and Language Therapist working predominantly with children. Experiences during this time, and indeed during the author's four years as an undergraduate Speech and Language Therapy (SLT) student, gave rise to an interest in the nature of SLT practice and the patterns which characterised it. Additionally, the personal interest the author had in language, which no doubt influenced the choice of SLT as a profession, also sparked a professional interest in how some of the objects of SLT practice (such as language and communication) were specified and defined by the profession. These experiences led the author to gather data about the issues of concern for Speech and Language Therapists (SLTs), in an area of SLT practice where language and communication are particularly a focus, namely clinical pragmatics.

The SLT profession has only lately begun to reflect on the nature and historical origin of its practice, as can be seen in recent efforts at mapping the historical development of the profession, in the United States (Duchan, 2002, 2005), and exploring the international and interdisciplinary roots of the profession of SLT (Supple & Soderpalm, 2010). Historically speaking in an Irish context, a three-year undergraduate course was first established in 1969 which enabled its graduates to practise as SLTs (Leahy & Supple, 2002; Montgomery, 2006). Prior to this, clinicians who had qualified outside of the Republic of Ireland, as well as "teachers, elocutionists, and nursing staff", provided services to people with "communication problems" in the Republic of Ireland (Leahy & Supple, 2002, p. 88).

The profession of SLT has emerged, in a hybrid fashion, from a number of disciplines—most notably from the worlds of education, medicine and elocution (Duchan, 2002). Some of these early educationalists and medical personnel acted in order to professionalise their work in the area of speech correction. The formation of professional organisations of practitioners with particular entry criteria, who worked in the area of communication, was one way in which this professionalisation occurred (Duchan, 2002). Certain individuals, such as self-proclaimed speech correctionists, who had also worked with people with communication differences and difficulties,

began to be excluded by the emerging profession as "quacks—people who falsely claimed they had a secret technique or cure for particular speech disorders" (Duchan, 2005, p. 4). Today professional organisations exist, such as the Irish Association of Speech and Language Therapists (IASLT) and the Royal College of Speech and Language Therapists (RCSLT), which represent and advocate for the profession of SLT.

The emergence of SLT as a profession in its own right, in the earlier part of the 20th century, coincided with the "testing movement" and the rising popularity of the scientific method in the area of medicine (Duchan, 2005, p. 203). Unsurprisingly, perhaps, SLT has subsequently been underpinned by a variety of frameworks following on from the historical context of its origins, as Duchan comments:

> In the 19th century, before the medicalization of the profession, elocutionists were the ones who worked with individuals with communication disabilities. They offered "courses" or regimens to their "pupils" without diagnosing their problems.
>
> Later, with the influence of scientific and medical models, the field became a clinical one, adopting diagnostic practices and thinking that continue to this day. The medical view of diagnosis, which locates the problem within the individual, preferably within the person's biological system, provided the centrepiece around which revolved other aspects of service provision.
>
> (Duchan, 2005, p. 215)

Thus, the professional identity of SLTs might well be linked with a divergent past which positioned the Speech and Language Therapist with one foot in the clinical and medical professions and another in the educational sphere. The medical model has been traditionally associated with SLT practice and, indeed, clinical practice in general (Gabe, Bury & Elston, 2004), influencing the organisation of SLT work in terms of assessment, diagnosis and intervention (Duchan, 2006). The medical model has now been somewhat usurped by alternative frameworks which influence practice, such as the social model of disability (Bunning, 2004; Byng, Cairns & Duchan, 2002; UPIAS, 1976).[1] Anderson and van der Gaag (2005) have noted how a spectrum of models currently informs SLT practice with clinicians drawing on medical and more socially-orientated models, as well as intermediary models.

The early days of SLT practice were characterised by a focus on the motoric and sensory aspects of speech production (Rae-Smith & Leinonen, 1991). These same authors noted how in later years, theory from the areas of linguistics and cognitive processing was drawn on for guiding practice. Despite theoretical advancement in many other areas of linguistics, developments in the

[1]The Union of the Physically Impaired Against Segregation (UPIAS) is an organisation which is commonly cited as one of the pioneering movements involved in the development and popularisation of the social model of disability (e.g., Barnes, 2004; Oliver, 1990).

area of mainstream pragmatics have attracted considerable attention from clinicians. A rising disquiet with purely structural accounts of language saw pragmatic approaches to language becoming increasingly popular in linguistics, cumulating in a "Pragmatics revolution" which spilled over to influence the SLT community (Kamhi, 2000, p. 182). Since the 1970s, the profession of SLT has been borrowing concepts and constructs originally developed in the area of mainstream pragmatics. These pragmatics notions have been applied to guide SLT interventions and supports in an area of SLT practice which has become known as clinical pragmatics (Cummings, 2010a). Thus, the area of mainstream pragmatics has provided a wealth of concepts for SLTs to draw on and incorporate into clinical practice, and these concepts have come to gain considerable popularity within the more recent years of the profession's short history.

The use of pragmatics notions within SLT practice has not been particularly well charted or heavily explored in the literature. There is a scarcity of research on how the theory of mainstream pragmatics is being interpreted and used within the SLT community. However, the available literature suggests that significant incongruity exists between how the domains of clinical and mainstream pragmatics interpret pragmatics notions (Cummings, 2007a; Perkins, 2007).

The literature reveals some dissatisfaction concerning how mainstream pragmatics theory has been applied to clinical practice in the area of communication and communication disorder. Claims of misappropriation of pragmatics notions have been made—as have charges of inconsistency of terminology use—in the area of clinical pragmatics (Body & Perkins, 2006; Cummings, 2007a). For example, the SLT community has been charged with taking an overtly linguistic focus within their interventions, and also with making "broad and vague" use of terminology from the area of mainstream pragmatics (Perkins, 2000, p. 22). Despite these accusations, regarding the mishandling of pragmatics notions, there have been few attempts to explore what issues might be of concern for the SLT community who are almost uniquely placed as users of pragmatic theory in clinical settings. Additionally, how concerns might be managed or responded to by members of the SLT community in the area of clinical pragmatics appears to have been neglected in the research literature to date. This thesis aims to explore issues of importance or concern to members of the SLT community in relation to SLT practice and clinical pragmatics. As such, the following research question was generated:

- "What are the main concerns of the SLT community with regard to SLT practice and clinical pragmatics?"

1.2 STRUCTURE OF THE THESIS

This thesis comprises four sections. The initial section introduces the fields of mainstream and clinical pragmatics in order to provide a background to the area in which this study was set. The second section discusses methodological choices and details how data generation and analysis took place. The third section focuses on data analysis by explicating the nature of the participants' concerns and how these were managed vis-à-vis the theory of *Reshaping Remit*. Finally, the fourth section considers the theory of *Reshaping Remit* against the relevant, extant literature and reflects on theoretical directions for further study.

Section 1: This section describes the scene in which this study was set. As such, the literature of mainstream and clinical pragmatics is explored in relation to the way in which pragmatics has been defined and approached in both of these areas. Although this literature review is presented prior to a discussion of data analysis, the actual review of literature was carried out following the completion of data analysis, as is typical in Grounded Theory (GT) studies.

Chapter 2: This chapter presents a limited literature review of the area of mainstream pragmatics by exploring the delineation and development of the broad field of mainstream pragmatics. Similarities and differences in how pragmatics has been conceptualised across the literature, exposes mainstream pragmatics as an area which lacks coherence. This chapter provides a backdrop for considering the emergence of clinical pragmatics and also contextualises the later discussion of data analysis.

Chapter 3: The first half of Chapter 3 presents a literature review of the area of clinical pragmatics which links the rise of clinical pragmatics with the pragmatics revolution in linguistics. The evolution of clinical pragmatics highlights its progression from being a neglected aspect of SLT intervention, to being considered a field in its own right and a standard area addressed during SLT intervention. The second half of Chapter 3 provides a brief overview of how SLTs enact assessment and intervention in relation to clinical pragmatics.

Section 2: Section 2 concerns methodological choices and tactics.

Chapter 4: The general methodology of GT is introduced in Chapter 4. The historical development of GT and the similarities and differences between divergent schools of GT are considered before focusing the discussion on Classic GT. The selection of Classic GT, as the methodology of choice for this study, will then be discussed. Finally, the procedures of Classic GT are outlined.

Chapter 5: The realisation of Classic GT procedures are detailed in this chapter. As a GT study, this study did not follow the traditional, linear research trajectory but was iterative. A trail of the iterative process of data generation and analysis is provided in this chapter.

Section 3: Section 3 presents the outcome of data analysis. As this study employed Classic GT as a methodology, this section presents a theoretical account of the main concerns of participants and discusses patterns in the data pertinent to how this concern was managed. In this study, *Reshaping Remit* emerged as the core variable to conceptually account for how participants dealt with their main concern of *Uncertainty* in relation to SLT practice and clinical pragmatics. *Uncertainty* will be illustrated and discussed prior to explicating the theory of *Reshaping Remit* as an account of how participants managed uncertainty. *Reshaping Remit* was characterised by three main patterns of response to *Uncertainty*, which were linked with clinicians' assessments of their role and the role of the client during intervention.

Chapter 6: Chapter 6 specifies the nature of the participants' main concern, i.e., *Uncertainty*. *Uncertainty* emerged as a multifaceted and distributed phenomenon, within the data, with four interacting facets. Each facet of *Uncertainty* is explicated in this chapter and illustrated with data.

Chapter 7: Each of the three main patterns of responding to *Uncertainty* will be discussed in a separate chapter. As such, *Shrinking Remit* is explicated in Chapter 7 and illustrated with data. The non-provision or cessation of intervention was portrayed by *Shrinking Remit,* as a response to *Uncertainty*. This discussion of *Shrinking Remit* highlights how particular variables were drawn on as reasons why participants should not and/or could not continue to offer intervention in the context of *Uncertainty*.

Chapter 8: *Containing Uncertainty through Homogenisation* is explicated in this chapter and illustrated with data. This response to *Uncertainty* was characterised by drawing on standardised and clinician-led approaches to intervention in an effort to contain *Uncertainty*.

Chapter 9: *Stretching Remit* is explicated in Chapter 9 and illustrated with data. *Stretching Remit* captured patterns in the date related to the recruitment of client perspectives for informing clinical decision-making in the face of *Uncertainty*. This chapter explains how abandoning extant norms and embracing *Uncertainty* facilitated participants in responding to *Uncertainty* in a flexible manner. As such, intervention was offered which was hallmarked by high levels of personalisation and collaboration between the client and clinician.

Section 4: In this final section, the theory of *Reshaping Remit* is considered from the perspective of how it might be situated in existing theory from the areas of uncertainty management and clinical pragmatics in relation to SLT practice. In addition, the final two chapters in this section evaluate the adequacy and limitations of this study and present the main conclusions of this thesis.

Chapter 10: This chapter explores the nature and the ramifications of clinical uncertainty as it has been dealt with, both in the data and the literature. Similarities and differences between clinical uncertainty and uncertainty management, as they have been represented in the literature and as they emerged in the data, will be highlighted and discussed.

Chapter 11: Suggested directions for further research will be discussed in Chapter 11. Specific considerations for the advancement of the theory of uncertainty management and the theory of clinical pragmatics, in relation to SLT practice, are discussed.

Chapter 12: In this chapter, criteria from Classic GT are employed to evaluate the rigour of the research on which this thesis is based. Research limitations will also be outlined here.

Chapter 13: This chapter concludes the thesis by stating the main contributions made by this research. Additionally, the potential for using Classic GT in further clinical research will be briefly addressed.

CHAPTER 2. THE DIVERGENT FIELD OF PRAGMATICS: MAINSTREAM PRAGMATICS

INTRODUCTION

A review of the literature of mainstream pragmatics will be provided in this chapter. Pragmatics is a broad subject area which cuts across a range of disciplines (e.g., Austen, 2007). Subsequently, pragmatic theory has been applied to a wide range of research problems and phenomena. However, I will be delimiting this introductory discussion by attending specifically to how pragmatics has been defined in the literature. This short introduction to mainstream pragmatics is intended to contextualise the emergence of clinical pragmatics, as discussed in Chapter 3.

This chapter considers the historical development of the area of mainstream pragmatics in Section 2.1, prior to discussing divergent approaches to defining pragmatics in Section 2.2.

2.1 THE EVOLUTION OF MAINSTREAM PRAGMATICS: A BRIEF INTRODUCTION

2.1.1 THE DELINEATION OF MAINSTREAM PRAGMATICS

It is generally agreed that current incarnations of pragmatics have developed from the study of the semiotic (Morris, 1938), the philosophy of language (Austin, 1962; Searle, 1969, 1976) and disquiet with the study of language as a purely abstract structural entity (Lakoff, 1971; Lakoff & Ross, 1976). This latter unrest has been associated with the emergence of doubts about the centrality of syntax in linguistic theory. Other commentators have also highlighted the role which was played by thinkers such as John Dewey, George Herbert Mead and William James in shaping modern day pragmatics (Duchan, 1995, pp. 2-17; Formigari, 2004).

Charles Morris's (1938, p. 6) trifid split of linguistic theory into the areas of "syntactics, semantics" and "pragmatics" has been widely recognised as a defining moment for mainstream pragmatics (e.g., Levinson, 1983). Morris's oft-cited definition of pragmatics emerged from his attempts to carve up semiotics into three constituent foci of study. In this division, pragmatics was defined as being inextricably linked with language as it was used and interpreted, as when Morris (1938, p. 6) stated:

> Pragmatics as the study of the relation of signs to interpreters, semantics as the study of the relation of signs to the objects to which the signs are applicable and syntactics as the study of formal relations of signs to one another.

Many theories in present-day mainstream pragmatics owe much to earlier theories which emerged at the delineation of pragmatics. Some of the most important and salient concepts within mainstream pragmatics today were founded on the "fertile ideas"[2] provided by those affiliated with the philosophy of language (Verschueren, 1999a, p. 256). For example, the Theory of Generalized Conversational Implicature (Levinson, 2000) and Relevance Theory[3] (Sperber & Wilson, 1995) have been developed following on from seminal work carried out by Grice at the delineation of the field. Thus, current pragmatic theory has been built on, and hence remains orientated towards, previous work which set out to explore meaning-making and "human inferential behaviour" within a philosophical-linguistic framework, in that:

> For centuries before the field had a label or identity, pragmatics as we now understand it had radiated outward from that aspect of human inferential behaviour Grice calls implicature, the aspect of speaker meaning that distinguishes what is (strictly) said from what is (more broadly) meant.
>
> (Horn & Ward, 2004, p. xii)

In the 1950s and 1960s, the philosophy of language was studied under two opposing schools of thought, namely Ideal Language Philosophy and Ordinary Language Philosophy (Huang, 2007). The tradition of Ideal Language Philosophy approached the study of language principally from the point of view of logic. Authors such as Russell (1905), Carnap (1956) and Tarski (1956) pioneered this approach by focusing on formal languages. By attending to formal languages, these authors attempted to account for language in general. Both Huang (2007) and Recanati (2004) have noted how attention to formal linguistic structure has laid much of the foundation for the development of later areas of linguistic study such as formal semantics (as discussed by Saeed, 2008) and formal pragmatics (e.g., Kadmon, 2001).

In opposition to Ideal Language Philosophy stood the tradition of Ordinary Language Philosophy, with which Austin (1962) and Grice (1975) were affiliated. From an Ordinary Language Philosophy perspective, language was approached as a highly contextualised process—rather than a product. Consequently, language use was deemed to provide a porthole through which language in general, including language structure, could be studied and understood. Ordinary Language Philosophers were predominantly interested in the study of natural languages. The

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[2] Examples of these founding ideas include Searle's Speech Act Theory (Searle, 1969, 1976) and Grice's notions of speaker meaning and implicature (Grice, 1975).

[3] Relevance Theory (RT) posits that human cognition is both rational and efficient, and that the principle of relevance guides the process of language interpretation by drawing on context. According to RT, context is positioned as a resource employed in order to enrich and assign referents to disambiguate linguistic meaning. Following this, explicatures are produced which can then be elucidated further via drawing on world knowledge and other aspects of context in order to deduce an implicated conclusion during the process of utterance interpretation (Sperber & Wilson, 1995).

tradition of Ordinary Language Philosophy put forward the premise that language use and the meaning of language were heavily interlinked.

> Words-world relations are established through, and are indissociable from, the use of language. It is therefore misleading to construe the meaning of a word as some worldly entity that it represents or, more generally, as its truth-conditional contribution. The meaning of a word, insofar as there is such a thing, should rather be equated with its use-potential or its use-conditions.
>
> (Recanati, 2004, p. 443)

The 1970s and 1980s were marked by the prominence of a structuralist approach to the study of language, founded on Ideal Language Philosophy, exemplified by the work of Noam Chomsky (1969, 1972, 1977). Chomsky (1969, p. 4), following Ferdínand de Saussure's (1983) spilt of language into "*langue-parole*", called for linguists to attend to competence rather than performance. Thus, Chomsky (1969, p. 4) has noted that "we thus make a fundamental distinction between competence (the speaker-hearer's knowledge of his language) and performance (the actual use of the language in concrete situations)." Performance remains considered by Chomsky (2006, p. 102) as "the actual observed use of language" which involves a wide variety of non-linguistic influences and therefore the "does not simply reflect the intrinsic sound-meaning connections established by the system of linguistic rules" that comprises grammar or competence.

This structuralist approach to the study of language has not been embraced by all. Indeed, some of Chomsky's students went on to call for a revision of linguistic theory in order to accommodate a more contextualised approach to the study of language (e.g., The Generative Semantics approach advocated by Lakoff, 1971; Lakoff & Ross, 1976).

Pragmatics, as an area of linguistic inquiry, broadened following the appearance of this anti-structuralist thinking, enabling a wider research paradigm. This broader research paradigm often placed on the use of language, rather than competence or actual linguistic structure, as a central focus of study. Pragmatics came to represent a field of study, in its own right, which concerned itself with language use and the broad context in which language was, dually, a constituent and an outcome. Contextual influences on language use (such as social and cultural phenomena) became legitimate objects of study. This monumental change in linguistic thinking has been described by Koyama (2006, p. 31) as:

> The move from the early quasipragmatic theories, which generally embraced the componential view and focused on illocutionary and other propositionally centered [sic] referential pragmatics regularities in microsocial speech events, to the next generation of more full-fledged pragmatic theories...paying attention to the social-indexical (especially cultural) aspects of pragmatics as well

Significant growth has been noted in the area of pragmatics since its delineation. The proliferation of academic paraphernalia (such as books, conferences, organisations[4] and so on) which focus on pragmatics has been taken as an indication of the high level of interest in the area of pragmatics and that "pragmatics has come into its own, and is here to stay" (Mey, 2001, p. 3). The emergence of journals,[5] and special editions of journals,[6] which specifically focus on the area of pragmatics has also been taken to substantiate the claim that pragmatics is an established field. However these examples which have been listed as indicators of pragmatics being an established field have also been taken as indicators of the institutionalisation of pragmatics (Verschueren, 1999b).

However, the "conflicting definitions" and divergent methodologies noted in the area of pragmatics have led some to note that pragmatics is still establishing itself as an area of study and is in "the process of developing into a field in its own right" (Bratt Paulston & Tucker, 2003, p. 71). Indeed, pragmatics is now such a diverse and far reaching field, with significant cross disciplinary links, that it may not be amenable to being called a field in the traditional sense (Haberland & Mey, 2002; Verschueren, 1999b).

2.1.2 PRESENT-DAY MAINSTREAM PRAGMATICS

Present-day, mainstream pragmatics continues to be perceived as following two distinct schools of thought, in line with the thinking of Ordinary Language Philosophy and Ideal Language Philosophy, namely the "European"[7] and "Anglo-American" schools of pragmatics (Horn & Ward, 2004; Huang, 2010).

In looking at patterns of how pragmatics has been defined, it has been said that amongst European scholars there remains a "broader and more sociological conception of pragmatics that encompasses all aspects of language use not falling strictly within formal linguistics theory" (Horn & Ward, 2004, p. xi).

The Anglo-American tradition advocates a "narrower" approach to pragmatics (Levinson, 1983, p. ix). The Anglo-American outlook approaches pragmatics as "the systematic study of meaning, by virtue of, or dependent on, language use", rather than viewing pragmatics as a

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[4] Such as "The International Pragmatics Association".

[5] For example, *The Journal of Pragmatics* (Elsevier), *Pragmatics* (The International Pragmatics Association) and *Pragmatics and Cognition* (Benjamins).

[6] For example, in 1999, the journal *Brain and Language* produced a special issue which was dedicated to pragmatics (Stemmer, 1999).

[7] The terms "European" and "Continental" are used interchangeably in the literature to capture an approach to pragmatics which is affiliated with an Ordinary Language Philosophy and/or socio-linguistic perspectives on language use, as pointed out by Huang (2010). This school of thought was inspired by the thinking of Ordinary Language Philosophers and stemmed from universities and research centres in Europe. The term "European" will be adopted in this thesis.

broader cognitive, social and cultural perspective on linguistic phenomena and their usage (Huang, 2007, p. 4). In comparison to the breadth of definitions of pragmatics from the European school, the Anglo-American tradition represents a tidier "more narrowly circumscribed" view of pragmatics (Horn & Ward, 2004, p. xi).

One of the main contentions about European approaches and definitions of pragmatics is that it becomes difficult to differentiate pragmatics from other areas of linguistic study (such as sociolinguistics, psycho-linguistics and linguistic anthropology). For example, Levinson identified an overlap between sociolinguistics and the European approach to pragmatics when he pointed out that "in contrast, the continental tradition is altogether broader, and would include much that also goes under the rubric of *sociolinguistics*" (Levinson, 1983, p. ix).

Present-day pragmatics, particularly when a "European" approach to pragmatics is adopted, is a particularly interdisciplinary enterprise as pragmatic theory is both applied and contributed to by a wide range of disciplines (Cummings, 2005). The plethora of sub-disciplines which populate the realm of modern day, mainstream pragmatics are diverse, as Mey (2007, p. 1) points out: "Since Pragmatics itself cannot be narrowly defined, the topics that we consider 'applied' are rather diverse." Pragmatics is now regularly associated with fields of study (such as psycho-linguistics, neuro-linguistics and so on), which have a marked interest in their "own extra-linguistic correlational object" (Verschueren, 1999a, p. 10). Areas such as neuro-pragmatics (Stemmer, 2008; Stemmer & Schönle, 2000) and clinical pragmatics (Cummings, 2010a) have also become increasing salient in the literature.

The broad remit of pragmatics, when conceived of from a European tradition, and the absence of specific units and/or methods of analysis has also led to "*methodological pluralism* which allows for *various types of evidence*" in the area of mainstream pragmatics (Verschueren, 1999a, p. 271). This broad-based approach to pragmatics has been framed in both a negative (Gendler Szabó, 2005) and more positive light (Hymes, 2000). The lack of strict delimitation and disciplinary boundaries in pragmatics has opened up the scope of pragmatics to many divergent approaches to the study of its "object", in that:

> We can also say that exactly because we didn't necessarily conceive of pragmatics as a discipline that engages in a competition with other sub-disciplines about subject matters, topics, or truth sources, today we can still stubbornly cling to the notion that what matters is not *what* you single out as an object of scrutiny, but *the way* you look at your object....As to the nature of the object itself, defined earlier by us as "the use and users of language" (1977:7), there seems not to be much room for doubt.
>
> (Haberland & Mey, 2002, p. 1673)

However, confusion has emerged in the area of pragmatics because of a lack of a unitary "angle", (such as a methodological and/or analytical approach) with which to explore all things pragmatic or to guide research in the area (Haberland & Mey, 2002, p. 1673). This lack of theoretical and methodological coherence has been taken to suggest that pragmatics is still an "insecure science" despite being institutionally established (Spencer-Oatey & Žegarac, 2002, p. 74). A lack of theoretical agreement and consistency within pragmatics has meant that the outposts of pragmatics are positioned divergently within different studies.

The potential for pragmatics to be applied to other areas and to be utilised in such a far reaching and interdisciplinary manner rests particularly with the notion that there are important "other sources" at play, outside of de-contextualised linguistic structure or "code", which are important for developing an understanding of language and language use, as highlighted by Spencer-Oatey & Žegarac (2002, p. 75):

> Modern approaches to pragmatics recognize that human communication largely exploits a code (a natural language such as English, German or Japanese), but they also try and do justice to the fact...that human communicative behaviour relies heavily on people's capacity to engage in reasoning about each other's intentions, exploiting not only the evidence presented by the signals in the language code but also evidence from other sources, including perception and general world knowledge.

The contrasting levels of attention given to different "other sources"[8] when it comes to studying language and language use have caused serious disagreement in mainstream pragmatics. The absence of a unified theory of pragmatics to support certain methodological choices and research foci has made for a lively debate about what "other sources" both could and should be attended to in the area of pragmatics.

As Verschueren (1999a) highlights below, present-day pragmatics remains a disjointed area, in which the topics covered and methodologies utilised are variable. Pragmatics appears to be interpreted and defined in light of individual affiliations and theoretical stances, rather than being defined by a unitary theory or methodology. While perusing the literature labelled "pragmatic", the reader may note a lack of consensus within the collection of phenomena and

[8] As an example of the contrasting priorities given to different phenomena when studying language and language use, those working within the area of pragmatics utilising Relevance Theory (Sperber & Wilson, 1995) have been criticised for ignoring societal and cultural factors (Mey, 2001). However, Mey's own definition of pragmatics, which follows, could be critiqued as neglecting to limit in any definite way the "other sources" relevant to the study of language use and meaning-making. Mey defines pragmatics as: "the study of the way humans use their language in communication, bases itself on a study of those premises and determines how they affect and effectualize human language use. Hence, *Pragmatics studies the use of language in human communication as determined by the conditions of society*" (Mey, 2001, p. 6). If "the conditions of society" are interpreted broadly, then this definition could be considered as being so inclusive that it excludes nothing from the study of pragmatics. Some authors would prefer to see pragmatics more tightly defined (e.g., Davis, 1991; Gendler Szabó, 2005).

topics discussed there, except that they are all loosely related to language use and/or context. For example, Huang (2007) has defined pragmatics by topic when he specified pragmatics as "the systematic study of meaning by virtue of, or dependent on, the use of language. The central topics include implicature, presupposition, speech acts, and deixis" (Huang, 2007, p. 2). These types of definitions of pragmatics have been critiqued as trying to force coherence by defining pragmatics as a "repository of interesting topics" (Verschueren, 2009, p. 8). However, others have also attempted to generate guidelines which would explicate theoretically why certain topics or phenomena should be included or excluded from the area of pragmatics (e.g., Cummings, 2007a, pp. 424-429).

This lack of theoretical unity may have contributed to arbitrary groups of phenomena being considered representative of pragmatics, according to Verschueren (1999a, pp. xi-xii), who notes that:

> There is no shortage of pragmatics textbooks today....All of them, however, restrict their theoretical or their empirical scope, or both. They tend to focus on a somewhat random set of phenomena, including deixis, implicature, presupposition, speech acts, conversation, and the like. Cognition is brought in regularly, but only for theory-specific purposes. Social and cultural factors fail to be accounted for systematically; a chapter on "societal pragmatics" may be added as if it were an afterthought.

2.2 Defining and Delimiting Pragmatics: A Spectrum of Definitions

Prior to discussing the area of clinical pragmatics, a descriptive overview of how pragmatics is defined across the area of mainstream pragmatics will be provided. This review of definitions of pragmatics, within the literature of mainstream pragmatics, is not intended to be complete or exhaustive. As an introductory foray into the literature of mainstream pragmatics it is intended to be a backdrop to the discussion, in later chapters, about the issues which emerged as concerns for the participants in this study in relation to clinical pragmatics and SLT practice.

An exploration of the definitions of pragmatics across the broad field of mainstream pragmatics revealed that it was a controversial area, in which an absence of one unitary definition was apparent. Different definitions of pragmatics may contain overlapping and even contradictory specifications. In light of these theoretical disparities, this discussion of definitions of pragmatics will be structured using the notion of a spectrum. A spectrum refers to the existence of a wide range of associated phenomena which have divergent individual characteristics yet posses overlapping features. Here, the term spectrum has been used to capture the "interrelated sequence or range" of definitions of pragmatics which can be found in the literature of mainstream pragmatics (*Longman Dictionary of the English Language*, 1991, p. 1553).

The spectrum of definitions of pragmatics available in the literature will be discussed for clarity's sake under three separate headings.[9] The headings used here offer arbitrary, not definitive, divisions in order to highlight how definitions of pragmatics weave together and diverge at different points.

In the remainder of this chapter, definitions of pragmatics will be discussed under the following headings:[10]

- Pragmatics as a component of linguistic theory
- Pragmatics as the use of language for contextualised meaning-making
- Pragmatics as a critical linguistic outlook on language use.

The issues of language use and context are germane to a discussion of definitions of pragmatics as they highlight some of the most salient commonalities and contrasts between different definitions. Correspondingly, "language use" and "context" will be drawn on and used as sub-headings to further structure the discussion in the following sections.

2.2.1 PRAGMATICS AS A COMPONENT OF LINGUISTIC THEORY

2.2.1.1 LANGUAGE USE

Since the delineation of pragmatics, definitions of pragmatics habitually make reference to language use as a defining characteristic. One of the founders of mainstream pragmatics, Charles Morris (1938), noted the importance of "the use of language" as a feature which identified studies as being "pragmatic" when he stated: "if in an investigation explicit reference is made to the speaker, or, to put it in more general terms, the use of language, then we assign it to the field of pragmatics" (Morris, 1938, p. 7). Early views in linguistic theory often assumed language could be fractured into constituent parts; subsequently interaction between different constituents was not always addressed (Crystal, 1987). Following on from this, language use has often been dealt with as an isolable phenomenon within linguistic theory.

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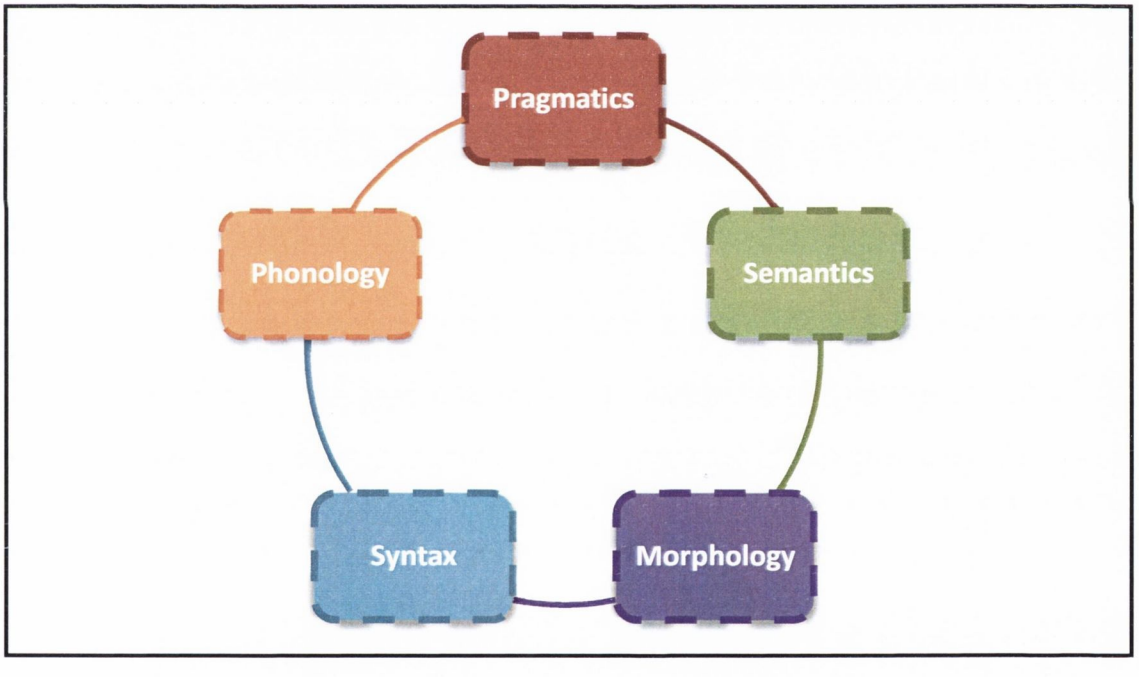
[9] Drawing on the idea of a spectrum to conceptualise the similarities and differences between definitions of pragmatics precludes having to definitively sort definitions of pragmatics into discrete categories, as might be unintentionally suggested by the use of these headings.

[10] The headings used here echo how pragmatics has been discussed in the literature. For example, Huang (2010, pp. 13-15) states that "contemporary pragmatics" is comprised of "two main schools of thought: the Anglo-American tradition...and the Continental tradition...Alternatively, the two traditions are also called the component and perspective views of pragmatics, respectively".

The definitions which are discussed in this section could be loosely called componential, as they situate pragmatics as a discrete segment within linguistic theory.[11] These definitions of pragmatics are founded on an assumption that the grammar of a language can be divided up into separate segments which all have different functions. As such, each component (e.g., the phonological component, the syntactical component and so on) can be studied independently. Each constituent segment of a language can then be viewed as being governed by its own set of rules and/or principles. Thus, different components of linguistic theory have also been called "rule systems" (Kadmon, 2001, p. 3).

Definitions of pragmatics as a component of linguistic theory are most often associated within the formal linguistic tradition (as noted by Mey, 2001). Rather than conceptualise pragmatics as something which permeates all aspects of language, formal approaches to pragmatics define it as another segment of linguistic theory on a par with semantics or phonology, (as depicted in Figure 1 below).

FIGURE 1: PRAGMATICS AS A COMPONENT OF LINGUISTIC THEORY



When situated as a component of linguistic theory, pragmatics has the potential to partake in the traditional division of labour when studying language evident in mainstream linguistics. For example, semantics is frequently purported to be a component of grammar with its own units of analysis that deals, in particular, with de-contextualised, abstract, linguistic meaning. Semantics

[11] The term "modular" has not been used and the term componential has been favoured in its place. This usage of terminology aims to avoid a loaded debate regarding modularity, akin to the debate about the domain-specific/domain-general nature of the human mind, that exists in the literature of Linguistics, Neuropsychology and other Cognitive Sciences (for example, Fodor, 2001; Karmiloff-Smith, 1995).

has been defined as, the "study of the linguistic meaning of morphemes, words, phrases, and sentences" (Fromkin, Rodman & Hyams, 2007, p. 174). Thus, pragmatics becomes the area of linguistic theory that is responsible for the study of language use in particular.

Positioning pragmatics as a component of linguistic theory often sees pragmatics characterised as an area which is concerned not with the entire embodied, social process of language use, but which is concerned with only the abstract, structural ramifications of language use. Leech demonstrated an appreciation of pragmatics as an abstract segment of linguistic theory when he noted that pragmatics could be identified as a separate "domain" of linguistic theory, dealing with how grammar was used, in that "...grammar (the abstract formal system of language) and pragmatics (the principles of language use) are complementary domains of linguistics" (Leech, 1983, p. 4). However, Leech (1983) also stressed that both formal and functional approaches might be necessary in the study of language.

A view of pragmatics as a component of linguistic theory has been noted as being only one of the possible "methodological stances" which can be taken in relation to pragmatics (Koyama, 2006, p. 30). However, dissecting language as a whole into its constituent segments remains to be considered a fruitful approach by many linguists, as stated by Saeed (2008, p. 10) who highlights that for some linguists there may be a "utility" in "identifying distinct modules for knowledge about pronunciation, grammar and meaning".

When pragmatics is defined as the component of linguistic theory that primarily deals with how language is used, it is also often delimited to attending only to language as a grammatically encrypted code. Subsequently, pragmatics can be considered an additional layer of rules to be applied during the creation of a grammatical language product. As such, non-grammatical phenomena may be deemed irrelevant to the area of pragmatics. A restricted view of both context itself and the importance of context can be taken when pragmatics in defined as an isolable component of linguistic theory.

2.2.1.2 Context

Most definitions of pragmatics make some reference to the "notion of context" as pointed put by Kasher (1998, p. 148). Defining what exactly might be meant by context is highly controversial and varies across the literature (Auer, 2009). How contextual phenomena influence linguistic meaning is a divisive question in linguistics, yet this question is at the heart of pragmatic studies of language because the influence of context is often considered crucial in the realm of pragmatics. As Wharton (2010a, p. 75) noted: "In pragmatics context is everything."

The nature of pragmatics is often defined by highlighting contrasts between the areas of pragmatics and semantics (as seen, for example, in Koyama, 2006; Peccei, 1999; Recanati, 2004).

When pragmatics is defined as a component of linguistic theory, it is often defined by exclusion by being differentiated from semantics. As semantics is also concerned with the study of meaning it has been deemed to be the closest neighbour to pragmatics (Cruse, 2000). It is often posited that it is pragmatics which deals with linguistic meaning-making and context, while semantics deals with de-contextualised linguistic meaning (for further discussion see Saeed, 2008).[12]

Consideration of pragmatics as a component of linguistic theory implies that all things pragmatic are amenable to analysis as abstract phenomena, at the level of linguistic structure, which can preclude macro-level phenomena[13] from being addressed by pragmatic theory. For those ascribing to the view of pragmatics as a component of linguistic theory, how grammar and context interact often remains a key interest, although context is more likely to be defined in a restricted manner. Contextual influences which are relevant for the study of linguistic structure are often constrained to phenomena within the immediate linguistic environment of an utterance, particularly the preceding or "prior discourse", as pointed out by Wharton (2010a, p. 75), who noted how limiting context in this manner is problematic because

> these are far from the only aspects of context that play a role in utterance interpretation. Context can be viewed from a much wider, sociolinguistic perspective, to include also the socio-cultural nature of the communicative event taking place, or the social status of those involved in it.
>
> (Wharton, 2010a, p. 75)

Context is qualified by Stalnaker (1970) in a restricted fashion to refer to features of the surrounding "speech" in which a proposition is embedded.[14] This limited view of context suggests the exclusion of other phenomena from being considered as relevant, contextual variables in understanding how linguistic meaning is generated as when Stalnaker (1970, p. 275) commented:

> syntax studies sentences, semantics studies propositions. Pragmatics is the study of linguistic acts and the context in which they are performed. There are two major problems to be solved within Pragmatics: first, to define interesting speech acts and speech products; second, to characterise the features of the speech context which help determine, which proposition is expressed by a given sentence.

---

[12] For example, Kaplan identified "character" as the linguistic meaning which does not vary with context, while "content" was used to relate to the level of linguistic meaning that varied with context. Thus, Kaplan associated "content" with the area of pragmatics, while "character" was taken as the object of semantics (Kaplan, 1989, pp. 505-507).

[13] The distinction between "macro" and "micro" levels of analysis is one made across the Social Sciences literature which generally positions macro levels of analysis as pertaining to broad overarching issues of social life, at the level of populations or organisations, while micro levels of analysis are purported to be more focused on face to face interaction (e.g., Johnson, 2000).

[14] These constrictive views of context were no doubt influenced by the popularity of the structuralist paradigm that emerged at this time (Chomsky, 1969, 1977) which emphasised the importance of studying language as an abstract structural code. In comparison, many modern day notions of context which are utilised within linguistics are significantly broader (as noted by, Fetzer, 2004).

This restricted view of context is often regarded as being a "traditional linguistic account" of context, as Fetzer (2004, p. 4) has pointed out below. There is, however, a much wider understanding of context which has become increasingly evident in the literature both within and beyond pragmatics:

> In traditional linguistic accounts of context, context is conceived as comprising the immediate features of a speech situation in which an expression is uttered, such as time, location, speaker, hearer and preceding discourse. However, context is a much wider and a far more transcendental notion than what these accounts imply. In philosophical approaches to intentionality and action, language is no longer examined as consisting of de-contextualised sentences. Instead, the focus investigation has shifted towards the examination of language use which is seen as embedded in larger activities through which they become meaningful.
>
> (Fetzer, 2004, p. 4)

Macro-level elements of context (such as culture, politics and non-verbal behaviours) are often excluded from being considered relevant when pragmatics is defined as a component of linguistic theory. An exclusive focus on the linguistic products of language use, while neglecting the macro-level ramifications and influences on the process of language use, is a key criticism made of approaches to pragmatics which define pragmatics as a component of linguistic theory, in that:

> Pragmatics is the linguistic subdiscipline that is most concerned with real people and real situations. But...there is a constative approach to linguistics that also downplays real people in real situations as much as possible, and replaces them with abstract structures as well.
>
> (Robinson, 2006, p. 19)

The notion that language is both a product and a part of the context in which it is produced means that pragmatics and context are closely linked (Mey, 2006). Context has been conceived of as being constructed by an ongoing communicative event as well as being the setting in which a communicative event (or an event of language use) is situated (Cook-Gumperz & Gumperz, 1976). As such, it may not be possible to separate language or pragmatics from context. However, definitions of pragmatics as a component of linguistic theory often attempt to separate pragmatics from its context, by delimiting context narrowly and focusing on strictly linguistic aspects of context.

This interdependence between context and language clashes with the dichotomy popularised, in part, by Chomsky (1969), which split form and meaning (i.e., "competence") from use ("performance"), as discussed above. It has been posited that rather than being divided, meaning and form are synergistically interwoven with use (Mey, 2001; Robinson, 2006). All facets of language, including pragmatics, are thus reliant on context, as language cannot be considered

as a product "independent" from its context of use. If pragmatics is seen as a reflection of performance, not competence, then a wide view of context is needed.

> Most pragmaticians would disagree with this [Chomsky's] componential presentation because unlike other tools, language is not a "thing" which leads an independent and unchanging life once it has been "made". It requires constant adaptations to different purposes and circumstances of use. And for a descriptive account of the meaning and an explanatory account of the form of linguistic entities, it is often necessary to refer to conditions of their appropriate use. Strictly speaking, every aspect of competence is part of one's competence to perform. Thus, the form/meaning vs. use opposition is not unproblematic.
>
> (Verschueren, 2009, p. 8)
> [Words in brackets have been added]

Definitions of pragmatics which echo a componential perspective frequently consider pragmatics to exist at the level of an internalised grammar. For example, Kadmon (2001, p. 4) has commented: "Let us assume that the grammar contains a semantic component and a pragmatic component". Viewing pragmatics as a component of internal grammar can often preclude non-linguistic features of context from being considered relevant to pragmatics.

However, this exclusion of non-linguistic phenomena from definitions of pragmatics is a hotly contested topic (Wharton, 2010b). Other types of definitions of pragmatics offer a considerably broader scope, by placing the outposts of context and pragmatics much further apart than those who advocate a view of pragmatics as a component of linguistic theory. The next section discusses the issues of language use and context in relation to broader conceptualisations of pragmatics.

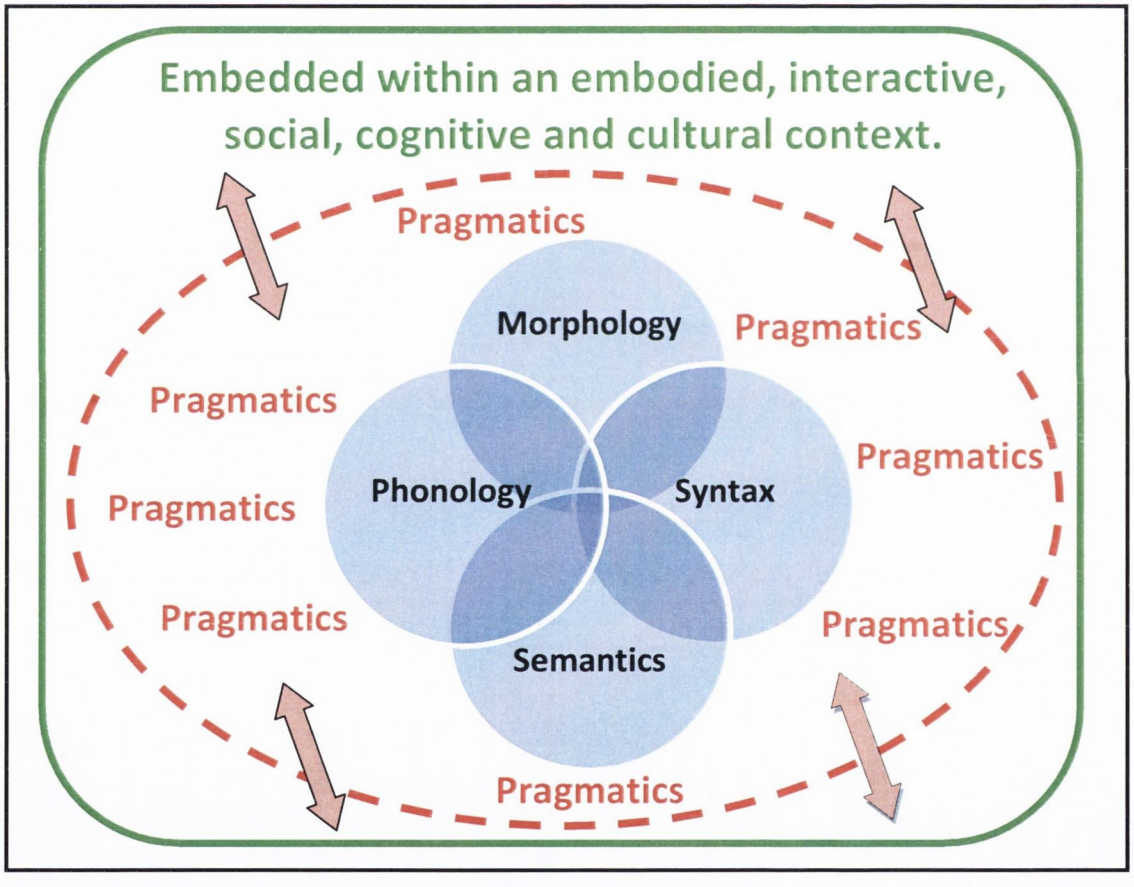
2.2.2 PRAGMATICS AS THE USE OF LANGUAGE FOR CONTEXTUALISED MEANING-MAKING

It is important to be cognisant of the fact that some of the definitions of pragmatics discussed in this section share as many differences as they do similarities. Many of the definitions discussed here share a functionalist leaning, view context broadly, and also prioritise context and language use in exploring linguistic structure and/or language use.[15] A generic representation of these types of definitions of pragmatics is proposed below in Figure 2.

[15] For example, cognitively orientated approaches to pragmatics, such as Relevance Theory (Sperber & Wilson, 1995) are often considered to be dissimilar to sociolinguistic approaches to pragmatics (e.g., Labov, 1972), as one approach focuses particularly on internal cognitive phenomena, while the other attends to social and cultural factors. However, their shared appreciation of context and the priority given to language use as a mechanism for understanding meaning-making sees them united in this section.

Pragmatics has also been defined as a process involving the use of language for contextualised meaning-making. As such, it assumes a position of priority as an overall organisational system which regulates all other linguistic components and acts as an interface between language and context. The definitions discussed in this section could be loosely labelled "functionalist", in relation to the functional linguistic tradition emergent from the work of the Ordinary Language Philosophers. Those working within an Ordinary Language Philosophy rejected the notion that meaning in language could be understood by focusing on the truth-conditional and formal aspects of language alone or by exploring linguistic structure divorced from its context of use.

FIGURE 2: PRAGMATICS AS THE USE OF LANGUAGE FOR CONTEXTUALISED MEANING-MAKING



Functionalists have also viewed pragmatics as a junction at which form-function mapping exists. Many definitions of pragmatics which stem from the functionalist tradition present pragmatics as a contextualised, super-ordinate linking system which operates between linguistic forms and communicative functions. The "competition model" is one such framework that might be situated within the functionalist tradition and which Craig utilised when defining pragmatics, as follows:

> An alternative approach treats pragmatics not as a separate module, but as an interactive, competitive system.....Rather than conceptualizing pragmatic rules as a system in parallel to other linguistic systems, pragmatics can be viewed as an additional system of patterns that establishes linkages between linguistic forms and discourse functions... Accordingly, pragmatic knowledge consists of a set of connections that are interactive in nature, specifying the dependent relations between forms and functions.
>
> (Craig, 1996 pp. 631-632)

2.2.2.1 LANGUAGE USE

When pragmatics is conceptualised as the use of language for contextualised meaning-making, the usage of language is naturally of paramount importance. From this perspective, pragmatics cannot be contained to one component of linguistic theory or one aspect of grammar, but is considered to be an overall driving force and/or regulatory system involved in all instances of language use. Indeed, many definitions which will be discussed in this section treat pragmatics and language use synonymously. In doing so, the breadth of what could be considered to fall within the realm of pragmatics is widened to include almost any instance of language use which is communicatively motivated.

Defining pragmatics as the use of language for contextualised meaning-making represents a broad category, and can be used to capture both restrictive and extreme (or radical) functional accounts of pragmatics. As previously noted, many of the definitions which are discussed in this section stem from a functionalist tradition in which language use, as opposed to structure, is the foci of study. Taken to the radical extreme, the separation of linguistic form and function can mean that the meaning of a linguistic expression can only be identified with its concrete and authentic use (e.g., Taylor, 2010).[16] Advocates of extreme perspectives, which focus on use or function of language rather than structure, have even gone so far as to suggest that language should not be associated with a "fixed code" or structure per se (Love, 2004, p. 529)

More moderate, functional pragmatic theories accept the existence of a shared linguistic code to different extents. For example, functional pragmatic theories have been developed to explain the other linguistic components of a language (such as syntactical aspects of grammar, e.g., Halliday, 1994). When pragmatics is conceived of as the use of language for contextualised meaning-making, the process of language usage becomes the site in which linguistic structures become ascribed with meaning, rather than linguistic meaning existing as a static and extant aspect of linguistic structure. The importance of language use as a mechanism by which meaning is created is stressed in Marmaridou's definition of pragmatics as "the study of the use of

[16] Taylor (2010) provides a brief overview of semantic minimalism versus radical contextualism which presents both extreme and more moderate views on linguistic meaning being dependent on context.

language to structure reality as meaningful experience. According to this definition pragmatic meaning emerges interactionally while language is so being used" (Marmaridou, 2000, p. 61).

However, one critique of these types of broad-based definitions of pragmatics is that they are too expansive and result in theoretical eclecticism and overlap with other areas of linguistics. Ambiguous definitions of pragmatics can result when pragmatics is defined bluntly as the study of "language use" as pointed out by Dietrich Tschaepe (2010, p. 341) when he commented that:

> Pragmatics is a rapidly growing field in contemporary linguistics. But what is Pragmatics? It can generally be defined as the study of language in use. However, such a definition may be too general to be of much use.

When the notion of "language use" is defined as the object of study, without theoretical qualification, it may be difficult to ascertain the limits and boundaries of such a study. Neglecting to specify a theoretical backdrop or clear explication through which an author might be conceptualising potentially loaded and generic terms (such as "language" and/or "language use"), in definitions of pragmatics, places pragmatics in an uncertain position with regard to other areas of study. Consequently, boundaries may not be identified which would distinguish pragmatics from any other areas of linguistic or indeed non-linguistic study. This point is captured succinctly when Verschueren (1999a, p. 1) discusses the potential confusion that can occur by relying exclusively on "base-level" terms in defining pragmatics. However, Verschueren (1999b) has also identified the positive way that this lack of borders impacts on the area of pragmatics and has resulted in interdisciplinary collaboration.

> At the most elementary level, pragmatics can be defined as *the study of language use*, or, to employ a somewhat more complicated phrasing, *the study of linguistic phenomena from the point of view of their usage properties and processes*. This base-level definition does not introduce a strict boundary between pragmatics and some other areas in the field of linguistics, such as discourse analysis, sociolinguistics, or conversational analysis. Yet is rarely disputed, and when thinking through its logical consequences it has interesting implications for the way in which pragmatics is to be situated in the science of language in general.
>
> (Verschueren, 1999a, p. 1)

Within broad definitions of pragmatics as the use of language for contextualised meaning-making, more attention is accorded to context and usage than linguistic structure. Subsequently, the division between linguistic components becomes less important. These broad-based definitions of pragmatics clash with reductionist views of pragmatics, as a component of linguistic theory. If meaning-making is, first and foremost, dependent on context and usage rather than the linguistic structure, then a clear division in linguistic theory between form (or competence) and function (or performance) cannot be maintained. According to Gendler Szabó (2005, p. 1), "those who

subscribe to the view that the meaning of a linguistic expression is identical to its use reject the proposed distinction between semantics and pragmatics".

In considering pragmatics as the use of language for contextualised meaning-making pragmatics is often used synonymously with the term "language". Pragmatics is viewed as an area through which language, in a general sense, can be studied and understood. There is no specifically pragmatic aspect of language per se, as "all language is pragmatic to begin with" (Bates, 1976b, p. 420). Following on from this view of pragmatics, a broader view of context may be necessitated.

2.2.2.2 Context

As noted previously, the types of contextual variables which are deemed relevant to pragmatics diverge considerably across the definitions discussed in this section (i.e., Section 2.2.2). Definitions of pragmatics as the use of language for contextualised meaning-making can be extremely inclusive depending on how broadly the notion of context is defined. Different authors have prioritised various aspects of context as being particularly important within their conceptualisations of pragmatics.

The pertinence of non-linguistic aspects of context, to pragmatics, remains heavily debated across the field of pragmatics (Taylor, 2010). A broad view of context enables any aspect which interfaces with language to be deemed relevant to pragmatics. Consequently, extra-linguistic or "non-linguistic" variables, such as gesture eye contact and so on, have been included for consideration within the realm of pragmatics—an inclusion which Wharton has defended:

> The approach favoured by many linguists is to sift these [non-verbal] behaviours out, in order to focus better on the rule-based grammar that constitutes language. However, the pragmatist has to cast a broader net. The central aim of pragmatics is to describe and explain the process of utterance interpretation, and utterances after all, have non-linguistic as well as linguistic properties.
>
> (Wharton, 2010b, p. 294)
> [Words in brackets have been added]

In a similar vein, pragmatics has been defined as the process by which people draw on both linguistic and extra-linguistic resources and context in order to generate meaning. In Yule's (1996) definition of pragmatics below, the embodied and live nature of the construction of meaning is highlighted. Yule (1996) tentatively dismissed the importance of attending to linguistic structure alone (i.e., "what the words or phrases might mean by themselves") during the enterprise of meaning-making, when he pointed out that:

> Pragmatics is concerned with the study of meaning as communicated by a speaker (or writer) and interpreted by a listener (or reader). It has, consequently, more to do with the analysis of what people mean by their utterances than what the words or phrases in those utterances might mean by themselves. Pragmatics is the study of *speaker meaning*
>
> This type of study necessarily involves the interpretation of what people mean in a particular context and how the context influences what is said...*Pragmatics is the study of contextual meaning*....
>
> (Yule, 1996, p. 4)

Language has been posited as being "intimately linked" with aspects of context including cognitive, social, cultural, psychological and ecological phenomena (Rudzka-Ostyn, 1993, pp. 1-2). As such, context becomes an amalgamation of different types of linguistic and non-linguistic phenomena which are not easily divisible into constituent elements. This view of language may be particularly incongruent with specifications of context as a narrow range of linguistic variables, and also precludes the acceptance of a clear division between separate components of linguistic theory in that:

> Given the interaction among language subcomponents as well as the interaction between language and other domains of cognition, the various autonomy theses and dichotomies proposed in the linguistic literature have to be abandoned; a strict separation of syntax, morphology and lexicon is untenable; furthermore it is impossible to separate linguistic knowledge from extra-linguistic knowledge.
>
> (Rudzka-Ostyn, 1993, p. 2)

A dependency on context, in order to make meaning with language, entails that linguistic structures are not the ultimate site in which meaning is encrypted. Definitions which conceptualise pragmatics as an organisational interface, at which and in which meaning is generated, suggest a decoupling of linguistic form and meaning. Linguistic units do not hold a "pragmatic" meaning which can be accessed independent of their use, as Cruse (2000, p. 16)[17] has commented when he noted that pragmatics

> can be taken to be concerned with aspects of information (in the widest sense) conveyed through language which (a) are not encoded by generally accepted convention in the linguistic forms used, but which (b) none the less arise naturally out of and depend on meanings conventionally coded in linguistic forms used, taken in conjunction with the context in which the forms are used.

The social, cultural and embodied exercise of meaning-making via language use draws attention away from linguistic structure and towards the setting in which language is in use. Context is

[17] Additionally, Cruse (2000) deems certain aspects of world knowledge which do not relate to the conventional meaning of the words used as being irrelevant to pragmatics.

credited as being the ultimate site in which meaning is generated. Meaning does not exist in the linguistic structure of "indices", but rather meaning is created contextually in real time. In Thomas's (1995) definition below, we see that context is evoked as the location in which meaning emerges. The notion of context is elucidated somewhat as pertaining to "physical, social and linguistic" phenomena (1995, p. 22). Meaning is conceptualised as something which is generated collaboratively. Meaning-making is implied to be a linguistic, yet highly contextualised and interactive process

> I shall be working towards a definition of pragmatics as *meaning in interaction*. This reflects the view that meaning is not something which is inherent in the words alone, nor is it produced by the speaker alone, nor by the hearer alone. Making meaning is a dynamic process involving the negotiation of meaning between speaker and hearer, the context of the utterance (physical, social and linguistic) and the meaning potential of an utterance.
>
> (Thomas, 1995, p. 22)

However, not all views of pragmatics as the use of language for contextualised meaning-making ascribe to such expansive definitions of context. For example, Sperber and Wilson's (2008) more "focused" definition of pragmatics below, also highlights that context is deemed essential for the recovery of linguistic meaning. However, in their definition, the notion of "linguistic meaning in the interpretation of utterances" is used to delimit the focus of pragmatics. The use of "interact", in this definition, highlights how pragmatics has been conceptualised as an intersection between context and linguistic meaning:

> Pragmatics is often described as the study of language use, and contrasted with the study of language structure. In this broad sense, it covers a range of loosely related research programmes from formal studies of deictic expressions to sociological studies of ethnic verbal stereotypes. In a more focused sense (the one we will use here), pragmatics contrasts with semantics, the study of linguistic meaning, and is the study of how contextual factors interact with linguistic meaning in the interpretation of utterances.
>
> (Sperber & Wilson, 2008, p. 468)

Sperber and Wilson reject the notion that context can be "specified in advance" and instead advocate for an understanding of context that is mutually and dynamically constructed (Sperber & Wilson, 1995, p. 132). Thus, they endorse a broad view of context, rather than identifying with the "traditional" notion of context drawn on in linguistics (see Fetzer, 2004 in Section 2.2.1.2), which posits that the assumptions expressed in the proceeding and preceding discourse are the only relevant aspects of context in studying language occurs. Others have also stipulated that context cannot be defined in a static or a priori fashion, as when Cruse (2000, p. 370) notes: "the proper context for the interpretation of an utterance is not given in advance; it is chosen by the hearer" thus context is something which is constructed anew during each interaction. Multiple potential

contexts are available according to Relevance Theory, and it is the principle of Relevance which directs the listener towards the most suitable context for both fleshing out and narrowing down the meaning of any given linguistic structure.

> The set of premises used in interpreting an utterance (apart from the premise that the utterance in question has been produced) constitutes what is generally known as the *context*. A context is a psychological construct, a subset of the hearer's assumptions about the world. It is these assumptions, of course, rather than the actual state of the world, that affect the interpretation of an utterance. A context in this sense is not limited to information about the immediate physical environment, or the immediate physical environment or the immediately preceding utterances: expectations about the future, scientific hypotheses or religious beliefs, anecdotal memories, general cultural assumptions, beliefs about the mental state of the speaker, may all play a role in interpretation.
>
> (Sperber & Wilson, 1995, pp. 15-16)

The amorphous nature of context has long been viewed as problematic across the scientific community in general (Mishler, 1979). Context can be defined in multiple ways and at a variety of levels (as noted by Kasher, 1998). Subsequently, context is notoriously difficult to define as it represents an entity with an indefinite and vacillating nature (Prutting, 1982).

Context can be defined in a narrow way, as for example as Norbury (2005) has done, when context was operationalised as the grammatical information in the linguistic environs of an ambiguous word. Alternatively, context can be defined in a broader way (as in, for example López & Leekam, 2003, p. 286). In this study by López and her colleagues, children with and without autism were shown to be facilitated in naming items when contextual cues where provided. Context, in the first two experiments in López and Leekam's (2003) study, was defined both in verbal and visual terms (i.e., as pictures and words were used to prime participants with "contextual information"). Wider still definitions of context have been advocated in studies exploring language use. One well known example of a wide definition of context was developed by Hymes (1972). The SPEAKING mnemonic was generated as a framework for delimiting aspects of context relevant to the study of language from an ethnographic perspective (Hymes, 1977).[18]

What is evident from looking at definitions of context utilised when defining pragmatics is that they often fail to specify exactly what phenomena are relevant to the notion of context. Context continues to be a somewhat "elusive" concept:

---

[18] The SPEAKING mnemonic identifies the contextual components of an interaction, which might guide ethnographic considerations of language in use. These contextual components of interaction were grouped together as Setting and Scene, Participants, Ends, Act sequence, Key, Instrumentalities, Norms and Genres (Hymes, 1977, pp 51-62).

> Finally, we need to address the issue of context. Context is a complex and somewhat elusive concept (Duranti & Goodwin 1992; Ely & Gleason, 1995). In its broadest sense, context refers to the background or frame in which behaviour occurs. In this regard, it can encompass both micro- (e.g. discourse) and macro- (e.g. culture, gender) level factors.
>
> (Ely & Gleason, 2006, p. 603)

The definitions of pragmatics in this section have focused on the use of language for context-dependent meaning-making. In the final section of this chapter below, definitions in which pragmatics assumes a distinctly political and critical nature will be discussed.

2.2.3 PRAGMATICS AS A CRITICAL LINGUISTIC OUTLOOK ON LANGUAGE USE

Envisaging pragmatics as a critical outlook on language use enables a political stance to be taken with regard to how language is studied (Mey, 1985; Verschueren, 1999b). As such, pragmatics deals with language "from the perspective of the goals it serves in human activity" (Verschueren, 2009, p. 7). The definitions of pragmatics discussed in this section are also often affiliated with an approach to the study of language founded on Ordinary Language Philosophy and the functionalist "broader Continental" approaches to pragmatics (Levinson, 1983, p. 6). The position of pragmatics as a segment of linguistic theory is rejected as:

> Pragmatics is not only situated outside the contrast set to which phonetics, phonology, morphology, syntax and semantics belong; neither does it fit into the set of interdisciplinary fields such as neurolinguistics, psycholinguistics, sociolinguistics and anthropological linguistics....Pragmatics is concerned with the full complexity of linguistic behaviour.
>
> (Verschueren, 1999a, p. 7)

2.2.3.1 LANGUAGE USE

Language use is of central importance here, however attention is centred on the process and outcomes of language use as opposed to how "language resources are being used", or how form-function mapping is achieved specifically (Verschueren, 1999a, pp. 7-8). This shift in focus differentiates these definitions of pragmatics as a critical linguistic outlook on language use, from views of pragmatics as the use of language for contextualised meaning-making.

Defining pragmatics as a critical linguistic outlook on language use draws on a common linguistic heritage with many of the definitions of pragmatics discussed in the previous section.[19] As such, some overlapping characteristics of both types of definitions to pragmatics may be

[19] Both types of definitions of pragmatics (discussed in Sections 2.2.2 and 2.2.3) lean towards the functional and Ordinary Language traditions in linguistics and philosophy.

noticed by the reader.[20] However, the upfront political agenda and quest for social justice here marks this approach to pragmatics as something distinctly more critical than other approaches to pragmatics encountered within the functionalist tradition. Additionally, one of the advocates of defining pragmatics from this critical stance sees this approach as distinct from a "functionalism orientated" definition of pragmatics (as in Verschueren's 1999a, quotation below). Therefore, it was deemed appropriate that a small set of additional definitions of pragmatics would be briefly discussed in this separate section as part of the spectrum of definitions of pragmatics.

While definitions of pragmatics (as discussed in Section 2.2.2) embrace the interaction of language use and context for the purpose of meaning-making, the focus often remains specifically on how various resources are employed in the process of language use. However, when Verschueren (1999a, pp. 7-8) defines pragmatics, the focus is on the function of language in the lives of its users:

> Summing up, we can now further specify pragmatics as *a general cognitive, social, and cultural perspective on linguistic phenomena in relation to their usage in forms of behaviour* (where the string "cognitive, social, and cultural" does not suggest the separability of what the terms refer to). Thus the question of how language resources are being used rephrases itself as: How does language function in the lives of human beings?

When pragmatics is defined as a critical linguistic outlook on language use, it is emphasised that there is a pragmatic aspect to all components of linguistic theory. Other functionalist inspired definitions of pragmatics, previously discussed, typically capture pragmatics as an overall regulatory or mediatory system which interfaces between language and context to create meaning. The characterisation of pragmatics as a critical outlook or perspective on all things linguistic focuses not on the actual interface or linkages between context and linguistic structure, but focuses instead on the actual socially embodied use of language and how language functions for people and organisations that use it. As Verschueren noted (in his introduction):

> This book will also avoid a functionalism orientated at the identification of *functions* of language, viewed as links between formal systems and their use. Without ignoring the need for generalizable explanations...pragmatics ought to focus straightforwardly on the *functioning* of language in actual contexts of use....the suggestion that pragmatics is a *perspective*, "the linguistics of language use" in its most general sense, ought to be taken literally. As a perspective it is all-encompassing.
>
> (Verschueren, 1999a, pp. 9-10)

[20] For example, overlap between Sections 2.2.2 and 2.2.3 is evident in the inclusion of quotes from authors affiliated with the view of pragmatics as critical linguistic outlook on language use within the previous section dealing with definitions of pragmatics the use of language for contextualised meaning-making.

Pragmatics as a critical linguistic outlook on language use is conceptualised as a fresh method of exploring all things linguistic and all aspects of language use, rather than limiting itself to one particular component of linguistic theory. As such, pragmatics is defined as a way of generally exploring language use: "linguistic pragmatics...can be said to characterise a new way of looking at things linguistic rather than marking of clean borderlines to other disciplines" (Haberland & Mey, 1977, p. 5). Proponents of this outlook on pragmatics have "not been willing (or able?) to mark a clean line between what is pragmatics and what is not" (Haberland & Mey, 2002, p. 1674). In this sense then, everything linguistic can come under the radar of pragmatic scrutiny, as Verschueren states:

> Clearly, the linguistic phenomena to be studied from the point of view of the usage can be situated at any level of structure or may pertain to any type of form-meaning relationship....Therefore, pragmatics does not constitute an additional component of a theory of language, but it offers a different *perspective*...But there are definitely *no* linguistic phenomena, at any level of structure, that a pragmatic perspective can afford to ignore.
>
> (Verschueren, 1999a, pp. 2-3)

2.2.3.2 Context

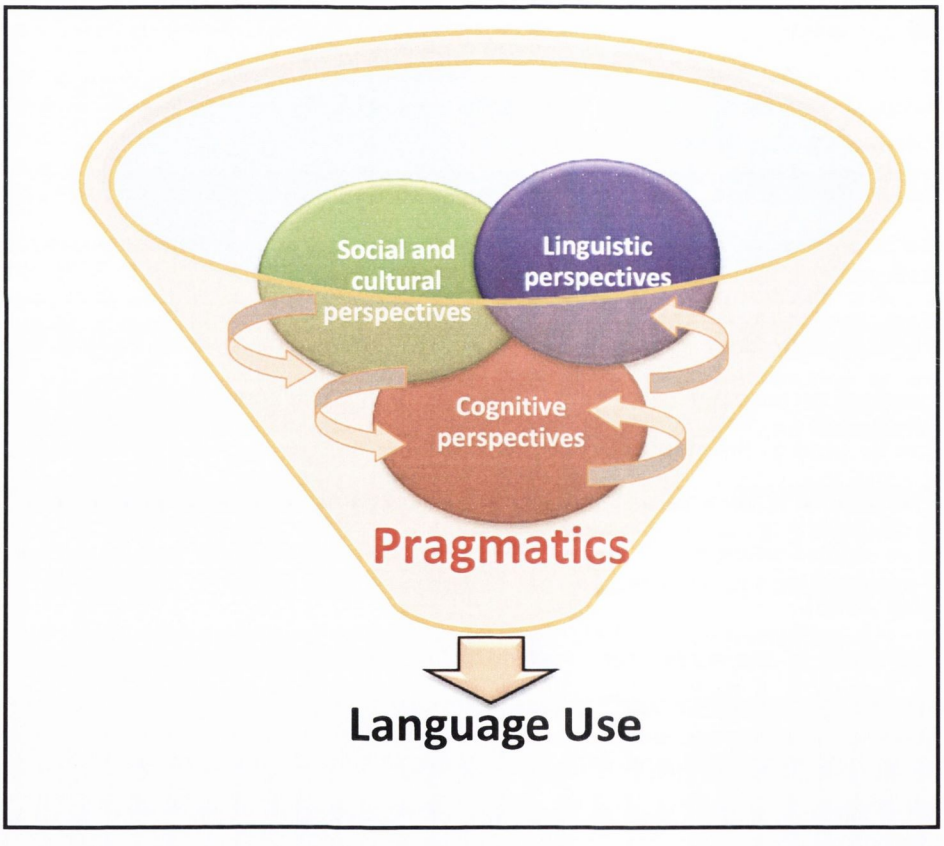
The "actual contexts of use" discussed in the quote above by Verschueren (on page 28) are taken at face value to expose a concern with the politically and socially embodied experiences of language users. The context of language use is viewed widely and critically here. Some of the broadest conceptualisations of context are advocated by those who view pragmatics as a critical linguistic outlook on language use. There is flexibility within this approach as almost any aspect of context can be used to develop a framework to explore language use, as highlighted by Figure 3 below. A mixture of many layers of context, or one particularly salient aspect of context, can be drawn on in studies advocating a definition of pragmatics as a critical outlook on language use (e.g., Winter, 1993).

The "role of the body" has received a "renewed attention", within the approach to pragmatics as a critical outlook on language use (Haberland & Mey, 2002, p. 1680). Broad-based definitions of pragmatics affiliated with the "European school" have long been associated with exploring the socio-linguistic contributions and ramifications of language use (Levinson, 1983). However, a fresh recognition of the embodied nature of language use has seen language use conceptualised as a simultaneously political, social, cultural and embodied act. Previously, the physical aspect of language use had not always been fully dealt with alongside these socio-linguistic layers of context. Thus, extra-linguistic factors such as "gesture" and "body moves" have been posited as areas of growing interest in pragmatics (Haberland & Mey, 2002, p. 1680).

Definitions of pragmatics as a critical outlook on language use have a proclivity to draw heavily on the synergy between context and language use to expose connections between micro and macro-levels of analysis. While language use may be explored at a micro level, it is the outcomes of language use in macro-level (i.e., social, political and cultural) contexts that pragmatics is particularly concerned with here.

The notion of Pragmatics as a critical outlook on language use can be summarised in the following definition from Verschueren, in which he stated that "I will talk about pragmatics as 'general *functional perspective* on (any aspect of) language', i.e. 'as an approach to language which takes into account the full complexity of its *cognitive, social and cultural* (i.e. '*meaningful*') *functioning* in the lives of human beings'." (1999b, p. 870).

FIGURE 3: PRAGMATICS AS A CRITICAL LINGUISTIC OUTLOOK ON LANGUAGE USE



SUMMARY

Before turning to explore the area of clinical pragmatics, it must be noted that this literature review of definitions of pragmatics, within the area of mainstream pragmatics, does not in any way claim to be exhaustive. Rather, its purpose is to highlight the context from which clinical pragmatics has emerged.

In summary, from this brief perusal of the mainstream pragmatics literature, it is evident that disparity exists in terms of how best to delimit the area of pragmatics and define its remit. There appears to be heavy reliance on the notions of language usage and context when defining pragmatics as Cummings (2005, p. 4) has noted: "No definition of pragmatics would be complete in the absence of some mention of context." The elusive nature of context and a failure to specify what is meant by context seems to have contributed to some of the variance and inconsistencies noted across divergent definitions of pragmatics.

Those interested in pragmatics have employed many different methodologies and frameworks in their attempts to "do" pragmatics. The author particularly appreciates Levinson's use of the verb "sprung" in his reflection below (about the evolving and wide ranging interpretations and uses of pragmatic theory), as it captures the energy and momentum provided by Morris's original trifid revision of linguistic theory, as when Levinson (1983, p. 5) noted "to summarize, a number of distinct usages of the term *pragmatics* have sprung from Morris's original division of semiotics".

The following chapter will explore one of the "distinct usages" of pragmatics in more depth. Chapter 3 discusses how pragmatic theory has informed research and clinical practice in the area of communication disorder vis-à-vis the area of clinical pragmatics.

CHAPTER 3. THE DIVERGENT FIELD OF PRAGMATICS: CLINICAL PRAGMATICS

INTRODUCTION

Over the last 30 years or so, clinical pragmatics has been putting theory from the area of mainstream pragmatics to use in clinical practice and research settings, when working in the areas of communication and communication disorder (Cummings, 2010a). The area of clinical pragmatics has evolved from being considered a branch of applied pragmatics to being seen as an area which is "catching up" to become an important part of "the pragmatic landscape" (Verschueren, 1999a, p. 254). Consequently, clinical pragmatics is now considered "a field of study in its own right" (Cummings, 2009, p.1).

It has been suggested that clinical applications of pragmatic theory may be one form of empirical road-testing which might help further validate and refine pragmatic theory (Cummings, 2005). Pragmatic theory has also been drawn on by disciplines other than SLT and continues to be widely applied and employed to areas beyond clinical research and practice.[21]

In Section 3.1 of this chapter, the emergence of the area of clinical pragmatics will be briefly outlined. This will be followed, in Section 3.2, by a discussion of some of the assessment and intervention procedures utilised by the SLT community within the area of clinical pragmatics.

3.1 THE EVOLUTION OF CLINICAL PRAGMATICS

Cummings (2009, p. 1) has commented that, "a greater level of academic interest in clinical pragmatic issues is scarcely imaginable". The presence of sections of conferences dedicated to clinical pragmatics, the emergence of special editions of journals devoted to clinical pragmatics and the existence of numerous publications which boast "clinical pragmatics" in their titles or as their "central theme", all testify to the high level of interest in the area of clinical pragmatics, according to Cummings (2009, p. 1).

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[21] For example, a 2007 edition of the *Journal of Pragmatics,* which was dedicated to various topics in applied pragmatics, featured "rather diverse" contributions (Mey, 2007, p. 1). The contributions to this special edition of the journal came from various backgrounds including Psychology, Applied Linguistics, The Arts and Second Language Learning. The diversity within the area of applied pragmatics was also reflected in the wide range of topics covered in this edition ranging from an investigation of humour in the context of international business meetings (Rogerson-Revell, 2007), to the exploration of the functions of prosody in children's explanatory talk (Kern, 2007).

Attending to pragmatics has become a customary aspect of clinical work for many SLTs, as described by Hewitt (2000a, p. 257): "A modern language diagnostic incorporates analysis of pragmatics as a matter of routine". The following section briefly charts the progression of pragmatics from being an area which was once neglected within SLT practice (as noted by Duchan, 2000b), to commanding high levels of interest and being deemed a "standard part" of the clinical process, as Cummings (2007b, p. 99) has vouched: "The position of pragmatics in clinical practice and research is now secured. Pragmatics is a standard part of the assessment and treatment protocols of developmental and acquired language disorders."

3.1.1 THE IMPACT OF THE PRAGMATICS TURN

Changes in the theoretical landscape in linguistics, in or around the 1970s, have been dubbed the "pragmatics turn" (Mey, 2006, p. 59). This theoretical revision arose in response to disquiet regarding the then popular purely structural and abstract approaches to the study of language. Mey has described the structural approaches that dominated linguistics in the 1960s and 1970s as an "insufficiency" which motivated the pragmatics turn:

> The insufficiency of the standard linguistic method when it came to capture the full reality of human language use was keenly felt....Rather than focusing uniquely on the words, pragmatics tries to capture the situation as a whole and works its way to the inside, where the spoken words are found....Thus, the pragmatics turn in linguistics can be described as a shift from the paradigm of theoretical grammar (in particular, syntax) to the paradigm of the language user.
>
> (Mey, 2006, pp. 58-59)

Ordinary Language Philosophy, which rejected the priority accorded to syntax in linguistic theory (as discussed in Chapter 2) laid the theoretical foundations for exploring language as a contextualised and dynamic process. The emergence of John Austin's (1962) work on Speech Acts, which explored language use as action, has been linked with the onset of the pragmatics turn. This shift in thinking in linguistics has been viewed as a "pragmatics revolution" which subsequently impacted on how SLTs conceptualised language and carried out their clinical work (Duchan, 2000b, p. 190).

Austin's work provided an alternative framework for understanding language as an active, interactional and functional tool. It was posited that getting things done with language involved not only the encryption of meaning at the linguistic level of an utterance (locutionary aspect), but also involved considering the intentions of the speaker (illocutionary force) and the perspectives and actions of the listener (perlocutionary force) (Austin, 1962). The notion of language as a

dynamic process used for relating and acting in the world provided an alternative paradigm to the then common conceptualisation of language as a linguistic code—through which meaning was transmitted embedded within a static language product. Thus, SLT assessment began to slowly move away from focusing solely on the linguistic structures used by clients to focus on context. SLTs were legitimised by the pragmatics turn to look beyond linguistic structure (and units such as phonemes, words and sentences) within their assessments and interventions. Duchan noted the way in which the SLT perspective of communication was "broadened" by this fresh emphasis on language use in linguistics:

> During the 1970s, under the influence of John Austin's speech-act theory, the field moved away from thinking of meaning as contained in language "form" and "content" and added "use" to its assessment framework....The pragmatics revolution resulting from "use theory" broadened our view of communication considerably. We began to assess children's communicative intents, whose meanings were located outside of the linguistic system. Using such a framework, clinicians were even able to assess the meaning of infants' and children's pre-linguistic communications, as well as the indirect speech acts of more mature language users.
>
> (Duchan, 2000b, p. 190)

However, pragmatics notions appeared to be commonly interpreted, within the SLT community in the 1970s and 1980s, vis-à-vis formally orientated approaches to language. Correspondingly, pragmatics became positioned as an additional domain of linguistic competence. A "new" component of linguistic theory was imported into the clinical practice of the SLT community which could be used to evaluate particular linguistic competencies of those accessing SLT services, as Duchan has pointed out:

> Characteristic of the profession in these last 30 years has been an elaboration of information processing frameworks that serve as models of how a person interprets speech and language (see Duchan 2004, for examples). These models were first developed to represent adult language and cognitive knowledge systems (e.g., Osgood and Miron, 1963, Wepman, 1960)....The models depicted linguistic levels in separate boxes that included phonology, morphology, syntax, and semantics. A new pragmatics box was added in the 1970s to represent a newly developing diagnostic/assessment domain having to do with the contextual understandings of communication.
>
> (Duchan, 2005, pp. 211-212)

Prutting (1982) has credited Bates (1976b), with introducing pragmatics to the SLT community. The work of Bates (1976a, 1976b) and others in the area of child language acquisition had a strong impact on how the SLT community perceived pragmatics and child language in general. Increasing evidence emerged within the language acquisition research (e.g., the work of Bruner, 1974; Bruner & Watson, 1983; Dore, 1974, 1975; Halliday, 1975), which posited that children acquired

and developed language in a interactionally-based manner, rather than acquiring language exclusively as a pre-programmed product or via operant conditioning. Language learning was increasingly envisaged as an embodied and highly contextualised process which was socially and culturally mediated. The priority accorded to pragmatics in accounts of child language acquisition began to permeate the thinking of the SLT world. Doubts began to emerge about the amount of influence which the behaviourist and structuralist paradigms had previously had on the practices of SLT community (e.g., Craig, 1984).

Language "use" became increasingly included in many definitions of language, such as Bloom and Lahey's (1978, pp. 21-23) tripartite taxonomy for defining language (which posited that language was synergistically comprised of "content, form" and "use"). However, attempts to integrate pragmatics into linguistic theory, by simply adding a pragmatic component to language, became increasingly questioned by those who acknowledged the priority of "use" in driving all language development. For example, Bates's (1976b) position reflected a synergistic, rather than additive, view of pragmatics as an overarching driving force behind all language:

> At first, it seemed that pragmatic information was ancillary to the rest of semantics, something that could be added onto studies separately. It is now far less clear that this is the case...it does not define a separate kind of linguistic structure or "object". Rather, all of language is pragmatic to begin with.
>
> (Bates, 1976b, pp. 420)

Following the pragmatics turn, functionalist-inspired approaches to intervention led to the entire context of an individual becoming a palette from which intervention goals could be manufactured. Given the primacy of language usage and context advocated by the pragmatics turn, the teaching of static language structures was no longer seen as the only way in which SLT intervention might be mediated. For example, Carlomagno and colleagues (2000, p. 338) commented on this new "focus" for intervention, by saying that "the 'functional' view has led to shifting the focus of therapeutic practice from traditional language tasks to dyadic communicative interaction".

The "profound impact" of the pragmatics turn on clinical work has been further explicated by Cummings (2008, p. 12).[22] With reference to "pragmatic" goals, clinicians could now identify the targets of their intervention as being outside of the individual client and residing within the "context of communication" (Cummings, 2008, pp. 11-12). The forefronting of contextual phenomena enabled factors extrinsic to an individual to become legitimate targets and

[22] It should be noted that Cummings has been critical of clinical applications of pragmatics (2009) and that she has charged the clinical practice and research community with an interpretation of pragmatics that has "lacked both focus and rationale" (2008, p. 12). However, Cummings (2008, pp. 11-12) has also highlighted some of the more positive changes in clinical practice which the pragmatics turn has facilitated.

agents of SLT intervention. Attention to contextual phenomena and active on-line meaning-making, via language use, entailed that factors which were once deemed extraneous became of paramount importance within clinical interventions (Prutting, 1982).[23] This re-targeting of SLT interventions represented a significant departure from previous patterns of SLT provision, in which the client and his behaviour were automatically assumed to be the sites in which all changes induced by SLT interventions should happen:

> In its relatively short intellectual history, pragmatics has included the study of diverse phenomena not all of which have exhibited conceptual coherence....Greater understanding of and attention to pragmatics have enabled clinicians to develop more realistic goals of therapy and to achieve these goals through more appropriate means....Also, the pragmatic emphasis on the context of communication has seen the spouse of the client, and indeed other family members and friends, assume an altogether more proactive role in the therapeutic process....it should be clear to the reader that this "newest" branch of linguistic inquiry has had by far the most profound impact on clinical linguistic practice.
>
> (Cummings, 2008, pp. 11-12)

The interest that the SLT community has demonstrated towards the area of pragmatics has been described as being nothing less than a "theoretical shift" (Prutting, 1982, p. 123). However, the extent to which the so-called pragmatics turn has influenced the clinical practices of the SLT community is not completely clear, as this has never been fully charted. It may be salutary to note that changes in linguistic thinking are not always proportionately mirrored by changes within the SLT community, as noted by McTear & Conti-Ramsden (1990, p. 20) who pointed out that "a close correlation does not always exist between developments in linguistic theory and developments in speech-language pathology practice".

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[23] Phenomena in the environment of the client, such as the communication skills of friends, family members, and spouses of individuals with communication disorders are now often the focus of SLT intervention across many different settings (e.g., Byng & Duchan, 2004). For example, factors once considered extraneous to SLT intervention and outcomes might have included phenomena such as non-linguistic variables, compensatory strategies, communicative skills of conversational partners and interactional outcomes of language use. Whereas following the pragmatics turn, phenomena such as these were incorporated into SLT goal setting and formed the basis of outcomes of SLT interventions (as in Kagan, Black, Duchan, Simmons-Mackie & Square, 2001). Here, clinical outcomes are measured by evaluating the skills gained by conversational partners of people with aphasia, with a view to creating environments more conducive to communication, rather than re-teaching particular linguistic constructions to the person with aphasia.

3.1.2 AFTER THE PRAGMATICS REVOLUTION: CHARTING NORMAL AND DISORDERED PRAGMATICS

Following the recognition that pragmatics notions could be usefully applied to clinical research and practice in the area of communication and communication disorder, research in clinical pragmatics began to focus on describing the patterns of pragmatic impairments evident across differing clinical populations and charting the course of typical pragmatic development (Cummings, 2010a).

Rising interests in mapping and delimiting the development of pragmatics in various populations of children produced collections of developmental milestones focusing specifically on the acquisition of pragmatic skills and behaviours (e.g., Conti-Ramsden & Gunn, 1986; Wetherby & Prutting, 1984). These pragmatics norms became the foundations for assessment and intervention in the SLT clinic, which slotted into the practice of using developmental norms to inform the choice of intervention targets as in other areas of SLT practice (Duchan, 2004). Cumming's (2010a, p. 41) comments below highlight how pragmatic "norms" became the templates for identifying behaviours and skills as being impaired when she noted that "an understanding of pragmatic norms against which findings of impairment could be compared gave impetus to the study of a range of pragmatic impairment in normally developing children."

Dissociations between structural linguistic skills and communication skills were revealed in studies courtesy of the licence that the pragmatics turn had given researchers to explore language use as well as language structure.

On one hand, studies began to identify adequate and effective communication skills, despite the presence of significant linguistic challenges (e.g., Holland, 1982; Penn, 1988). Practitioners employed pragmatics notions to account for the communicative skills which many of their clients possessed despite simultaneously demonstrating compromised and/or unconventional structural linguistic skills. People with aphasia were one of the first clinical populations in which dissociations between communication skills and linguistic skills were noted. For example, clinicians such as Audrey Holland (1979, 1980, 1982) and Martha Taylor Sarno (1969) pointed out that people with aphasia were competent communicators. These authors set about trying to expose communication skills possessed by people with aphasia, as when Holland (1979, p. 173) stated, "I am trying to convince you that aphasics probably communicate better than they talk". This stance challenged the assumption that the presence of communication difficulty automatically ensued from the presence of linguistic impairment. The trend of decoupling linguistic and communication skill continues today in studies of aphasia and beyond, where the

use of sparse linguistic resources to achieve impressive and effective interactional results continues to be exposed (Beeke, Wilkinson & Maxim, 2007; Ulatowska & Olness, 2007).

On the other hand, studies of people with strong structural language skills identified that sometimes these same individuals, despite their adequate structural linguistic skills, lacked functional communication skills (e.g., Wetherby & Prutting, 1984). The conversational behaviour and the lack of functional communication skill observed in particular clinical populations began to be regarded as being disproportionately compromised in light of the simultaneously strong structural linguistic abilities they possessed (e.g., the ability to produce grammatically well-formed sentences).

Clinically significant interactional and language differences became linked with terms such as pragmatic difficulty. Currently, certain patterns of pragmatic language skills and/or deficits are assumed to be a characteristic of the behavioural profile of certain diagnoses. Perkins (2005b, p. 375) has stated: "In the language pathology literature...the term 'pragmatic disability' is most commonly restricted to behaviours resulting from the type of socio-cognitive impairment found in autism, right hemisphere brain damage and traumatic brain injury".[24]

Terminology has been borrowed from the area of mainstream pragmatics to describe certain unconventional linguistic patterns which were then taken as evidence of the presence of certain types of language or communication difficulty (e.g., Adams & Bishop, 1989; Bishop, 1989; Rapin & Allen, 1983). Consequently, superficial, descriptive patterns of conversational and social behaviour became inconsistently associated (Body & Perkins, 2006) with terms such as Semantic-Pragmatic Disorder (e.g., Adams & Bishop, 1989; Bishop & Adams, 1989), Conversational Disability (e.g., Conti-Ramsden & Gunn, 1986; Willcox & Mogford-Bevan, 1995), Pragmatic Language Impairment (e.g., Adams & Lloyd, 2007), Primary Pragmatic difficulties (e.g., Botting & Conti-Ramsden, 2003), Pragmatic communication difficulties (e.g., Leinonen, Letts & Rae-Smith, 2000)

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[24] Additional examples of particular diagnoses and clinical populations being linked with differences and difficulties in the area of clinical pragmatics can be found in Cummings (2009). Certain clinical populations became routinely affiliated with labels such as "pragmatic impairment" and cognate terms. In a recent overview of the area of clinical pragmatics, Cummings (2009) surveyed "developmental pragmatic disorders" and "acquired pragmatics disorders", by discussing the clinical populations of "Developmental language disorder, Autistic spectrum disorder, Emotional and behavioural disorders, Mental retardation" and by discussing "Left-hemisphere damage, Right-hemisphere damage, Schizophrenia, Traumatic Brain Injury, Neurodegenerative Disorders" (Cummings, 2009, p. vii). A further example of the pairing of particular clinical populations and particular interactional and language patterns in the area of clinical pragmatics is noted when Stemmer (2008) points the dissociation between linguistic and conversational skill evident in people with Right Hemisphere Damage (RHD), in that "...it is usually assumed that damage to the right hemisphere can lead to pragmatic impairment. RHD patients are often described as behaving conversationally oddly or inappropriately in social situations, despite intact linguistic abilities. Their conversational style has been described as embellishing, rambling, tangential, non-informative, irrelevant, repetitive, confabulatory, and literal" (Stemmer, 2008, p. 62).

and other variants of these terms. The next section briefly discusses the development of these terms.

3.1.3 THE NOSOLOGICAL DEBATE IN CLINICAL PRAGMATICS

The interest in language use sparked by the pragmatics turn also gave rise to a revision of how language difficulties and differences were labelled, in that "the pragmatic turn in the study of language pathology has also brought about a major revision in the nosology of developmental language disorder" (Cummings, 2010a, p. 41). New categories of disorder such as Semantic–Pragmatic Language Disorder and Pragmatic Language Impairment were devised. However, the way in which clinical significance in the area of pragmatics has been labelled and talked about, by clinicians and researchers is not consistent across the literature.

The controversies around the diagnostic categories used within the SLT community in the area of clinical pragmatics are embedded within a larger debate across the fields of Psychology, Psychiatry, Neurology and beyond about the underlying nature of particular disorders. There is an ongoing and inconclusive debate regarding how Specific Language Impairment (SLI), Pragmatic Language Impairment (PLI), and Autistic Spectrum Disorders (ASD) interact (Baron-Cohen, Wheelwright, Skinner, Martin & Clubley, 2001; Bishop, Chan, Adams, Hartley & Weir, 2000; Bishop, Whitehouse, Watt & Line, 2008; Hoekstra, Bartels, Verweij & Boomsma, 2007).

It may be possible that all three are separate entities, but this seems unlikely due to the similarities seen across these groups, which has led some researchers, such as Bishop and Norbury (2002), to advocate that PLI be considered as an intermediary condition existing somewhere between SLI and ASD. Bishop (2000, p. 99) has stated, "in our current state of knowledge it may be sterile to debate whether language impaired-children with pragmatic difficulties should be categorised with SLI or autistic disorder: truly intermediate cases may exist". However, others have suggested that PLI may be better conceived as a subtype of Autism (Tager-Flusberg, 2006), although this view has not gone uncontested (Whitehouse, Barry & Bishop, 2008).

Currently within the clinical community in general, labels pertaining to the area of pragmatics are used descriptively to refer to divergent profiles across different diagnostic groups. Correspondingly, PLI and related terms reflect significantly "heterogeneous profiles" of skills and abilities, as identified on language testing (Adams & Lloyd, 2007, p. 227). In a similar vein, terms

such as PLI, SPD and Pragmatic Language Disorder (PLD), which emerged in the late 1970s and 1980s,[25] have since been employed across the SLT community in disparate ways.

Amongst the variety of terms used in the literature of clinical pragmatics, some are used in a "neutral" and purely descriptive way to refer to any difficulty with the use of language, as when "Pragmatic Disability" is used to refer in a neutral[26] and blanket fashion to "children's difficulties in using language" (McTear & Conti-Ramsden, 1990, p. 53). Correspondingly, authors have noted that labels (such as PLI) hold little explanatory value and are being used disparately as when Perkins (2007, p. 8) pointed out: "Thus, 'pragmatic impairment' and other cognate terms are used to describe an excessively wide range of disparate conditions, and are often used inconsistently".

In addition to the descriptive nature of much of the terminology in the area of clinical pragmatics, a barrage of shifting and evolving terms has been used to date within the brief history of clinical pragmatics. A distinction has sometimes been made between "PLI-pure" and "PLI-plus" (Botting & Conti-Ramsden, 2003, pp 521-522). The term PLI-pure has been used to describe when a person presents with an impairment which is restricted to being linguistic in nature; the term PLI-plus has been used to describe when a language difficulty co-occurs with impairments in other domains of functioning such as "narrow interests, obsessions and marked social difficulties" (Botting & Conti-Ramsden, 2003, p. 522).

The terms "Primary" and "Secondary Pragmatic Disorders" are also evident within the literature of clinical pragmatics (Cummings, 2009, pp. 32-34). The term Primary Pragmatic Disorder has been used to describe when a person presents specifically with an impairment of pragmatic competence (for example, when a person presents with Theory of Mind difficulties). A Secondary Pragmatic Disorder may be present in cases where the cognitive and linguistic processes which underlie pragmatic language are not specifically impaired, yet language use remains a challenge. Thus, the term Secondary Pragmatic Disorder is used to capture how there can be pragmatic "consequences" resulting from the presence of difficulties with other areas of language or speech (Bishop, 2000, p. 101). The debate regarding the nature of the diagnostic

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[25] Initially Rapin and Allen (1983) in the United States developed the term "semantic-pragmatic deficit syndrome" which was used as one of six descriptive subtypes of language disorder/impairment that could occur across all clinical populations (e.g., ASD and SLI). At the same time, in the United Kingdom, Bishop and Rosenbloom (1987) began to use the term Semantic Pragmatic-Disorder (SPD), in a more diagnostic sense.

[26] The term "neutral" refers here to the usage of a term outside of an explict theoretical framework and devoid of the theoretical associations and meanings which the concept may have once had (Müller *et al.*, 2008, p. 3). Correspondingly, an example of one such neutral definition of clinical significance in the area of pragmatics is provide by Craig (1996 p. 624) when she noted that "Pragmatics is the study of language usage, and 'pragmatic impairments' then is the term that refers to clinically significant problems in using language".

categories used within the area of clinical pragmatics across the SLT community rages on (for example, see Adams & Lloyd, 2007; Bishop, 2000; Botting & Conti-Ramsden, 2003).

3.1.4 SYNONYMISING PRAGMATICS WITH FUNCTIONALITY AND ECOLOGICAL VALIDITY

As well as having a significant impact on the classification of language difficulties and differences, the pragmatics turn influenced the targets which were focused on during SLT intervention and the manner in which interventions were mediated. Intervention guided by pragmatic theory shifted the emphasis from the teaching of particular linguistic structures to facilitating the development of functional and effective communication. Additionally, as Kamhi noted below, pragmatic theory has guided the SLT community to use more naturalistic settings for mediating therapy:

> Pragmatic notions have been an integral component of speech-language therapy for almost 20 years. The so-called "pragmatics revolution" has profoundly changed the way clinicians assess and treat children with speech and language disorders. In many cases, effective communication has replaced more specific structural objectives as the overarching goal of speech-language therapy....Consistent with pragmatic notions, it has been assumed that to achieve the goal of effective communication, specific syntactic, semantic, and even phonological objectives must be taught in naturalistic, functional, communicative, and meaningful contexts.
>
> (Kamhi, 2000, p. 182)

Terms relating to ecological validity, such as "functional communication...real-life...communication efficiency" intervention, began to be used interchangeably with the term pragmatics (as noted by Manochiopinig, Sheard & Reed, 1992, p. 521). Interventions that evoked a naturalistic setting for carrying out therapy or that focused on achieving ecologically valid goals were assumed to be pragmatic interventions. In perhaps an oversimplification of the original intentions of the functionalist perspective in linguistics, pragmatics is now commonly used as a synonym for functional[27] communication, as highlighted by Penn (1999) and others.

A shift towards "functional" therapy (i.e., interventions which have high levels of ecological validity) emerged following the growing realisation that clinicians were targeting phenomena in their interventions which had little meaning for clients and which were of little

[27] Here, "functional" is used to refer to interventions which are ecologically valid and carried out in naturalistic settings, as opposed to how the term functional is used in mainstream pragmatics to refer to a school of linguistic thought founded on Ordinary Language Philosophy (as discussed in Chapter 2).

real-life use and value.[28] A drive towards the use of more meaningful therapy targets has been frequently labelled as the provision of intervention which is more functional for clients. For example, functional goals for SLT interventions might include targets such as "participation in life's activities, relationships and personal self-esteem" (Worrall, 2006, p. 320).

In the SLT community, interventions which target environmental variables in response to the presence of an "impairment" have often been considered as being both functional and pragmatic. However, this synonymisation of pragmatics and functional (i.e., ecologically valid and/or intervention which is carried out in a naturalistic setting) is an over-simplification of the complex relationship between language and context espoused within functionalist-inspired approaches to pragmatics from the area of mainstream pragmatics. This point is captured by Carlomagno and colleagues when they stated that:

> The pragmatic approach to aphasia assessment and therapy have [sic] initially focused on relationships between patient and environment and on therapeutic strategies allowing compensation for defective language processing in daily communicative contexts. Such a "functional" view is incomplete with respect to the concept of pragmatics as the study of relationships between language and context.
>
> (Carlomagno et al., 2000, pp. 337-338)

While the client's life-world is of course the ultimate context, for any individual in which language and interaction fuse with context to create meaning, functional therapy overlaps but has a divergent meaning to functional definitions of pragmatics, as derived from mainstream pragmatics. Functionalist-inspired definitions of pragmatics, with their attention to pragmatics as a contextualised process of meaning-making involving language use, beautifully complement a functional approach to SLT intervention which looks to the client's everyday context to identify meaningful SLT goals. However, a functional approach to intervention is just that; it is an approach to intervention which particularly prioritises the client's perspective and life-world as sites for generation of ecologically valid and meaningful intervention targets. To use the notion of functional, (i.e., meaningful and/or ecologically valid from the client's perspective), as being totally synonymous with either the functionalist approach to pragmatics or the entire paradigm of clinical pragmatics is a significant oversimplification. Indeed, it has been noted that functional approaches to clinical pragmatics are often heavily steeped in formalist tradition and thus may actually clash with functionalist-inspired approaches to pragmatics outlined in the mainstream pragmatics literature (Müller, Guendouzi & Wilson, 2008, pp. 6-7).

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[28] For example, Crystal's (1995, p. 79) discussion of the "postilion sentences" targeted during SLT intervention and also Dormandy & van der Gaag's (1989) discussion about the child orientated nature of assessment used with adults with learning difficulties highlighted a lack of ecological validity and meaningfulness of certain targets focused on during SLT assessment and intervention.

Manochiopinig and colleagues (1992) have discussed the proclivity of clinicians to confuse functional linguistics and functional goal setting. They noted that "strictly" pragmatic assessments attend to pragmatic phenomena only, while other assessments focus on exploring how "effective" and "functional" certain communication skills (including "pragmatic behaviours") are for a person in their daily life. As these Manochiopinig et al., 1992, p. 521 have pointed out,

> ....it is important to make the distinction between pragmatic and functional assessment, as the two approaches to assessment have different purposes. The previously mentioned observational profiles that directly identify specific pragmatic behaviours are strictly pragmatic assessments. On the other hand, the communication efficiency measures of this second group reflect the combined effectiveness of a number of pragmatic behaviours in achieving functional communication. The component pragmatic behaviours necessary to achieve functional communication are not directly identified or assessed in such measures. Rather, the end measure of a person's ability to function in real-life situations is the goal of such functional assessments

Thus, the SLT community appears to have demonstrated a tendency to equate pragmatics with ecologically valid and meaningful intervention targets. However, the lack of consensus and clarity in the field of mainstream pragmatics (as noted in Chapter 2) could be taken to suggest that the presence of this kind of theoretical blurring is hardly unfounded or surprising.

3.1.5 THE EMERGENCE OF SITUATED PRAGMATICS

Initially, formal perspectives dominated how pragmatics was approached clinically. Linguistic phenomena, such as "formal pragmatic devices" and restricted lists of "speech acts", were interpreted as being the totality of what pragmatics meant in the SLT clinic (Adams, 2008, p. 189). Componential views of pragmatics were influenced by structuralist models of language, which focused clinical pragmatics on abstract and de-contextualised skills. This formalist-inspired view perceived pragmatics to be "a set of pragmatic entities such as speech acts and pragmatics rules governing their occurrence" with "impairments" being "viewed as problems in acquiring basic constituents, such as speech acts" (Craig, 1996, p. 624).

The prevailing perspectives on language in general, as "being made up of a set of boxes or levels and different aspects of a message being processed at the different levels", and pragmatics as a component of language, began to lose popularity (Duchan, 1984, p. 83). A movement followed in which functionalist-inspired conceptualisations of language became increasingly endorsed by members of the SLT community. This movement enabled a wider view of language and pragmatics to be taken, in that the "paradigm of pragmatics...encompasses methods and

principles for studying the whole of the communicative event rather than its separate components" (Rae-Smith & Leinonen, 1991, p. 1).[29]

Other authors in the 1990s, within the SLT community, continually advocated for the acceptance of a broader definition of pragmatics based on functional linguistics and Ordinary Language Philosophy (e.g., Craig, 1996; Duchan, Hewitt & Sonnenmerier, 1994; Gallagher, 1991). More expansive definitions of pragmatics were anticipated positively as influencing how the SLT community thought about the whole enterprise of intervention. Drawing on broader definitions of pragmatics was perceived to enable clinicians to move beyond focusing on pragmatics as a discrete segment of "linguistic rules", presenting a fresh outlook on "language learning" and a new framework for SLT intervention.

> This book represents and argues for a new evolution in the development of pragmatics. The early pragmatic approach, which could be called Stage One Pragmatics, was focused on divorcing itself from two marriages: behaviourism and transformational grammar. The aims of Stage One Pragmatics were to treat learning as more than reinforced stimulus-response associations and to treat language learning as more than the accumulation of linguistic rules....Stage Two Pragmatics expands the focus on context to include discourse genres other than conversations and to include event structure in its theorizing and practice.
>
> (Duchan et al., 1994, pp. 2-3)

Correspondingly, clinicians were urged to set goals which took the entire communicative situation or setting, and how this influenced the client's linguistic performance, into account. This reappraisal of where SLT interventions might focus also called for a revision of how SLTs identified outcomes, that is:

> The amalgamation of the conversational-social nature of the situation with the structural-linguistic knowledge necessary to participate in it becomes the first priority for speech-language pathology goal setting. The actual goals have been enriched. Not only are we remediating problems with structure and content but also problems with language use in social interactions.
>
> (McTear & Conti-Ramsden, 1990, p. 202)

Pragmatic theory was used to highlight that the entirety of context, including the socio-cultural reality and ramifications of communication and communication challenges, were relevant during SLT interventions (e.g., Barrow, 2008; Duchan & Black, 2001; Lyon, 2004). When the pragmatics turn happened, it enabled a broader conceptualisation of communication to be imagined. Communication was now related to the process of meaning-making across the entirety of the

[29] This quote comes from one of the earliest clinical textbooks to use the title of clinical pragmatics, within the English language, according to a search on the "Global books in print" database (on 29/05/10) using the terms "clinical" AND "pragmatic". Texts in languages other than English were not included in this search.

client's context, rather than the simplistic encoding and decoding of information. Other arenas (such as self-esteem, community participation, educational inclusion and access to information) which had been traditionally considered as being outside of the purview of the SLT became ripe platforms for couching and mediating SLT intervention. Thus, clinical outcomes broadened in SLT practice, when the importance of context was more fully appreciated in working with communication and communication disorder.

3.1.6 THEORETICAL CONFUSION IN CLINICAL PRAGMATICS

Clinical pragmatics is an evolving field. Despite the changing linguistic landscape from which clinical pragmatics has emerged, there remains an acknowledgement that formal approaches to pragmatics, which view pragmatics as an additional and de-contextualised layer of language skill and/or knowledge, have been clung to within the SLT community (as noted by Duchan, 2000b, 2004). Formalist-inspired, componential approaches to pragmatics which reflect a structural understanding of language continue to preside in much of the literature of clinical pragmatics, in that:

> The modular approach is the most traditional and widely adopted approach to the pragmatics of language....The modular approach has also been adopted in the majority of studies related to pragmatic disability. In essence, a child with primary pragmatic disability shows an intact or less impaired ability to apply to semantic, phonological, syntactic, and morphological rules of a language with significant difficulties in the domains of communicative interaction and discourse rules.
>
> (Verhoeven & van Balkom, 2003, pp. 284-285)

However, formalist-inspired approaches are not the only views of pragmatics evident in the area of clinical pragmatics. The fast paced growth of the field and the divergent paradigms used to approach pragmatics have meant that a general lack of "coherence" has been perceived within the area of clinical pragmatics:

> The study of pragmatics in a speech and language pathology context experienced a considerable rise in interest in the 1980s and 1990s (see e.g. Gallagher and Prutting, Grunwell and James 1989 for earlier contributions to the area). This interest has, at this time, by no means abated (witness recent collection such as Paradis, 1998), despite, or maybe even because of, an often perceived lack of coherence and concentration in both methodology and data analysed.
>
> (Müller, 2000, p. 2)

In light of the absence of an agreed definition of pragmatics and a general consensus on appropriate methodologies within the area of mainstream pragmatics (Müller, 2000; Spencer-

Oatey & Žegarac, 2002), it is perhaps unsurprising that clinical pragmatics is a field which is characterised by clashing perspectives and a lack of unity. This general state of confusion has left practitioners in a compromising position about how their intervention should proceed. Adams (2008) noted that practitioners have responded by being enterprising in their provision of interventions, yet she notes that this "resourceful" approach to pragmatics may result in providing intervention in an atheoretical and resource-led way:

> Practitioners have also been resourceful in the development of intervention programmes (Firth & Venkatesh, 1999; Rinaldi, 2001), which are widely used and which draw on a typology of pragmatic behaviours rather than a theoretical framework....There is, nevertheless, some consensus that therapy is resource-rather than principle-driven due to the research vacuum, and that there is little or no existing guidance to support these decisions.
>
> (Adams, 2008, pp. 191-192)

When looking to define the area of clinical pragmatics, a cacophony of disparate versions of pragmatics appear in the literature. Some authors within the clinical community (such as Perkins below), argue for a broad-based view of pragmatics which attends to a variety of linguistic and non-linguistic phenomena, and which considers all "communicative disorders" as being indicative of the presence of "pragmatic impairment", in that:

> Clinical pragmatics has been a major growth area in clinical linguistics and speech and language pathology over the past two decades. Its scope is vast: if we define pragmatics in broad terms, there are no communicative disorders which do not involve pragmatic impairment at least to some degree.
>
> (Perkins, 2005a, p. 363)

Others within the SLT community have argued for a narrower definition of clinical pragmatics which excludes non-linguistic phenomena. Thus, pragmatics would be seen as part of a speaker's linguistic competence (e.g., Ninio, Snow, Pan & Rollins, 1994). In particular, Cummings (2007a, 2009) has continually called for the SLT community to tighten up their definitions of and approaches to clinical pragmatics, and to restrict their interpretation of clinical pragmatics to linguistic phenomena only.

3.1.7 THE EVOLUTION OF CLINICAL PRAGMATICS: WHERE ARE WE NOW?

The divergent perspectives which evolved following the pragmatics turn have led to an increasingly obvious division within the clinical literature, between those who treat pragmatics as a discrete component of linguistic competence and those who approach pragmatics as an overall

organisational system for language use and meaning-making. In the clinical context, it is apparent that there may be authors who see all aspects of language and communication as being inherently pragmatic (Duchan, 1984; Perkins, 2003, 2005a) and those who view pragmatics in a more limited sense (Cummings, 2007a, 2009).[30]

It would appear that, as Perkins has (2000) noted, in certain corners of the literature of clinical pragmatics notions have been imported directly into clinical practice and research without alteration. In particular, definitions of pragmatics as a component of linguistic theory seem to have been translated into clinical definitions of pragmatics as a single component of the linguistic competence of an individual and correspondingly as a set of visible skills or behaviours.

The clashing perspectives in clinical pragmatics seem to be due, in many respects, to the definitional hangover which has lingered since the 1970s within the disjointed field of mainstream pragmatics. However, members of the SLT community appear to have further muddied the water, by working in a compromised position (i.e., carrying out clinical practice atheoretically because of the lack of firm theoretical grounding available), as noted by Perkins (2005a, 2007), Cummings (2009) and Adams (2008), who has pointed out that:

> Speech and language practitioners, being a dynamic and inventive group, have simply got on with the job of creating therapies that address specific pragmatic problems in the absence of intervention frameworks. To take the example of inference, practitioners talk about "assessing inference," "not being very good at inference," "doing inferences" in therapy. There is an implicit assumption that (a) we all understand what inferences are and (b) it is possible to improve the ability to make inferences during therapy. In reality, inferences are very difficult to identify and subtype, and we have no idea whether inference improves with therapy. By examining these assumptions, there is potential to explore the problems that an absence of theoretical framework brings.
>
> (Adams, 2008, p. 192)

[30] For example of a limited view of pragmatics is noted when particular aspects of communication (such as the role of linguistic phenomena in the recovery of implicature) are understood as being truly pragmatic (as advocated by Cummings, 2007a, 2009), while the usage of extra-linguistic phenomena for communicative purposes is not considered relevant in a discussion of pragmatics.

3.2 CLINICAL PRAGMATICS: SLT ASSESSMENT AND INTERVENTION

3.2.1 SLT ASSESSMENT: AN INTRODUCTION

As previously noted, the assessment of pragmatics is now a "standard part" of SLT practice, as highlighted by both Cummings (2007b, p. 99) and Hewitt (2000a). Prior to moving onto the following discussion, it should perhaps be mentioned that assessment, in general, is considered an integral part of the SLT process of intervention (e.g., Duchan, 2005; Duchan, Maxwell & Kovarsky, 1998). The crucial role of assessment in SLT practice might also be noted from a brief perusal of many of the available SLT textbooks (e.g., Paul, 2007; Shipley & McAfee, 2009).

Assessment, in the context of SLT practice, can occur as a discrete phase[31] or can be woven into the process of intervention in a more continuous fashion (e.g., as a method of monitoring progress). Continuous assessment is advised by many of the more recent texts regarding SLT practice in general (e.g., Bunning, 2004, pp. 11-12; Hasson & Joffe, 2007) and in relation to SLT interventions with particular language impairments or age groups (e.g., Burton & Watkins, 2007; Gutierrez-Clellen, 2000, respectively).

Current clinical guidelines issued by a SLT professional body, from the UK, have linked the rationale of assessment with the process of diagnosis and with the establishment of baselines for planning intervention and gauging progress. As such, it has been suggested that a SLT assessment should aim to generate:

> A complete picture of the individual, their skills (including strengths and weakness), the activities they undertake, and the areas of participation in life that are impaired by their difficulty....A detailed assessment should provide information to enable diagnosis of a speech and language disorder, and to formulate a hypothesis relating to the disorder and its treatment....The assessment should (at least in part) contribute to a measureable baseline for treatment against which the outcome of any intervention can be measured.
>
> (Royal College of Speech and Language Therapists, 2005, pp. 14-15)

Certain characteristics of SLT assessment have been noted. A reliance on standardised formal assessment has been highlighted within the SLT world. This tendency towards using standardised assessments has been described as:

> More the norm than the exception, clinical and research scientists measure children's progress in language intervention either by partially or completely relying on standardised language tests or other scientist-designed measurement tools that examine isolated aspects of language.
>
> (Apel, 1999, p. 100)

[31] Assessment can be carried out as a phase prior to the initiation of intervention and/or a phase which occurs after intervention or before discharge (e.g., Kersner, 2001).

In drawing on assessment for directing intervention, assessments can become a lens through which an individual is viewed and evaluated, in that assessment becomes "a visibility through which one differentiates and judges them" (Foucault, 1979, p. 184). Assessment results often function to highlight the areas in which SLT inputs are needed. Thus, the way assessment is carried out may significantly shape the intervention trajectory, as pointed out by Duchan:

> Interventions goals are likely to differ depending upon the assessment instruments used. Speech-language pathologists and teachers working within different assessment frames will create different kinds of intervention goals. The models most commonly used by speech-language pathologists are linguistic ones, leading to goals formulated as language rules, and information-processing ones, leading to goals that have to do with enhancing identified areas of information processing.
>
> (Duchan, 2004, p. 86)

A representative review of how clinicians have realised the practice of assessment or intervention in the context of clinical pragmatics will not be provided in this section. A complete account of SLT practice in the area of pragmatics is not in line with the overall aim of this thesis (i.e., to shed light on the main concern of the SLT community in the context of clinical pragmatics and SLT practice) and thus this has not been attempted. An introduction via a brief description of the methods and procedures which are available for clinicians to draw on for assessment and intervention in the context of clinical pragmatics will be provided. This is intended to give the reader an introduction to some of the ways in which pragmatics may be approached in a clinical setting.

The resources and tools used within the SLT context to assess pragmatics will be discussed under the three categories, following both Adams (2002) and Cummings (2009), as specified below:

- Formal and standardised assessments or tests
- Non-standardised interview and observational schedules/checklists
- Systems for the analysis or coding of naturalistic and elicited discourse.

These categories are not mutually exclusive. The scarcity of research in the area of clinical pragmatics makes it a challenge to establish from the literature how exactly assessment in the area of clinical pragmatics is carried out within the SLT world. It also makes it difficult to identify pragmatic assessments from other assessments that might be used within the SLT clinic.[32]

[32] For example, Manochiopinig et al.'s (1992) review of "pragmatic" assessments, used in the context of aphasia, included tools which assessed "communication efficiency" even though the authors noted that these assessments focused on language use in activities of daily living rather than examining any specifically pragmatic skills, in the mainstream pragmatics sense (Manochiopinig et al., 1992, pp. 525-526).

3.2.1.1 FORMAL AND STANDARDISED ASSESSMENTS OR TESTS

There are very few published, formal and standardised[33] assessments or tests devoted exclusively to the area of pragmatics available to SLTs.[34] This may be a reflection of the acceptance that the use of formal, structured assessment in the area of pragmatics is inappropriate. The dynamic, contextual influences which are so crucial to pragmatics, as noted in the discussion of definitions of pragmatics in Chapter 2, may not be readily replicated in a standardised testing situation. Consequently, it has been suggested that alternative assessment methods, may be more suitable in the area of clinical pragmatics, so that:

> Although there are tests designed to assess pragmatic skills in children a "test" of pragmatics is almost a contradiction in terms. Since pragmatics involves the use of language for real communication, we really need to assess it in a more naturalistic context, and this implies using criterion references or informal procedures.
>
> (Paul, 2007, p. 364)

The *Test of Pragmatic Language* (TOPL) (Phelps-Terasaki & Phelps-Gunn, 1992a), now in its second edition (Phelps-Terasaki & Phelps-Gunn, 2007), is one of the few formal and standardised assessments currently available which is exclusively devoted to the area of pragmatics (as noted by Adams, 2002, p. 976 and Cummings, 2009, p. 185). The *TOPL-2* can be used with children and adolescents between the ages of 6 and 18 years and it takes 45-60 minutes to administer (Phelps-Terasaki & Phelps-Gunn, 2007).

Administering the *TOPL* involves posing questions to the test taker about situations depicted in pictures. The test taker's responses to these visually and verbally presented test items are then scored as being "correct" or "incorrect", according to the specifications identified by the test.[35] The *TOPL* provides different measures by which the total number of "correct" versus "incorrect" answers given (i.e., the test taker's raw score) can be compared and contrasted to the

---

[33] The term "formal and standardised" is being used with reference to assessment/tests, which are administered in a standard manner and which quantitatively compare an individual's performance and score against a cohort of peers.

[34] However, as this review is not exhaustive, only a selection of the available standardised formal assessments will be discussed in this section. Other standardised assessment tools may be available. For example *The Pragmatic Language Observation Scale* (Newcomer & Hammill, 2009) is an observational schedule which explores pragmatics and offers standardised or normed scores.

[35] For example, as one example of a question used in the course of administering the *TOPL,* the test taker is instructed to show a picture to the test taker, as per the instructions below:
"Hold up Picture #3 and say, Tom was walking with Jill. Tom did not see a big mud puddle at the side of the street. Jill did not want Tom to step in the big mud puddle, what did she say to Tom?" (Phelps-Terasaki & Phelps-Gunn, 1992b, p. 2). The test taker's response is marked as correct, with a score of 1, if they answer as follows: "the response must be a statement of warning. 1-Watch out. Look for the mud puddle. There's a mud puddle; don't step on it" (Phelps-Terasaki & Phelps-Gunn, 1992b, p. 2). The test taker's response is marked with a score of 0 if they answer as follows: "0-don't know. You're walking wrong. Where are you going?" (Phelps-Terasaki & Phelps-Gunn, 1992b, p. 2).

scores of a cohort of children of the same age. The standardised scores provided by the *TOPL* include norm-referenced percentiles, standard scores and age equivalents.

Another frequently cited tool which provides normative data for children between the ages of 4 and 16 years of age is the *Children's Communication Checklist* (CCC-2)[36] (Bishop, 2003a). The *CCC-2* has evolved from earlier versions of checklists, such as *Children's Communication Checklist*, also known as *CCC* (Bishop, 1998) and the *Checklist for Language Impaired Children* (Bishop, 2003b, pp. 24-26). The *CCC-2* is a 70 item checklist which rates the frequency of certain behaviours on ten subscales (Bishop, 2003a).[37] These ten subscales are "speech, syntax, semantics, coherence, inappropriate initiation, stereotyped language, use of context, non-verbal communication, social relations" and "interests" (Bishop, 2003a, p. 11).

The *CCC-2* checklist generates both a "General Communication Composite Score" and a "Social Interaction Deviance Composite Score" (Bishop, 2003a, p. 11). These two compound scores "may be used to identify children likely to have clinically significant communication problems" or "can help identify children with a communicative profile characteristic of autism" respectively (Bishop, 2003a, p. 11).

As the formal and standardised assessments discussed here are descriptive and behavioural, they categorise individuals on the basis of observations and reports of an individual's performance of particular skills or behaviours. Thus, formal and standardised assessments do not explain why a particular pattern of communication is present, but superficially capture a description of the communication behaviours and/or language skills of an individual.

The descriptive nature of many of the available standardised assessments may mean that they are not complete assessments in the sense that they fail to explain why a behaviour is occurring. The *TOPL-2,* for example, provides evidence that a test taker cannot provide "correct" answers to the assessment questions (as specified by the assessment), but it does not provide evidence of why a test taker might be finding the generation of correct answers a challenge. Assessments in the area of clinical pragmatics which focus on description and which neglect to account for underlying contributory factors have been deemed simplistic and inadequate:

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[36] More recently an adult version of this checklist, for use with people between the ages of 17 and 79 years, has become available (Whitehouse & Bishop, 2009).

[37] In administering the *CCC-2*, people who know the child being assessed (for at least 3 months) are asked to decide how well various statements apply to the child according to a frequency judgement of "0= less than once a week (or never), 1= at least once a week, but not every day, 2= once or twice a day, 3= several times (more than twice) a day (or always)" (Bishop, 2003b, p. 3). Examples of the statements found on the assessment checklist include "talks repetitively about things that no-one is interested in....does not look at the person s/he is talking to...is left out of joint activities with other children....stands too close to other people when talking to them." (Bishop, 2003b, p. 2).

> If assessing pragmatics is simply motivated by description of features present it would indeed be a trivial pursuit. The motivation should be the exploration of the underlying reasons for communication failure in children's interactions. It is therefore necessary that assessments are based on strong theoretical positions that allow the assessor to relate communication failures to underlying factors such as cognitive deficits or an inability to employ word knowledge to the act of communication.
>
> (Adams, 2002, p. 974)

Behavioural, descriptive assessments provide limited information about contributory factors or underlying causes of challenges in the area of pragmatics and, as such, they may be of limited value for differentiating between clinical subgroups or for planning intervention (Perkins, 2010). Indeed, the author of the *CCC-2,* and others, have noted that the *CCC-2* has limited use for identification of a "diagnostic answer" in the clinic, but that it may be useful for identifying "discrete" groups in research settings, in that:

> Clinically, the CCC-2 provides information about one of the dimensions that contributes to a child's communicative profile and should be seen as complementing other sources of information rather than as providing the diagnostic answer itself. In research contexts, in might be desirable to divide children into discrete subgroups, and it would be possible to do this using the CCC-2.
>
> (Norbury, Nash, Baird & Bishop, 2004, pp. 361-362)

Formal standardised assessments in clinical pragmatics have been criticised for failing to account for contextual influences on pragmatics. There is a growing recognition that contextual and environmental factors should be considered during SLT intervention in general,[38] and in the area of clinical pragmatics in particular.

As noted in Chapter 2, pragmatics is increasingly being considered as something which is heavily influenced by a myriad of dynamic and interchangeable contextual variables yet standardised tests attempt to neutralise these variables by making them uniform. Thus, despite the benefits of administering standardised and formal assessments, they may not be entirely appropriate in the area of clinical pragmatics:

> Standardised tests are time-efficient and may be effective at separating typically developing children from children with disabilities. Unfortunately, pragmatic skills do not lend themselves to standardised assessment formats. Pragmatic behaviours, by definition, are influenced by contextual and social variables. Formal tests attempt to neutralize these factors by standardizing context to allow reliable comparison of performance to a normative standard.
>
> (Fujiki & Brinton, 2009, p. 412)

[38] For example, it was stressed that an evaluation of "contextual factors", external to the client, should be included during the assessment process in SLT in general, during the discussion of "core clinical guidelines" relevant to all areas of SLT practice (Royal College of Speech & Language Therapists, 2005, pp. 14).

The de-contextualised nature of formal standardised assessments has been suggested by Adams (2002) as one of the reasons why these types of tools, despite their popularity in many other areas of SLT practice (Apel, 1999), have not been developed within the field of clinical pragmatics. The nature of standardised assessments, in terms of the rigidity of administration and scoring they entail in order to achieve valid psychometric scores, may be incompatible with the assessment of pragmatics as a dynamic interface reliant on and responsive to an evolving and epiphenomenal context.

Isolating pragmatics as a definite set of skills and behaviours neglects to fully appreciate the wide palette of contextual variables which influence pragmatics, as noted in many of the functionalist-inspired definitions of pragmatics discussed in Chapter 2. Echoes of formalist-inspired approaches to pragmatics are seen when pragmatic behaviours, skills and knowledge of an individual are considered separate from the context in which they are performed. Bloom and Obler (1998, p. 12) have commented that "one element common to research from a formal perspective is that it places the source of pragmatic disorder within the speaker's language system". Definitions of pragmatics which take a wide view of context, and prioritise contextual variables over structure, assume that influences on the performance of pragmatic behaviours and skills may not be isolable at the level of an individual. Correspondingly, pragmatic performance is considered as a synergistic and distributed property of an interaction, dependent on a variety of skills and parties (e.g., Prutting, 1982), and not readily reducible to set questions with definite answers as some formal and standardised assessments assume.

Formal assessments of pragmatic phenomena have also been critiqued for lacking an appreciation of the "large variations in personal style" that influence how pragmatic behaviours and skills are performed (Adams, 2002, p. 979).

In an effort to control internal validity, standardised assessments may exclude particular individuals from the standardisation process (e.g., those with co-morbid conditions or individuals who are bilingual). However, these efforts at maintaining high levels of internal validity often reduce external validity, in that the standardised scores produced are valid for only a certain segment of the general population (Dollaghan, 2007). Standardised assessments may also be "normed" on populations which differ in nationality and culture from the target population. In smaller countries (such as Ireland) many of the assessments available to the SLT community provide norms which have been developed from larger populations, such as those in the UK and USA (e.g., *Clinical Evaluation of Language Fundamentals-4* or *CELF-4*) (Semel, Wiig & Secord, 2003a). Disparity between the population on which a standardised assessment has based its scores and the individual with whom an assessment is being used may make it inappropriate to consider such standardised scores as being valid.

Debates continue regarding how amenable the area of clinical pragmatics is to formal and standardised testing, although the sway of the debate appears to rest with the notion that standardised assessment procedures are not suitable as complete assessments in the realm of clinical pragmatics. Cummings (2009, p. 185) points out that: "Little test development has occurred because of the wide-spread view that few aspects of pragmatics permit of [sic] formal testing." However, Adams (2002, p. 973) has highlighted that particular aspects of clinical pragmatics, such as "the assessment of the comprehension of pragmatic intent" may be suitably assessed, using formal and standardised assessment procedures.

3.2.1.2 NON-STANDARDISED INTERVIEW SCHEDULES AND OBSERVATIONAL CHECKLISTS

In comparison to the availability standardised formal assessments, as discussed above, the types of assessments discussed in this section are more plentiful in number (Adams, 2002; Cummings, 2009). Included in this category of SLT assessments are checklists and profiles which are completed live during a structured interview with an individual or someone who knows the individual being assessed. Alternatively, some of these tools function as a schedule which structures a live or recorded observation of an individual. The interview schedules and observational checklists discussed here do not provide standardised scores and are usually criterion referenced or qualitatively analysed. Interview schedules and observational checklists are typically completed by the people who know or work with an individual (such as teachers, parents and other professionals). However, some self-rating checklists do also exist.[39]

The person who completes the interview schedule or observational checklists is often placed in the position of evaluating or rating a variety of phenomena relevant to a client's communication skill or the communicative context in which these skills are used. As discussed by Manochiopinig, Sheard and Reed (1992), some of these tools aim to evaluate specific pragmatic behaviours or certain pragmatic skills, while others ask the examiner to make an overall global judgement about the client's combined use of a number of skills. Global evaluations can include measurements of overall communicative efficiency or functionality in particular situations.[40]

One example of a prominent observational checklist (Cummings, 2009) is the *Pragmatics Protocol* (Prutting & Kirchner, 1987). This checklist explores thirty variables or parameters (such as

[39] Examples of self-rating checklists can be found in *Socially Speaking* (Schroeder, 1996), *Talkabout* (Kelly, 2001) and the *Social Use of Language Programme* (Rinaldi, 1992b). These resources contain interview schedules which facilitate an individual in self-rating their own language and communication skills. A "self report" version of the *Pragmatics Profile* also exists (Dewart & Summers, 1996b).

[40] For example, measurements of overall communicative efficiency or functionality, such as "Communicating physical problems such as aches and pains...Participating in a conversation with strangers" and "Describing or discussing something in depth" are included as some of the global evaluations rated using *The Communicative Effectiveness Index* (Lomas et al., 1989, p. 124).

"variety of speech acts...vocal quality...body posture") which are divided into the categories of "verbal, paralinguistic" and "non-verbal" (Prutting & Kirchner, 1987, p. 117). The rater is asked to make appropriacy judgements, about how certain skills and patterns of conversational behaviour are performed by the client, by evaluating each one of the thirty parameters as being "appropriate, inappropriate" or noting that there was "no opportunity to observe" (Prutting & Kirchner, 1987, p. 117). Each parameter is evaluated, dependent on how the rater thinks a client's enactment of a particular parameter facilitated or impeded the interaction.

The *Pragmatics Profile* (Dewart & Summers, 1995a) is an interview schedule which is used to structure an informal interview with parents and/or teachers about the communicative behaviours of children. Two different interview schedules are available for use dependent on the age of the child, i.e. one for preschool children (Dewart & Summers, 1995c) and one for children between the ages of 5 to 10 years (Dewart & Summers, 1995b). There are adult versions of this assessment also available (Dewart & Summers, 1996a, 1996b). The examples below are taken from the *Pragmatics Profile* interview schedule developed for use with school-aged children between the ages of 5 to 10 years of age (Dewart & Summers, 1995b).

The first section of the *Pragmatics Profile* examines "Communicative Functions" and contains questions which relate to the form and function of communicative behaviours used by the child (Dewart & Summers, 1995b, pp. 1-4).[41] In the second section, the interviewer asks about how a child responds to a variety of communicative forms and functions. Exploring how a child responds when an interactant attempts to gain a child's attention, make requests, uses idioms or sarcasm and so on is probed in this second section of the *Pragmatics Profile* (Dewart & Summers, 1995b, pp. 4-7).[42] The third section of this interview investigates interactional and conversational style and aims to uncover how a child typically interacts by exploring how a child initiates, joins in, repairs and terminates a conversation (Dewart & Summers, 1995b, pp. 7-9).[43] The final section namely "Contextual variation", focuses the interview on how a child's communication varies with time, topic, situation and partner (Dewart & Summers, 1995b, pp. 9-12).[44]

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[41] The first section of the *Pragmatics Profile* explores the way a child expresses "a range of intentions, such as requesting, greeting and giving information, through a variety of communicative behaviours, such as gesture, vocalisation and language" (Dewart & Summers, 1995a, p. 5)

[42] For example, in using the *Pragmatics Profile* in exploring how a child responds to idioms, the interviewer asks: "If you use an expression, such as 'keep your hair on' or 'wipe that smile off your face', does (child's name) ever have difficulty? How does (he/she) react?" (Dewart & Summers, 1995b, p. 5).

[43] For example, in the *Pragmatics Profile* in investigating the area of: "Terminating a conversation", the interviewer asks, "How does a conversation with (*child's name*) generally end?" (Dewart & Summers, 1995b, p. 9).

[44] For example, in exploring how the "topic" of conversation influences the communicative behaviour of the child, the interviewer using the *Pragmatics Profile* asks: "What things does (*child's name*) like to talk about?" (Dewart & Summers, 1995b, p. 10)

The *Pragmatics Profile* provides prompts for each question on the interview schedule, for use when an interviewee has difficulty in generating a response. As such, there may be the chance that interviewees are led in providing particular answers, although the authors stress that prompts are to be used only when the interviewee is finding generating a response challenging.[45] The *Pragmatics Profile* interview is not advocated for use as a complete assessment, but is just "one person's perceptions" and it is suggested that other data is used to "validate" the data collected when using this tool (Dewart & Summers, 1995a p. 15).

Another more recent example of a observational checklist is *The Pragmatics Profile*, which is included as an additional subtest on the fourth edition of *CELF* (Semel, Wiig & Secord, 2003a). This is the first time that a section exclusively addressing pragmatics has appeared on this popular children's assessment.

The use of individual profiling, as opposed to standardised assessment, has been advocated in SLT practice in general (Crystal, 1989; Joffe, Cruice & Chiat, 2008), and in the area of clinical pragmatics in particular (e.g., Conti-Ramsden, Crutchley & Botting, 1997). Non-standardised assessments have been praised as methods which enable clinicians to explore pragmatics in contextualised and ecologically valid ways, in that they allow for "describing performance in the context of real-world settings and activities, and exploring the effects of systematic changes in communication and cognitive demands and partner supports" (Coelho, Ylvisaker & Torstar, 2005, p. 223).

It has been noted that concepts from mainstream pragmatics were not developed for clinical use and that their "wholesale importation...direct and unmodified application" in clinical settings can be problematic (Perkins, 2000, pp. 8-9). Many of the checklists and observational tools available to the SLT community draw heavily on concepts from the area of mainstream pragmatics which are descriptive rather than explanatory.[46] The descriptive nature of some of the evaluations made by using these observational checklists and profiles means that test takers may be evaluated with regards to the superficial performance or enactment of behaviours. For example, the presence or absence of behaviours such as "compliance with social conventions" (Dewart & Summers, 1995b, p. 12), and "student avoids use of repetitive/redundant information" (Semel, Wiig & Secord, 2003b, p. 22) are evaluated on particular assessments. Perkins (2005b) has stressed that concepts from mainstream pragmatics cannot presently be used to explain the

[45] For example, the following prompts are suggested for use if the interviewee is unable to self-generate answers to the question of "If people are having a conversation, how does (child's name) try to join in?....Examples: Hovers nearby until included, will contribute to the discussion, will try to interrupt when someone else is speaking, tries to switch the topic to something that interests him/her and doesn't try to join in" (Dewart & Summers, 1995b, p. 9).

[46] Following Perkins (2005b, p. 369), the term "descriptive" is used to refer to surface rather than explanatory accounts of a behaviour.

causal and contributory factors which result in challenges in the area of pragmatics. Thus, the descriptive rather than explanatory nature of pragmatics notions, from mainstream pragmatics, has been used to suggest that pragmatics notions, as they stand, may be "rarely adequate" for intervention planning (Perkins, 2005b, p. 369).

Correspondingly, descriptive taxonomies, such as observational checklists, may not be particularly suitable for classification in the area of clinical pragmatics, as they do little to explain the underlying contributory factors and causes of difficulties. There are likely to be multiple, and even mutually exclusive, underlying factors contributing to many of the behaviours taken as being indicative of PLI and cognate terms.[47]

> Pragmatic Impairment is a term used in connection with individuals who experience difficulties with language use. Rather than referring to a straightforward, unitary disorder, this single label is in fact an umbrella term applied to a wide range of disparate phenomena with no single underlying cause.
>
> (Perkins, 2010, p. 227)

The lack of flexibility, in terms of being able to assign weight or priority to different phenomena as being more or less relevant in an individual's particular case, has also been noted as a concern with regard to the use of observational checklists in the area of clinical pragmatics (Ball, 2000). There may be an assumption made through the use of checklists of discrete behaviours, that pragmatics can be equated with a definite set of skills which are relatively stable in their presentation and unwavering in their relevance to different contexts. This stability seems unlikely, given the highly contextualised nature of pragmatics as discussed in Chapter 2.

The manner in which theory has been translated directly, with little or no modification, from the world of mainstream pragmatics into clinical pragmatics is particularly noticeable in some checklist and observational profiling tools. For example, Roth and Spekman (1984a, 1984b) have presented an "organizational framework for the assessment of pragmatic abilities in children" which proposed the assessment of pragmatics via an "examination of *communicative intentions....presupposition*" and also the "*social organization of discourse*" (Roth & Spekman, 1984a, p. 2). The authors are clear about the purpose of this framework, "it is our intention that this assessment framework be viewed as an extension of existing diagnostic models" (Roth & Spekman, 1984a, p. 2). Their two well known papers followed on from the framework outlined in an earlier publication (Spekman & Roth, 1982) which was directly founded on concepts and

[47] More generally, concerns have emerged about the use of any assessment in the clinical context which attempts to measure variables or identify difficulties at a behavioural level only (Law & Garrett, 2004).

constructs from the area of mainstream pragmatics.[48] Roth and Spekman's (1984a, 1984b) assessment framework has influenced the literature of clinical pragmatics. For example, although not explicitly referencing Roth and Spekman, Lees and Urwin (1997, pp. 65-66) provide a "checklist of pragmatic abilities" which they suggest could be used as "a framework within which to evaluate the language-impaired child's pragmatic abilities" that examines the areas (as highlighted in Roth and Spekman's 1984a, 1984b framework) of "range of communicative intents....organisation of discourse" and "presupposition".

As well as critiques about the way in which pragmatic theory has been applied in clinical practice, without alteration or amendment (Perkins, 2000), concerns have also been voiced regarding the ways in which some of the available checklist and observational tools group concepts from the area of mainstream pragmatics. Perkins (2007, p. 8) has been critical of how pragmatics notions are mixed in a theoretically incompatible manner. This mixture of pragmatic notions can blur the boundaries between different theories from the area of mainstream pragmatics and produce clinical tools which "are constructed around an eclectic set of items drawn from a range of sources where theoretical consistency is scarified for comprehensiveness". The idea that pragmatics can be viewed as a standard component of linguistic theory complements an assumption that pragmatics can be assessed via a checklist of relatively static and de-contextualised behaviours. Checklists often contain a set list of predetermined phenomena to be assessed, but the meaningfulness of these criteria through which pragmatics is considered in the SLT clinic is not always apparent as Hyter points out:

> An underlying assumption of these checklist and observational protocols appears to be that there are specific pragmatic behaviours...that are produced by an individual in relationship with another (or others) and that the identification and categorisation of these intentions can provide meaningful information....counting and categorising pragmatic behaviours may not provide sufficient information regarding communicators' strengths and needs.
>
> (Hyter, 2007, p. 131)

The subjective nature of clinical evaluations has also been highlighted as a concern when pragmatics is evaluated via the use of an interview schedule or observational checklist as the "acceptability or otherwise of a particular pragmatic behaviour is not so clear-cut, and may depend on the assessor, or the delicacy of the scoring mechanism...affecting the usefulness of the profile as a diagnostic tool and guide for intervention" (Ball, 2000, p. 91). Thus, subjectivity

[48] Much of Roth and Spekman's (1984a, 1984b) assessment framework appears to be founded on theory from the area of mainstream pragmatics. For example, Spekman and Roth (1982, p. 430) outline how the "communicative intention" parameter of their assessment framework draws on the work of Austin (1962) and Searle (1969).

confounds the reliability of the evaluations made in the area of clinical pragmatics. Appraisals of appropriacy may often be open to multiple interpretations, so that "the remaining problem with appropriacy judgements is that they are subjective and therefore influenced by the way in which the assessor construes the world" (Adams, 2002, p. 983). The issue of subjectivity may also have contributed to the disparate ways in which pragmatics notions are used across the literature of clinical pragmatics (Perkins, 2007).

3.2.1.3 SYSTEMS FOR THE ANALYSIS OR CODING OF DISCOURSE

Discourse has a broad frame of reference relating to both the process and product[49] of language use "above and beyond the sentence" (Schiffrin, Tannen & Hamilton, 2001, p. 1).

The analysis of discourse in clinical situations appears to predominately draw on theories from the areas of Conversation Analysis (CA) and Discourse Analysis (DA).[50] Different types of discourse have been utilised as data for clinical assessment. DA can be used to explore a variety of different types of discourse. Conversation, narrative, descriptive and procedural discourse appear to be among the most commonly cited genres of discourse which are examined in clinical settings (Cummings, 2009). However, a "great variability within such genres" has been highlighted questioning the validity of this division (Body & Perkins, 1998, p. 963).[51]

Some have suggested alternative divisions between "conversational" (or interactive) discourse and "monological" discourse[52] as a useful distinction for describing the different genres of discourse for the purpose of SLT assessment and intervention (as in, for example, Coelho, 2007). Although, theoretically, it has also been argued that all discourse is in some sense interactive as it is created and expressed with a reader or listener in mind, even if listener or speaker is the self, as Bakhtin (1986, p. 125) has noted "Dialogic relations are thus much broader than dialogic speech in the narrow sense of the word. And dialogic relations are always present, even among profoundly monological speech works."

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[49] This duality of discourse is explicated by Müller et al., (2008, p. 3) as, "The Latin word *discursus*, which became 'discourse' in English (Onions, 1966, p. 272), means 'running to and fro'....Thus, within disciplines that deal with human language, speech and communication, can be understood, in the widest sense, as both the process of running to and fro, an exchange, between a human being and his or her environment, and the products arising from such exchanges".

[50] Some authors consider CA to be subsumed within the broad field of DA (e.g., Cameron, 2001), while others see CA as a field in its own right.

[51] Additionally, it has also been noted that the categorisation of discourse into genres or types, such as "narrative, procedural, descriptive" may be somewhat arbitrary as discourse types and genres are not mutually exclusive. For example, a descriptive segment of discourse may also contain narrative and procedural elements. However, this type of classification (i.e., dividing discourse into genres of descriptive, narrative, procedural, persuasive, expository and conversational) has been suggested to serve some useful functions in clinical contexts (Müller et al., 2008).

[52] "Conversational discourse" is used with reference to interactive forms of discourse, while "monological discourse" refers to non-interactive discourse, which might be elicited, for example, via picture description tasks, or by requesting that an individual retell a story or describe a procedure (Coelho, 2007).

The analysis of discourse is a widely endorsed method of assessment in the context of pragmatics, across a wide variety of clinical populations (Bloch & Beeke, 2008; Boles, 1998; Brinton & Fujiki, 2003). It has been suggested that the analysis of discourse, such as narrative, may be a particularly effective way of exploring language as it is used in day-to-day life "where the performance [of the client] would bear some relation to communication in the outside world" (Body & Perkins, 2004, p. 721) [Words in brackets have been added]. As such, utilising DA within clinical settings has been posited as being more revealing than the use of other forms of assessment, such as formal standardised testing, alone (Beeke, Wilkinson & Maxim, 2003; Ulatowska & Olness, 2007)

Conversation Analysis (CA) is one framework in which clinical approaches to discourse may be embedded. CA emerged from anthropological and sociological explorations into language use and principally developed from the work of Harvey Sacks and his colleagues (Sacks, Schegloff & Jefferson, 1974; Schegloff, 2007; Schegloff, Jefferson & Sacks, 1977). CA specifically explores how talk is managed collaboratively and locally by all participants in an interaction. The structural and sequential management of talk in interaction,[53] rather than the identification of a pre-specified linguistic impairment, is the focus of CA. Thus, when applied to the clinical setting, CA does not automatically presume that the impairment is problematic or a source of conversational trouble:

> CA like pragmatics, considers language use in context, but it differs from other analytical frameworks because the clinician is not making interpretations about how an aspect of language should be coded or judging whether an utterance is successful or adequate in terms of communication.
>
> (Beeke, Maxim & Wilkinson, 2007, p. 136)

There are now examples of commercially available assessments for clinical use which draw on CA as their analytic framework. Two examples will be discussed below, *CAPPA* or *Conversation Analysis Profile for People with Aphasia* authored by Whitworth, Perkins & Lesser, (1997a) and SPPARC, also known as *Supporting Partners of People with Aphasia in Relationships and Conversation* (Lock, Wilkinson & Byran, 2001).

Administering the *CAPPA* involves the clinician carrying out a structured interview with the person with aphasia and/or with a significant conversational partner. These interviews explore various conversational behaviours under the headings of "linguistic abilities, repair, initiation and turn taking, topic management, pre- and post-morbid communication style" and "opportunities" in relation to the person with aphasia (Whitworth, Perkins & Lesser, 1997a, pp.

[53] The terms "talk in interaction" and "discourse" will be used synonymously for the sake of simplicity, although both terms can evoke different theoretical affiliations and traditions.

14-18). To complete the *CAPPA* fully, the clinician must also analyse a 10-minute sample of conversation along the guidelines specified by the resource. The aim of this assessment is to expose strategies which facilitate conversation and those which do not.

The assessment carried out when using the *SPPARC* programme involves a CA-based analysis of a videotaped sample of conversation. The focus of analysis is on three areas in conversation; "trouble and repair, turns and sequences" as well as "topic and overall conversation" (Lock et al., 2001, p. 41). The clinician uses an analysis form to evaluate 19 pre-specified conversational behaviours, in order to define the conversational patterns of the couple and to generate recommendations for a conversational training programme.

Another avenue for analysing discourse in clinical situations is to draw on theory more generally from the area of DA. As noted previously, DA explores discourse at various levels or units of analysis. Different concepts from DA are germane to different levels of discourse. Discourse can be explored at a microlinguistic (i.e., within sentence level), microstructural (i.e., the analysis of phenomena across sentences) and at a macrostructural and/or superstructural level (Coelho, 2007). Broadly speaking, macrostructural analysis explores the overall "global semantic content" or the overarching topic of a piece of discourse (van Dijk & Kintsch, 1983, p. 194). Superstructural level analysis focuses on exploring the organisation of content or information within the discourse (e.g., narrative schema[54] or argumentative schema as pointed out by Cummings, 2009).

The terms which refer to different levels of discourse are used disparately in the literature of clinical pragmatics. For example, the terms macrostructural and superstructural appear to be used somewhat interchangeably. While once these terms were used to refer to text processing levels outside of clinical studies and possessed strong theoretical affiliations, they tend to be used more "neutrally" within the literature of clinical pragmatics (Müller et al., 2008).

Different concepts from the area of mainstream pragmatics have been used to analyse different levels of discourse clinically. For example, Halliday and Hasan's (1976) cohesive ties[55] have been used as methods of evaluating cohesion at the microstructural level of discourse (as in Craig & Evans, 1993). A further example is analysis of the level of narrative superstructure using Labov's (1972) high point analysis (as in Rollins, 2000).

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[54] For example, the regularities evident in the internal structure of narratives have been called "story grammars" (Stein & Glenn, 1979) and these grammars or schema for story structure can be analysed at a superstuctural level.

[55] Halliday & Hasan (1976, pp. 333-339) noted that cohesion can be achieved via the use of "cohesive ties" which fall into the following categories: Reference, conjunction, substitution, lexical relations, ellipsis and repetition.

The analysis of narrative discourse has become increasingly prominent as a tool in clinical settings (Botting, 2002; Boudreau, 2008; Johnston, 2008). Narrative ability has been assessed clinically along the dimensions of content and manner (Bliss & McCabe, 2008; Bliss, McCabe & Miranda, 1998) and also for structure (Rollins, 2000). Narrative skills have also become a platform from which particular patterns of impairment can be identified. For example, certain narrative structures (e.g., presenting elements of a story out of sequence as a "leap-frogging narrative") have been linked with the presence of language impairment (Miranda, McCabe & Bliss, 1998 p. 654). The presence of tense making errors, shorter story length and a lack of story organisation in narratives have been tentatively suggested as useful in distinguishing children with and without SLI (Botting, 2002). Particular patterns of narrative production have also been associated with particular diagnoses, such as Down Syndrome (Boudreau & Chapman, 2000).

Despite a general consensus about the usefulness of narrative as a clinical tool (Johnston, 2008), the personal and cultural variation of narrative skills has been strongly stressed (Bliss & McCabe, 2008; Rollins, 2000). "Wide variations in narrative performance" within groups of children who are "typically developing" have been noted (Norbury & Bishop, 2003, p. 310). The natural variation of narrative produced by individuals may have ramifications for using standardised scores in assessment of narrative, as is the practice when administering certain narrative assessments such as *The Bus Story Test* (Renfrew, 1997).

The analysis and coding of discourse may require a considerable investment of clinical time, due to the lengthy process of transcription that is involved in this type of analysis (Cummings, 2009). Others have highlighted how tools drawing on the areas of DA and CA have been developed to meet the needs and profiles of particular communication disorders only, which precludes their more general use with other populations (Body & Perkins, 2004).

The use of concepts outside of the theoretical frameworks in which they were developed, has also been noted as resulting in the dilution and oversimplification of some of the concepts from the area of DA (Müller et al., 2008). The use of concepts from the areas of DA and CA in a prescriptive way in clinical settings has resulted in the pathologisation of certain discourse patterns. Body and Perkins (2004, p. 709) have discussed how the notion of story grammar has been used clinically with an "assumption that stories that do not adhere to this structure are in some way 'underdeveloped' or simply incorrect, is the basis on which the application of story grammar theory to the investigation of disordered discourse is founded". The proclivity of SLTs to focus their assessment on patterns of deficit is, however, not something which is unique to situations in which DA and CA are applied to communication disorder in that:

> Language samples and standardized tests are designed to reveal deficits....Pragmatics approaches have also been cast within the pathology framework. Pragmatics deficits are found, and therapies are designed to fix them. Children are evaluated, for example, for whether they can express the expected number and types of communicative intents and, if they do not meet the criterion of expectation, they are enrolled in intervention programs for remediate their pragmatic deficits.
>
> (Duchan, 1997, p. 2)

3.2.1.4 SUMMARY: SLT ASSESSMENT

As noted previously, assessment is a crucial aspect of SLT practice and often directs the consequent intervention. The process of assessment is confounded by the lack of consensus about how best to assess pragmatics in the SLT clinic and the theoretical eclecticism underpinning the approaches and tools used for assessment (Perkins, 2007). The development of assessment tools outside of explicit theoretical frameworks has also contributed to concerns that clinicians' subjective opinions are being used to evaluate the client (Ball, 2000; Ball, Davies, Duckworth & Middlehurst, 1991). The appropriacy of subjective versus objective evaluations being used in assessment is a contentious issue that is embedded within much larger epistemological debates about the kinds of evidence that should qualify as evidence in clinical practice (e.g., Kovarsky, 2008). This debate will be explored in greater detail in Chapter 10.

3.2.2 SLT INTERVENTION: AN INTRODUCTION

As with the brief review of assessment in the area of clinical pragmatics, this review of SLT interventions in the area of clinical pragmatics will not be exhaustive. As noted previously, SLT intervention in the area of clinical pragmatics is not particularly well charted or mapped (Müller, 2000). Despite the lack of theoretical acuity in the field of clinical pragmatics (Cummings, 2007a), there is a growing selection of resources and tools which are commercially available to the Speech and Language Therapist which purport to focus on the area of clinical pragmatics (as noted by Adams, Baxendale, Lloyd & Aldred, 2005).

The lack of theoretical development in the area of clinical pragmatics presents a challenge for clinicians when it comes to devising intervention. Interventions have developed from the ground up, in a practice-led manner, in that interventions in clinical pragmatics tend to be "resource rather than principle driven, due to the research vacuum" (Adams et al., 2005, p. 229). SLT Intervention in the area of clinical pragmatics has been described as being "eclectic" and guided by a clinician's experience and exposure to resources and intervention methods, rather than external evidence, as Cummings suggested:

> An equally eclectic group of techniques is used in the intervention or treatment of pragmatic disorders. These techniques often reflect the particular experience of a clinician and the availability of resources. Certainly, few of these techniques have been the subject of efficacy studies. There is a very important sense, therefore, in which most interventions of pragmatics lack the type of clinical evaluation that we have come to expect of interventions in areas such as phonology and syntax.
>
> (Cummings, 2009, p. 177)

As noted previously, in Section 3.2.1, the descriptive nature of many of the constructs from mainstream pragmatics means that they may not always offer explanation of pragmatic phenomena. Thus, there may not be the relevant theoretical foundations in the literature to guide the planning of intervention, as Perkins has pointed out:

> ...although theories of pragmatics provide a means of *describing* pragmatic impairments, the level of *explanation* they afford is rarely adequate for clinicians, in that it does not translate easily into clinical intervention. For example...the child might be *described* as breaking Grice's maxims...but such descriptive labels do not get us very far when trying to design a remedial programme. One can hardly tell the child to "stop breaking Grice's maxims!"
>
> (Perkins, 2005b, p. 369)[56]

Cummings (2009), who has provided one of the most recent overviews of assessment and interventions in the area of clinical pragmatics, has noted how SLT intervention in the area of pragmatics can be both indirect (consisting of advice giving sessions with parents to support them in facilitating their child's language development) and direct.[57] SLT intervention has been traditionally orientated towards providing intervention by "intervening directly with the intrinsic aspects of their clients' communication deficits" until relatively recently (Graves, 2007, p. 104). Working directly with individual clients, or small groups of clients, and focusing on the

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[56] Grice's conversational "maxims" were developed from his theory of Conversational Implicature in which he proposed that communicative behaviours are inherently rational and co-operative. Grice's theory of conversational implicature is based on one super-ordinate Cooperative Principle, which is "make your contribution such as is required, at the stage at which it occurs by the accepted purpose of the talk exchange in which you are engaged" (Grice, 1975, p. 47). The Cooperative Principle was divided into four sub principles or maxims which Grice posited that all conversationalists follow (i.e., the maxims of quality, quantity, relation and manner).

[57] The term "direct intervention" has been used to describe therapy which is carried out by the SLT, while the term "indirect intervention" describes a mode of SLT intervention in which therapy is carried out by other parties (such as a SLT assistant, Special Needs Assistant or Parent), following training and guidance from a Speech and Language Therapist. For example, Boyle, McCartney, O'Hare, and Forbes (2009) used the term direct therapy to apply to situations in which the Speech and Language Therapist mediated intervention, while indirect therapy was used with reference to situations in which a SLT assistant provided intervention under the guidance of a Speech and Language Therapist. Direct interventions, in the area of clinical pragmatics, have been discussed as predominantly focused on the areas of "Conversation skills....Social communication....Pragmatic skills training" and "Teaching Theory of Mind" (Cummings, 2009, pp. 195-209).

development of the client's intrinsic skills has been characteristic of the traditional delivery of SLT input (Duchan, 2004).

However, the contextual and intra-personal influences on pragmatics, which have been referred to in many of the definitions of pragmatics discussed in Chapters 2, entail that interventions may need to focus on more than an individual's intrinsic competencies (such as a client's knolwedge, skills and behaviours) and may need to explore the context in which these competencies are constructed. According to Owens (2004), a decreased acceptance of formal definitions of pragmatics has caused a shift in the focus of SLT interventions, towards context.

> The formalist model has been replaced by one in which pragmatics is the overall organising framework. Increasingly, SLPs are recognising that structure and content are influenced heavily by the conversational constraints of the communication context.
>
> This view of language necessitates a very different approach to language intervention. In effect, intervention has moved from an *entity approach*, which targets discrete bits of language, to *systems or holistic approach* which targets language within the overall communication process (Norris & Hoffman, 1990a). The major implication is a change in both the target and the methods of training. If as formalists contend, pragmatics is just one of five equal aspects of language, then it offers yet another set of rules for training....In contrast, an approach in which pragmatics is the organising aspect of language necessitates a more interactive conversational training approach.
>
> (Owens, 2004, pp. 8)

In light of the influence of contextual variables in definitions of pragmatics, both within the literature of mainstream and clinical pragmatics, one might correspondingly expect contextual variables to be a significant focus of SLT interventions in the area of pragmatics. This is however not entirely the case as highlighted in a discussion regarding how intervention resources, available in the area of clinical pragmatics, are orientated towards the promotion of intrinsic linguistic skills:

> Despite the lack of an evidence base, a range of therapeutic materials is readily available for use in pragmatics therapy. Many published resources focus on developing formal linguistic aspects of pragmatics instruction such as use of register and speech acts....
>
> (Adams et al., 2005, p. 229)

As already noted in this chapter, SLT intervention in the area of pragmatics may be lacking in terms of a firm theoretical grounding. Consequently this brief outline of SLT intervention will employ superficial "topics" in order to discuss SLT intervention in the area of clinical pragmatics, namely:

- Social communication skills
- Conversational skills
- Discourse and narrative
- Higher level language

3.2.2.1 SOCIAL COMMUNICATION SKILLS

While pragmatics is often used interchangeably with terms such as social communication skills, there remains a lack of consensus about the nature of the relationship between pragmatics and social communication skills, as noted by Cummings (2009). Social communication skills[58] is an umbrella term which pertains to a wide variety of phenomena. It has been noted that there is currently a significant interest in social communication skills as is reflected in their inclusion as part of the clinical and educational programmes offered in many different settings (Adams, 2008).

The popularity of social communication skills training is also suggested by the broad array of disciplines who attend to social communication skills in their work, including for example those who work in educational settings (as noted in the quote below) and also those professionals working in the areas of Psychiatry (Wallace, 1998), Occupational Therapy (Gol & Jarus, 2005; Tsang & Pearson, 2001) and Social Work (De Mey, Coussee, Vandenbroeck & Bouverne-De Bie, 2009). The role of the Speech and Language Therapist in social communication skills training and the precarious evidence of effectiveness in this area have been noted:

> Social skills training are now the intervention norm in educational settings in the United Kingdom for children with such conditions [social communication difficulties or ASD] and is frequently supported by the speech and language therapist within a consultant model....Alarmingly, social skills training is being increasingly rolled out with inappropriate assumptions made about the effectiveness of this training for many groups of children. The merit of social skills training as a blanket approach to remediation of social communication disorders in children may, therefore be especially suspect. The rationale of social skills training as promoting "performance" of communicative acts is far removed from the development within the child of an understanding of, and reflection upon, the complex rules of language and social interaction.
>
> (Adams, 2008, p. 192-193)
> [Words in brackets have been added]

As an example, one intervention framework focused on social communication skills will be discussed below. Adams (2005, 2008) has recently developed a framework for intervention in which pragmatics becomes subsumed as one of many "social communication" skills which might require attention during intervention. Within this approach to intervention, social communication is seen as "the interdependence of social interaction, social cognition, pragmatics and language processing" (Adams, 2005, p. 181). This intervention approach identifies different priorities for each individual based on individual strengths and weakness across these areas in order to generate a programme of intervention.

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[58] The term social communication skills and social skills are often used interchangeably in the literature and here the term social communication skills will be used to refer to both.

A broad overview of the types of activities carried out in intervention is provided in Adams and colleagues' (2005) descriptions of two case studies with children who have been described as having Pragmatic Language Impairment (Adams et al., 2005) and with children who were described as presenting with more generalised "interpersonal communication problems" (Adams, 2005, p. 181). In these case studies, intervention was focused in part on "communication adaptation" that involved working to modify environmental variables, such as conversational styles of interaction partners (Adams et al., 2005, p. 233). "Social cognition" aspects of the intervention programme consisted of direct work with the children in question on "developing empathy....understanding emotions" using visual supports (such as employing cartoon stories and scripts to learn about emotions and events) and also by having an adult label the child's emotions and explicate idioms and metaphors to the child in literal terms (Adams et al., 2005, pp. 233-234). The "language pragmatics therapy" aspect of the social communication approach focused on "explicit exercise and classroom support in exchange structure, turn-taking, topic management, conversational skills" (Adams et al., 2005, p. 234).

3.2.2.2 CONVERSATIONAL SKILLS

Conversational skills and social communication skills are often positioned as skills which are associated in a super- or sub-ordinate relationship (i.e., conversational skills are a subset of social communication skills, or vice versa).[59] Intervention focusing on social and conversational skills often co-occurs. Conversational skills training has been noted as being a ubiquitous characteristic of "pragmatic" intervention in that: "Remediation of conversation skills is typically part of most pragmatic language interventions." (Cummings, 2009, p. 197)

Broadly speaking, two theoretical underpinnings of intervention focusing on conversational skills are evident in the literature. Intervention focusing on conversational skills has drawn on the behaviourist tradition, in which language use is treated like any other behaviour, and as such intervention techniques are based on the assumption that "learning takes place when association between stimuli and responses are built up via conditioning" (Hewitt, 2000b, p. 189). Resultantly, it is believed that an individual will learn to pair the surface grammatical construction (for example, of how to greet a stranger or give a compliment) with the settings and situations in which they are appropriate for use. Correspondingly, conversational skills can be taught "within a behaviourist model...with a rationale based on modelling and reinforcement of the performance of specific social communicative acts, such as 'greetings' and..." (Adams, 2008, p. 192-193).

[59] For example, the *Talkabout* resource is subtitled as a "social communication skills package" and includes a section (Kelly, 2001 pp. 103-129) which describes its aim as "to explore and improve conversational skills".

In order to provide intervention, conversation is often broken down into constituent parts. Conversation may be deconstructed as, for example, "poor listening....good listening...poor turn taking...good turn taking...asking questions badly...asking questions well...be relevant" (Kelly, 2001, p. 103). Breaking down conversation into component parts assumes that these isolated behaviours can be taught as separate skills and eventually be assimilated and used together. The old adage, of practice makes perfect, can also be seen to resound throughout many of the activities advocated in conversational skills programmes (e.g., Schroeder, 1996). Clients are often exposed repeatedly during intervention to situations in which a particular subset of behaviours and skills are elicited, and then clients are supported to repeat targeted skills and behaviours until they have learned how to perform them to certain specifications.

Certain conversational skills may also be elicited and practised in mock situations in which the clinician and client assume pretend roles. For example, in the *Social Use of Language Programme*, one activity advocated in this resource (called "simulating social contexts") involves "setting up social contexts in the classroom/clinic setting" (Rinaldi, 1992b, p. 49). The client is asked to perform particular skills and to pretend that they are in certain hypothetical situations, so that a child is asked to pretend to be in "the post office" and "asking for directions" in role play with the therapist (Rinaldi, 1992b, p. 55).

Some programmes may provide additional tasks which aim to generalise the skill to settings outside of intervention by, for example, assigning homework in which clients have to practise skills in their local community and report back to the clinician. Alternatively, the clinician may use props (such as being advised to use a "table, real or pretend food") to create a more natural atmosphere, or carry out intervention with the client in natural settings within a client's local community (such as the local "cafe") in order to facilitate the generalisation of social skills learnt during intervention to everyday settings (Schroeder, 1996, pp. 140-142).

Interventions for language in general and pragmatics in particular, which are based on behaviourist theories, have been critiqued as being somewhat superficial by Hewitt (2000b) and Cummings (2009). They note how behaviourist techniques can lead to the acquisition of the target skill, but in a restricted way (i.e., targets may be acquired rigidly and may only be used in the context in which they were taught). Cummings (2009, pp. 238-239) highlighted the superficiality of drawing primarily on this approach in the context of clinical pragmatics when she noted that "the child is merely learning conversational rules" and that "when speakers produce utterances with considerations of context in mind, they are not merely applying a number of learnt rules of conversation. Rather, they are exercising a form of reason-based judgement". This approach to intervention is deemed inappropriate on account of the fact that it fails to tackle underlying contributory factors and as such is deemed as being "ultimately misguided on account of its

assumption that targeting particular conversational behaviour will produce gains in language pragmatics–it is only the development of a certain rational competence that will lead to such gains" (Cummings, 2009, p. 239).

Conversational Analysis (CA) is another framework which has been drawn on in SLT contexts for both analysing (as discussed in Section 3.2.1.3 above) and guiding intervention in the area of conversational skills. CA has been used during intervention as a framework for coaching clients and their conversational partners about strategies which might facilitate conversation, in light of the presence of a communication disorder, such as aphasia.[60] Conversational partners are trained by SLTs following a CA analysis to continue to use effective strategies and to cease using strategies which impede the conversation. Additional strategies not yet used within the dyad may also be suggested by the Speech and Language Therapist during intervention.

CA assumes a mutual responsibility for the progression of a conversation and, as such when utilised as a tool in intervention, it may identify the conversational partner of the person with a communication disorder to be the location of change during intervention, so that "CA intervention begins with the premise that changing the conversational behaviour of either partner...may provide an opportunity for change in the conversational behaviour of the other speaker" (Beeke et al., 2007, p. 141).

3.2.2.3 Discourse and narrative

Intervention involving discourse and narrative can aim to cause change at one of the four levels of discourse (i.e., at a microlinguistic, microstructural, macrostructural and superstructural levels) as previously discussed in Section 3.2.1.3.

Intervention can focus on facilitating increased grammatical complexity and productivity at microlinguistic or within sentence level of discourse. An example of this might be working with a client to facilitate him in using a greater number of clauses per T Unit,[61] in order to increase the grammatical complexity of utterances used by an individual (as discussed by, Coelho, 2007). Microstructural level intervention may focus on phenomena (such as cohesion) which are relevant to the achievement of sense of local coherence between sentences in discourse. Macrostructural and superstructural levels of analysis have regularly been dealt with as one level of analysis in the literature of clinical pragmatics. Intervention at these levels of discourse might focus on facilitating the development of overall thematic or global coherence.

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[60] Examples of programmes which draw on the CA approach include *Supporting Partners of People with Aphasia in Relationships and Conversation* (SPPARC) authored by Lock and colleagues (2001) as discussed in previously and an approach named *Supported Conversation for Adults with Aphasia* (Kagan et al., 2001).

[61] T units can be defined as "one main clause with all its subordinate clauses attached to it. The number of subordinate clauses can of course be none" (Hunt, 1965, p. 20).

Often intervention will aim at a number of levels of discourse at the same time (e.g., both local coherence and global coherence were addressed by interventions discussed in Rogalski & Edmonds, 2008). Intervention focusing on different levels of discourse has been carried out within a variety of approaches ranging from the didactic teaching of discrete linguistic structures in a piecemeal fashion (as discussed in Duchan, 1995, p. 24), to using more naturalistic approaches which focus on generating a meaningful context for language learning as an integrated whole (e.g., Hoffman & Norris, 1994; Norris & Hoffman, 1994). Additionally, approaches to intervention are also available which reflect an intermediate position between atomistic and whole language approaches.

Narrative is one form of discourse which is particularly salient in the literature of clinical pragmatics. Narratives have been defined as a piece of discourse in which at least two events are presented as being related in some way, e.g. temporally or causally (as described in Boudreau, 2008). Building on the seminal sociolinguistic work carried out by Labov (1972) and earlier explorations into narrative (i.e., Stein & Glenn, 1979) clinicians have begun to assess and teach clients about story grammars in an effort to facilitate the development of narrative skills.

Intervention focusing on narrative often explicitly teaches story grammars. Explicit teaching of story grammars has been shown to improve the comprehension and expression of narratives (e.g., Davies, Shanks & Davies, 2004;[62] Swanson, Fey, Mills & Hood, 2005). Using peers, parents and other professionals to foster narrative skills (McGregor, 2000;[63] Peterson, Jesso & McCabe, 1999; Swanson et al., 2005, respectively) has been shown to have some impact on children's narrative development.

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[62] For example, Davies et al. (2004) provided a collaborative school based SLT intervention, in conjunction with teachers and other support staff, to 5- 7 year olds which focused on the area of narrative. The aim of the intervention was to facilitate the development of narrative skills by the teaching of story grammars. Post-intervention measures revealed significant improvement in expression of story grammars. The provision of indirect intervention (e.g., encouraging adults to: spend more time in narrative conversation with children, follow a child's topic choice, use elaboration and open-ended questions and (how to) use repetition and back channel behaviours to encourage narratives of increasing length and so on) have been suggested as ways for development of narrative skills.

[63] For example, McGregor (2000, p. 56) matched discordant peer pairs of 3-5 year olds ("e.g., older tutor and younger tutee; tutor without disability and tutee with disability") and supported them (by providing specifically created story books and scaffolding techniques) in fictional narrative-based tasks. Analysis of the intervention revealed an increase in the use and repertoire of story elements and increased Mean Length of Utterance (MLU) in post-intervention narratives. Analysis and also revealed that both members of the discordant peer pairs benefitted in terms of language gains, not just the "tutee".

3.2.2.4 HIGHER-LEVEL LANGUAGE

The term "higher-level language" is used in the SLT context to refer to language that is ostensively non-literal[64] and as such it is a term used to capture a wide range of skills which are deemed to particularly involve pragmatics and pragmatic interpretation. Higher-level language is often assumed to be related to skills acquired during later developmental periods and which continue to develop in early adulthood (Nippold, 2007). Higher-level language skills have been linked with critical reasoning, literate vocabulary, navigating increasingly complex social situations and using language in increasingly subtle and nuanced ways (e.g., to complain, persuade or negotiate). Additionally, the term "higher-order language" has been used to refer to the certain language and linguistic skills which are thought to be particularly reliant on an interface between language and cognition (for a review, see Coelho, 2007, p. 128-129).

Thus, higher-level language has come to be associated with the increasingly sophisticated and nuanced ways in which language develops in late childhood/early adulthood. The description below of the types of "difficulties" which can be encountered in the secondary school-aged population captures some of the kinds of phenomena that might be considered representative of higher-level language:

> The types of language and learning difficulties experienced by young people of secondary school age are varied, however they include difficulties in: understanding and using non literal language appropriately: word learning and retrieval; inference and prediction; understanding abstract concepts; social interaction; organisation and memory; integrating new learning with prior knowledge; generalising learning literacy and numeracy.
>
> (Malcolm & Myers, 2001, p. 481)

SLT services have typically been focused on age groups outside of secondary school age children (i.e., early intervention or work with primary school-aged children and specific clinical populations of adults) which might explain a lack of data regarding the phenomena deemed representative of higher-level language, as pointed out by McCartney (2000).

Higher-level language may often be targeted under the rubrics of social communication skills. For example, Adams and Lloyd (2007, p. 230) describe "work on the child's social understanding" as including "directly teaching an understanding of emotional language...encouraging flexibility in thinking...working directly on an [sic] understanding social and verbal inferences, metaphors and hidden meaning in language", which overlaps with some of the items listed above. There seems to be sparse theoretical motivations for grouping aspects of

[64] However, some theoretical accounts of language posit that all language comprehension involves some level of non-propositional comprehension (i.e., beyond the interpretation of semantics and truth conditions) which could be used to suggest that all language is in some sense non-literal (e.g., Sperber and Wilson, 1995).

language together as being higher-level language, except that these aspects of language often emerge in adolescence or early adulthood and may pertain to increasingly sophisticated and subtle developments in language involving the interpretation of blatantly non-literal language.

3.2.3 SUMMARY: SLT INTERVENTION

Focusing intervention on the teaching of isolated linguistic structures utilising methods which echo behaviourist traditions (such as positive reinforcement like providing sticker charts as rewards for each "correct" or "right" elicitation) would seem to be incongruous the context sensitivity of pragmatics in that: "The essential point about pragmatics-based therapy is that the client is not cast in a passive role, but is helped to use communicative behaviour for his or her own purposes." (Rae-Smith & Leinonen, 1991, p. 252) When pragmatics is treated as a conditioned, verbal behaviour the contextualised, dynamic and synergistic nature of pragmatics (as discussed in Chapter 2) is replaced with a view of pragmatics as a discrete set of definite behaviours and/or superficial linguistic structures. This handling of pragmatics is discordant with definitions of pragmatics as an overall organisational system for language use, such as the definition advocated by Rae Smith and Leinonen (1991, pp. 42-43):

> If we consider the field of pragmatics in its widest of interpretations, it provides practicing clinicians and researchers with an all-encompassing framework for studying communicative ability and inability as dynamically developing and functioning entities. What we call "Clinical Pragmatics" explores:
>
> 1 How methods and principles from the fields of pragmatics and discourse analysis can be applied in clinical management of communication disorders.
>
> 2 A framework focusing on the influences which bear upon communicative behaviour in the context of communication disorders; a framework which enables one to piece together components of communication in order to explore communication as a whole.

Definitions of pragmatics may colour how intervention in the area of clinical pragmatics is tackled. Increasingly evident is the view that pragmatics is not a separate aspect of grammar, but is rather an extensive influence on all aspects of language use, in that "pragmatics is therefore not a discrete and isolable component of our communication–it is all pervasive" (Perkins, 2005b, p. 376). Viewing pragmatics in this broad fashion prioritises pragmatics and behoves those who work with language, communication and communication disorder to attend to pragmatics their interventions.

When pragmatics is not considered to be a pervasive influence on communication and instead is defined as a discrete segment of linguistic competence, pragmatics may be considered

not quite as vital in the clinical context. Pragmatics is demoted in this view to being just another facet of grammar on a par with syntax or semantics. In this sense then, there is a chance that formalist-inspired definitions of pragmatics could be used to support a consideration of pragmatics as an advanced or final set of skills that can be mastered only once other more "basic" communication or language skills have developed. Kasper (1997) has noted that this de-prioritisation of pragmatics has partially occurred in the context of Second Language Learning. Kasper (1997, para. 6) has objected to the secondary role accorded to pragmatics by highlighting that "pragmatic competence is not extra or ornamental, like the icing on the cake".

Formalist-inspired definitions of pragmatics, which view pragmatics as a set of specific behaviours or a range of particular skills, situate intervention in clinical pragmatics as being focused on a definitive set of surface skills. Cummings (2009, p 43) comments that treating pragmatics as a "catch-all term for a range of surface conversational behaviours" oversimplifies the nature of pragmatics and neglects to acknowledge the synergistic combination of contributory factors (such as underlying cognitive skills) which enable the on-line contextualised use of language. Treating pragmatics as an isolable aspect of language has led to strong criticisms about pragmatics being misinterpreted by clinicians and clinical researchers: "A distorted notion of pragmatics...leads investigators to believe that they can treat language pragmatics merely by instructing children in the use of surface conversational behaviours." (Cummings, 2009, p. 243)

There is an incongruity between definitions of pragmatics as a dynamic and contextualised process of meaning-making and approaches to pragmatics, in clinical practice, in which context is neglected. Consequent to context being neglected, pragmatics can be treated as an independent subset of discrete skills possessed by an individual. This de-contextualised view of pragmatics sits well with de-contextualised approaches to SLT practice in general, as Gould (2009, p. 65) stated: "Assessment and therapy practices within the field of speech pathology primarily reflect a perspective of communication as context independent behaviour."

In noting the failure of clinicians to facilitate changes in the underlying cognitive skills which contribute to pragmatics, Cummings (2009) highlighted that interventions have instead tended to result in the acquisition of superficial linguistic skills which have been taught and learnt, one by one. Cummings goes on to imply that SLT interventions in the area of clinical pragmatics have become oversimplified as the process of simply teaching surface grammatical structures, as opposed to making an impact on an individual's underlying abilities to infer meaning from language. According to Cummings (2009), misappropriation of pragmatics has led to dubious clinical claims within the research and intervention communities in that:

> I argued that misunderstandings about the nature and extent of pragmatics have adversely affected how clinicians and researchers assess and treat pragmatic language disorders. Some of these misunderstandings have led investigators to overlook the pragmatic significance of conversational exchanges and to attribute pragmatic impairments to subjects in areas that are not pragmatic in nature. Other misunderstandings, particularly the neglect of the rational, cognitive basis of pragmatics, have led practitioners to treat pragmatic impairments by instructing subjects in a type of conversational performance.
>
> (Cummings, 2009, pp. 243-244)

There is also a lack of consensus in that there is not one theory of pragmatics on which all things pragmatic are hung in the SLT clinic and with which intervention is approached. This brief discussion of assessment and intervention in the area of clinical pragmatics has been confounded by a lack of consistency regarding how the clinical practices of the SLT community are reported within the literature, because, as noted by Adams (2001, p. 301): "Approaches to pragmatic therapy currently in use tend to be eclectic and a 'method' of intervention would currently be difficult to identify."

Despite the lack of consensus and the challenges noted within the literature utilised in this chapter, a discussion about the evolution of clinical pragmatics and the way in which pragmatics has "sprouted" and evolved in the clinical context (as noted by Duchan below) was seen as a necessary, in order to elucidate and illustrate the nature of the field in which this study is set.

> Since its emergence in the 1970s, pragmatics has sprouted....*Pragmatics* is now an umbrella term covering areas as disparate as social and interactional competencies and discourse abilities. For example, assessments of children's pragmatics abilities might include their use of politeness forms, their ability to accomplish appropriate conversational turn taking and repairs if the conversation breaks down, their ability to initiate and maintain topics in conversation, and their ability to assume the other's perspective when they engage in discourse.
>
> (Duchan, 2004, p. 59)

SUMMARY

In this chapter, the disparity and confusion in clinical pragmatics have been linked with a definitional hangover from the area of mainstream pragmatics. Additionally, the manner in which clinical pragmatics might be approached in the SLT context, via the processes of assessment and intervention, has also been briefly sketched. Chapter 4 will introduce the methodology of grounded theory in order to explicate how this study, set in the area of clinical pragmatics and SLT practice, was approached from a methodological perspective.

CHAPTER 4. INTRODUCING GROUNDED THEORY

INTRODUCTION

Grounded Theory (GT) is a "general" research methodology comprising a set of procedures which are used to generate a theoretical account of latent patterns observed in data (Glaser, 2005, p. 3). GT assumes that life is patterned and seeks to identify and conceptualise these patterns (Glaser, 2001).

The process of GT involves the analytic rendering of empirical data via coding and memo writing at increasingly abstract levels. The essential process of GT revolves around simultaneously gathering and analysing data, constantly comparing data to other data with further data being collected as theoretically indicated by the ongoing analysis (Walker & Myrick, 2006). As well as being an iterative process, GT is a data-driven methodology as theory is generated from empirical data without the use of extant theory unless it becomes relevant as indicated by analysis.

The process of GT is based on a "concept-indicator model" in which instances found in the data are coded as indicators of concepts (Glaser, 1978, p. 62). The concepts induced from the data must then be verified via further theoretically guided data collection and analysis. Finally, following extensive memo writing and analysis, hypotheses are formed about the most significant concepts and their relationships to other concepts and this is written up as a grounded theory.

A grounded theory is organised around one or more core categories. A core category captures patterns related to the participants' attempts at resolving their main concern. As Punch (2005, p. 205) concisely notes, "The essential idea in discovering a grounded theory is to find a core category, at a high level of abstraction, but grounded in the data which accounts for what is central in the data".

4.1 THE HISTORICAL DEVELOPMENT OF GROUNDED THEORY

4.1.1 CLASSIC GROUNDED THEORY

GT developed during a time when quantitative and positivist approaches to research dominated. In this context, researchers were receptive to GT as an alternative yet systematic methodology to the prevailing research methods culture of that time. In fact, it has been suggested that the development of GT emerged as a reaction to the established culture of theory testing and verification that was particularly prominent in the early part of the twentieth century (Bryant &

Charmaz, 2007b). GT essentially holds that the systematic analysis of data has the potential to be exploited for theory generation, rather than working from the premise that data should only be approached with extant theories to be tested.

GT emerged from the collaborative research of Barney Glaser and Anselm Strauss who were studying the process of dying in hospital. The two original proponents of GT came from divergent backgrounds. Barney Glaser came from a quantitative background, while Anselm Strauss's background was immersed in the tradition of qualitative research and symbolic interactionism. The success of their early joint work on dying—*Awareness of Dying* (Glaser & Strauss, 1965)—led to the publication of a methodology book introducing and explicating the GT process (Glaser & Strauss, 1967). Glaser and Strauss published further studies together (Glaser & Strauss, 1968, 1971, 1975; Strauss & Glaser, 1970) before moving on to develop GT in separate directions.

As GT grew in popularity, disagreements developed between the two co-originators of GT. Later writings by the founders of GT espoused divergent positions on the nature of the methodology and how the GT methodology should be developed. Glaser objected publically, via the publication of *Basics of Grounded Theory Analysis: Emergence versus Forcing* (Glaser, 1992), to Strauss's developments of GT. Glaser contended that GT should be data-driven, stressing the point that all concepts used during data analysis should emerge from the data. Correspondingly, Glaser (1992) has viewed Strauss's development of specific technical procedures and use of extant concepts during analysis as being prescriptive and incongruous with this basic tenet of GT.

GT has split into two distinct schools, Classic GT[65] and Straussian GT. Anselm Strauss has developed the GT methodology in collaboration with others, particularly Juliet Corbin (Strauss & Corbin, 1990, 1998). Following Anselm Strauss's death, Corbin has continued to write about the GT method (Corbin & Strauss, 2008). The Straussian approach to GT has been and continues to be widely adopted in the research literature (for examples see Strauss & Corbin, 1997), with other schools of GT also emerging.

4.1.2 STRAUSSIAN GROUNDED THEORY

Straussian GT and Classic GT share many commonalities but they take different stances regarding the use of certain techniques for coding. In opposition to Classic GT, Straussian GT provides clearly stated and in-depth techniques for use during coding (Corbin & Strauss, 2008; Strauss & Corbin, 1990, 1998). One such technique is the "conditional/consequential matrix", which is a coding

[65] Classic grounded theory is also known as "Glaserian grounded theory" (e.g., Kelle, 2007, p. 204).

device that enables the researcher to develop a visual representation of the interactions or transactions between context and the phenomena under study (Strauss & Corbin, 1990, 1998).[66] The conditional/consequential matrix explicates the relationships between concepts and context during analysis by "helping the researcher to identify contextual factors and then to link them with process" (Corbin & Strauss, 2008, p. 89). Originally, the conditional/consequential matrix depicted action at the centre of the conditional/consequential matrix (Strauss & Corbin, 1990), while the 1998 edition of *Basics of Qualitative Research* placed the individual at the centre of the conditional/consequential matrix (Strauss & Corbin, 1998, p. 184).

Glaser has alluded to the automatic use of concepts for coding (such as the conditional/consequential matrix favoured by Strauss) as "forcing" the data, in that the data is made to fit into a pre-existent framework. Glaser has stressed that extant concepts should be used in a GT study only when they exhibit "earned relevance" (Glaser, 2003, p. 45). Strauss and Corbin (1990, 1998) have argued that the conditional/consequential matrix is simply a coding device that helps the researcher remain theoretically sensitive to a range of variables in a systematic way during analysis. It has also been argued that the concepts used in the conditional/consequential matrix are purposely generic (in that they pertain to elements of macro-level context) and thus require data to be fully explicated and made relevant to each individual study (Corbin & Strauss, 2008; Strauss and Corbin, 1998).

4.1.3 CONSTRUCTIVIST GROUNDED THEORY

Other members of the GT family of methods exist, of which two more will be discussed here (see Figure 4, on page 80). Constructivist Grounded Theory (CGT) has firmly positioned itself as an interpretive method. Much of Kathy Charmaz's work and development of CGT has focused on the experiences of people with chronic illness. The topics of time and identity often emerge as prominent issues in her work (Charmaz, 1983, 1990).

Charmaz's application of GT contains a distinct epistemological and ontological stance. Charmaz's time studying GT under the tutorage of Strauss is reflected in the strong symbolic

[66] The conditional/consequential matrix is a conceptual framework which is used during analysis to enable the researcher "to keep in mind several analytic points" (Strauss & Corbin, 1998, p. 182). It functions to attune the researcher to elements in the context of the phenomena being studied, and to consider how these might be relevant to the emerging theory. The conditional/consequential matrix encourages the researcher to think about how "macro conditions/consequences" and "micro conditions/consequences" might impact on the data and highlights different associations between these in terms of "consequences" and "contingencies" (Strauss & Corbin, 1998, p. 181). Charmaz defines the "conditional/consequential matrix" as "a coding device to show the intersections of micro and macro conditions/consequences on actions and to clarify the connections between them" (Charmaz, 2006, p. 187).

interactionist underpinnings of CGT. Multiple realities, the co-construction of data and the interpretative nature of analysis figure prominently in the Constructivist "take" on GT as is explicated in the following quote:

> My approach explicitly assumes that any theoretical rendering offers an *interpretative* portrayal of the studied world, not an exact picture of it (Charmaz, 1995b, 2000; Guba & Lincoln, 1994; Schwandt, 1994). Research participants' implicit meanings, experiential views-and researchers' finished grounded theories-are constructions of reality.
>
> (Charmaz, 2006, p. 10)

The relationship between CGT and Classic GT has been hotly contested by Glaser and others associated with Classic GT (Glaser, 2002; Glaser & Holton, 2004). Glaser rejects CGT as being a GT methodology and sees CGT as being better situated as a form of Qualitative Data Analysis (QDA) (Glaser, 2003, pp. 167-180). Attempts to attach GT to particular ontological and epistemological values have been viewed as a degradation of the GT method by some proponents of Classic GT (Glaser, 2002, 2003). One of the most salient criticisms which has been levied at the Constructivist approach to GT is that it produces an oftentimes rich and dense but essentially descriptive account of the data as opposed to generating a conceptual grounded theory. Glaser (2001, 2003) considers CGT an approach to data analysis which results in descriptive coverage of the studied phenomena, rather than a theoretical rendering of data. Glaser (2002) has critiqued Charmaz's development of GT by saying that:

> She is misled in thinking that the constructivist vision is in fact GT. It is just another QDA method in pursuit of accuracy.
>
> ...descriptive capture overwhelms GT in many researchers professing themselves as a grounded theorist. Descriptive procedures divorce data analysis from GT conceptualizing procedures, as if the descriptive procedures are GT and they are not. Describing what is going on, does not explain conceptually what is going on as a fundamental pattern of process, typology, cutting point, binary etc."
>
> (Glaser, 2002, para. 40-41)

The fact that GT "is not descriptive and unit bound" (Glaser, 2001, p. 5) means that it creates hypotheses which conceptually explicate the patterns of behaviour within the data. As GT transcends the data in this manner, it is an inappropriate methodology to use when attempting to representatively capture the lived experiences or voices of participants. Methodologies such as CGT, with their concern for achieving full descriptive accuracy and for avoiding re-authorship, are much more amenable to representing the voice of participants. Classic GT firmly acknowledges that it is a methodology which is best suited to the generation of conceptual accounts of patterns of empirical behaviour.

4.1.4 SITUATIONAL ANALYSIS

Situational Analysis is one of the most recent additions to the GT family of methods. It expands, in particular, on Strauss's concern with context. Adele Clarke is one of the main proponents of this approach to GT, in which context or "situatedness" is placed at the heart of GT enquires. Clarke builds on Strauss's use of the social world and the social arena concepts, as can be seen in the quote below.

> For him [Strauss] commitments people make to various groups and their positions, especially the commitments to action in situations where these groups are involved, organise social life. He termed such groups social worlds.
>
> Social worlds (e.g., a recreation group, an occupation, a theoretical tradition, a discipline) generate shared identities and perspectives among participants that then form the basis for individual and collective action.
>
> (Clarke & Friese, 2005, p. 364)
> [Words in brackets have been added]

The premise here is that the situation or context not only influences the data, but is the data, so that "in situational analysis, the situation *itself* is a key unit of analysis per se" (Clarke & Friese, 2005, p. 364). Visual mapping in the form of "situational maps....social worlds/arenas maps.... positional maps" become key analytic tools in this application of GT (Clarke & Friese, 2005, p. 366).

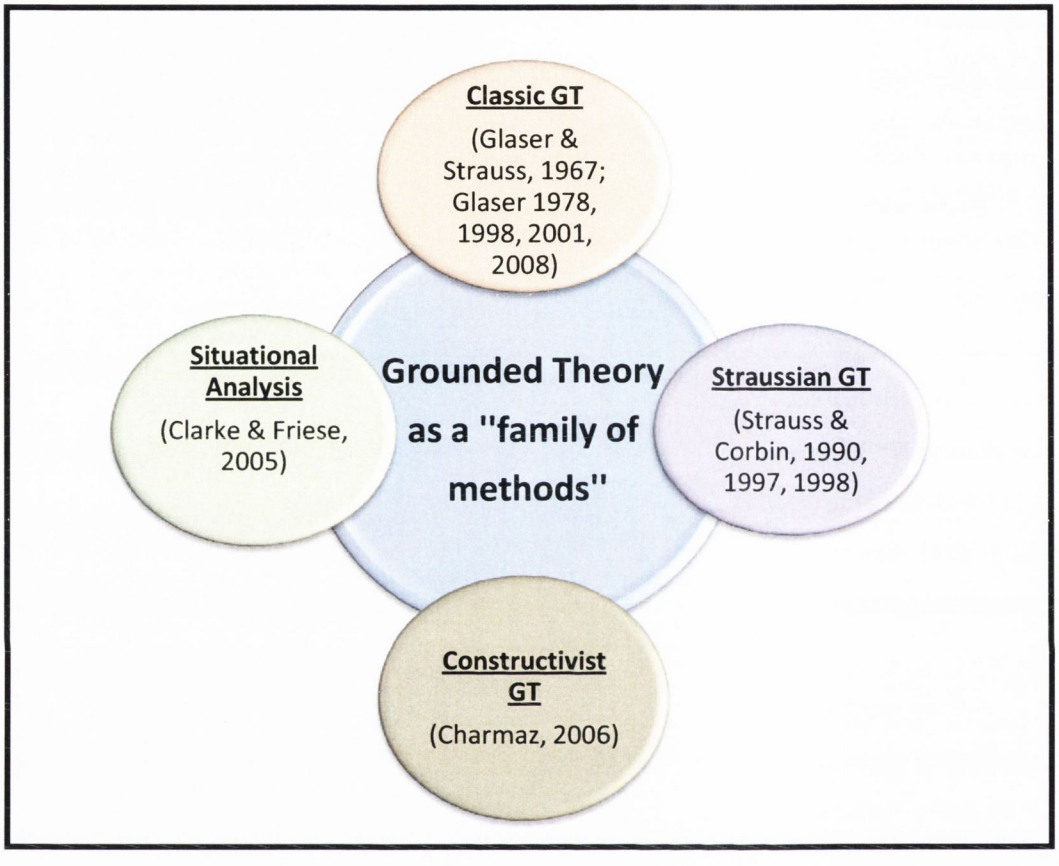
GT has been applied in many disciplines and to a variety of problems. It offers a flexible yet structured approach to research which allows for the abstract handling of data. GT has been used by many researchers within the Social Sciences and beyond and is now a prominent and widely used research methodology (Bryant & Charmaz, 2007a; McCann & Clark, 2003a). Glaser firmly maintains that GT is equally applicable to all types of data and as such he positions GT as being relevant to all types of data, including quantitative data (Glaser, 1978, 2002, 2008). However, there is less evidence in the literature of GT being applied and used with quantitative data.

4.2 GROUNDED THEORY AS A FAMILY OF METHODS

As represented in Figure 4 below, GT is a methodology that has evolved since its initial incarnation into a "family of methods" (Bryant & Charmaz, 2007a, p. 11). GT is a general methodology amenable to a wide variety of data types and ontological and epistemological stances and, as such may be best viewed as a "package of research methods" (Elliott & Lazenbatt, 2005, p. 48).

The family of methods known as GT share similarities in the basic process of "doing" a GT analysis but can have differing ontological and epistemological assumptions. The underlying premise of iteratively coding, conceptually organising and analysing data in a systematic way with a view to theory formation is common to many of the GT approaches.

FIGURE 4: GROUNDED THEORY AS A FAMILY OF METHODS



4.2.1 CLASHING ONTOLOGICAL AND EPISTEMOLOGICAL PERSPECTIVES WITHIN THE GT FAMILY OF METHODS

The position of GT in relation to objectivist or constructionist epistemological stances is a continuing discussion in the literature. One of the co-originators of GT has claimed GT to be ontologically and epistemologically neutral. Subsequently, GT has been posited as being compatible with divergent assumptions about the nature of reality and the researcher's relationship to knowledge, in that: "GT does not have an epistemology with an attached theoretical perspective....Remember, GT is a general methodology that can use any kind of data or data in combination" (Glaser, 2005, p. 17).

However, it has been suggested that Classic GT treats data in an objective manner assuming that theory lays waiting to be discovered within the data (Annells, 1996; Denzin &

Lincoln, 2005). The emphasis on discovery, as opposed to co-construction of theory, has led some to claim that Classic GT is not the neutral and general method it has claimed to be and that Classic GT is contaminated by positivist underpinnings (Charmaz, 2004). Consequently, Classic GT has been critiqued for perpetuating a claim that an author can remain neutral to the data and that the author's views and beliefs do not influence how the data is rendered and represented during the research process (Charmaz & Mitchell, 1996).

In light of these critiques of Classic GT, other schools of GT have made their philosophical assumptions transparent. In doing so, some grounded theorists have aligned themselves with particular philosophical assumptions regarding the nature of reality and the researcher's relationship to knowledge, thus rejecting the premise that GT is an epistemologically neutral method (Charmaz, 2006; Charmaz & Mitchell, 1996).

Glaser has stressed that GT is a methodology which is simply concerned with identifying patterns in empirical data at a conceptual level and as such denies that GT is bound to particular ontological and epistemological stances (Glaser, 2002, 2003). Additionally, proponents of Classic GT have noted that GT procedures can isolate and reduce the researcher's influence on the data, but only to a certain extent (Holton, 2007, 2009). The way in which the data is consistently and constantly compared during the GT process has been posited as a self-correcting mechanism which should, if adhered to, weed out the researcher's bias (such as pre-conceived thoughts about what might be happening in the data) in so far as this is possible. However, this self-correcting mechanism does not mean that the concepts generated via GT analysis are objective truths or facts. GT is concerned with translating and transcending empirical data to generate a theoretical or conceptual account of the data. As such, the emerging theory and its concepts are not amenable to being considered, in an objective sense, as being right or "wrong", true or false (Glaser, 1998, p. 237). Simply, GT procedures facilitate the generation of concepts which are posited as being significant for and relevant to patterns in the data in question (Glaser, 2003). Glaser does not deny that researchers exert an influence on data and indeed he has even pointed out that the collection of information as data colours and transforms the data to some extent:

> Let us be clear, researchers are human beings and therefore must to some degree reify data in trying to symbolize it in collecting, reporting and coding the data. In doing so they may impart their personal bias and/or interpretations—ergo this is called constructivist data. But this data is rendered objective to a high degree by most research methods and GT in particular by looking at many cases of the same phenomenon, when jointly collecting and coding data, to correct for bias and to make the data objective.
>
> (Glaser, 2002, para. 24)

In summary, it would appear that Glaser has posited that both the systematic treatment of data, via Classic GT methodological procedures, and the conceptual rather than descriptive analytical focus of Classic GT can ensure some "degree" of objectivity in the emergent theory, as noted above. However, this author takes a weaker stance on the objective rendering of data and contends that GT is simply a set of procedures and an approach to research which facilitates the researcher in prioritising the concerns of the participants as the focus of a piece of research. Additionally, this author believes GT is a methodology which is suitable for developing theory (in the form of conceptualisations) about latent patterns in data.

4.2.2 PHILOSOPHICAL ASSUMPTIONS UNDERLYING THIS STUDY

For this author, one of the most significant challenges in undertaking this study has been engaging with and reconciling personal philosophical assumptions regarding the research process in relation to choosing a particular methodology.

The epistemological assumptions held by this author can be briefly summarised as a belief that knowledge cannot be definitively known and is relative to the reality in which it is embedded. As Crotty (1998) notes, epistemological assumptions are couched within the ontological stance a researcher takes. This author recognises the potential existence of multiple realities, but also appreciates that shared collective understandings exist between people which results in some relative stability of knowledge, but in a way that is imperfect, possibly reflecting a subtle or critical realist ontological stance (Duncan & Nicol, 2004; Hammersley, 1992). Thus, rather than viewing data as being "rendered objective" by the use of GT (as noted by Glaser, 2002, in the quote above) the author posits that GT procedures enable the researcher to produce a conceptually thorough and rigorous account of the data and the patterns therein.

The author contends that the data, by virtue of being deemed and collected as "data", cannot be immune from the researcher's influence. There are multiple ways of knowing the data, and as such, the analysis here represents just one way of knowing the data.

In light of the complex nature of all data, it may be salutatory to note that there may potentially be numerous patterns embedded in the data, of which the researcher has focused in on just one as J.A. Holton (personal communication, August 18, 2010) pointed out when she noted: "GT captures one latent pattern of social behaviour in a social setting while recognizing that given the complexity of behaviour in any social scene that there is always more than one latent pattern."

This study was carried out using Classic GT (Glaser, 1978, 1998; Glaser & Strauss, 1967). Specific reasons for choosing Classic GT as a methodology will be dealt with in the following section.

4.3 SELECTING CLASSIC GROUNDED THEORY AS A METHODOLOGY

Issues which were considered in selecting a methodology will be discussed under the following subheadings in order to account for Classic GT as the final methodological choice.

- Will this methodology complement the author's ontological and epistemological assumptions?
- Will this methodology support the current research purpose?
- Choosing Classic GT as a method.

4.3.1 WILL THIS METHODOLOGY COMPLEMENT THE AUTHOR'S ONTOLOGICAL AND EPISTEMOLOGICAL ASSUMPTIONS?

The underlying premise of iteratively coding, conceptually organising and analysing data in a systematic way, with a view to theory formation, is common to all the GT approaches. However, the author was interested to explore the possibility that there was a particular method from the GT family of methods which was the most appropriate for this piece of research that would dovetail with the author's personal philosophical assumptions.

Classic GT claims no ties to any particular ontological and epistemological assumptions (Glaser, 2003; Glaser & Holton, 2004), a stance which has been heavily debated (Charmaz & Mitchell, 1996).

As a methodology, Classic GT claims not to produce a theory which can be proven wrong or right, or true or false (in objective terms), but which is conceptual (Glaser, 1998). A conceptual rendering of the data is not amenable to evaluation by exploring accuracy, representativeness or full description because "GT does NOT generate findings: it generates hypotheses about explaining the behaviour from which it was generated. GT is conceptually abstract from time, place and people. GT, to repeat, gets applied to explain theoretically the variation in substantive behavior" (Glaser, 2001, p. 5).

The Classic GT process comprises the use of particular procedures which attune the researcher's attention to regular and meaningful patterns in the data. Correspondingly, patterns or concepts which the researcher might have imposed onto the data are exposed (in so far as this is possible) and are subsequently discarded. However, it would be radical to suggest that a

researcher's values and beliefs do not influence the research process in any way. As a general methodology, Classic GT accommodates a variety of philosophical assumptions (Holton, 2008), including the author's own about the nature of the being and knowledge, as Holton (2009, p. 38) points out:

> This is not to suggest that classic grounded theory is free of any theoretical lens but rather that it should not be confined to any one lens; that as a general methodology, classic grounded theory can adopt any epistemological perspective appropriate to the data and the ontological stance of the researcher.

The product of a Classic GT study is not assumed to accurately document or describe the data, in full detail, and thus does not claim to be the only representation of participants' concerns. The systematic approach to data and analysis undertaken in a Classic GT study does not preclude or dismiss alternative analysis or conclusions generated via other research methods. Highlighting this point, Glaser (1999, pp. 836-837) notes "Now, all research is grounded in data in some way....Research methods go in many different directions, using many methodological approaches....It [GT] is no better or worse than other methods. It is just another option for researchers." (Words in brackets have been added) GT simply claims to prioritise the concerns of the participants in rendering latent patterns in data visible. Thus, a GT study will focus on identifying the main concern of the participants and how this is resolved and it does so at a theoretical level.

Classic GT also does not claim to faithfully represent the voices and/or lived experiences of the research participants. Consequently, the issues of authoring and re-authoring of data which would be of concern from both my ontological and epistemological stances can be sidestepped. Classic GT clearly defines the end product of a GT analysis as the researcher's conceptual rendering of patterns in the data, which relate to the participants' main concern and its resolution.

4.3.2 Will this methodology support the current research purpose?

GT is an approach to data which has theory generation as its fundamental aim, as noted by Creswell (2007, p. 62): "The intent of a GT study is to move beyond description to generate or discover a theory, an abstract analytical scheme of a process."

The scarcity of research for guiding practice within the area of clinical pragmatics and SLT practice has been noted (Adams, 2008). Published, conceptual explorations into the SLT community's concerns in the area of clinical pragmatics are virtually non-existent. By applying

Classic GT to the collected data (and indeed, to guide the process of gathering data) data can be analysed conceptually with a view to generating a theory that explicates what is happening within the data. Thus, it was expected that the methodology of GT would enable the generation of theory and potentially contribute to gaps in knowledge about the concerns of the SLT community with regards to their practice in the area of clinical pragmatics.

Additionally, GT would enable the researcher not only to expose these concerns, but to explore conceptually how they were being managed by participants. As such, it was hoped that this study could contribute to the theoretical understanding of SLT practice in the area of clinical pragmatics.

4.3.3 Choosing Classic GT as a methodology

Classic GT is a methodology which provides a package of procedures that take the researcher from the start to the end of an inquiry. To develop a fully integrated grounded theory, Classic GT demands that all of its procedures are completed, rather than picking and choosing between procedures. Thus, Classic GT is systematic and synergistic, with each procedure moving the analyst along an increasingly abstract and theoretical trajectory in her understanding of the data:

> The decision to use a classic grounded theory methodology is a "full package" decision. It requires the adoption of a systematic set of precise procedures for collection, analysis and articulation of conceptually abstract theory. On the menu of research methodology, classic grounded theory is "table d'hote" menu, not "a la carte".
>
> (Holton, 2009, p. 45)

Despite the promise of GT as a methodology, untangling the family of GT methods (as depicted in Figure 4 on page 80) and selecting a particular one of these, as a methodology, was challenging for this author. The process of studying and comparing different GT methods presented a steep learning curve and also provided an opportunity to engage with the lively methodological debates in the literature. The superficial similarities within the GT family of research methods perhaps mask the complex and intricate differences between them, particularly in relation to their purpose and end product.

The proponents of a Straussian approach to GT endorse a highly structured method for approaching data. The conditional/consequential matrix utilised in their GT framework entails that a theoretical code is assumed and applied onto the data. Although, Straussian GT specifies and details the GT procedures and processes, it does so in a conceptually doctrinaire fashion by insisting on the use of particular theoretical codes. As the author was interested in a relatively novel area of research it could not be predicted that the use of the conditional/consequential

matrix, as a theoretical code, would complement the latent patterns in the data (Corbin & Strauss, 2008). This latter point ruled Straussian GT out as a viable method because the researcher was interested in approaching this novel of research interest without preconceived codes.

Charmaz's Constructivist GT was also an initial contender for guiding this study due in no small part to her succinct and extremely accessible methodological texts (e.g., Charmaz, 1990, 2006). However, deeper reading across the area of GT highlighted gaps in how some of the GT procedures might be realised (such as theoretical coding) by the novice researcher if following Charmaz's texts on Constructivist GT (e.g., Charmaz, 2006).

More significantly, the strong constructivist stance taken by Charmaz (2006; Charmaz & Mitchell, 1996) sparked concerns that by utilising this approach to GT the author might be claiming to accurately capture the voice and experiences of the participants. Claims about researcher and participants co-constructing theory in the absence of specific procedures for involving participants in data analysis raised concerns. Although, this author believes that representing the perspectives of research participants and inclusive research projects are extremely important and much needed research enterprises, constructivist grounded theory fails to provide enough guidance and thus methodological rigour for supporting claims that it is a methodology that produces truly co-constructed piece of research—consequently representing the voice of participants in an accurate fashion. These ontological and epistemological claims would have impacted on the claims made about the nature of the end product of the study. Additionally, ensuring quality in the research (such as preventing accusations of re-authoring) may have arisen as a significant challenge.

In summary, Straussian GT's reliance on pre-existent concepts and frameworks for structuring data analysis and the emergent account of the data precluded it being considered as an appropriate methodology for the present study. It was believed, by this author, that the Constructivist approach to GT failed to fully specify how to generate of a truly co-constructed account of the data. Subsequently, an alternative from within the GT family of methods was chosen.

Classic GT's limited preconditions for use, openness to a variety of data types and ability to explore novel areas of research has seen it used across many disciplines and with many differing topics, particularly in areas where there is a dearth of extant theory to guide research. Classic GT's framework was adopted for this research in order to make the implicit concerns of the SLT community with regards to the area of clinical pragmatics, explicit and visible at a conceptual level. Thus, it was posited that Classic GT would offer the most systematic, yet flexible, approach for the theoretical handling of data regarding a relatively novel research area.

4.4 CLASSIC GROUNDED THEORY METHODOLOGICAL PROCEDURES

GT comprises "a total package, which takes the researcher from data collection through several stages to a theory" (Glaser, 1999, p. 837). Procedures utilised during a GT study are embedded within an iterative data generation and analysis process. As such, a GT study does not necessarily follow the traditional, linear research trajectory (i.e., the completion of an initial literature review, followed by the generation of a research hypothesis with subsequent discrete phases of data collection and analysis). GT procedures enable the researcher to approach the data in a cyclical fashion with the aim of exposing and exploring the concerns of participants in "a 'learner' role rather than a 'tester' role" (Damico & Simmons-Mackie, 2003, p. 138).

4.4.1 THE CORE VARIABLE

The core variable is a category of codes which captures the patterns and variation in the data that relate to and account for how the participants resolve their main concern.[67] All GT procedures are orientated towards finding and explicating the participants' main concern and conceptually elucidating how this is resolved. The action in the data which stems from participants' attempts to manage their main concern is the core variable, in that "the goal for a research using grounded theory is to discover the core variable as it resolves the main concern" (Glaser, 1998, p. 115).

The core variable is significant in that it relates to most of the other categories and their properties which are emergent from the data. The core variable carries weight in how it meaningfully explains what is happening across the rest of the data thus cohering the data.

> As the researcher proceeds to compare incident to incident in the data, then incidents to categories, a core category begins to emerge. This core variable, which appears to account for most of the variation around the concern or problem that is the focus of the study, becomes the focus of further selective data collection and coding efforts. It explains how the main concern is continually resolved.
>
> (Glaser & Holton, 2004, para. 54)

The core variable is central to the emerging theory; it is stable and emerges with significance and frequency across the entire data set. Figure 5 visually represents the interaction between

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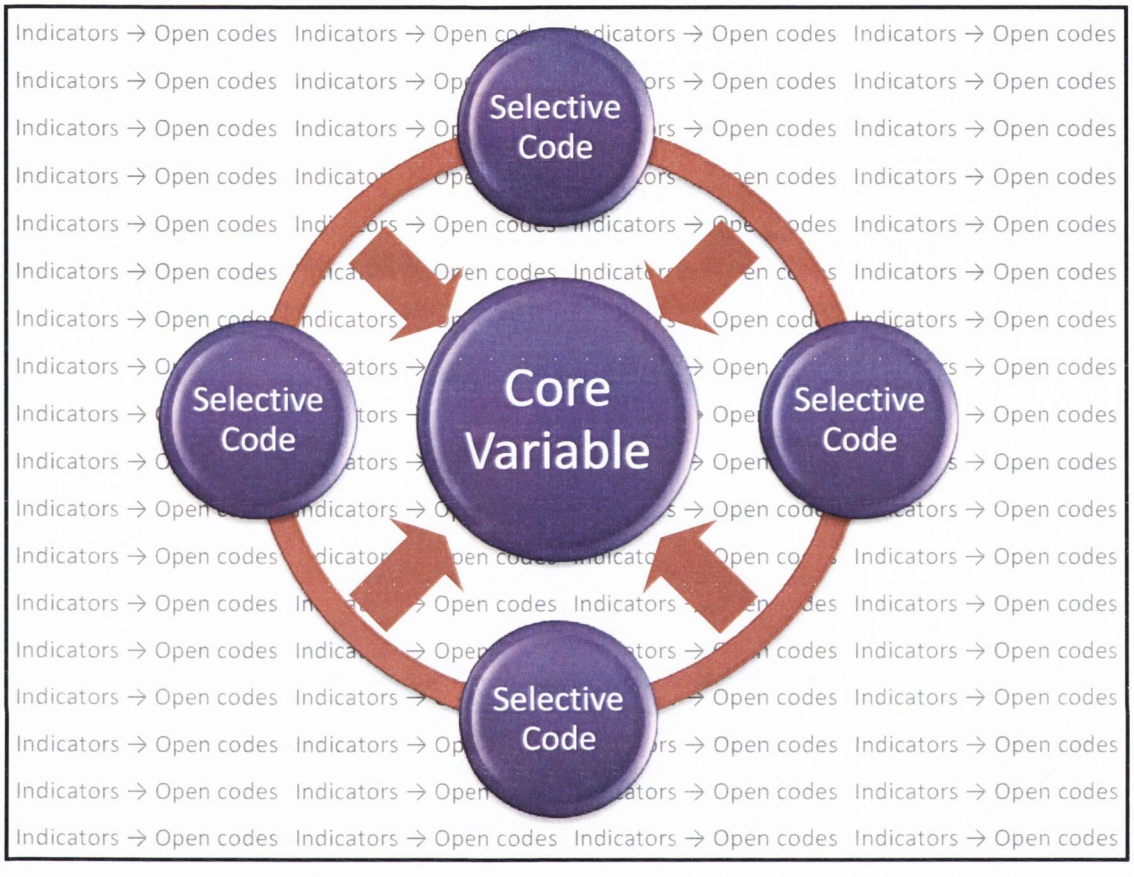
[67] As an example, in a study of nurses working in palliative care the main concern of "becoming emotionally overloaded by their work" was responded to and managed by the core variable of "Striving for Emotional Survival". "Striving for Emotional Survival" comprised three strategies, namely: "Emotional Shielding through Professional Shielding or Cold Shielding; Emotional Processing through Chatting, Confirmation Seeking, Self-Reflecting, or Ruminating; and Emotional Postponing through Storing or Stashing" (Sandgren, Thulesius, Fridlund & Petersson, 2006, P. 79).

selective codes, theoretical codes and the core variable. In Figure 5, the dynamic and integrating functions of theoretical codes are depicted in red.[68]

FIGURE 5: DIAGRAMMATIC REPRESENTATION OF THE RELATIONSHIP BETWEEN INDICATORS, CODES AND THE CORE VARIABLE.



4.4.2 THE CONSTANT COMPARATIVE PROCESS

A GT analysis is driven by the constant comparative process. This process involves the researcher consistently and continuously comparing the data with other data. As the research progresses, comparisons are made between empirical and more abstract forms of data. The constant comparative process is built on the "concept indicator model" (Glaser, 1978, p. 62). An indicator is a segment of the empirical data which indicates or denotes a particular concept. Indicators are interchangeable, so that the researcher identifies various different instances of data which indicate the same concept, during coding. Indicators become increasingly interchangeable and

[68] In Figure 5 the smaller purple circles represent selective codes, while the red arrows and red circle, which links all of the selective codes, represents a theoretical code that explicates the interconnections and relationships that exist between selective codes. The indicators and open codes are the foundation on which selective and theoretical codes are developed, eventually resulting in the generation of a grounded theory (Glaser, 1998).

eventually redundant in the final theoretical account. Glaser further details the constant comparative process below.

> From the comparisons of indicator to indicator the analyst is forced into confronting similarities, differences and degrees of consistency of meaning between indicators which generates an underlying uniformity which in turn results in a coded category and the beginning of properties of it. From the comparisons of further indicators to the conceptual codes, the code is sharpened to achieve its best fit while further properties are generated until the code is verified and saturated.
>
> (Glaser, 1978, p. 62)

Specifically, the constant comparative method involves comparing indicators within the data to other data, comparing data to the concepts emerging from the data analysis, and comparing concepts with concepts. Glaser and Strauss (1967, p. 105) discuss the process of constant comparison as a method involving four stages. These are "(1) comparing incidents applicable to each category, (2) integrating categories and their properties, (3) delimiting the theory, and (4) writing the theory". This process of constant comparison continues throughout the entire research project, at increasingly abstract levels, until the participants' main concern and its resolution, via the core variable, are conceptually accounted for.

The way in which the data is consistently and constantly compared within the GT process aims to act as a corrective process. The process of constant comparison facilitates the researcher in identifying patterns in the data and countervails the data being imbued with concepts which are not of the data or regularly recurring in the data. As Glaser said, "interchangeable indices correct impressionistic concepts" (Glaser, 2009).[69]

The constant comparative process is also vitally important in identifying gaps in the analysis and, hence it identifies further sites for data gathering. As previously noted, GT does not strive for descriptive accuracy and has no concern for representativeness in that sense. GT strives for conceptual density. Conceptual density is achieved, in part, by the process of constant comparison and also by employing the procedure of theoretical sampling in order to achieve theoretical saturation.

4.4.3 THEORETICAL SAMPLING

Theoretical sampling pertains quite simply to the fact that "the process of data collection is *controlled* by the emerging theory" (Glaser & Strauss, 1967, p. 45). Data sites are identified in

[69] This is a direct quote taken from Dr. Glaser as he spoke at a seminar, hence the absence of a page number. See references for other details.

order to complete and flesh out, at a conceptual level, the properties of the emerging concepts and theory.

In light of GT's aim of developing a conceptually dense theoretical account of the main concern of participants, sampling in GT is theoretical. Sampling is carried out at a conceptual level following the theoretical directions specified by the emerging theory, so that "sites and sources are selected flexibly for their theoretical relevance in generating comparisons and extending or refining ideas, rather than for the representational value in allowing generalisations to particular populations" (Dey, 2004, p. 80).

This theoretically purposive sampling strategy is crucial in ensuring analysis remains data-driven. Theoretical sampling allows for the researcher's emergent conceptual understanding of the research problem to fuel further sampling and data gathering. The sampling method employed within classic GT entails that GT cannot make claims about developing full or accurate descriptions of data. Theoretical sampling is conceptual and focused on generating a dense, theoretical, data-driven account of the patterns of behaviour evident in the data.

4.4.4 THEORETICAL SATURATION

The iterative data generation-analysis process comes to a close when all properties of prominent and meaningful categories are identified and fully fleshed out at a conceptual level. Theoretical saturation is said to be reached when the emergent theory ceases to be further theoretically refined by the data, as when no new conceptual insights are identified during analysis. When theoretical saturation has been achieved, the process of data collection ceases.

Theoretical sampling is delimiting as it focuses the data collection on sites which are relevant for the developing theory. All emerging concepts and categories from the analysis do not hold equal theoretical weight in a Classic GT study. The core theoretical categories are specifically relevant to the participants' main concern and its resolution, and require in-depth analysis resulting in full saturation so that "*core* theoretical categories, those with the most explanatory power, should be saturated as completely as possible...continue to saturate all categories until it is clear which are core categories" (Glaser & Strauss, 1967, p. 70-71).

Reaching theoretical saturation is characterised by data analysis essentially revealing nothing new, or as Charmaz (2006, p. 113) described: "Categories are 'saturated' when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of these core theoretical categories".

Theoretical saturation refers to achieving satisfactory conceptual density as opposed to achieving full description, representativeness or accuracy. Correspondingly, defining an adequate sample cannot occur prior to engaging with the data, as

> ...data completeness is based only on theoretical completeness not on numbers or lengths of interviews of number of interviewees. There is no "N" just sampling for saturation and completeness which yields a well integrated grounded substantive theory with parsimony and scope.
>
> (Glaser, 1998, p. 159)

4.4.5 MEMO-WRITING

Memo writing is an integral part of GT and occurs throughout the entire research process. Quite simply, "memos are theoretical notes about the data and the conceptual connections between categories" (Holton, 2007, p 281).

Memo writing is the keystone in analysis, as it captures the development of the emergent theory and developments in the researcher's thinking about the data, at all stages of the study. As such, memos are:

> The *core* stage in the process of generating theory, the bedrock of theory generation....*Memos are the theorizing write-up of ideas about codes and their relationships as they strike the analyst while coding.* Memos lead, naturally to abstraction or ideation. Memoing is a constant process that begins when first coding data and continues through reading memos or literature, sorting and writing papers or monographs to the very end.
>
> (Glaser, 1978, p. 83)

Memo writing is intuitive. Grammatical concerns, spelling and other superficialities are unimportant. It is vitally important to interrupt, whatever the researcher is doing, to commit to paper an idea or thought relating to the study as these occur. Memos may allude to a variety of phenomena such as codes, categories, reflections from being in the field, frustration at a false lead, or insights from a supervision session. In short, memos may concern anything that impacts on the research and on the emergent theory.

Memo writing provides an explicit trail of the development of the emerging theory and memos develop in sophistication as the theory becomes more complete. Once a full bank of memos has been developed, they are sorted. This process of sorting memos, and indeed the development of further memos from this sorting, facilitates the writing up of a theory, as Glaser (1978, p. 86) stated: "A highly sortible [sic] memo fund is the source of all writings and lectures from a grounded theory study". A bank of memos is continuously added to throughout the research process and forms the foundation for writing up the grounded theory.

4.4.6 THE LITERATURE REVIEW

The function of the literature review is contested amongst grounded theorists. Classic GT views reading in the substantive area of research, prior to data collection-analysis, as problematic because it is feared that reading at this stage may contaminate the researcher with pre-existent ideas and concepts (Glaser, 1978). The differing opinions regarding prior literature consumption by the researcher, and the use of extant concepts during the initial stages of a study may have arisen because of contradictory beliefs about the role that interpretation plays in data analysis amongst the various schools of GT.[70] From a Classic GT perspective, minimal or no pre-specified concepts are used during the analysis process, unless they prove relevant once the main analytic direction of the study has been established. Proponents of Classic GT claim that the end product of GT is one which arrives solely from the data and the researcher's action on the data (i.e., explicating patterns within the data gathered).

Glaser does not completely prohibit the use of prior reading outside of the substantive area which is being investigated, as discussed in Section 4.4.7 below (Glaser, 1998, pp. 68-73). From a Classic GT perspective, the literature is used, in later stages of analysis, to substantiate the conceptual account provided by the emergent theory. Classic GT advises that reading within the substantive area (in which the inquiry is focused) should take place, but only once a strong analytic direction has been established. Thus, Glaser suggests that the literature review should occur when "the grounded theory is nearly completed during sorting and writing up, then the literature search in the substantive area can be accomplished and woven into the theory..." (Glaser, 1998, p. 67). Also, as the researcher's main task when carrying out a Classic GT study is to uncover the participants' main concern, and how this is being addressed and resolved in the data, it would be impossible to locate which literature to review. Thus, the emergent concern of participants and its resolution specify which literature will be relevant for a discussion about the results of the study. In carrying out a literature review prior to data collection-analysis, the researcher would be pre-empting what the data would reveal (i.e., by presuming to know at the beginning of the study what the nature of the main concern was and how the participants were resolving this).

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[70] For example, Constructivist grounded theorists (Charmaz, 2006) are more forgiving and lenient in terms of extant literature and concept usage, as they see it as impossible to profess to being uncontaminated by any prior professional or personal ideas when approaching the data. Constructivist grounded theorists worry less about contamination from prior reading because of the explicit acknowledgement they make regarding the role that interpretation plays in the CGT research process.

4.4.7 THEORETICAL SENSITIVITY

The preclusion of a prior literature review also enables the researcher to approach the data with less preconceived notions about what might be happening in the data. Glaser noted that reading extant literature dealing with the substantive area under investigation, prior to data collection-analysis, may decrease theoretical sensitivity when he stated: "the first step in gaining theoretical sensitivity is to enter the research setting with as few predetermined ideas as possible-especially logically deduced, a prior [sic] hypotheses" (Glaser, 1978, pp. 2-3). The inclusion of "as possible" has been taken to acknowledge the impossibility of the researcher entering the field as a tabla rasa, entirely free from any prior assumptions.

Theoretical sensitivity concerns the cultivation of a frame of mind which is conducive to conceptualisation and theory generation. Theoretical sensitivity has been defined as "the ability to generate concepts from data and to relate them according to normal models of theory in general, and theory development in sociology in particular" (Glaser & Holton, 2004, para. 43)

How the researcher facilitates the development of theoretical sensitivity varies depending on which version of GT is adopted. Classic GT advocates remaining open, pacing the inquiry, allowing time for concepts to emerge and avoiding any reading within the substantive area (Glaser, 1998). However, reading outside of the substantive areas is recommended, in order to develop theoretical sensitivity by identifying and reflecting on the substantive and theoretical codes emergent in other data (Glaser, 1978).

In order to foster theoretical sensitivity, the researcher asks questions of the data as she codes including: "What is this data a study of?....What category does this incident indicate?" and "what is happening in the data?" (Glaser, 1978, p. 57). Glaser expands on the use of these questions by noting that:

> These three types of question keep the analyst theoretically sensitive and transcending when analyzing, collecting and coding his data. They force him to focus on patterns among incidents which yield codes, and to rise conceptually above fascinating experiences.
>
> (Glaser, 1978, p. 57)

4.4.8 CODING

In Classic GT, coding is the naming of concepts in the data. Codes conceptually condense and capture what is happening in any particular segment of data. Coding is the action that initiates the conceptualisation process which will eventually lead to theory formation as "Coding gets the analyst off the empirical level by fracturing the data, then conceptually grouping it into codes that then become the theory which explains what is happening in the data" (Glaser, 1978, p. 55).

From a GT perspective, coding should not reflect general or descriptive themes in the data. Coding is the naming of patterns as they emerge during analysis. GT assumes that life is patterned and that latent or underlying "patterns" of behaviour exist which people may not be aware of (Glaser, 1998, p. 117). Codes are the foundation for theory development, as depicted in Figure 6 below. As the data is coded, it becomes detached from the place, time and people it was initially associated with. Coding is the initial phase of the GT empirical to abstract transformation, as "by coding (or conceptualizing or categorizing), the data are analyzed by being cut into slices that are constantly compared, and subsequently they may become put together again differently" (Christiansen, 2007, p. 47).

Two different stages of coding are utilised in Classic GT namely substantive and theoretical coding. "Open coding"[71] and "selective coding" occur during the initial stage of coding known as "substantive coding" (Glaser, 1978, p. 55). Substantive coding aims to uncover basic, ideational concepts in the data. "Open coding" is the first form of coding which aims to find the core variable and main concern in the data (Glaser, 1978, pp. 56-61). Once a clear analytic direction has been established (i.e., the participants' main concern has emerged), selective coding is initiated. "Selective coding" aims to delimit the data by focusing coding on the concepts which are relevant only to the core variable (Glaser, 1978, pp. 61-72). The second stage of coding is "theoretical coding" which aims to expose relationships between substantive codes and thus coheres substantive codes into a theory (Glaser, 1978, pp. 72-82). Each form of code will be discussed in more detail below.

4.4.8.1 Open coding

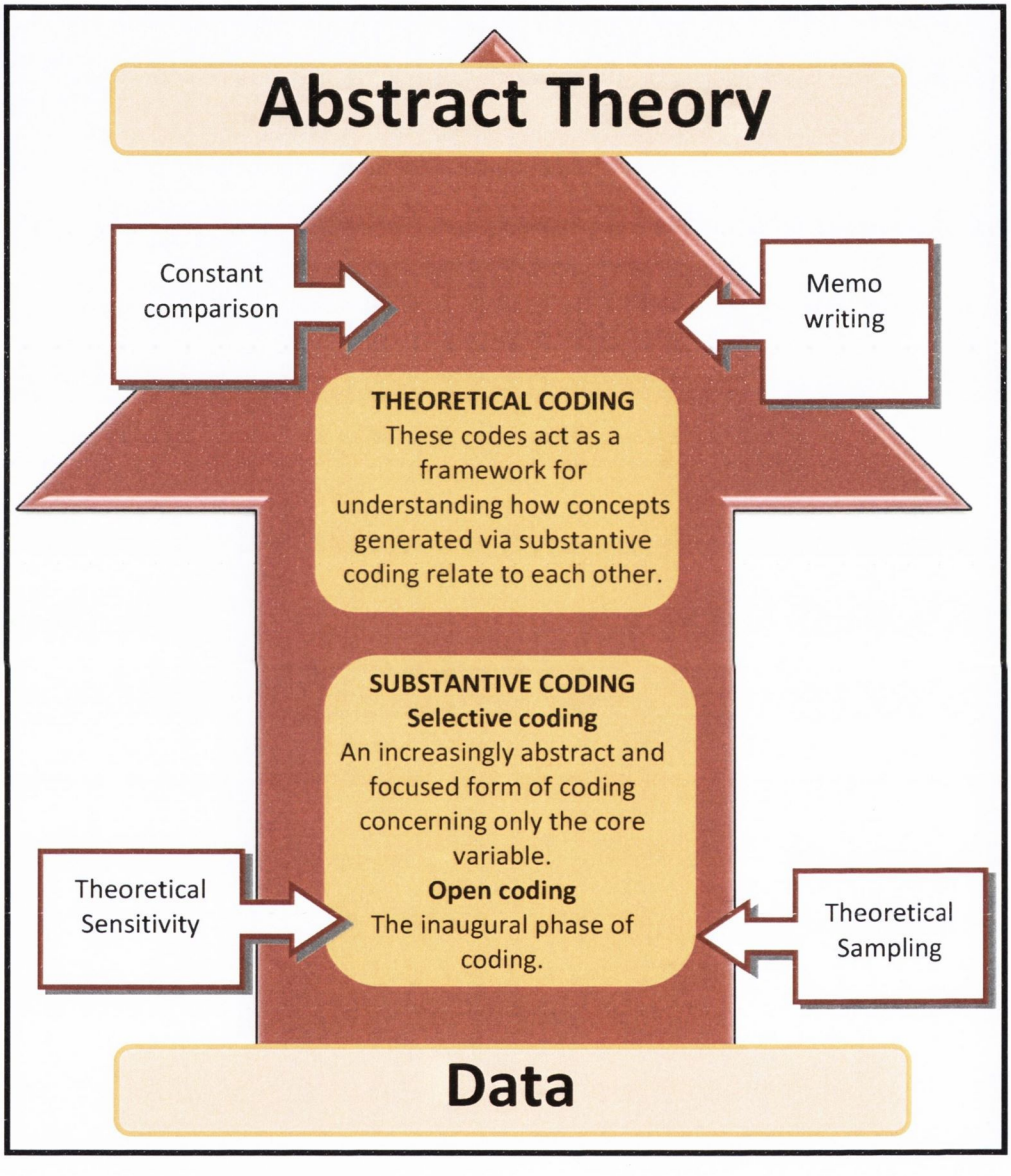
Open coding is the inaugural or initial phase of coding undertaken in a GT analysis. The analyst begins by coding the data in every way possible, breaking the data open and identifying patterns in the data. Open coding can be carried out by examining the data word by word, line by line and/or by comparing incident to incident (Glaser & Strauss, 1967). Open coding is preliminary. It is a catalyst for directing the focus of further sampling in that: "Open coding allows the analyst to see the direction in which to take the study by theoretical sampling before he/she has become selective and focused on a particular problem." (Glaser & Holton, 2004, para. 49).

Codes can be named in a variety of ways. Code names can be generated by the researcher or alternatively, code names can be taken from the subjects' own language used in the data (Glaser & Strauss, 1967). Codes which are labelled by using direct quotes from the participants are known as "in vivo" codes (Glaser & Strauss, 1967, p. 40). In vivo codes are posited as being

[71] In some GT texts, the terms "open" and "initial coding" are used synonymously. However, here the term open coding in preferred, following Glaser (1978, pp. 56-61).

theoretically powerful in capturing latent patterns of behaviour as they explicate taken-for-granted process in the data. Also endorsed is the use of gerunds or action words during coding to expose action in the data. This use of gerunds when labelling codes may facilitate the emergence of processes, as opposed to products and fixed phenomena, in the data (Charmaz, 2006).

FIGURE 6: GROUNDED THEORY PROCEDURES



4.4.8.2 SELECTIVE CODING

Selective coding is discriminating and focused. Selective coding occurs only once the main concern of the participants has emerged from the data. This is because selective coding delimits coding by focusing only on coding data which is pertinent to the main concern of participants. Selective coding involves the re-coding of all the data collected, up until that point, using only codes which are related to the main concern of participants.

Selective codes have the power to integrate large chunks of data. This phase of coding employs second-order conceptual codes, enabling the researcher to group data in order to follow particular analytic paths. Inherent in the process of selective coding is the act of prioritising certain open codes as the codes which are the most significant and relevant to the main concern of participants. The close relationship between the core variable and selective coding is explicated by Glaser and Holton (2004, para. 55) when they note that: "Selective coding means to cease open coding and to delimit coding to only those variables that relate to the core variable in sufficiently significant ways as to produce a parsimonious theory."

As selective codes chunk larger units of data, they are often categories of concepts. Categories can emerge during all phases of coding but are more likely to emerge later during more advanced coding stages (such as selective coding or theoretical coding). Categories are higher-order codes which subsume other codes. As such, they are super-ordinate codes which function to integrate and organise the data. GT categories have been defined as "a conglomeration of similar coded indications with a common label" (Hylander, 2003, p. 271).

Categories are stand alone concepts which are conceptually dense and robust. The various aspects of a category are known as properties, as Glaser & Strauss (1967, p. 36) point out: "A category stands by itself as a conceptual element of the theory. A property, in turn, is a conceptual aspect or element of the category."

4.4.8.3 Theoretical coding

The relationship between selective codes is made explicit using theoretical codes. Theoretical codes serve a different purpose to substantive codes in that they explicate the relationships and associations between codes. Theoretical codes emerge during the later stages of analysis when the data has been fractured open into abstract codes and facilitates the data being reintegrated conceptually into a coherent whole. Theoretical codes act as a model or conceptual framework on which a grounded theory is hung. Theoretical codes integrate the emergent theory by explicating the conceptual relationships, associations and associations between substantive concepts (i.e., open and selective codes) which have arisen from the data.

A theoretical code can remain implicitly stated in the discussion of the data, but when explicated it can foster an increased sense of coherence in the grounded theory as:

> Theoretical codes implicitly conceptualise how the substantive codes will relate to each other as a modelled, interrelated, multivariate set of hypotheses in accounting for resolving the main concern. They are emergent and weave the fractured substantive story turned into substantive concepts back into an organized theory.
>
> (Glaser, 2005, p. 11)

Extant families of theoretical codes are available in GT texts (Glaser, 1978, 1998, 2005).[72] However, other theoretical codes always await existence in the data and the list of theoretical codes provided within GT texts is intended to be suggestive rather than exhaustive. As pre-specified concepts, extant theoretical codes should only be used in the instances in which they fit the data (Glaser, 1978).

4.4.9 CONCLUSION: THE GT END PRODUCT

In summary, the generic procedural characteristics of GT are as follows: coding, constant comparative analysis, memo writing, theoretical sampling and theoretical saturation (Glaser, 1998, 2005a).

As oversimplified as it sounds, it is important to be cognisant of the fact that the aim of Classic GT methodology is to produce a grounded theory. The aim is not to produce an accurate and representative description, or to verify extant theories. Classic GT aims to create an abstract and integrated conceptual account of the subjects' main concerns which emerge from the data collected. Thus, the Classic GT end product is a conceptual theory that accounts for, yet also transcends, the patterns and variations within the data it was generated from, in that:

> The goal of grounded theory is to generate a conceptual theory that accounts for a pattern of behaviour which is relevant and problematic for those involved. The goal is not voluminous description, not clever verification.
>
> (Glaser, 1978, p. 93)

4.5 GROUNDED THEORY AS A RESEARCH METHODOLOGY IN HEALTH CARE

4.5.1 THE SUITABILITY OF EMPLOYING GROUNDED THEORY IN CLINICAL CONTEXTS

Since its delineation, GT has grown in popularity and is now a commonly employed methodology enlisted across the broad field of qualitative research (Titscher & Jenner, 2000). A significant body of research exists employing GT as a method, across the various disciplines involved in the health care services, most notably within the discipline of nursing (McCann & Clark, 2003b).

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[72] The extant coding families available in the GT literature offer codes which have emerged in previous studies as models for various phenomena and process such as: "...the temporal family...social constraints... the causal family..."(Glaser, 2005, pp. 22-29).

GT has the potential to be utilised in applied knowledge professions. GT may be useful in explicating the taken-for-granted processes which influence the application of knowledge, in settings such as health and business, as noted by Glaser (1999). GT is useful for exploring issues regarding the practical task of delivering support and intervention in health care services. GT's ability to deal with "dynamic" environments and to expose implicit phenomena makes it amenable to exploring many aspects of heath care services:

> The environment in which health care is provided is dynamic. Practitioners' perspectives of giving care are important and so is the impact of the policies on the provision of care. Using Grounded Theory to make these explicit and can provide others with knowledge to change or enhance their own practice for the benefit of clients.
>
> (Bluff, 2005, p. 157)

4.5.2 GROUNDED THEORY AND SPEECH AND LANGUAGE THERAPY

GT is not yet widely employed as a research methodology within the discipline of SLT, yet it provides a potentially effective research tool for the profession, as pointed out by Damico and Simmons-Mackie (2003, p. 139), "though not widely used in clinical speech-language pathology, this tradition of inquiry [Grounded Theory] does provide some powerful analytic power that can be effectively applied in our discipline" [Words in brackets have been added].

GT has been used by researchers to explore a range of phenomena, across SLT practice. However, studies which attempt to shed light on service user perceptions are disproportionately represented in the relatively small body of SLT research which has employed a GT approach (e.g., Fourie, 2009).

Briefly, GT has been used within the context of SLT to expose similarities and differences between service user and SLT models of language and intervention (Marshall, Goldbart & Phillips, 2007); to explore the process of discharge (Hersh, 2003, 2009); to uncover issues relevant to quality of life in the presence of speech and language difference and difficulty (Markham & Dean, 2006) and to explore the clinician-client therapeutic relationship (Fourie, 2009). GT has also been used to investigate the implementation of new methods for evaluating SLT inputs (Skeat & Perry, 2008a) and to explore particular models of SLT service delivery (Graves, 2007).

GT has been advocated as a potent tool for the purposes of research within the SLT community, particularly in light of the dearth of theory within the discipline of SLT (Damico & Simmons-Mackie, 2003). GT as a methodology is particularly amenable to the goal of conceptualisation and moving beyond description, which may be particularly relevant to a discipline which lacks "theoretical frameworks":

> Grounded theory allows discovery of concepts which provide explanation and understanding, rather than a thorough description.
>
> Qualitative research is being embraced by the profession, and grounded theory, although sometimes a difficult method for a beginner to grasp, offers a means of providing a better understanding of complex areas of speech and language therapy practice. For this reason this methodology lends itself to speech and language therapy research, particularly in areas where theoretical frameworks are few and far between, and/or where clarity is needed about underlying social process.
>
> (Skeat & Perry, 2008b, p. 108)

SUMMARY

As GT is amenable to exposing subjects' main concerns and how these are managed, in areas where little or no research has taken place, it presents as a suitable research method for the current study. GT's ability to offer the researcher a systematic, yet flexible approach to the process of data gathering and analysis endorses it as a valuable research tool for guiding the present exploratory study. Additionally, GT's openness to a variety of data sources and its ability to facilitate the researcher in generating an analytical account of the data make it readily applicable to the current purpose.

This chapter has demonstrated the author's grasp of GT procedures and has highlighted the complexities and contentions which exist between different members of the GT family of methods. Additionally, the reasons for selecting Classic GT as the methodology of choice for the present study were discussed. The following chapter details how the process of Classic GT was operationalised by the author.

CHAPTER 5. DATA GENERATION: OPERATIONALISING CLASSIC GROUNDED THEORY

INTRODUCTION

Chapter 4 gave an overview of Classic GT as the methodology of choice for the current study. The purpose of this chapter is to present a transparent account of the data generation-analysis process, prior to a discussion of the results of data analysis in Chapters 6-9. In doing so, an account will be provided illustrating how Classic GT procedures were realised in this study. Additionally, the use of questionnaires, documents, focus groups and interviews as data gathering tools in this study will be discussed.

5.1 OVERVIEW OF THE PROCESS OF DATA GENERATION

Data collection was initiated by inviting practising SLTs to complete questionnaires. The only inclusion criteria set were that the participants were practising SLTs, at the time of participation, and that they were interested and available to participate. Convenience sampling was used to recruit initial participants. As is typical when using the Classic GT methodology, the process of theoretical sampling[73] was employed following an initial period of convenience sampling.

In order to explore the emerging concerns of the SLT community arising from questionnaire data in greater depth, focus groups with practising clinicians were initiated, as was the analysis of commercially available intervention resources. Initial data analysis, drawing on questionnaire data, had suggested that certain resources in the form of commercially available materials were significant for participants in the context of clinical pragmatics and SLT practice. These documents (i.e., published intervention materials) were targeted as sites for data generation. The intervention materials chosen for analysis were those which were commonly cited by participants in questionnaires.

Following the analysis of questionnaires, focus groups and commercially available intervention materials, a final phase of data gathering comprising interviews with practising SLTs and SLT educators was embarked upon. In this final stage of data gathering, specific conceptual facets of the emerging theory were explored in depth with participants and theoretical saturation was achieved.

[73] As discussed in Chapter 4, theoretical sampling involves sampling on the basis of the emerging concepts and sampling for increasing the conceptual density and completeness of the emergent theory.

The processes of data gathering and analysis occurred concomitantly, which allowed both processes to influence each other. Figure 7 gives an overview of all of the data sites involved in this study and illustrates the methods employed to collect data in each site. The interaction between data sources and GT procedures is also depicted in Figure 7.[74]

5.2 SELECTING AND CREATING TOOLS FOR DATA GENERATION IN EACH SITE

As highlighted in Figure 7 below, questionnaires, documents, focus groups and interviews were the methods used in gathering data from different members of the SLT community. The purpose, construction and use of these data gathering tools will be discussed, in turn, below.

5.2.1 QUESTIONNAIRES

5.2.1.1 THE PURPOSE OF QUESTIONNAIRES

Questionnaires were used as the initial data gathering tool in this study.[75] It was anticipated that the use of questionnaires would not only generate an initial source of data, but that the analysis of questionnaire responses would also reveal a direction for further data sampling and analysis.

As an initial data gathering tool, some of the questions on the questionnaire were open in order to expose the SLT community's main concern with reference to the area of clinical pragmatics. Closed or multiple-choice questions were also employed to target more specific aspects of practice with reference to the subject area of clinical pragmatics (such as diagnostic practices and criteria used for discharge).

The use of questionnaires as a viable method for obtaining information regarding the clinical practice of SLTs has been suggested in the literature (Pring, 2005). As well as obtaining some descriptive data (such as the names of materials and resources used by clinicians), it was expected that the questionnaires would provide initial tentative information about issues and concerns in the area of clinical pragmatics and SLT practice. As noted by Robson (2002, p. 235), questionnaires can provide more than descriptive information, as it is possible "to use the survey to provide explanations of the phenomena studied and the patterns of results obtained". Explicating patterns in the data for the purpose of theory generation was, of course, the aim of this study. Although it is possible to carry out a Classic GT study utilising questionnaire data only (e.g., Thulesius, 2009), the relatively thin data returned in these questionnaires required supplementary data collection.

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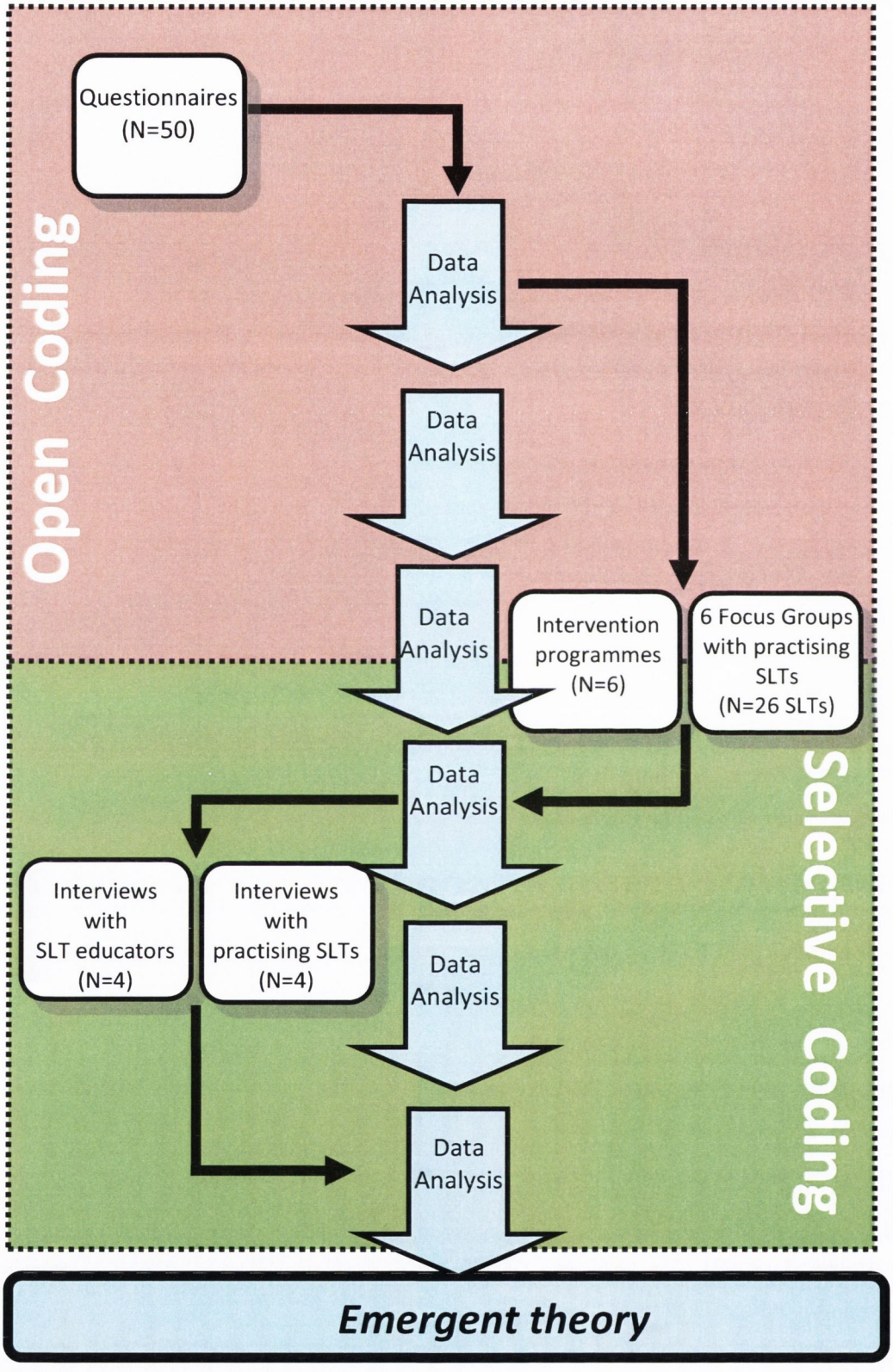
[74] Appendix 1 contains a figure outlining, in greater detail, the sequence of data generation-analysis, in relation to seeking ethics approval, at the appropriate junctures.

[75] A blank questionnaire can be found in Appendix 2.

FIGURE 7: OVERVIEW OF THE DATA GENERATION-ANALYSIS PROCESS



5.2.1.2 Developing questionnaire content

It has been suggested that when using questionnaires, large discrepancies can exist between reported beliefs/attitudes and actual behaviours (Foddy, 1993). However, there are safeguards which can be used during questionnaire design to minimise these discrepancies, as will be discussed below. Also, the use of multiple data sites, as in this study, helped to ensure that any discrepancies might be made explicit via the process of contrasting and comparing data from different sources during analysis.

Forty-three of the questionnaires were returned anonymously in the post, while seven questionnaires were returned via email. No identifying information was sought in questionnaires. If any was obtained inadvertently (as some questionnaires were returned via email and as there were open questions on the questionnaire), this identifying information was subsequently omitted from further data analysis. The use of self administered questionnaires, rather than face-to-face questionnaires, has been suggested as a method for reducing the risk of social desirability influencing the way in which questionnaires are completed. Social desirability may account in part for the discrepancy between reported beliefs/attitudes and actual behaviour (Bowling, 2002).

The content of the questionnaires was developed by considering how best to begin uncovering concerns about SLT practice in the area of clinical pragmatics. Table 1, below, highlights the focus of the questions which were included on the questionnaire.

Table 1: Exploring questionnaire content

Question Numbers	Question focus	Examples	Question type
1-5 & 18	Explored how the subject area of pragmatics was conceptualised in the context of SLT practice.	Q 1. In your clinical experience, by virtue of presenting with Speech and language difficulties, clients also present with Pragmatic language difficulties, to some extent. ☐ True ☐ False ☐ Unsure ☐ Don't know	Closed
6-9	Explored the process of assessment, in relation to pragmatics in a clinical context	Q 7. What features lead you to suspect Pragmatic language difficulties in an adult or child?	Open

10-14	Explored the intervention process in relation to pragmatics in a clinical context	Q 10. In one of your SLT sessions focusing on Pragmatics, what might 3 typical objectives/goals/areas of focus be? Q 14. In your experience, SLT Intervention for clients with Pragmatic language difficulties generally occurs in which of the following settings: ☐ 1:1 setting ☐ 2/3:1 setting (small group) ☐ 4+:1 setting (larger group) ☐ 1:2 setting (joint setting with other professional) ☐ Other, please specify : _____	Open Closed
15-17	Explored the measurement of intervention with regards to pragmatics in a clinical context	Q 15. In your daily clinical practice, differences or changes in Pragmatic language are measured pre and post therapy? ☐ Yes Please specify method(s) used: _____ ☐ No ☐ Sometimes ☐ Don't know	Closed
19	Explored how much of their intervention a clinician considered to be pragmatically orientated	Q 19. Roughly speaking what percentage of your therapy is pragmatically orientated, i.e. focuses on the area of pragmatics? ☐ 0-10% ☐ 10-30% ☐ 30-50% ☐ 50% or more ☐ Other, please specify: _____	Closed
20-21	Specific biographical and demographical information sought	Q 20. How long are you practising as a SLT: ☐ 0-5 years ☐ 5-10 years ☐ 10-15 years ☐ 15+ years	Closed

Questions numbered 1-5, and question number 18 focused on shedding light on the participants' conceptualisations of the subject area of pragmatics. The response frame for these questions was

both open and closed. Open questions explored how pragmatics, and cognate terms, were described by participants to other parties (such as parents, other professionals and SLT students) during the clinical process.

Questions numbered 6-9 focused on the assessment process. The author sought a description of the tools and resources being used by SLTs when assessing pragmatics clinically, and also sought information on the phenomena and domains that were considered important when assessing individuals with regards to clinical pragmatics. Here, the question response frames were open and closed (e.g., using multiple choice questions to examine if participants considered it appropriate for a clinician to independently make a diagnosis of Pragmatic Language Impairment).

Questions numbered 10-14 explored various aspects of the SLT intervention process with reference to clinical pragmatics. These questions varied from asking about particular details of practice in the area of clinical pragmatics (with regard to intervention settings or collaboration with others during intervention), to using open questions to shed light on the types of activities and goals focused on during SLT intervention in this area.

Questions numbered 15-17 focused on exposing how intervention in the area of clinical pragmatics was measured. Question number 19 sought specific information about how much of their interventions the participants regarded as involving pragmatics. Finally, questions numbered 20-21 sought some biographical information in order that general characteristics of the participants involved were made known to the researcher.

As might be noted from the examples given in Table 1, the response frames within the questionnaire varied and included open and closed questions. The open questions included short clinical vignettes (i.e., brief hypothetical clinical situations which requested a response). Other open questions involved questions which sought information about aspects of practice (e.g., "**Q 7. What features lead you to *diagnose* Pragmatic language difficulties in an adult or child?**"). It has been noted that the answers to hypothetical questions (as in the clinical vignettes used in this questionnaire) may supply more realistic descriptions of behaviour when the subjects questioned have had direct experience or knowledge of the topic in the hypothetical question (Arksey & Knight, 1999). The clinical vignettes which were used in the questionnaire were constructed to reflect situations therapists might have encountered while working as a Speech and Language Therapist, such as the situations described in questions numbered 2 and 5, in Table 2 below.

TABLE 2: QUESTIONS NO. 2 AND NO. 5 FROM THE QUESTIONNAIRE

Question Number	Questions taken from Questionnaire
Q. 2	"If you had to describe 'Pragmatics/Pragmatic Language' to a parent/carer/spouse what would you say?
Q. 5	"A final year Speech and Language Therapy student is on clinical placement with you. She/he asks you what 'Pragmatic Language Difficulties/Impairment' means? How would you explain this to the student?"

The closed question-answering frames ranged from multiple choice questions to true/false style questions. The design of the questionnaire followed general guidelines taking into account factors such as question ordering, seeking verification before knowledge, reducing bias in language used and maintaining participant interest (Bowling, 2002; Foddy, 1993; Leedy & Ormrod, 2005; Robson, 2002).

Self-administered postal questionnaires have a notoriously low response rate (Robson, 2002). Guidelines for maximising response rate were followed. These guidelines included, enclosing a stamped addressed envelope with postal questionnaires, enclosing a cover letter discussing the purpose and significance of the research, keeping the questionnaire brief, using reminder letters[76] and also using an inviting and clear questionnaire format (Leedy & Ormrod, 2005). Typical response rates for questionnaire return have been cited as 25% (when a general population is targeted) and 50% when a specific population is sampled (Pring, 2005). These figures vary considerably in the research literature. No definitive figure can be generated for the response rate of questionnaire for this study because of the methods in which questionnaires were distributed (i.e., via post and email to SLT managers). The SLT managers, as gatekeepers, were invited to use their discretion and to distribute the questionnaire to as many SLTs as they saw fit (i.e., electronically or by the distribution of hard copies of the questionnaire).

The questionnaire was piloted on three practising SLTs, with a view to troubleshoot any unforeseen difficulties with question structure or content, prior to distribution of the questionnaire on a larger scale. After completing the pilot questionnaire, a short discussion with each participant and feedback in terms of ease of completion, question comprehension and question style was carried out. Any suggested amendments were then made.

[76] See Appendix 4 for a copy of these reminder letters.

To conclude this discussion of the development of questionnaire content, it is may be salutary to acknowledge that the questions drew on the SLT vernacular and made use of terms such as "Pragmatic Language Difficulties/Impairment". References to terminology such as these exposed the difficulty of disengaging the clinical from researcher perspective in carrying out a study in a familiar substantive area. The related issue of researcher bias will be discussed in more detail in Chapter 12 in relation to an evaluation of rigour and limitations of the current study. For now perhaps it is sufficient to acknowledge that it was accepted that the researcher's status as a practising SLT, exposed in particular by this use of SLT jargon, was impossible to fully divorce from her role as a researcher. However, as the researcher was also a practising clinician, it was notable that participants engaged readily with the researcher in the SLT vernacular and that participants appeared to respond to her status as a SLT colleague by offering open, and at times in-depth, accounts of issues of importance and concern to them.

All terms used in developing the questionnaire content such as "Formal Assessment...Pragmatic Language Impairment" exposed the researcher's prior knowledge about SLT practice and the objects that characterise it. Unlike, later data gathering in which data collection was live, the researcher could not follow the lead of the participants by using their language and paraphrasing their concerns during data collection. As noted, however, the purpose of the questionnaires was to get a sense of issues of importance and concern for members of the SLT community with a view to further data sampling and the generation of denser forms of data.

5.2.1.3 Distribution of questionnaires

Questionnaires were distributed to a convenience sample of SLTs, following permission being granted from the relevant Research Ethics Committee.[77] Firstly, SLT managers were contacted as participant gatekeepers, via post and email. Subsequently, soft (electronic) and multiple hard (printed questionnaire) versions of the questionnaire, were sent to 26 SLT managers, with a cover letter.[78] The managers were invited to distribute the questionnaire electronically or alternatively to allocate or photocopy additional hard copies of the questionnaires that were supplied to them as they required.

Secondly, the chair of a national SLT managers association was asked to invite members of that organisation to be participant gatekeepers for the study. Consequently, this chairperson

[77] Trinity College Research Ethics Committee granted permission on (a) 18/02/08, (b) 04/11/08, and (c) 30/04/09 for the author to (a) invite practising SLTs to participate in focus groups and questionnaires, (b) invite SLT educators to participate in interviews, and (c)invite practising SLTs and clinicians from other disciplines to participate in interviews.

[78] A copy of the template cover letter inviting participants to complete questionnaires and take part in focus groups can be found in Appendix 3.

forwarded an electronic version of the questionnaire to SLT managers (for distribution to their staff as they saw fit), with a cover letter from the researcher.

Thirdly, the questionnaire was also distributed to a group of 44 SLTs, following a meeting organised by a national professional association of SLTs. (Permission to distribute questionnaires was granted by prior arrangement, via email, with the then chair of this organisation.)

In total, fifty completed questionnaires were returned, all of which were submitted for analysis. The questionnaire responses provided a glimpse of the issues of concern to the 50 SLTs surveyed.[79]

5.2.2 Documents: Commercially Available Intervention Resources

5.2.2.1 The Purpose of Analysing Commercially Available Intervention Resources

Initially, I was interested to uncover the types of commercially available materials which were utilised by members of the SLT community in relation to clinical pragmatics. As such, SLTs were asked which of these they used during their practice in the context of pragmatics (questions numbered 9 and 13 on the questionnaire; as illustrated in Table 3 below).

Table 3: Questions no. 9 and no. 13 from the questionnaire

Question Number	Questions taken from Questionnaire
Q. 9	"A client presents with language and communication difficulties despite the fact that their standardised scores from formal assessment (e.g. The Test of Pragmatic Language 2, Western Aphasia Battery, or the Clinical Evaluation of Language Fundamentals) are all falling within the average range. What further assessments or forms of assessment might you carry out?"
Q. 13	"When working with clients with Pragmatic language difficulties please specify which published materials and resources you use (e.g. assessments, therapy programs, books etc). Please rate each one on a scale of 1 to 5, with 1 being not very useful, and 5 being very useful."

The analysis of questionnaire data revealed that references to these commercially available intervention resources were being made elsewhere on the questionnaire. For example,

[79] The relatively small numbers of practising SLTs in Ireland means that 50 SLTs reflected a sample of approximately 7% of the national population of working SLTs. This figure is based on the total figure of working SLTs being 735, as noted in the *"Current and Future Supply and Demand Conditions in the Labour Market for Certain Professional Therapists"* report, funded by the Irish government, regarding current and future demand for various clinicians including SLTs (Peter Bacon and Associates, 2001, p. 16).

frequently, formal assessments and checklists from pragmatics programmes appeared to be used to confirm clinical hunches in clinical decision-making.

These clinical resources (namely intervention assessments and programmes) were also cited by participants as being used as a reference for explaining pragmatics to student SLTs, as illustrated in Extract 5.1. As such, these documents appeared to play a significant role and particular function in SLT practice, in the area of clinical pragmatics (which was subsequently explored in greater depth in focus groups and interviews following theoretical sampling).

EXTRACT 5.1

"Q 5. A final year Speech and Language Therapy student is on clinical placement with you. She/he asks you what 'Pragmatic Language Difficulties/Impairment' means, how would you explain this to the student?

Again I would give a similar explanation I might give more detail eg re: intonation, volume, rate development of pragmatic skills beginning with turn taking. I would give the book Talkabout for him/her to look through"

Questionnaire No. 6

Thus, it was decided that a selection of these documents would also be included in analysis. Six commercially available intervention resources were submitted as data, as discussed below, and subsumed within the overall GT analysis.

5.2.2.2 INTERVENTION RESOURCES SAMPLING PROCEDURE

The resources and materials which were explicitly referenced by SLTs in completed questionnaires were used as a pool from which to select documents for analysis. As noted above, references made by participants to clinical resources (such as intervention programmes and assessments), resulted from explicitly asking clinicians to detail the resources they found useful in the area of clinical pragmatics. Participants also spontaneously made reference to these documents during questionnaire completion. Despite a wide variety of materials being mentioned, there was a considerable consensus around the choice of a core group of programmes and assessments (see Appendix 7 for details of the frequency of citation of these resources, in questionnaire responses). The *Conversational Analysis Profile for People with Aphasia*, despite its low rate of citation by participants, was included as it was one of the few resources which was specified in questionnaire responses orientated towards an adult clinical population. Additionally, documents which were total intervention resources, as opposed to assessment resources only, were chosen for analysis. Total intervention resources often contained an assessment section or assessment materials. The

selection of these documents facilitated the researcher in exploring the process of intervention as well as the assessment process. The materials below in Table 4 were selected for analysis:

TABLE 4: DOCUMENTS SUBMITTED TO ANALYSIS

Commercially available intervention resources submitted to GT analysis
1-*Socially Speaking* (Schroeder, 1996)
2-*The Social Use of Language Programme* (Rinaldi, 1992a, 1992b)
3-*Semantic-Pragmatic Language Disorder* (Firth & Venkatesh, 1999a, 1999b, 1999c)
4-*Working with Pragmatics* (Anderson-Wood & Rae-Smith, 2001)
5-*Conversational Analysis Profile for People with Aphasia* (Whitworth, Perkins & Lesser, 1997a, 19997b, 1997c, 1997d, 1997e)
6-*Talkabout* (Kelly, 2001)

5.2.3 FOCUS GROUPS

5.2.3.1 THE PURPOSE OF FOCUS GROUPS

The next phase of the data generation process involved the use of focus group interviews with practising SLTs. Focus groups and interviews have been noted as being useful because not only can they facilitate an in-depth exploration of complex issues, but they also allow for on-line discussion and clarification of issues as they arise (Puchta & Potter, 2004). The use of talk in interaction (generated via focus groups and other methodologies) as a rich and rewarding data form is well established (Wetherell, Taylor & Yates, 2001). Perhaps, then, it is unsurprising that grounded theorists tend to be drawn towards generation of data using focus groups and interviews, in particular, as noted by Charmaz (2006).

Focus groups also provided a platform for exploring any negative evidence that emerged. Negative evidence is data which does not conform to previous data gathered and refutes or offers alternatives to initial hypotheses. Focus groups allowed for on-line exploration of any negative evidence as it arose. While quantitatively this kind of data can be problematic, variance in data is often embraced within many qualitative methods (Miles & Huberman, 1994), as it is from the GT perspective (where concepts are generated based on both the patterns and variance in data). Variance in data or negative evidence in the emergent patterns can suggest a new or alternative analytic lead and may result in a new direction for theoretical sampling. Variance is also helpful in confirming or disconfirming emerging theoretical assumptions within a GT framework (Glaser, 1978).

5.2.3.2 FOCUS GROUP SAMPLING PROCEDURE

As noted previously, initially in this study convenience sampling was employed, followed by theoretically purposive sampling. Focus group participants were recruited initially by distributing flyers which were attached to the blank questionnaires. This initial recruitment tactic resulted in a poor response rate. Therefore, the researcher contacted a sample of SLT managers (from divergent areas of practice) directly by phone and email in order to invite participation. This method of inviting participation proved more successful, with six focus groups resulting. Directly contacting SLT managers, in this manner, also allowed for sampling of SLTs who were working with specific clinical populations. I chose to specifically sample some SLTs working within areas which were more traditionally considered to be associated with clinical pragmatics, and some who were not. Therapists working with clients diagnosed with Autistic Spectrum Disorders have traditionally focused their interventions on speech and language skills which have been deemed pragmatic in nature (Bishop, Maybery, Wong, Maley & Hallmayer, 2006; Philofsky, Fidler & Hepburn, 2007; Rapin & Dunn, 1997, 2003). I also sampled clinicians who were working with clients whose diagnoses would not traditionally be associated with intervention orientated towards pragmatics. For example, SLTs working with children with a diagnosis of "Primary Speech and Language Delay" or disorder may or may not work on facilitating the development of pragmatic language or pragmatic skills with their clients (Law, Garrett & Nye, 2004).

Clinical guidelines from one of the SLT profession's representative organisations have also alluded to a coupling of interventions focusing on pragmatics with diagnostic groups. Here, pragmatics has been considered particularly relevant or irrelevant for individuals with specific speech and language diagnoses and/or for specific clinical populations (Royal College of Speech & Language Therapists, 2005).

Thus, therapists working with different clinical populations (as detailed in Table 5 below[80]) were sampled as a way to generate data that contained some variance (participants who worked with different clinical populations) as well as similarities (participants all worked as SLTs) in the overall data set.

Concepts and codes that arose from previous analysis of questionnaires and intervention programmes were used to develop an awareness of issues which might arise in the focus group data. As focus group data generation progressed, initial open codes and conceptual categories emerged. The emerging concepts which were recurrent and significant were incorporated into the prompts used in later data collection. Thus, information from data analysis informed and

[80] More in-depth face sheet/biographical information about the participants in each focus group is provided in Appendix 5.

influenced further data generation in an ongoing and iterative manner, throughout the entire data generation process.

TABLE 5: INFORMATION ON CLINICAL SETTINGS IN WHICH FOCUS GROUP PARTICIPANTS WORKED

Focus Group No.	Clinical Populations	No. of subjects
Focus Group 1	Paediatric community care setting: All SLTs had a general paediatric caseload.	9
Focus Group 2	Paediatric setting: All SLTs were working with children with physical and learning disabilities and/or acquired neurological injuries. One Speech and Language Therapist in this focus group also worked with adults with physical and learning disabilities and/or acquired neurological injuries.	5
Focus Group 3	Paediatric setting: All SLTs were working specifically with children who had been diagnosed with Autistic Spectrum Disorders (ASD). One participant in this focus group also worked with children with learning disability and developmental language disorders.	3
Focus Group 4	Paediatric community care setting: All SLTs had general paediatric caseload. One Speech and Language Therapist also worked with a caseload of children who had been diagnosed with ASD.	3
Focus Group 5	Adult setting: All SLTs were working exclusively with adults with intellectual disability and/or mental health issues.	3
Focus Group 6	Adult acute hospital setting: All SLTs were working with adults with acquired neurological disorders and voice disorders.	3

5.2.3.3 CONDUCTING THE FOCUS GROUPS

The focus groups were loosely structured group interviews involving groups of 3-9 SLTs as participants. The author's role during the focus group was to act as the focus group facilitator. The group facilitator acts as a catalyst in initiating the interaction and facilitating the continuation of the discussion via the use of a topic schedule or by following the emerging concerns of participants.

A topic schedule is a list that can be used to both facilitate and guide discussion (Bowling, 2002, p. 395). A very loose "template" of a topic schedule was brought into each focus group. The topic schedule comprised of prompts which might focus the discussion on exploring some of the most significant concepts that had emerged from the data analysed up until that point. The use of a topic schedule is not endorsed from a GT perspective (Glaser, 1998). However, a topic schedule was developed to act as a mechanism which ensured that if prompts were needed by the group facilitator (particularly, in light of her status as a novice researcher), a bank of prompts were available which were specifically relevant to the emerging concepts. A topic schedule was also

developed in part to satisfy Research Ethics Committee requirements. However, the precautionary provision of the topic schedule was not required in any of the focus groups, as participants were observed to readily engage in discussions about their concerns, with limited prompting from the group facilitator. Thus, the group facilitator's input to the discussion was often quite minimal and tended to function only to explore, expand or clarify a particular point which had been raised by participants, or to seek clarification from the participants regarding previously emerging concepts. In line with the GT focus of developing an understanding of and uncovering issues of concern to participants, a flexible and "responsive" interviewing structure was evoked in which "many of the questions asked emerge only during the course of the research" (Rubin & Rubin, 2005, p. 35).

In order to minimise disruption to clinical schedules, focus groups were held in the participants' places of work. The groups ran for no longer than two hours and a break of between 10-20 minutes was included midway through the recording. As is advised, light refreshments were provided throughout the focus group (Bloor, 2001). Prior to initiating the interview, ground rules for the focus group were stated and agreed with all participants as part of the introduction or "briefing" (Kvale & Brinkmann, 2009, p. 128). Each focus group was introduced with a briefing during which the researcher discussed the purpose and format of the focus group, highlighted focus group ground rules, and asked if participants had any questions or concerns they would like to voice before the recording equipment was switched on. Additionally, informed consent was obtained in writing prior to each recording.[81] Participants had access to information about the nature of the research at least one week before the focus group took place, and participants were free to withdraw from participation at any time prior to or during the focus group, as had been agreed when research ethics approval was granted. At the closing of each focus group a consensus was reached that the focus group was over by asking participants if they would like to contribute any final points or return to or revise any earlier part of the discussion.

The remit of focus group facilitator also included ensuring that the audio-equipment was functioning correctly. Audio recordings were made during each focus group, using both digital and analogue equipment (an Olympus digital voice recorder VN-4100 PC and a Sony mini-disc MZ-G750 recorder). The data from the focus groups was transcribed from audio-recordings by the researcher, as soon as possible after each focus group, following Jefferson transcription conventions (Jefferson, 2004). However, for ease of reading and as this is a grounded theory study, the data is presented throughout the thesis orthographically, rather than in full Jefferson style transcription.

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[81] See Appendix 6 for a template of the form used to secure informed consent from participants.

By the time later focus groups were being carried out (i.e., when running Focus Groups 5 and 6) a main concern was emerging consistently across the data. At this stage, selective coding was commenced. As discussed in Chapter 4, selective coding focused data analysis on concepts relevant to the subjects' main concern and its resolution. Certain codes appeared significant both in terms of frequency and, more importantly, in terms of the explanatory power which they possessed in making sense of the data. These codes were prioritised in data gathering from this stage onwards and the researcher began to focus data gathering and analysis on the theoretical saturation of these concepts in particular.

The entire body of data which had been gathered up to this point (i.e., data collected via the use of questionnaires, focus groups and the analysis of published, commercially available intervention materials) was re-analysed in light of the emergence of these selective codes. During this phase of analysis some increases in the conceptual density of the selective codes was achieved, and some analytic leads regarding the relationships and associations between the codes were suggested.

However, the selective codes remained unsaturated at this stage and further data generation was required. Thus, after the completion of six focus groups it became evident that conceptual understanding of the categories and properties of the selective codes, specifically in terms of how they related to each other, required further data collection and analysis. Ethics permission was again sought and granted at this juncture. Subsequently, the researcher approached individual SLTs and SLT educators to participate in interviews. This was to be the final phase of data collection.

5.2.4 INTERVIEWS

5.2.4.1 THE PURPOSE OF INTERVIEWS

The purpose of interviewing practising SLTs and SLT educators was to increase the conceptual density of the emergent theory by saturating the concepts apposite to it. Additionally, a greater understanding of the relationships and associations between significant concepts was required. Interviews were specifically employed at this later stage of data analysis, as they were a data gathering tool which would allow for theoretical sampling of particular concepts and the emergent theory in some depth.

5.2.4.2 INTERVIEW SAMPLING PROCEDURE

As the setting or area of practice in which participants worked had not been a significant issue in terms of influencing the emerging patterns in data analysis, it was not necessary to seek

participants who worked with any particular clinical population for this phase of data gathering. However, the regular references to third-level education as an influential and even primary site in which clinicians learned about clinical pragmatics led the researcher to specifically sample SLT educators. Permission to contact SLT educators was gained from the heads of academic departments. Following this permission being obtained, a general invitation was emailed to all members of these departments inviting any member of the teacher staff, who self-selected themselves as drawing on the area of pragmatics in their teaching of SLT students, to participate in interviews. This resulted in four SLT educators contacting the researcher. Additionally, a convenience sample of four practising SLTs were contacted directly, via email, and were invited to participate in interviews. General face sheet/biographical details about interview participants are provided in Table 6 below.[82]

TABLE 6: GENERAL FACE SHEET/BIOGRAPHICAL INFORMATION ABOUT INTERVIEW PARTICIPANTS

Interview No.	SLT educator/clinician	Total years working as a SLT or SLT educator
Interview No.1	SLT educator and practising clinician	5-10 years
Interview No. 2	SLT educator and practising clinician	0-5 years
Interview No. 3	Practising clinician working with children with developmental speech and language difficulties, physical disability, learning disability, ASD and SLI.	5-10 years
Interview No. 4	Practising clinician working with children with in a language unit.	10-15 years
Interview No. 5	Practising clinician working with adults in the areas of traumatic brain injury, voice, acquired neurological disorders, fluency and dysphagia.	5-10 years
Interview No.6	SLT educator	5-10 years
Interview No. 7	Practising clinician working with children in the areas of child psychiatry, ASD and ADHD.	10-15 years
Interview No.8	SLT educator and practising clinician	5-10 years

As a strong analytic direction had been established by this phase of data gathering, theoretical sampling indicated that more specific questions and prompts could be now used than the generic and open ended prompts and questions which had been used in previous data gathering. In order to follow the analytic direction proposed by the emergent theory, more focused questioning and prompting would be needed. Thus, theoretical sampling at this phase of data generation specifically involved sampling for concepts during data gathering by using more focused prompts.

[82] Due to the relatively small population of clinicians who are both practising SLTs and SLT educators, it was decided not to supply information here regarding the specific area of SLT practice in which these SLT educators also practised. It was felt that this information could be potentially identifying.

5.2.4.3 CONDUCTING INTERVIEWS

Interviewees were invited to choose from three locations for the interview. The author offered to travel to their place of work, meet interviewees in the Department of Clinical, Speech and Language Studies (on the Trinity College campus), or arrange an alternative venue in consultation with the interviewee if the first two options were not convenient for them. Subsequently, six of interviews were carried out in the interviewees' places of work and the remaining two interviews were carried out the Department of Clinical, Speech and Language Studies, Trinity College Dublin.

Participants had been given information about the study at least a week in advance of the interview. As had been the practice in previous focus group interviews, a short briefing was held prior to switching on recording equipment (as advised by Kvale & Brinkmann, 2009). Prior to initiating the interview, informed consent was agreed and ground rules for the interview were stated. At this time, it was re-iterated that the interview could be stopped at any time, without consequences of any kind for the participant, at the discretion of the participant.

Interviews were all initiated with broad, general questions and prompts, inviting the subjects to discuss their main concerns in relation to SLT and clinical pragmatics, as had been the practise throughout the focus groups. Thus, the participants were still encouraged to voice their concerns at the outset of the interview. However, more specific and probing questions were used at later stages in the interview. These probing questions explored specific aspects of the emergent theory and attempted to flesh out and saturate certain concepts and the relationships between concepts.[83] Thus, in the interviews a greater proportion of "direct" and "structuring questions"[84] were used than in earlier focus group interviews (Kvale & Brinkmann, 2009, p. 136). These questions were employed particularly, in the second half of interviews once initial general open questions had been asked and discussed. As with the data generated from focus group interviewing, the data from the interviews was transcribed by the researcher, following Jefferson (2004) transcription conventions as soon as possible after each interviews.

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[83] For example, when early on in Interview No. 5, the participant noted that "**a lack of clarity about what way to approach pragmatics problems**" was an issue for her in relation to clinical pragmatics (Interview No. 5: Page 2, line 61-65), the researcher specifically probed if certain aspects of the main concern of other participants, as had arisen from data analysis, were relevant to the participant by asking: "**When you're talking about that lack of clarity is it around em just to expand on that is it around the actual area of pragmatics itself or around our interventions in pragmatics or around the efficacy of or it could be around loads of different things you know what I mean?**"

[84] Structuring questions involve the interviewer blatantly moving the interview onto a specific topic. An example of a structuring question from interview No.1 is "**I'd like to ask you more about em is about the realm of pragmatics and what goes in there and what doesn't**"(Interview No.1: Page 1, lines 113-117).

SUMMARY

The data generation process has been explicated in this chapter, in an effort to contextualise the following discussion of the data analysis. This chapter also aimed to demonstrate how safeguards were put in place to ensure rigour, quality and transparency in data generation. The next chapter opens Section 3, and as such, will explicate and illustrate the emergence of the participants' main concern, during data analysis.

CHAPTER 6. THE EMERGENCE OF *UNCERTAINTY* AS THE PARTICIPANTS' CORE CONCERN IN RELATION TO CLINICAL PRAGMATICS AND SLT PRACTICE

INTRODUCTION

The previous chapters introduced the scene in which this study was set and the methodology which guided this study. The following chapters will present the findings of the study; explicating and illustrating the main concern of participants by discussing patterns observed in the data which characterised both the nature of this concern and how this concern was resolved. These findings will then be considered against the relevant literature before closing this thesis with a discussion of research quality and limitations, and contributions made by this study.

The main concern that emerged from the data was *Uncertainty.*[85] *Uncertainty* was conceptualised as being complex, in that it was multifaceted and distributed. Although *Uncertainty* did not manifest as an identical concept in each data site, a pattern emerged which captured the general nature of *Uncertainty* as it emerged across the whole data set.

The nature of *Uncertainty*, as revealed in the data, will be discussed in this chapter, while a conceptual account of the ways in which *Uncertainty* was responded to will be provided in Chapters 7-9. In Section 6.1 of this chapter, the data will be used to explicate and illustrate how *Uncertainty* emerged from the initial data sources sampled, right through the entire data set collected, as the main concern of the participants.

In this study, *Uncertainty* emerged with four distinct yet overlapping facets which specified and characterised the nature of *Uncertainty* pertinent to the area of clinical pragmatics and SLT practice. In Section 6.2, each of these four facets of *Uncertainty* will be discussed in turn.

[85] When italicised and capitalised the term *Uncertainty* will be used in this thesis to refer specifically to the concept of uncertainty, as it emerged from the data as the participants' main concern, as opposed to referring to clinical uncertainty in a more general sense.

6.1 TRACKING AND TRACING THE EMERGENCE OF THE PARTICIPANTS' MAIN CONCERN

Significant patterns were revealed in the data which were conceptualised, by the researcher, as being motivated by and reflective of the participants' attempts to manage and respond to *Uncertainty*. As discussed in Chapter 5, the initial phase of data gathering involved the distribution of questionnaires.

Analysis of completed questionnaires suggested disparity across the reported practice patterns of the SLTs who were sampled. A lack of consensus was also evident in questionnaire data regarding how terminology from the area of pragmatics was reported as being used in clinical practice. These patterns have also been suggested in some of the literature of clinical pragmatics, as noted in Chapter 3. However, in following the initial analytical directions suggested by the questionnaire data, a more complex and distributed concept of *Uncertainty*, beyond that which has been noted in the literature of clinical pragmatics, emerged from this initial data analysis and guided later data collection.

Questionnaires were never anticipated as being the ultimate tools for fully exposing the participants' main concern, as discussed in Chapter 5. In light of the intended function of questionnaires (i.e., as a preliminary data gathering tool which would point to potential areas of concern for participants and guide later data collection), the data generated via questionnaires will be discussed briefly below, utilising some descriptive statistics to illustrate how *Uncertainty* began to emerge as problematic within the earliest stages of data analysis before being verified as the participants' main concern during later data analysis. Once the salience of *Uncertainty* in the data has been demonstrated to the reader, the nature of each facet of *Uncertainty* will then be discussed in greater detail.

6.1.1 AN INITIAL GLIMPSE OF THE PARTICIPANTS' CONCERNS

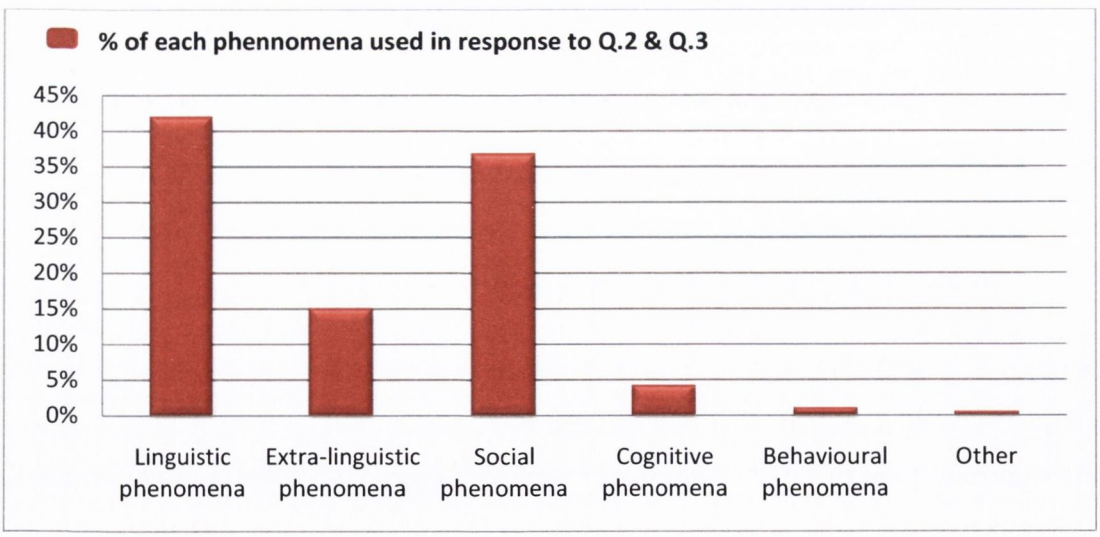
The analysis of 50 questionnaires completed by practising SLTs comprised the initial phase of data analysis. This initial analysis suggested that disparity and variation were evident in how concepts and constructs from the area of pragmatics were defined and described by SLTs. Variation was evident in the reported practice patterns regarding the enactment of intervention in the area of clinical pragmatics. More specifically, variation in practice patterns was evident in accounts of the use of pre- and post-intervention measurements and the use of multiple approaches to

diagnosing Pragmatic Language Difficulties.[86] Variation in practice has been noted in prior studies of SLT practice patterns outside of the area of clinical pragmatics (Anderson & van der Gaag, 2001; van der Gaag, McLoone & Reid, 1999).

In defining pragmatics, a wide variety of phenomena were employed by participants. Questionnaire responses revealed that a variety of different concepts (pertaining to a wide range of domains and skills) were included in the definitions of pragmatics, and cognate terms, that were generated by participants. (Thereby, implying divergent conceptualisations of pragmatics.) Participants were asked in two open questions (Q.2 and Q.3) to detail how they would describe "Pragmatics/Pragmatic language". The phenomena in the responses to these two questions were grouped and coded by the author, revealing the categories illustrated on the X axis of Figure 8.[87]

Six categories were generated from the phenomena cited by participants in their definitions of pragmatics (namely, *Linguistic Phenomena, Extra-linguistic Phenomena, Social Phenomena, Cognitive Phenomena, Behavioural Phenomena* and *Other*), as seen in Figure 8 below. These categories were generated by the researcher as simple descriptive groupings capturing the type of phenomena used to define the area of "Pragmatics/Pragmatics Language" in participants' responses. Although there was potential for overlap between categories, each phenomenon was coded as belonging to only one category so that categories were mutually exclusive.

FIGURE 8: PHENOMENA USED IN PARTICIPANTS' DEFINITIONS OF "PRAGMATICS/PRAGMATIC LANGUAGE"



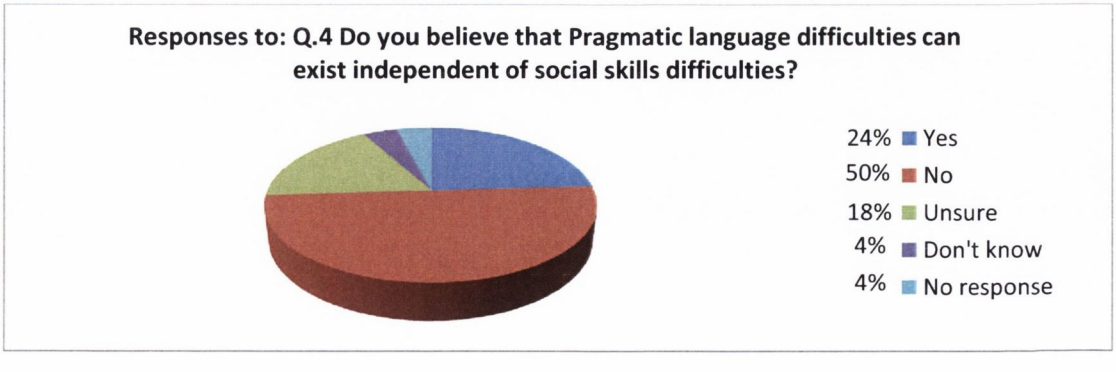
[86] "Pragmatic Language Difficulty/Difficulties" reflects the terminology used in the questionnaire tool. "Pragmatic Language Difficulty/Difficulties" will hereafter be referred to as PL difficulty/PL difficulties.

[87] Appendix 8 can be consulted for further details about the data used to construct Figure 8.

Linguistic Phenomena was a category which captured approximately 42% of the features used by participants in their descriptions of "Pragmatics/Pragmatic language", including for example, "**Child's ability to take conversational turns....Also ability to initiate conversation**" (Questionnaire No. 11), and "**how well we get our message across to people using words...**" (Questionnaire No. 46). Fifteen percent of the features used in participants' descriptions of "Pragmatics/Pragmatic language", were coded as being *Extra-Linguistic Phenomena*, such as "**eye contact**" and "**tone of voice**", (Questionnaire No. 40) and "**facial expression, gesture etc.**" (Questionnaire No. 50). The category of *Social Phenomena* included, "**knowledge of social rules**", (Questionnaire No. 3) and "**child having difficulty relating to their peers**" (Questionnaire No. 43). *Cognitive Phenomena* emerged as a category grouping features such as "**taking the listener's perspective**", which were cited in the participants' definitions of pragmatics (Questionnaire No. 7). Finally, *Behavioural Phenomena* was a category which captured features used in participants' definitions of pragmatics, such as "**an unusual eccentric personality**" (Questionnaire No. 29) and "**odd c [with] reg [regard to] beh [behaviour]**" (Questionnaire No. 24) [Words in brackets have been added].

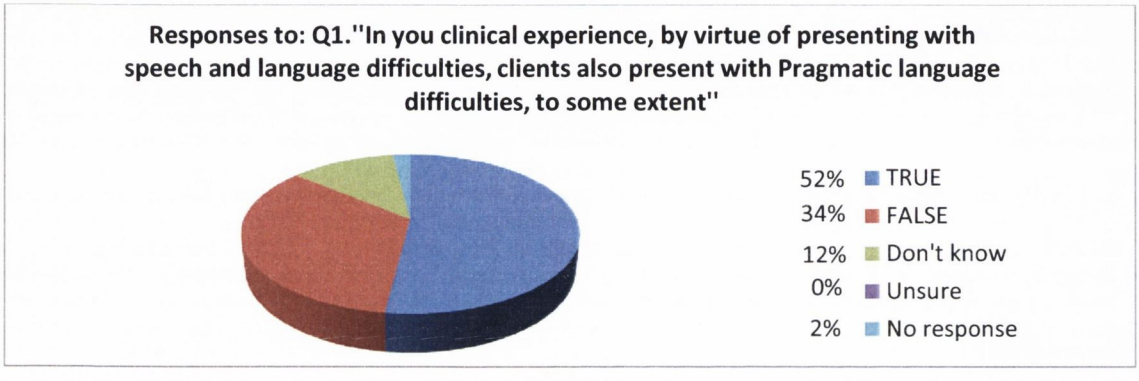
Variation emerged within the questionnaire data in how pragmatics was associated with the other skills and abilities a client possessed. A lack of consensus was evident in how SLTs conceptualised the relationship between pragmatics, social skills and other aspects of speech and language development. Question No. 4 sought information from the participants about how they saw the relationship between pragmatics and social skills difficulties. It was revealed that 50% of the participants surveyed believed that PL difficulties entailed difficulties with social skills, while 24% of the participants believed that PL difficulties did not necessarily entail social skill difficulties, as depicted in Figure 9.

FIGURE 9: PARTICIPANTS' VIEWS ON THE RELATIONSHIP BETWEEN "PRAGMATICS" AND "SOCIAL SKILLS"



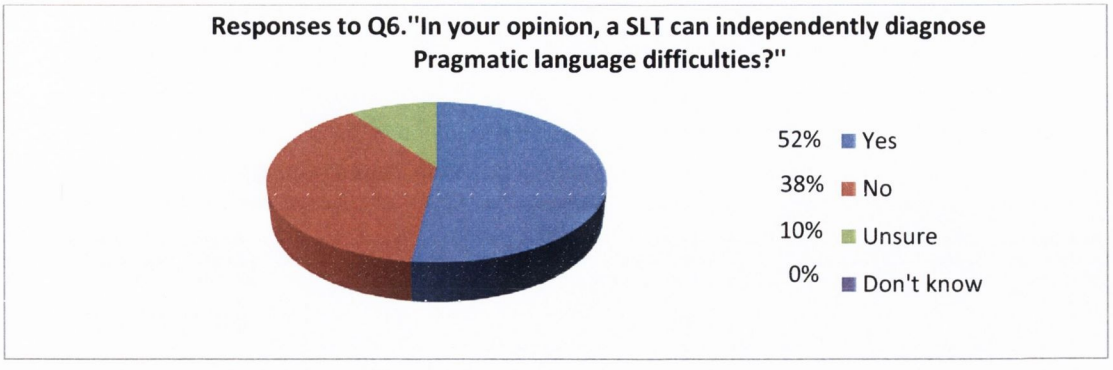
In question No. 1, when asked about the co-occurrence of PL difficulties and speech and language difficulties, in general, 52% of participants noted that the presence of SLDs entailed the presence of PL difficulties, as noted in Figure 10 below. Thirty-four percent of participants stated that SLDs would not necessarily be assumed, by virtue of the presence of PL difficulties.

FIGURE 10: PARTICIPANTS' VIEWS ON THE RELATIONSHIP BETWEEN "SPEECH AND LANGUAGE DIFFICULTIES" AND "PRAGMATIC LANGUAGE DIFFICULTIES"



Inconsistency in daily clinical practices (such as the use of divergent discharge criteria and diversity in the diagnostic processes and practices in the area of clinical pragmatics) were suggested within the information supplied in the questionnaire responses. One example of a diverse practice pattern can be seen in Figure 11. Participants were asked if they thought that a SLT was capable of independently diagnosing PL difficulties in question No. 6. Figure 11 illustrates how 52% of the clinicians agreed that a SLT could independently diagnose PL difficulties. In contrast, 38% of participants disagreed with the assertion that a SLT could independently diagnose PL difficulties. While these responses cannot be taken as direct reflections of practice, they provided tentative suggestions that practice variation might exist in the context of clinical pragmatics and SLT practice. Alternatively, these responses could also suggest that the term "Pragmatic language difficulties", used in the question, may have been interpreted variably by participants. For example, "Pragmatic language difficulties" may have been viewed as a generic umbrella term relating to any challenges presenting in the area of clinical pragmatics or as a more specific term akin to "Pragmatic Language Impairment". However, a certain lack of consistency (in relation to practice patterns and/or the interpretation of terminology) in the area of clinical pragmatics appears to be implied by both of these potential underlying suggestions.

FIGURE 11: PARTICIPANTS' VIEWS REGARDING SPEECH AND LANGUAGE THERAPISTS INDEPENDENTLY DIAGNOSING PRAGMATIC LANGUAGE DIFFICULTIES

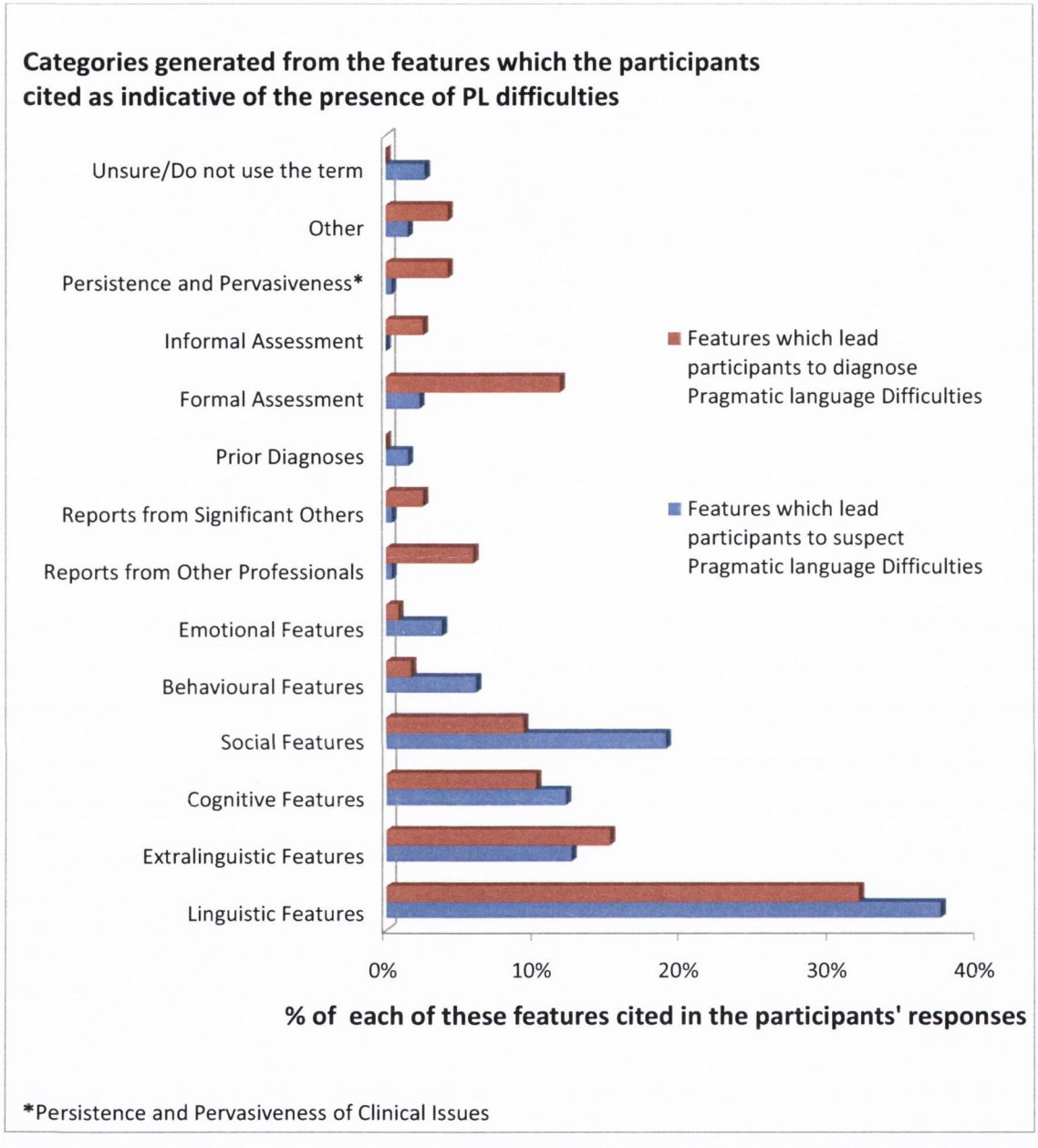


Information was sought in question No.7 and No.8, on the questionnaire, regarding which phenomena would lead participants to "suspect" and to "diagnose" PL difficulties. The responses to these questions, which detailed the features that were cited by participants to be indicators of PL difficulties, were collated and sorted by the researcher into mutually exclusive categories. It was revealed that participating SLTs posited a wide variety of factors from differing domains of functioning, as being significant for the purpose of identifying and diagnosing PL difficulties, as seen in Figure 12 below.[88] For example, phenomena which were categorised as being *Social Features* included having "**no friends**", presenting with "**difficulties with social functioning**" and "**difficulty forming and maintaining social relationships**" (Questionnaires No. 9, No. 10 and No. 47 respectively). Instances of *Linguistic Features* which were reported included "**poor topic management -i.e. flitting from one topic to another**", "**difficulties with higher end language: idiom/sarcasm, unusual semantic usage**" and "**stronger EL [expressive language] than RL [receptive language]**" (Questionnaire No. 2, No. 3, No. 32 and No. 33) respectively [words in brackets have been added].

As can be seen in Figure 12 below, *Social* and *Linguistic Features* were the most heavily cited when participants were asked about what might lead them to "suspect" the presence of PL difficulty (Question No. 7). By comparison the features of *Formal Assessment Results, Reports from Other Professionals, Reports from Significant Others* and *Persistence and Pervasiveness of Clinical Issues* were the categories which captured some of the features SLTs reported using when diagnosing PL difficulties (Question No. 8). Thus, it was also highlighted that participants reported relying particularly on formal assessment results and external information sources for diagnostic purposes.

[88] Appendix 9 can be consulted for further details about the data used to construct Figure 12.

FIGURE 12: FEATURES LEADING PARTICIPANTS TO "SUSPECT" AND "DIAGNOSE" PRAGMATIC LANGUAGE DIFFICULTIES



At this initial stage of the study, the emergence of variation and disparity as issues for participants was becoming increasingly evident. The information supplied about SLT practice and clinical pragmatics in the questionnaire data pointed towards variance and disparity in how pragmatics and cognate terms were being applied by clinicians. Much deeper and finer levels of exploration were required to unravel and unpack these emergent themes of variance, disparity and general confusion in the area of clinical pragmatics. Additionally, more in-depth analysis would be necessary to explore how these emergent issues related to the main concern of the SLT community and indeed to fully uncover the main concern of the participants. It became apparent

that the divergent perspectives which were emerging in the questionnaires were not amenable to full exploration via the use of questionnaires exclusively.

After the questionnaire data was analysed, the study became focused on the exploration of these emerging concerns in greater depth. Hence, focus groups with practising clinicians were initiated, as was the analysis of commercially available intervention materials. Following this, a final phase of data gathering involving interviewing practising SLTs and SLT educators was carried out, as detailed in Chapter 5.

As data was gathered, it was integrated into the ongoing analysis. Analysis was cyclical with the researcher revisiting earlier data and analysis in a systematic way in order to cohere data from all four data sites sampled. Thus, the analysis of questionnaire data provided initial analytic directions and suggestions which were developed in much greater depth, as well as being modified and extended via later data analysis. The questionnaires provided a starting point for later analysis by suggesting emerging themes and tentative directions for further sampling rather than being sites for the generation of dense concepts in the Classic GT sense. Thus, the analysis of questionnaire data instigated a focus on issues such as confusion, a lack of resources and consensus in the area of clinical pragmatics. However, the questionnaire data, possibly due to its inherently thin and researcher-led nature, did not become the most influential body of data on the emergent analysis but simply provided a preliminary and tentative glimpse of issues of importance and concern for participants.

6.1.2 THE SALIENCY OF *UNCERTAINTY* IN THE DATA

As noted above, themes of variance and disparity were evident from the analysis of questionnaire data, but *Uncertainty* patterned out (i.e., consistently emerged) as the main concern of participants during the analysis of intervention programmes and focus group data. In the data generated by focus groups and document analysis, clinical pragmatics was rarely presented as a straightforward or unproblematic area. For example, in Extract 6.1, clinicians in the initial focus group noted, early on in the discussion, how clinical pragmatics was a "**difficult**" area to work in.

EXTRACT 6.1.

"em I find that really hard and and it's and it's particularly diff- I think one of the most difficult things we have talk about and explain"

Participant No. 5: Focus Group No. 1
Page 5: lines 224-226

Clinical pragmatics in the context of SLT practice was regularly positioned as an area burdened with "**complexities**". Data analysis continuously revealed that the area of clinical pragmatics was considered to be both complicated and problematic, or a "**minefield**", as noted in Extract 6.2.

EXTRACT 6.2

"so it's just a minefield ((laugh)) the whole area of pragmatic language is em fraught with so many difficulties and complexities along the way"

Interview No. 7
Page 9: lines 357-359

Occasionally, uncertainty was explicitly named by the participants during data generation, as being their primary concern. As illustrated in Extract 6.3 below, the researcher often began interviews by asking if the participant would like to volunteer any opening comments (in lieu of the interviewer providing a question to open up the interview). The participant replied, as in Extract 6.4, by describing pragmatics as an "**uncertain area**". However, in much of the data, *Uncertainty* was more implicit in the data and was not named as being an issue in such a bald or direct manner.

Specifically, Extract 6.4, highlighted that *Uncertainty* impacted on the process of "**diagnosing...pragmatic language impairment**". A lack of perceived skill or knowledge was evident, as in Extract 6.4, when the participant highlighted that she did not feel "**confident**" in implementing diagnoses within the "**uncertain area**" of pragmatics. *Uncertainty* was situated as interfering with the clinical work of participants. In addition, Extract 6.4 suggested some confusion with regards to the wide array of terminology being used in the area of clinical pragmatics. Here, for example a lack of clear boundaries and potential overlap between the usage of the terms, "**pragmatic language impairment...autistic spectrum...SLI...pragmatic difficulties**" was implied.

EXTRACT 6.3

"as I said I'm really interested in hearing about your main concerns when it comes to the area of pragmatics and speech therapy em practice so if if you have any of those that you'd like to start off with before I ask any more specific questions"

Interview No.4 (Interviewer)
Page 1: lines 5-11

EXTRACT 6.4

"okay em yeah I suppose I wou- I mean it it is a d-it is an an uncertain area I would feel definitely and em I wouldn't be confident in kind of diagnosing a child with pragmatic language impairment I wouldn't feel em even though I've seen a lot of kids with SLI who you know would have some pragmatic difficulties but I would find it very difficult to to kind of separate that you know from you know other from SLI really or on the other hand from children who have who are on the autistic spectrum so as a discrete entity I would find it difficult to kind of pin down exactly what a child with pragmatic language impairment might look like"

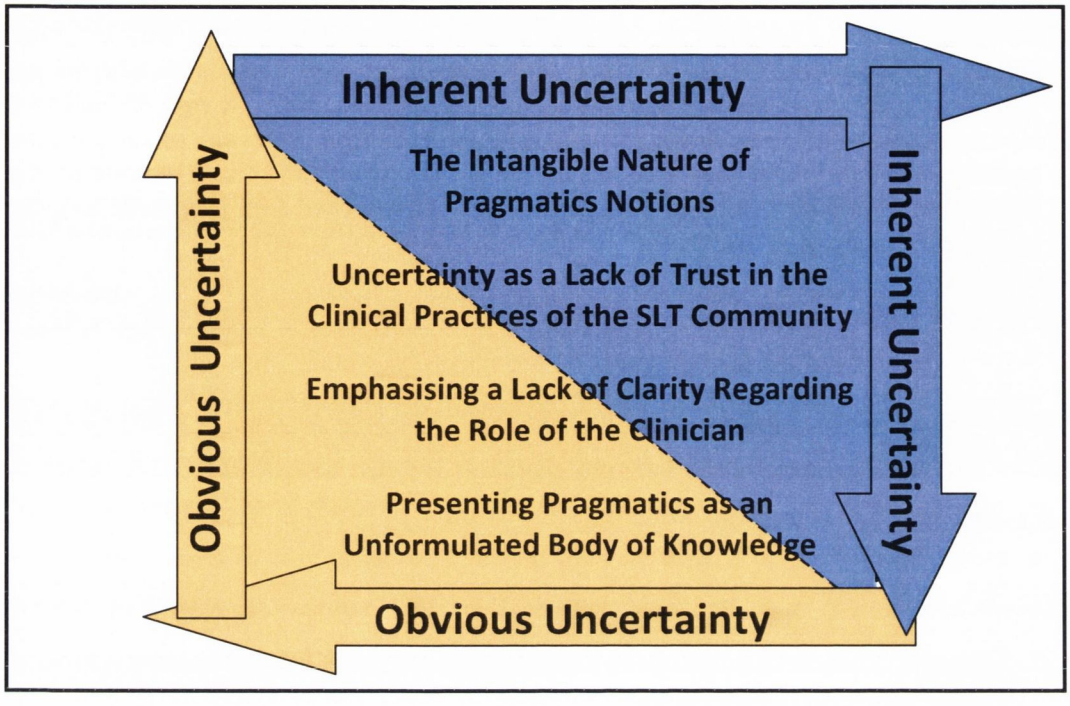
Interview No.4
Page 1: lines 12-27

Subsequently, analysis revealed that *Uncertainty* in the area of clinical pragmatics and SLT practice had both an obvious and inherent character and had four distinct facets which will be discussed below.

6.2 THE MULTIFACETED AND DISTRIBUTED NATURE OF *UNCERTAINTY* AS EMERGENT FROM THE DATA

The remainder of this chapter will consider the nature of each facet of *Uncertainty* as it emerged from the data. Each facet of *Uncertainty* represented a source and/or type of *Uncertainty* which troubled the participants, as depicted in Figure 13 below. The elusive and amorphous nature of intervention when concepts or theory from the area of pragmatics were involved in SLT practice was an element of *Uncertainty.* Thus, the facet of *Uncertainty* named *The Intangible Nature of Pragmatics Notions* emerged from the data. A lack of trust in the clinical practices of the SLT community in the area of clinical pragmatics was highlighted within the data as another facet of *Uncertainty* and was named *Uncertainty as a Lack of Trust in the Clinical Practices of the SLT Community*. Yet another facet of *Uncertainty* emerged as a lack of consensus regarding the scope of the role of the SLT, and was termed *Emphasising a Lack of Clarity Regarding the Role of the Clinician*. Additionally, the facet of *Uncertainty* named *Presenting Pragmatics as an Unformulated Body of Knowledge* emerged to capture how pragmatics was positioned as an incomplete and unsatisfactory body of knowledge for informing clinical practice.

FIGURE 13: THE MULTIFACETED AND DISTRIBUTED NATURE OF UNCERTAINTY AS EMERGENT IN THE DATA



As interacting and overlapping concerns, all four facets of *Uncertainty* were revealed to have both an inherent and obvious character (See Figure 13, above). The obvious character of *Uncertainty* was related to issues such as knowledge gaps and a paucity of research in the area of clinical pragmatics. Extract 6.5, from a commercially available intervention resource, provides an illustration of the obvious nature of *Uncertainty*. Here, *Uncertainty* was positioned as being directly resultant from gaps in knowledge due to the "**infancy**" of pragmatics and lack of "**theoretical models**" available.

EXTRACT 6.5

> **"What is Pragmatics?**
>
> **Pragmatics is a topic that is given many different definitions by clinicians and researchers. They include the following....The range of definitions presented at the beginning of the chapter highlights the various perspectives of different writers on the field of pragmatics and underlines the fact that pragmatics is an area still in its infancy as far as theoretical models and applications for practice are concerned."**
>
> *Working with Pragmatics*
> (Anderson-Wood & Rae-Smith, 2001, pp. 3-4)

Uncertainty not only emerged as an obvious issue of knowledge gaps, but it also recurrently emerged as a ubiquitous and an inevitable factor permeating many aspects of SLT practice in the area of clinical pragmatics. Thus, *Uncertainty* was situated as an "**inherent**" part of clinical practice involving pragmatics (Extract 6.6).

The ubiquitous and inevitable presence of *Uncertainty* in the clinical process was evident in Extract 6.7, when it was posited that even those with substantial "**experience**" could be confronted with instances of *Uncertainty*. *Uncertainty* was not necessarily viewed as a reflection or result of a lack of experience, or knowledge, but emerged as a natural part of everyday clinical practice in the data.

EXTRACT 6.6

"because I suppose I would find myself with the students that I deal with now saying well uncertainty is like an inherent part of speech and language therapy"

Interview No. 1
Page 14: lines 667-668

EXTRACT 6.7

"So it just shows you you can so- you know have certain number years of experience walk in to a situation and go I don't know"

Participant No. 1: Focus Group No. 3
Page 38: lines 1757-1760

Comparing and contrasting the similarities and differences of patterns in the data relating to the concern of *Uncertainty* led to the development of a concept of *Uncertainty* which amalgamated a wide variety of instances in the data. As depicted in Figure 13 above, *Uncertainty* emerged with four facets that interacted and overlapped. *Uncertainty* was specified as a discrete issue, related to gaps in knowledge and a lack of theoretical development. Thus, *Uncertainty* had an obvious character, while it was also revealed that *Uncertainty* was an issue more pervasive and ingrained in clinical practice and, indeed, "**inherent**" to clinical practice (as noted in Extract 6.6 above).

6.2.1 UNCERTAINTY AND KNOWLEDGE GAPS: *PRESENTING PRAGMATICS AS AN UNFORMULATED BODY OF KNOWLEDGE*

"I mean there was the period where semantic pragmatic language disorder was all in vogue and now that's nobody talks about that anymore we've moved on from that"

Interview No. 4
Page 24: lines 1196-1199

The facet of *Uncertainty* discussed in this section is entitled *Presenting Pragmatics as an Unformulated Body of Knowledge*. The absence of well established theory in the area of clinical pragmatics was reflected in the emergence of *Presenting Pragmatics as an Unformulated Body of Knowledge*. The knowledge base underpinning clinical pragmatics was situated in the data as containing significant gaps, lacking consistency and integration, as well as being deemed unstable and constantly evolving.

In the extract below, the fluctuating nature of the knowledge which underpinned pragmatics was highlighted by the participant. Dealing with the transient nature of terminology and the continuing changes to how pragmatics notions were used in clinical circles also reflected a significant challenge for participants. The fact that pragmatics notions were used in a manner which was "**so shifting all the time and moving**" (Extract 6.8), highlighted how the area of pragmatics was experienced as an unstable and somewhat untrustworthy body of knowledge. Here, the use of "**in vogue**" portrayed a shifting pattern of how pragmatic theory had been applied in clinical practice. A lack of trust in the stability of knowledge which underpinned practice (i.e., "**you kind of begin to wonder oh God okay well do any of these things exist**") was suggested in the data in Extract 6.8.

EXTRACT 6.8

"em and things change so much as well you know I mean there was the period where semantic pragmatic language disorder was all in vogue and now that's nobody talks about that anymore we've moved on from that and you know you you kind of begin to wonder oh God okay well do any of these things exist or do I just keep going or you know it it's all so shifting all the time and moving"

Interview No. 4
Page 24: lines 1196-1203

The area of clinical pragmatics was positioned as an imprecise and incomplete body of knowledge by highlighting that gaps in knowledge, and pockets of doubts and confusion, permeated the area of clinical pragmatics. The participants recurrently identified areas and topics related to clinical pragmatics that were relevant to clinical practice, but about which very little knowledge existed. Extract 6.9, illustrates how participants identified the existence of areas which remained unknown and uncharted in relation to clinical pragmatics and SLT practice (such as "**social rules**"). Thus, clinical pragmatics contained many areas which were poorly understood and/or not documented "**in any of the literature**".

A scarcity of resources and paradigms to use in the clinic was highlighted in Extract 6.10. The lack of a "**framework to help identify, treat, and manage**" clinical issues, was presented as a challenge for those working with clients in the area of pragmatics.

EXTRACT 6.9

"cos all the whole turn taking and pauses and you know do you listen for it do you is there a hierarchy is there a rule if you're sitting in a group does it tend to go round to one direction you know because these are social rules that we don't know and which not covered in any of the literature"

Participant No. 3: Focus Group No. 3
Page 37: lines 1705-1713

EXTRACT 6.10

"Today there is a great deal of published material regarding this language disorder [Semantic-Pragmatic Language Disorder]. However, those in day-to-day contact with the children often seem frustrated by the lack of a simple framework to help identify, treat, and manage this type of difficulty"

Semantic-Pragmatic Language Disorder
(Firth & Venkatesh, 1999a, preface)
[Words in brackets have been added]

The participants struggled to be informed by the unformulated body of knowledge and the lack of consensus in the literature. The knowledge base which informed clinical pragmatics was often situated as somewhat rudimentary and unfinished. In Extract 6.11, a detailed account of the developmental trajectory of pragmatics was identified as one "**that has not yet been completed**". The reported gaps in what was known, and the need for particular areas to be further investigated, accentuated the unfinished nature of the body of knowledge which underpinned clinical pragmatics.

EXTRACT 6.11

"First, we will examine some of the reasons why charting the course of pragmatic development is a difficult task that has not yet been completed"

Working with Pragmatics
(Anderson-Wood & Rae-Smith, 2001, pp. 16)

The concept of pragmatics held multiple potential meanings and divergent definitions in the data. In Extract 6.12 below, a lack of clear delineation in the area of clinical pragmatics was perceived to exist (i.e., "**confusion over what what is pragmatics**"). Pragmatics was positioned as being misappropriated by clinicians because intervention was perceived to be enacted in a theoretical vacuum. It was suggested that disparate definitions of pragmatics were related to the absence of theory, in the area of clinical pragmatics, available for clinicians to draw on to inform their practice. The application of pragmatics "**in practice**", in a manner in which "**people maybe don't necessarily have a clear model or a framework to work out of**", resulted in a "**mish mash**" of phenomena being dealt with under the "**broad umbrella**" of pragmatics and perpetuated "**confusion**" in the area.

EXTRACT 6. 12

"em then the other area I think that has contributed maybe eh to some difficulties in this area would be just confusion over what what is pragmatics you know meaning minus semantics or is it em where structure interacts with use and interaction you know is that what it is em and I think I've had to do some work myself and I think I'm still not one hundred percent sure as to you know what I don't know if we have and hopefully you're study's going to ((laugh)) clarify eh allow something clearer to emerge em but I

think that's one of the problems and ah for example semantic pragmatic dis disorder as a diagnostic grouping in some way contributed somewhat to the confusion em where there is meaning in pragmatics but its its the structural element taken out of it that would be my understanding of it you know em and the other thing is all everything that's not syntax morphology phonology and I'm taking a very boxy logically type way of looking at language when I say that everything that's not those things is pragmatics you know so it's we throw everything in there we throw in body language we throw in a whole mish mash of things under this one broad umbrella and therefore people maybe don't necessarily have a clear model or a framework to work out of when they're trying to apply it in practice"

Interview No. 8
Pages 3-4: lines 120-157

The fact that a lack of clinical consensus existed, in the sense that "**there is no definitive thing that we should all be doing**", was presented as an issue which complicated practice, for participants, as in Extract 6.13. Here, the use of pragmatics in the clinic was not deemed to be supported by a well formulated body of professional knowledge (such as definitive practice guidelines provided by "**higher powers**"). As such, the area of pragmatics was experienced as being "**woolly**", and prone to "**difficulties**" (such as "**issues about subjectivity**"). A lack of consensus led to the use of individual clinicians' preferences for guiding intervention. Subsequently, individual clinicians were able to "**do kinda what we want**", in light of the lack of formulated intervention guidelines being available for the participants to consult and use.

EXTRACT 6.13

"cos some people don't like certain language programmes or you know like I would never really use roads to language or something but loads of the girls here use it so you know I think clinician preference has a- has a definitely has a part to play em but it's also because there is no there is no definitive thing that we should all be doing like we should all be using the CELF-4 or the CELF preschool 2 technically but there isn't really anything definitively recommended by the higher powers that be in pragmatic language so it gives the freedom to do kinda what we want and that in itself probably has its own difficulties ((laugh)) cos that in itself throws up all the issues about subjectivity and em and accountability I guess but they're the challenges in working with pragmatic language ((laugh)) but I suppose everybody usually comes to the same conclusion within a broad sense to a degree because a lot of their difficulties are so obvious it doesn't really matter what you use to assess them because you'd see it the minute they walk in the door but it's about tightening it up for reports for em diagnostic reasons and things it gets a bit woolly"

Interview No. 7
Page 24: lines 1048-1074

In summary, the facet *Presenting Pragmatics as an Unformulated Body of Knowledge* captured how the area of clinical pragmatics was situated as a body of knowledge which was perceived to be lacking and incomplete.

Extract 6.13, above, illustrated how facets of *Uncertainty* interacted in that, the facet of *Presenting Pragmatics as an Unformulated Body of Knowledge* was linked with a lack of acuity regarding the scope of SLT practice in the area of clinical pragmatics, as captured by the *Emphasising a Lack of Clarity Regarding the Role of the Clinician* facet of *Uncertainty*.

6.2.2 UNCERTAINTY AND ROLE: *EMPHASISING A LACK OF CLARITY REGARDING THE ROLE OF THE CLINICIAN*

"all those types of things and is that our role? I dunno "

Participant No.2: Focus Group No. 1
Page 47: lines 2125

A pattern emerged within the data reflecting how the role of the Speech and Language Therapist was questioned and debated in the context of clinical pragmatics. As noted in the Extract 6.13, a lack of clarity regarding the role of the Speech and Language Therapist emerged, in part, from the incomplete and unformulated nature of the knowledge base which underpinned clinical pragmatics.

However, *Emphasising a Lack of Clarity Regarding the Role of the Clinician* emerged as a facet of *Uncertainty* in its own right, as participants were recurrently observed to struggle with defining the scope of their remit in the area of clinical pragmatics. The extract below was taken from an extended discussion about which areas the focus group participants considered appropriate to their role as SLTs. Divergent perspectives about the boundaries of a Speech and Language Therapist's remit were evident within this focus group and, indeed, throughout the data in general. Participant No. 2 in Extract 6.14, remained unsure of the limits of the SLT role (i.e., "**all those types of things and is that our role?**"). Here, the participant wondered what role a Speech and Language Therapist should have in providing therapy in the area of clinical pragmatics, in light of the unlikely result that SLT inputs would "**fix**" the clinical concern.

EXTRACT 6.14

"it just brings up those thoughts of you know the speech ther-like we are giving them the idea that we can fix it if we're giving them therapy for it that just brings up those issues of you know should we just be supporting them at their like I was talking about earlier today like at their self esteem making sure they're connected in the community that they've got opportunities all those types of things and is that our role? I dunno I just sort of-"

Participant No.2: Focus Group No. 1
Pages 46-47: lines 2116-2126

As well as confusion within the profession, other professionals were highlighted as lacking certainty about the nature and scope of SLT practice in the area of clinical pragmatics. In Extract 6.15, it was suggested that other disciplines (such as Psychiatry) were unaware and uncertain about what the Speech and Language Therapist "**could do**" and "**contribute**" due to a "**lack of clarity**".

EXTRACT 6. 15

"but it's an area where I can speak from my engagement in the past with a child psychiatrist em in the area where I work em when there was talk of recruiting em a speech and language therapist to that team and there was a huge huge gap in understanding in terms of what we could do and what we could contribute what would we do....yes now the same it's funny the same lack of clarity is just so something I've come across em"

Interview No. 8
Page: 13: lines 621-628
Page: 13: lines 643-644

It emerged from the data that other parties who might be involved in the therapeutic process (e.g., other clinicians and parents) might also be confused about the Speech and Language Therapist's role. In Extract 6.16, it was highlighted that clients and/or their families might not be fully aware of the supports and interventions that could be offered by SLTs in domains outside of the areas of "**talking**", "**articulation problems**" and "**speech difficulty**". The fact that clients and their families were unsure of the clinician's role, in this area, could result in a lack of understanding about why a client might be attending SLT services (i.e., "**sometimes the families don't even know why they're coming to see us**"). This lack of clarity about the remit of the clinician was also evident in Extract 6.17 below, when the "**awareness out there of what our role is in regards to social skills is very low**", was highlighted.

EXTRACT 6.16

"most of the children I work with have em autistic spectrum disorder ADHD or anxiety em and when they come in the families themselves don't expect a pragmatic language assessment or kind of social communication assessment what they think they're coming to from me em is the usual stuff like if the child has a speech difficulty and they can easily identify it or if they're not talking but they would never normally say pragmatics is an area of concern em and sometimes the families don't even know why they're coming to see us because em a lot of the kids do speak and they've no articulation problems and they wouldn't be aware of the the language side of things"

Interview No. 7
Pages 1-2: lines 39-49

EXTRACT 6.17

"and one of the things that came up was I had parents ringing up going em you sent out for my child to come in for a- an appointment he doesn't need speech and language

therapy...I think I had three or four parents rang up with the exact same query and I said that's fine but the referrals been made you've been referred in for a reason I suppose em and the liaison nurse had made the referral do you want to come in to meet me anyway and we can take it from there and she was like well I don't know I don't want somebody else to miss out an appointment and I said that's fine what's his social skills like oh terrible actually do you deal with that and like well ((laugh)) we can look at it but and then he came in and then it became apparent yeah that he definitely had huge social skill difficulties but even I suppose the awareness out there of what our role is in regards to social skills is very low as well''

Participant No.1: Focus Group No. 4
Page 4: lines 179-180
Pages 4-5: lines 191-205

The role and remit of the clinician varied depending on the organisation in which they worked. Extract 6.18 highlighted how the "**delineation**" of remit was partly accomplished on a setting-by-setting basis, which implied that disparity in practice might occur. Here, knowing the scope of one's clinical remit was described as a "**challenge**".

EXTRACT 6.18

"there are certain things we can contribute to a diagnosis but we don't diagnose you know things like that and and we teach them as much as we can about knowing what those boundaries are likely to be but I'd say until you're actually working in the job I don't know yeah and every setting would be different I mean I only every worked in rehab with a fairly clear delineation of what I was supposed to be doing but especially I think from the counselling side of things that's a challenge that's the challenge''

Interview No. 6
Page 22: lines 1088-1106

Relying on institutions to define the SLT role and remit, rather than having clear professional boundaries and/or a robust theoretical framework to guide practice, contributed to *Uncertainty* about the nature of the SLT role in the area of clinical pragmatics. Extract 6.19 also illustrates how clinical responsibility and remit were defined by the institution or setting in which an intervention was provided. Clinicians highlighted that "**where you come from**" (in terms of the organisation which employed a clinician) defined the nature of the clinical work which a clinician engaged in and influenced how clinicians focused their interventions on particular targets.

Historical precedents appeared to influence the scope of remit of the clinician. In Extract 6.20, hypothetical changes to the established status quo, by altering which discipline provided a particular intervention focusing on clinical pragmatics, was suggested as having the potential to lead to "**ownership issues**".

EXTRACT 6.19

"Well yeah cos I mean it also depends on em where you come from like if you work in a different organisation its often seen as very much an occupational therapy area as well as a speech therapy area sometimes it's seen as oh yeah there's there's input there from psychology"

Participant No. 1: Focus Group No.5
Page 14: lines 673-677

EXTRACT 6.20

"but it's it's unusual kind of an area because not no one discipline owns it so you could potentially have psychology work working on social communication skills em and we do a lot of our groups with OT em and that's I think that's just because there's been a history in XXX and XXX the OTs working on social skills with speech and language therapists so it's worked really well but it'd be interesting if a psychology a psychologist came into the service who was new and said I want to run social communication skills groups I think there would be i- em there would be concern ((laugh)) about not should they but who you know well is that not our role you know that there might be a few ownership issues"

Interview No. 7
Page 11: lines 457-472

The data in Extract 6.21 highlighted how the scope of clinical practice and the outline of disciplinary responsibility were perceived as somewhat uncertain (i.e., "**we do need to have input at some level I'm not altogether sure**"). A lack of certitude in terms of a clinician's scope of practice in this area resulted in a remit which overlapped with other professionals. Extract 6.21 suggested the fact that other professionals were carrying out similar interventions to SLTs (i.e., "**occupational therapists were doing pretty much the same work that we were doing in our pragmatics**"), implying a situation in which a clear division of labour between different professionals might become difficult to demonstrate.

EXTRACT 6. 21

"I dunno I remember I remember being on placement in another organisation and being surprised to hear that the occupational therapists were doing pretty much the same work that we were doing in our pragmatics em and then when I had a chance to go down and talk to them that it was we were pretty much working on the same goals but I suppose we do we would need to be involved with the fact that we work with adapting em things to ensure understanding of what's being presented but em I don't like like you were saying I don't think we completely own it I think where possible to work with other people is is really great em and I think we do yeah I suppose I do we do need to have input at some level I'm not altogether sure"

Participant No. 3: Focus Group No.5
Page 15: lines 731-739

In summarising the *Emphasising a Lack of Clarity Regarding the Role of the Clinician* facet of *Uncertainty,* it became evident that role boundaries and the scope of SLT practice were problematic for the participants, in that they were unclearly defined in the context of clinical pragmatics. The overlap of the work of the Speech and Language Therapist with the work of other professionals and the variance in clinical practice, depending in part on the organisation in which a clinician was employed, suggested a fractured and poorly defined conceptualisation of the SLT role in the context of clinical pragmatics. The facet of *Emphasising a Lack of Clarity Regarding the Role of the Clinician* portrayed how the Speech and Language Therapist's role in the area of clinical pragmatics was poorly defined and correspondingly vulnerable.

6.2.3 UNCERTAINTY AND CLINICAL PRACTICE: *UNCERTAINTY AS A LACK OF TRUST IN THE CLINICAL PRACTICES OF THE SLT COMMUNITY*

> **"I guess I feel a lack of em clarity in terms of which way to approach pragmatics problems yeah that's my biggest issue"**
>
> Interview No. 5
> Page 2: lines 61-62

The data revealed that *Uncertainty* also emerged in relation to how the area of clinical pragmatics was handled and approached by the SLT community. The presence of a lack of consensus and gaps in the knowledge base which supported clinical pragmatics, as well as role confusion, contributed towards the participants taking a doubting stance about the quality and integrity of the clinical practices they enacted as SLTs. Concerns about the effectiveness of SLT intervention were captured by *Uncertainty as a Lack of Trust in the Clinical Practices of the SLT Community*. Clinicians doubted the decisions they made and the work they did as SLTs in the area of clinical pragmatics.

One problematic aspect for participants when working with pragmatics in a clinical setting was ascertaining which types of intervention and which intervention tools might be the most appropriate to use in any given situation. In Extract 6.22, the participant highlighted how she had been "**struggling**" to uncover how best to approach intervention in the context of clinical pragmatics.

EXTRACT 6.22

> **"em and then I suppose with adults recently eh I've had a client with a head injury and quite significant pragmatic problems and em again like that I been kinda struggling to figure out what sort of resources to use and coming up with things in my- out of my own head em and wondering sometimes if if you know I was taking the right approach to it**

and em yeah I guess I feel a lack of em clarity in terms of which way to approach pragmatics problems yeah that's my biggest issue I think"

Interview No. 5
Page 2: lines 56-67

Extract 6.23 illustrates how *Uncertainty* was pervasive and ubiquitous; it permeated the intervention offered to "**all client groups**". The best ways to "**go about**" providing and structuring intervention was described as being "**quite unclear**" and "**quite uncertain**". The data in Extract 6.23 echoed the data in 6.22, in voicing concerns about the selection of intervention approaches. Extract 6.23 also queried if the SLT community should be approaching their work in the area of clinical pragmatics differently.

EXTRACT 6. 23

"because it is something that pervades all client groups I think em and I think most people or any of the therapists I spoken to seem quite unclear or quite uncertain what way to go about it em ((4 second pause)) and I wonder is the is it worthwhile em you know should we be using you know more videos or more em multimedia type stuff to support pragmatics and not relying just say on I'm just thinking I often wonder to myself like I wonder should I have used things like em you know say Mr. Bean videos or getting people to spot things in those that might be useful or you know where it's really not language based but things are really quite obvious in terms of things that he does that are really out of line ((laugh))"

Interview No. 5
Page 12: lines 579-594

The process of selecting intervention targets was also clouded in doubts and *Uncertainty*. The data in Extract 6.24 suggested that the participant had a lack of trust in her own clinical skills. Here, the participant wondered if "**more experienced therapists**" might identify differing intervention goals to the ones that she had tended to focus on.

EXTRACT 6.24

"I'd be interested maybe it'd be interesting to see you know when you talk I think maybe more experienced therapists as well like cos we're all you know we're all quite young whereas more experienced therapists are like are we over emphasising social skills you know I don't think it's the kinda thing that hits you in the face straight away like and it's more a thing you think it's gonna help them to cope with eh life like pragmatic skills but should you know there be more focus on the other stuff you know"

Participant No. 2: Focus Group No. 4
Page 43: lines 2112-2121

The data revealed that concerns about choosing appropriately between intervention approaches, materials and targets were not the only instances in which a lack of trust emerged regarding the

clinical practices of SLTs in the area of clinical pragmatics. Doubts about the integrity, efficacy[89] and quality of interventions offered to clients were also evident.

As discussed in Section 6.2.1, the knowledge base informing the SLT community's handling of pragmatics was situated as disjointed and incomplete. The outright gaps in knowledge contributed to the concern that, as of yet, SLTs did not know what interventions might be effective in the area of clinical pragmatics. It was suggested that the "**effectiveness**" of SLT interventions had not yet been firmly established, highlighting a need for "**further scientific investigation**", as in Extract 6.25. As such, *Uncertainty* about SLT practices in this area was accentuated.

EXTRACT 6.25

> **"We suspect that further scientific investigation of the effectiveness of treatment approaches will reveal that combinations of skills-based and communication-based approaches will provide the optimum form of treatment for many types of communication difficulty. Our proposal is that treatment effectiveness should always be judged on the basis of how clients perform in non clinical settings."**

Working with Pragmatics
(Anderson-Wood & Rae-Smith, 2001, p. 3)

Extract 6.26 captured scepticism about how "**valid**" some of the assessments used in the context of clinical pragmatics were. Doubts about the value of using the available resources were evident in the data. The clinical tools and approaches to intervention which were currently available to clinicians were not viewed as being particularly robust. The "**efficacy**" of SLT interventions was positioned as being "**questionable**" following on from this lack of trust in SLT tools.

EXTRACT 6.26

> **"I teach a little bit on on clinical pragmatics as part of our XXX module and I critique some of the available tools and point out that in some ways the idea that you can assess pragmatics by a standardised tool is just nuts you know ((laugh))....and I would be really question whether em ask- presenting somebody with a scenario and asking them what would you say in this scenario is anyway a valid assessment of conversation you know so that's just by way of a comment ((laugh))....I'm not knocking Talkabout everything has its place you know and suddenly that's what you do eh eh eh but that only focuses on one small area you know it's a social skills type package and then efficacy around social skills some of it is questionable you know"**

Interview No. 8
Page 1: lines 40-46
Page 6: lines 274-283
Page 7: lines 340-352

[89] Throughout this thesis, the terms "efficacy" and "effectiveness" are used synonymously in their lay sense, echoing how they have been used in the data. This more general usage differs from the usage of these terms in research contexts, where efficacy and effectiveness are used more specifically to distinguish between interventions which work in an ideal or controlled situation, versus those which work in a everyday, clinical setting (Robey, 2004; Straus et al., 2005).

In Extract 6.27[90] despite significant clinical experience being claimed, the participant still struggled with the use of clinical terminology and concepts related to pragmatics in her daily practice. This extract illustrates how participants expressed a concern about the process and practices of the SLT community with regard to how terms such as "**pragmatic language impairment**" were identified and diagnosed. *Uncertainty* manifested as a difficulty in being able to "**pin down**" particular phenomena in the area of clinical pragmatics in a definite way. The data collected via questionnaires also echoed the fact that terminology was used in a disparate manner, and that it was applied to describe divergent phenomena. Terms such as "**pragmatic language impairment**" were used differently across the participants surveyed. For example, a wide variety of indicators in differing combinations were taken by participants to be indicative of the presence of PL difficulties (as depicted in Figure 12, earlier in this chapter).

EXTRACT 6.27

"okay em yeah I suppose I wou- I mean it it is a d-it is an an uncertain area I would feel definitely and em I wouldn't be confident in kind of diagnosing a child with pragmatic language impairment I wouldn't feel em even though I've seen a lot of kids with SLI who you know would have some pragmatic difficulties but I would find it very difficult to to kind of separate that you know from you know other from SLI really or on the other hand from children who have who are on the autistic spectrum so as a discrete entity I would find it difficult to kind of pin down exactly what a child with pragmatic language impairment might look like"

Interview No.4
Page 1: lines 12-27

The fact that clinicians had doubts about their ability to effect change and provide intervention which resulted in meaningful outcomes was a significant concern. For example, in Extract 6.28 which follows, the participant noted how the impact of intervention could be "**slow**", or absent (i.e., "**if any**"). Similarly, the data in Extract 6.29 posited that pragmatics was something which could not be taught to a client, but which was "**innate**" implying that it may be beyond the reach of SLT inputs.

EXTRACT 6.28

"em but I think with pragmatics it always feels like you know you want the big leap but it has to be very much baby steps and and em it's k- slow progress if any but I do think the goals are hard to set it's hard to be specific because as I was saying sometimes it's it' so subtle and it's hard to pin it down"

Interview No. 5
Page 9: lines 436-443

[90] Extract 6.27 has been used previously (see Extract 6.4) to highlight how *Uncertainty* occasionally emerged baldly and directly as a concern for the participants during data generation.

EXTRACT 6.29

"or as well it's the idea that of all of kinda communication it [Pragmatics] is the bit that's really kinda innate and is unteachable like whereas the other bits are teachable to an ex- to a certain extent you know it's [Pragmatics] that bit that's then left over at the end that they just kinda don't have and won't have I suppose em"

Participant No. 1: Focus Group No. 1
Page 12: lines 517-530
[Words in brackets have been added]

Uncertainty as a Lack of Trust in the Clinical Practices of the SLT Community reflected a concern which permeated all aspects of the clinical process from assessment to discharge. As well as a lack of certitude about the integrity of SLT tools and inputs, the data revealed a concern about an absence of clarity when defining different points in the clinical process (such as when to discontinue intervention). *Uncertainty* was evident in defining when and whether intervention had been effective and adequate. Extract 6.30, illustrated how a questioning stance was taken about the clinicians' ability to accurately identify when intervention had worked well or not (i.e., "**when do you say okay that's not really working**"). Participants were also sceptical about their ability to define when the provision of intervention had been sufficient (i.e., "**what's not clear is when to stop intervening and when have you done enough**").

EXTRACT 6.30

"mm so I think it it is clear when to intervene but what's not clear is when to stop intervening and when have you done enough and when have you reached like a plateau and when do you say okay that's not really working or I'm not having any impact here what then"

Interview No. 5
Page 8: lines 359-366

In summary, the facet of *Uncertainty as a Lack of Trust in the Clinical Practices of the SLT Community* portrayed doubts and scepticism regarding the clinical processes and practices of the SLT community. The participants identified uncertainties about selecting the right tools and targets for intervention and also queried how well their clinical tools and skills worked in the area of clinical pragmatics. Data analysis revealed a lack of trust was evident regarding the ability of the SLT community to effect change when working in the area of clinical pragmatics.

6.2.4 UNCERTAINTY AND INTANGIBILITY: *THE INTANGIBLE NATURE OF PRAGMATICS NOTIONS*

"like the language thing is more tangible you know and it's more obvious whereas the pragmatics kinda side of things can be a little bit less well yeah"

Interview No. 1
Pages 9: lines 411-414

It emerged from the data that clinical pragmatics was situated as an amorphous area containing abstract and challenging concepts, constructs and theories. Pragmatics notions were positioned as being difficult to measure, and more generally use, in clinical practice. The field of clinical pragmatics was portrayed as being focused on subtle and oftentimes intangible aspects of interaction and communication. Clinical pragmatics was posited as an area that was not readily reducible to "**concrete**" terms, such as assessment scores, as captured by the facet of *The Intangible Nature of Pragmatics Notions* (e.g., Extract 6.31 below).

Intangibility manifested, in part, due to the absence of definitive and agreed units of analysis in relation to clinical pragmatics. In Extract 6.31, the lack of definitive and well recognised measurements and units of analysis was seen as problematic.

Intangibility also resulted in a challenge when communicating about pragmatics. Extract 6.31 also highlighted that sharing information about clinical concerns in relation to pragmatics was made difficult, because pragmatics was not as "**tangible**" as the other domains which the participant worked with and supported via her interventions. The absence of definitive formal markers of clinical significance (for example, the fact that "**you don't get a score**"), which might quantify the nature of the clinical concern in a concrete and definitive manner, was seen as a challenge. There was a power accorded to objective and definite phenomena in the clinical context. The participant noted how definitive and tangible clinical markers such as test scores (i.e., a child achieving "**two standard deviations below the mean on their CELF four**") held more "**leverage**" or weight in securing resources for clients.

EXTRACT 6.31

"I'm only like this is only coming to me now I suppose now is that let's say that it's not necessarily something that you don't get a ten- you don't get a score so it's not the-let's say for example if you've got somebody who's got a non- verbal verbal discrepancy and the there's two standard deviations below the mean on their CELF four and well that's what counts if you're trying to get resource teaching so that there's more pressure to be able to explain that or there's more leverage in terms of concrete kinda numbers eh and explaining that then there is necessarily in relation to pragmatics and I have a er like issues around that like I'm thinking for example another child that I see who is eight and has autism and the parents emphasis is very much on language and language skills that like you know matching and and identifying common objects by features and attributes

and all the rest and I'm like yeah but he's he doesn't initiate conversation or there isn't a sense of connection here isn't that more and is that not more important or at some point isn't that important em so there is that as well and that and that I wonder as well is it to do with parents are- like the language thing is more tangible you know and it's more obvious whereas the pragmatics kinda side of things can be a little bit less well yeah it depends and I don't know how how tuned in like I've never had a parent say to me oh well he doesn't establish eye contact"

Interview No. 1
Pages 8-9: lines 390-416

Participants contrasted the area of pragmatics with other areas of clinical practice which were more amenable to conclusive and concrete measurements. In Extract 6.32, the fact that particular "**aspects of pragmatics**" could be difficult to "**define**" and "**measure**" was noted. In other domains of practice, measurement was considered more straightforward and objective (e.g., the measurement of the "**percentage accuracy**" of speech sound production). The "**subjective**" nature of clinical pragmatics was often linked with intervention targets which were challenging to measure and evaluate, as in Extract 6.32. Thus, being unable to be objective and to represent clinical processes in a clear and concrete way emerged as a persisting and pervasive challenge when working clinically with pragmatics.

EXTRACT 6.32

"Possibly when like if you were writing smart goals or something it might be a little bit harder to define and to measure and it's subjective in that sense rather then you know your productions certain sounds certain percentage accuracy em you and and some aspects of pragmatics more than others some might be a little bit more measurable or whatever so in that sense it's a little bit hard to define and measure you know"

Participant No. 3: Focus Group No. 2
Pages 29-30: lines 1330-1341

The participants constantly struggled to accommodate the intangible character of pragmatics within their practice, in terms of defining and explicating their clinical activities. In Extract 6.33 the nature of pragmatics as a "**woolly subject**", was associated with the fact that pragmatics was not "**amenable to standardised testing**", and beyond definitive or objective certainty. Here, the fact that clinicians lacked tools to "**measure change**" highlighted that issues beyond straightforward gaps in resources and knowledge were also of concern.

EXTRACT 6.33

"em I suppose the main concern is that it's a very- although there has been a lot of research done in there aren't that many standardised ways of assessing it and its its something that's very hard to measure change in em....but at the same time its maybe it's not the kinda thing that is amenable to standardised testing anyway because it's such a woolly subject"

Interview No. 7
Page 1: lines 15-20
Page 1: lines 22-23

The indefinable nature of pragmatics notions entailed that it could be difficult for participants to communicate clearly what it was they did during intervention when they provided SLT supports to clients. The lack of robust objective measurements highlighted not only a difficulty clinicians had in explaining the content and goals of intervention, but also resulted in a difficultly in transparently demonstrating the effectiveness and need for SLT input.

Extract 6.34 illustrated how justifying intervention, in terms of costs and the reasons why intervention might be indicated, was made difficult by the presence of intangibility. Here, a lack of concrete intervention targets and intervention results meant that intervention could be "**iffy**", in that the participant "**couldn't always define what it's for**", when she was asked by parents, why intervention for a particular area (such as "**language**") might be indicated. It was implied in Extract 6.34 that the explanatory power of "**normative scores**" being unavailable in the area of clinical pragmatics contributed towards a lack of compliance with the SLT's recommendations.

EXTRACT 6.34

"I think the the the most difficult thing as well is the assessment part of it em because if you can write something up in a report and give the normative scores people are more likely to believe you and therefore follow the programme em and then you end up with the pragmatic profile and maybe parts of the CASL and maybe y-you might do a pragmatic test but very rarely do it cos you kinda get these isolated answers em think that resource wise is a huge problem but you can't really score it either because it's a qualitative kind of assessment because you can say okay on a scale of one to ten how effective do you think his conversational skills are and then that score will change if it's a teacher a parent or you doing it and and and how can we qualify what we're saying so I think it's a really hard thing as well and I don't know if it should be scored....where language therapy is always a bit iffy you can't couldn't always define what it's for and then to have to say to parents your child has a language problem you need to come for therapy it's gonna cost you this much eh and they go why and you go well it has an impact here and here and here okay fine we'll ring you ((2 seconds)) you know it's eh it's eh at least other therapists have very specific like OTs and physios have specific things that about you can see it you fix it and so we get the my child has problems fix them you go well language is not really that you know so...fix it yeah and fix what exactly"

Participant No. 1: Focus Group No. 3
Page 22: lines 982-1006
Page 40: lines 1846-1862

Effectively sharing information about intervention was posited as a constant challenge. Making the aims of the therapeutic process explicit was problematic when prediction and definition were untenable. The lack of clear boundaries in clinical pragmatics, due to the "**interplay**" between pragmatics and other domains, meant that the impact and aim of intervention was not always easy to communicate to parents (Extract 6.35).

In Extract 6.35, the participant noted that it became a challenge to clearly share information about their intervention trajectory and goals with others, in that it was difficult to "**communicate to parents where we're going and where we want to go**". It was also evident that clinicians found it a challenge to clearly reflect and define their own intervention goals for themselves (i.e., "**it's much more difficult to see where you're going for us to see where we're going**").

EXTRACT 6.35

"and I think especially when you get into the realm of pragmatic language I mean it's really difficult to predict how that's gonna all kind of turn out I think em you know as as people go- just because of that interplay between language and and or communication and and socialisation and em it's much more difficult to see where you're going for us to see where we're going ((laugh)) em and therefore to kinda communicate to parents where we're going and where we want to go and em so that makes it difficult as well ((laugh)) we're we just keep coming back to uncertainty ((laugh))"

Interview No. 4
Page 11: lines 512-526

Accurately identifying when a focus on pragmatics was appropriate in the clinic was a challenge. Pragmatics was presented as an overlapping and inseparable aspect of communication, and interaction in general, in much of the data as in Extract 6.36.

EXTRACT 6.36

"Very relevant but very difficult to isolate I would feel em nearly impossible for me to isolate pragmatics from other areas of language or other y- other social skills you know because it's all so intertwined"

Participant No. 3: Focus Group 1
Page 2: lines 70-76

It was suggested that communication and interaction skills were intertwined with so many other phenomena, including personality and personal preferences, leading one participant to highlight that "**everything is so integrated**" (Extract 6.37). Here, the "**interconnected**" nature of pragmatics, reflected how pragmatics was seen to be both a synergistic and indefinable phenomenon which was not readily reducible to discrete skills or behaviours. The perceived overlap between pragmatics and other interactionally relevant phenomena such as "**demeanour**"

was problematic for participants and clinicians who were subsequently left on uncertain grounds as to know "**what to do**" in interventions.

EXTRACT 6.37

> **"em what I struggle with is that everything is so integrated the idea of prosody and intonation and context and body language and people's eh demeanour is all so interconnected that's its very very hard there's there's a big question I I haven't em found any research regarding whether the building up of isolated skills leads to development in overall presentation cos generally what happens is if you teach a skill they get a skill em there's a little bit in pivotal response ideas which is that you can focus on underlying core deficits em but none of those focus largely on pragmatics they tend to be it's like joint attention is a product of two underlying ones as opposed to a core thing on its own which it's very interesting but it's hard to know what to do"**
>
> Participant No. 3: Focus Group No. 3
> Page 20: lines 884-902

In summary, *The Intangible Nature of Pragmatics Notions* reflected a facet of *Uncertainty* which posited that working in the area of clinical pragmatics was beyond certainty because of the elusive, vacillating and often value laden nature of concepts, constructs and theory in the area of clinical pragmatics. *The Intangible Nature of Pragmatics Notions* was reflected in challenges measuring and communicating about intervention targets and outcomes when working in the area of clinical pragmatics. Additionally, a perceived overlap between pragmatics and other areas apposite to communication such as personality and cultural interaction/communication patterns, left clinicians on uncertain ground when trying to specify intervention or to carve out intervention goals in detail. The fuzzy boundaries between values, beliefs and clinical knowledge resulted in a complex set of challenges in the area of clinical pragmatics.

SUMMARY

Uncertainty emerged as a multifaceted and distributed concept within the data, permeating many aspects of the clinical process. *Uncertainty* emerged with four interacting and overlapping facets.

Each facet of *Uncertainty* represented a type of *Uncertainty* which concerned the participants. *Presenting Pragmatics as an Unformulated Body of Knowledge* emerged, as a facet of *Uncertainty*, to capture concerns about the incomplete nature of the clinical pragmatics knowledge base. Another facet of *Uncertainty* named *Emphasising a Lack of Clarity Regarding the Role of the Clinician* emerged to capture a lack of consensus regarding the scope of the role of the Speech and Language Therapist. Decreased level of trust in the clinical activities and practices of the SLT community to effect change in the area of clinical pragmatics was highlighted as another facet of *Uncertainty* termed *Uncertainty as a Lack of Trust in the Clinical Practices of the SLT*

Community. Finally, the facet of *Uncertainty* named *The Intangible Nature of Pragmatics Notions* emerged from the data to portray the amorphous nature of intervention when pragmatics notions were involved in SLT practice.

The obvious nature of *Uncertainty* is particularly reflected in the facet of *Presenting Pragmatics as an Unformulated Body of Knowledge*. Thus, *Uncertainty* was a blatant and well recognised issue specifically tied to a lack of research and gaps of knowledge. The inherent nature of *Uncertainty* was especially portrayed by the facet of *Uncertainty* termed *The Intangible Nature of Pragmatics Notions*. The inherent nature of *Uncertainty* captured how *Uncertainty* was an issue concerning the interaction between values, beliefs and knowledge which was pervasive and inevitable in clinical practice, highlighting the imperfect nature of clinical knowledge for participants.

Uncertainty was revealed as the participants' main concern continually within the data across all of the data sites. As such, responding to and managing *Uncertainty* was revealed as the core variable in the data. Chapters 7-9 discuss how *Uncertainty* was responded to by participants.

CHAPTER 7. RESPONSES TO *UNCERTAINTY* IN THE DATA: *SHRINKING REMIT*

7.1 OVERVIEW OF THE THEORY OF *RESHAPING REMIT*

Before fracturing the theory of *Reshaping Remit* into three patterns of responding to *Uncertainty* over the course of the next three chapters, it may be salutary to provide an introductory overview of the theory of *Reshaping Remit* here.

In this study, the author analysed data arising from questionnaires, focus groups, documents and interviews related to clinical pragmatics and SLT practice. The theory of *Reshaping Remit* emerged from data analysis, explicating conceptually how members of the SLT community responded to their main concern of *Uncertainty*. Responding to *Uncertainty* by adapting and adjusting the SLT role was the action which unified the patterns noted in the data.

Uncertainty was conceptualised as having both an obvious and inherent nature which was reflected in all four facets of *Uncertainty* that emerged as the main concern for participants in this study. The four facets of *Uncertainty* related to 1) the incomplete nature of the knowledge base which underpinned the area of clinical pragmatics; 2) a lack of clarity regarding the role of the SLT; 3) a lack of trust in the practices of the SLT community; and 4) the intangibility of pragmatics notions, as discussed in Chapter 6.

Reshaping Remit is a theoretical account, emergent from the data, of how participants responded to this multifaceted and distributed concept of *Uncertainty. Reshaping Remit* involved three main responses to *Uncertainty*. Within each of these responses to *Uncertainty,* participants drew on divergent assessments of the SLT role in order to operationalise intervention in the uncertain area of clinical pragmatics. The role of the client was coloured by the response to *Uncertainty* drawn on by the clinician.

Shrinking Remit was a response to *Uncertainty*, characterised by the non-provision or discontinuation of SLT intervention. A sceptical stance towards the potential of SLT inputs to effect change in relation to a particular clinical issue, particularly in light of persisting or chronic conditions, was taken to support the discontinuation of SLT interventions. Additionally, situating clinical work as being outside of the realm of the Speech and Language Therapist, evoking organisational restrictions and limits in individual and collective clinical skills and tools in the area of clinical pragmatics were all reasons given as to why SLT intervention could not be provided.

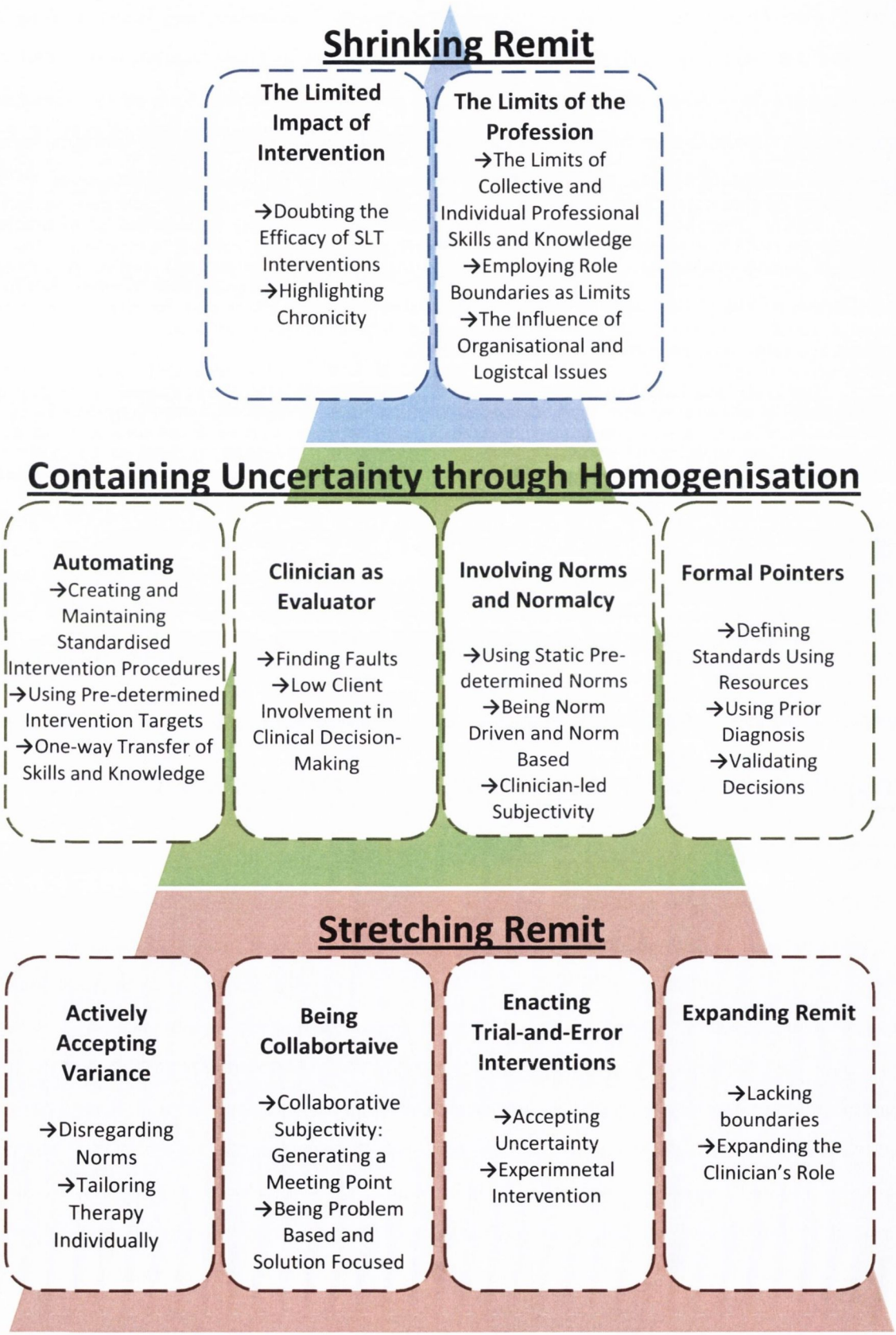
In addition, *Containing Uncertainty through Homogenisation* was a response to *Uncertainty* characterised by the continuation or provision of SLT intervention. This response to *Uncertainty* saw the clinician enact an evaluative role, leaving little room for client involvement in clinical decision-making. In order to manage *Uncertainty*, intervention was enacted along a standardised trajectory involving generic content and format and intervention was aimed at achieving pre-determined, universal goals. Universal goals were generated from extant resources or from the clinician's own subjective appraisal of normal. Norms, and cognate concepts, were posited as valuable clinical tools which enabled the enactment of standardised intervention.

Finally, *Stretching Remit* portrayed a response to *Uncertainty* hallmarked by increased levels of client involvement in clinical decision-making and a broad SLT remit. A shared perspective on the clinical issue at hand was generated, between client and clinician, in order to inform and tailor intervention on a case-by-case basis.

There was vacillation between the three responses to *Uncertainty,* captured by the theory of *Reshaping Remit.* Participants moved between the different responses based on a wide variety of factors. Thus, *Reshaping Remit* portrays a typology of interacting responses which conceptualises how clinicians dealt with *Uncertainty* in the context of SLT practice and clinical pragmatics.

Figure 13 below presents a diagrammatic representation of *Reshaping Remit.* In this figure, the sub-core categories (representing the overarching patterns of responding to *Uncertainty*) can be identified by the use of underlined and bold typeface. The categories (representing the defining characteristics of each of overarching patterns of responding to *Uncertainty*) of the each sub-core category can be identified by the use of bold typeface only. Finally, the properties of each of the categories have been presented in plain text and are preceded by an arrow.

FIGURE 13: DIAGRAMMATIC REPRESENTATION OF *RESHAPING REMIT*

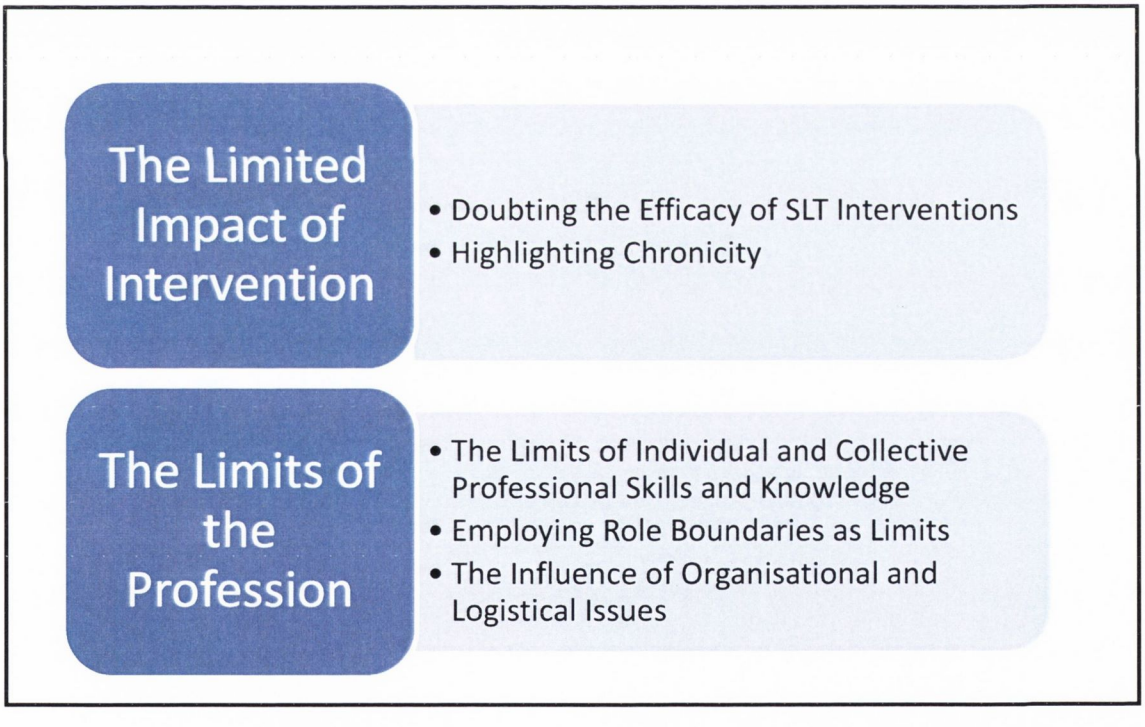


7.2 THE SUB-CORE CATEGORY OF *SHRINKING REMIT*: INTRODUCTION

As noted previously, the concept of *Shrinking Remit* evolved from the data to capture responses to *Uncertainty,* which were characterised by the withdrawal or non-provision of SLT intervention. As depicted in Figure 14 below, the category of *The Limited Impact of Intervention* explicated reasons why intervention should not be provided, while the category of *The Limits of the Profession* captured patterns in the data pertaining to why intervention could not be offered, in light of *Uncertainty*.

The category of *The Limited Impact of Intervention* highlighted that intervention should not be provided in light of a perceived lack of impact or change resulting from the provision of SLT input, particularly in the context of chronic conditions. The category of *The Limits of the Profession* captured why intervention could not be offered due to limits in clinical skills and tools, a client's need for supports from professionals other than the SLTs, and the organisational limits imposed on members of the SLT community.

FIGURE 14: THE SUB-CORE CATEGORY OF *SHRINKING REMIT:* ITS CATEGORIES AND PROPERTIES

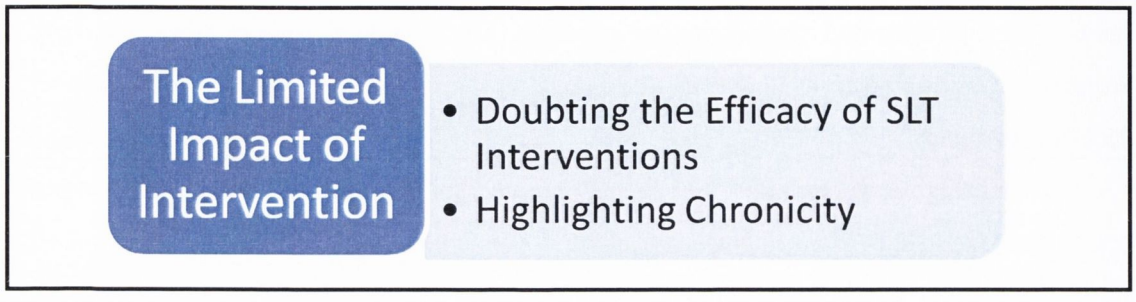


7.2.1 THE CATEGORY OF *THE LIMITED IMPACT OF INTERVENTION*

The Limited Impact of Intervention emerged as a category of *Shrinking Remit*, capturing how intervention inefficacy was portrayed in the data, as an impetus for intervention discontinuation. Highlighting the inefficacy of SLT interventions and the chronicity of certain conditions

contributed towards a construal of SLT intervention as being null and void. Participants reduced their clinical involvement in situations where SLT intervention was deemed ineffective. Figure 15 below depicts the category of *The Limited Impact of Intervention* and its properties.

FIGURE 15: THE CATEGORY OF *THE LIMITED IMPACT OF INTERVENTION* AND ITS PROPERTIES



7.2.1.1 THE PROPERTY OF *DOUBTING THE EFFICACY OF SLT INTERVENTIONS*

"I don't do that kind of thing anymore I just don't think it's effective"

Interview No. 4
Page 25: lines 1239-1241

During data generation, many of the participants reflected on the doubts they had about the efficacy of their interventions in the context of clinical pragmatics. Indeed, one facet of the participants' core concern of *Uncertainty*, namely *Uncertainty as a Lack of Trust in the Clinical Practices of the SLT Community*, centred around a lack of confidence in SLT practices in the area of clinical pragmatics to produce or facilitate change. However, when doubts about efficacy of SLT interventions emerged in support of decisions to withdraw SLT input; this was viewed as a response to *Uncertainty* in itself rather than just a facet of *Uncertainty*.

Uncertainty regarding the efficacy of particular types of intervention led clinicians to disengage from these particular approaches or types of therapy. For the participant in Extract 7.1, doubts about how much change SLT inputs could facilitate by working in "**a very impairment based way**" resulted in some interventions being considered a misuse of clinical energy and time (i.e., "**kind of a waste of time really**"). A decision to discontinue from addressing particular intervention targets or enacting particular types of intervention (such as "**the usual like social skills groups**") was presented as a response to doubts about the efficacy of these particular interventions.

Many of the participants displayed doubts about the potential of the intervention which they had enacted in the past to have effected meaningful change. In Extract 7.1 the participant regarded some of the interventions which she had previously performed dubiously. Types of

interventions which were deemed ineffective were situated as null and were discontinued (i.e., "**I don't do that kind of thing anymore I just don't think it's effective**").

EXTRACT 7. 1

"I think people yeah probably would be very tempted to work on eye contact or like whatever that means and work on turn taking or work and you know em try to work on it try to work on it in a very impairment based way em but I mean there's no kind of evidence that that works I know there's no evidence for many things we do ((laugh)) but I think of all ((laugh)) the things we do ((laugh)) working on eye contact with you know trying to get people to look at you when they don't want to look at you ((laugh)) is is kind of a waste of time really....em I mean I would have done the usual like social skills groups and all that sort of stuff em but I don't do that kind of thing anymore I just don't think it's effective"

Interview No. 4
Pages 24-25: lines 1203-1220
Page 25: lines 1238-1241

Echoing Extract 7.1, scepticism was perceived when the participant highlighted queries about the ability of a clinician to effect changes to an identified "**difficulty**" (as in Extract 7.2). Here, the data revealed concerns about the efficacy of intervention when therapy was focused on the teaching of particular skills from the "**realm of pragmatics**" (such as "**eye contact**"). Subsequently, participants questioned the nature, and indeed the continuation, of SLT input in the area of clinical pragmatics. In particular, the outcomes of interventions which aimed to "**teach**" discrete skills and transfer specific knowledge from the clinician to the client were regarded with some suspicion, as in Extract 7.2. This same participant later noted, in lines 202-207, how rather than teaching discrete skills to the client facilitating communication partners to modify their behaviour might be a more appropriate form of intervention. Thus, the clinician highlighted the discontinuation of one form of therapy, in light of *Uncertainty*, and the provision of an alternative form of intervention.

EXTRACT 7.2

"the eh tricky thing I think as well is in relation to how to actually intervene so let's say for example if you conclude that somebody has difficulty with non verbal aspect of communication and eye contact can you actually teach somebody how to establish and maintain appropriate eye contact I think would be an issue for example that's if you consider eye contact falling within the realm of pragmatics....so it is paying attention to how you take your turn now it's not couched in those terms but when you look at it that's what it's doing you're taking responsibility for your part in the interaction and modifying your part in the interaction and then looking at what happens as a result"

Interview No. 1
Page 3: lines 103-109
Page 5: lines 202-207

In reflecting on practice in the area of clinical pragmatics, the participant in Extract 7.3 actively questioned the limited results of intervention. In this extract, intervention was depicted as the superficial teaching of surface linguistic structures, such as "**idioms**". The restricted consequences of intervention led the participant to query why she should continue to carry out certain forms of intervention in the area of clinical pragmatics, when they had such limited impact (i.e., "**I question why I am doing pragmatics**"). Although the participant in this extract points out that SLT input can result in some limited yet discernable changes (such as the learning of specifically targeted idioms on an item by item basis), the participant questioned if she should continue to carry out interventions which have such a limited scope of effect. The participant noted that it would be "**ridiculous**" to continue providing intervention in this fashion, and thus, the discontinuation of intervention was implied.

EXTRACT 7.3

"you can't teach everyone of those things like you know like it would be ridiculous to even suggest it like....I think at times I question why I am doing pragmatics y- or why I am doing- looking at that or why I am doing idioms you know cos like it's just like they learn those five but that's it like you know it's sort of I dunno a bit..."

Participant No.3: Focus Group No. 4
Page 33: lines 1598-1603
Page 33: lines 1616-1623

In Extract 7.4, environmental changes were highlighted as changes which could be achieved by SLT intervention. However, the participant was reluctant to present SLT interventions as consistently effecting changes in internal competencies (such as the intrinsic skill levels of clients). Additionally, with reference to "**difficulties with pragmatics or social skills**" SLT interventions were posited as having a limited effect (i.e., "**there's not necessarily a whole lot we can do to actually sort of fix it as such**"). As such, a failure to pull back from providing intervention which was questionable in terms of efficacy and a failure to openly acknowledge the limited efficacy of SLT interventions to the client, were alluded to as being disingenuous. Thus, the lack of impact of SLT inputs meant that intervention should be discontinued as it was noted that there was "**no point**" of continuing to provide intervention.

By sharing information with clients and other intervention stakeholders about the limited scope of change that SLT intervention might achieve, the clinician prepared the client for the gradual withdrawal of SLT input. The hidden and potentially clashing intervention aims of client and clinician were highlighted in Extract 7.4 (i.e., pursuing curative versus supportive goals during therapy). Disclosing the limits of intervention to the client involved sharing information and defining the ways in which SLT input could and could not effect change (i.e., by openly naming the

limits of SLT interventions). It was suggested that there could be implicit misinformation indirectly communicated to the client by continuing to offer intervention in the context of divergent therapy aims and the clinician's silent doubts about the potential of intervention to achieve certain aims. SLT services became "**difficult to withdraw**" and a smooth discontinuation of SLT input could be hampered when open dialogue between clinician and client about intervention limits and aims was withheld.

EXTRACT 7.4

"You have to be honest with parents you know you've to tell parents with with anything and whatever you're working with fluency or something else you've got to say what you can do and can't do and there's no point in you know setting people up for failure by dragging them in and out to loads of you know social skills group wise I think that was kind of in the past there was much more of a vogue for that I think and I think you know I don't think that was necessarily hugely helpful do you know because you gave the impression therefore that you were going to fix something and that was probably never going to happen you know then it's very difficult to withdraw it then and say we're not going to give you anymore so I think you know like XXX was saying you're just very honest with parents you explain this is what what I'm seeing you know you're probably going to observe this too he may have – you know present in this particular way or you may see these difficulties with pragmatics or social skills and you kind of do something with the environment but it's not likely to disappear and there's not necessarily a whole lot we can do to actually sort of fix it as such you know"

Participant No. 3: Focus Group 1
Page 15: lines 664-689

The *Doubting the Efficacy of SLT Interventions* property portrayed how the discontinuation of intervention was supported in cases in which intervention was considered futile. The "**ineffective**" nature of SLT intervention in the area of clinical pragmatics was raised in Extract 7.5 as legitimising the participant's assertion that under the circumstances of inefficacy, clients might have been "**genuinely...better off**" not receiving any SLT input. The data revealed many instances in which a lack of efficacy was posited as a contra-indicator for providing intervention.

EXTRACT 7.5

"I think it's just eh a couple of probably five years ago or six years ago running a social skills group that actually ((cough)) well you know social skills pragmatics group that was completely ineffective and completely like what you know you may as well have been just banging your head off a brick wall and I thought what was- I mean I genuinely thought I thought at the end I think it was in the s- summertime and I thought to myself that those children genuinely would have been better off on a football team or something or you know outside- or...or in the park playing with other children actually that would have done them a whole lot more use"

Participant No. 3: Focus Group 1
Pages 18-19: lines 825-841

The pattern of discontinuation of SLT input was legitimised when the limited impact of intervention was highlighted, as captured by the property of *Doubting the Efficacy of SLT Interventions.* Accentuating the chronic nature of issues which arose in the SLT clinic also validated decisions to discontinue SLT intervention, as will be discussed in the following section.

7.2.1.2 The property of *Highlighting Chronicity*

> **"you know the difficulties are long term....at some point you have to let these children go"**
>
> Participant No. 1: Focus Group No. 1
> Page 44: lines 2016-2020

Acknowledging the persistent and long term nature of the difficulties experienced by clients (as well as highlighting doubts about the efficacy of SLT interventions) created a situation in which the discontinuation of intervention was valid for clinicians, as captured by the property of *Highlighting Chronicity.*

Pulling back from providing intervention, by letting "**go**" of clinical responsibility to clients, was facilitated by the creation of a profile of impairment which was "**long term**" or chronic, as can be seen in Extract 7.6 below.[91] Decisions to withdraw intervention were bolstered by the persistence of "**difficulties**".

Extract 7.6

> **"I think cos it's you know the difficulties are long term and you don't know how effective different types of intervention or therapy whatever might be and so if you're the only person involved your're feeling like your're responsible for this but at some point you have to let these children go because there aren't special services for children with pragmatics language impairment if that exists...but I mean the reality is that most children get discharged from XXX services when they're like I dunno correct me if I'm wrong like 8 or 9 and you know they may well have needs beyond 8 9 10 but it's just like where do they go who do they see how effective would it be if you keep them so then you probably won't keep them"**
>
> Participant No. 1: Focus Group No. 1
> Pages 44-45: lines 2016-2038

[91] Additionally, the data in Extract 7.6 also illustrates how conceptual categories interact and overlap in a segment of data. For example, this data also highlighted how doubts about how "**effective**" SLT interventions might be (illustrated by the property of *Doubting the Efficacy of SLT Interventions*), and how organisational tradition dictated the age at which clients get discharged from a particular service, (illustrated by the property of *The Influence of Organisational and Logistical Issues* to be discussed later in Section 7.2.2.3), emerged in tandem in this data to validate the cessation of SLT inputs.

In the area of clinical pragmatics it was stressed that "**difficulties will go on**" despite the provision of SLT input as in Extract 7.7. Here, the presence of issues beyond the reach of SLT input (such as "**underlying difficulty**") were often used to highlight chronicity and the lack of impact that SLT interventions were likely to have in this context.

A tentative list of skills and other phenomena to focus on during intervention (e.g., "**interpret facial expression....hypothesizing, pretending, or creating scenarios**") was provided in the data in Extract 7.8. Intervention was situated as being only "**sometimes helpful**". Here, a failure to "**make progress**" when "**addressing these problems**" through intervention was linked with the presence of "**neurological reasons**". Underlying factors such as "**neurological reasons**" were taken as long term and intractable "**problems**". A lack of "**progresses**", in light of certain diagnoses, could be viewed as a pre-sequence for the discontinuation of intervention. The success of intervention was couched within a proviso of potential failure due to irresolvable and chronic issues which were outside of the clinician's control, and beyond of the reach of SLT intervention.

EXTRACT 7.7

"I think that some pragmatics difficulties will go on....there might be underlying difficulty"

Participant No. 1: Focus Group No. 4
Page 33: lines 1605-1607

EXTRACT 7.8

"Clients whose difficulties seem to lie within the less severe sections of the autistic continuum (and this includes some with a diagnosis of Asperger's syndrome or semantic pragmatic disorder) certainly appear to have difficulty taking the thoughts and feelings of others into consideration. As yet, it is not at all certain why this should be the case. These clients may fail to interpret facial expression correctly (prosopagnosia); they may lack sympathy with other people for emotional reasons; or a difficulty in hypothesizing, pretending or creating scenarios (imagining) may lie at the root of the problem. Addressing these problems in intervention is sometimes helpful, although it needs to be borne in mind that some clients may be unable to make progress in these areas for neurological reasons (Culting, 1990; Aicardi, 1992; Joanette & Erownell, 1990)"

Working with Pragmatics
(Anderson-Wood & Rae-Smith, 2001, p. 13)

By explicitly highlighting the persistent and long term nature of clinical issues, these issues could be recast as being outside of the reach of the SLT inputs. Enabling parents and significant others to accept that the difficulties arising for clients were chronic also often occurred as a pattern in the data, prior to the SLT disengaging from actively providing intervention. Highlighting the ongoing nature of the difficulties as being beyond the reach of SLT intervention, (i.e., "**I'm not going to fix this you know this is not going away**") prepared the client for the withdrawal of intervention, as in Extract 7.9. Here, open dialogue regarding the limited impact of SLT input was

seen to prevent the clients from becoming reliant on the "**fairy godmother**" clinician and searching for a non-existent cure for what was framed as a chronic or "**lifelong**" difficulty.

When chronic difficulties were present, the provision of particular types of intervention or focusing on certain types of SLT goals (such as aiming to change skill and competency levels intrinsic to the client) was positioned as being inappropriate. It was suggested that the provision of certain interventions, in light of chronicity, was disingenuous as it portrayed the "**wrong**" remediative message to parents, as in Extract 7.9. A failure to acknowledge and disclose the limits of intervention, in light of chronic "**lifelong**" difficulty, was suggested as leading to the development of a dependency on intervention, or an "**addiction to therapy**".

EXTRACT 7.9

"but that balance totally shifts I think with the more language kids and certainly the ones who have more like pragmatic type difficulties em I mean impairment focused goals really are you know I mean I'm not sure that it's something you can necessarily really change so you're trying to kinda work around it I suppose as best you can and give strategies and that kind of thing so so you're kinda moving from the impairment em because I'm always very conscious of trying and maybe this is maybe I have this all wrong but I'm very conscious of trying to communicate that I'm not going to fix this you know this is not going away like em and so to kinda work in an impairment focused way would be reinforcing the wrong message....yeah yeah and ultimately I mean you're going to do a period of work with these kids but then the parents need to you know it's going to be lifelong for some of them and you know certainly for the school years or whatever anyway so they need to be able to just take it forward themselves em and not become really dependent on therapy to fix everything you know em but maybe I have that wrong I don't know I mean that's the way I would see it....yes there's a serious addiction to therapy eh well I see kids twice a week so you know we spend a lot of time together ((laugh)) twice a week you know for sometimes over a year so it's a lot of intervention but sometimes with the you know I would try with the language kids to gradually reduce that and eventually fade out ((laugh)) em because you don't want to be seen as the fairy godmother whose going to fix it that's my worst fear ((laugh)) cos then when you've stopped you know when you withdraw it's just like you know you're pulling the rug from under them"

Interview No. 4
Pages 12-13: lines 594-626
Page 13: line 633-652

Highlighting Chronicity portrayed how the persistent and ongoing nature of clinical issues was accentuated in order to support decisions regarding the discontinuation of SLT input.

7.2.1.3 *The Limited Impact of Intervention*: summary

Intervention was viewed as being ineffective when there was a lack of change brought about by SLT inputs, as captured by the property of *Doubting the Efficacy of SLT Interventions*. Interventions were also discontinued in light of the chronic and persisting nature of presenting clinical concerns, as portrayed by the property of *Highlighting Chronicity*.

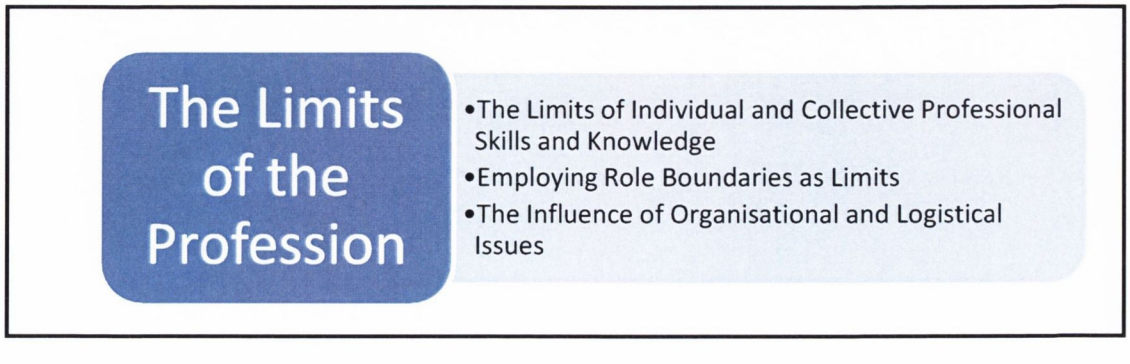
The Limited Impact of Intervention category captured how withdrawal of SLT inputs was legitimised in the presence of a perceived limited capacity for SLT interventions to effect change. Chronicity and inefficacy were highlighted in order to explicate why interventions should not be provided and thus, validated the withdrawal or cessation of SLT interventions.

7.2.2 The category of *The Limits of the Profession*

The Limits of the Profession category of *Shrinking Remit* captured how SLTs positioned themselves as being unable to provide intervention in the area of clinical pragmatics because of a perceived absence of particular clinical skills and tools. Additionally, professional boundary issues and organisational policy were also evoked as reasons why intervention could not be provided.

The property of *The Limits of Individual and Collective Professional Skills and Knowledge* highlighted how a lack of particular clinical skills and tools in the area of clinical pragmatics were drawn on to explicate why intervention could not be provided. The property of *Employing Role Boundaries as Limits* captured the pattern of identifying a client as requiring intervention and supports which were beyond the remit of the clinician, as a Speech and Language Therapist, and as such the Speech and Language Therapist could not provide intervention. Finally, *The Influences of Organisational and Logistical Issues* property highlighted how organisational or service-level issues, as well as everyday practical issues, also precluded SLTs from continuing to offer interventions in the area of clinical pragmatics.

Figure 16: The category of *The Limits of the Profession* and its properties



7.2.2.1 THE PROPERTY OF *THE LIMITS OF COLLECTIVE AND INDIVIDUAL PROFESSIONAL SKILLS AND KNOWLEDGE*

> **"we were hoping to have like kind of more training in that area before we delivered some service"**
>
> Participant No. 2: Focus Group No. 2
> Page 14: lines 631-633

One of the situations in which intervention was conceptualised as being outside of the remit of the clinician was when practitioners were positioned as being professionally ill-equipped to offer and carry out particular interventions. A lack of tools, training and skills were highlighted in the data as the ways in which practitioners were not fully equipped to work with pragmatics.

In Extract 7.10, the participants identified clinical pragmatics as a "**grey area**", as a result of an "**absence of courses**". The lack of training in the area of clinical pragmatics was cited as a reason for withholding the provision of intervention (i.e., "**we were hoping to have like kind of more training in that area before we delivered some service**"). The provision of intervention in this area was dependent on further training and "**courses**" for the participants:

EXTRACT 7.10

> **"Yeah actually the the absence of courses em in Pragmatics has left it to be bit of a grey area and there was one cancelled there recently em Wendi Rinaldi's course and you know a few of us had signed up for that hoping we'd be able to offer more em pragmatic eh you know groups and you know pragmatic orientated therapy to our older clients and of school age but we were hoping to have like kind of more training in that area before we delivered some service"**
>
> Participant No. 2: Focus Group No. 2
> Page 14: lines 615-633

In a similar vein, in Extract 7.11, the absence of "**training**" was correlated with a collective dearth of "**skills**", across the profession of SLT. Participants recurrently emphasised that they felt under-skilled, both as individual clinicians and as a profession as a whole. A lack of skills across the entire profession could be used to absorb individual responsibility for clinical competency as in Extract 7.11.

EXTRACT 7.11

> **"I just feel as a professional we're lacking in the skills rather than you know and it's not uh it's through no fault of our own like training is not there"**
>
> Participant No. 1: Focus Group No. 4
> Page 42: lines 2073-2074

In conjunction with a scarcity of training, a paucity of tools and materials were also deemed responsible for holding the participants back from providing intervention. Resourcing and logistical issues (such as an absence of funding, time and SLT staff) also presented as concerns for participants. These issues pertaining to a lack of resources, such as clinical time, mounting waiting lists and inadequate funding, will be dealt with in Section 7.2.2.3. These organisational and logistical resourcing issues differed from concerns about the absence of quality, commercially available training, tools and skills and resources to guide and inform intervention.

A lack of resources and technology with which to enact intervention was highlighted in the Extracts 7.12-7.15 below. In Extract 7.12, the absence of "**understanding**" contributed to the relatively empty "**tool kit**" that SLTs possessed. Extract 7.13 captured how a limited collection of resources to structure intervention were available to the clinician (i.e., "**it's the same kind of same few things that's ta- thrown around the department you know**"). Here, a lack of materials and tools or "**pragmatics stuff**", were available to the participants to aid them in carrying out clinical practice. The data in Extract 7.14 reiterated a concern about the quantity and "**quality**" of the resources which were available. Extract 7.15 highlighted that often "**no**" extant resources were perceived to be available to clinicians. Participants responded to this lack of technology by modifying available resources, using different sections from different resources and self-generating materials.

EXTRACT 7.12

"Maybe for some things like that we just lack the tools I think we lack the understanding but we certain- I think don't have the tool kit"

Participant No.3: Focus Group No. 3
Page 38: lines 1761-1763

EXTRACT 7.13

"But even pragmatics stuff in general we wouldn't have a lot of stuff on it's the same kind of same few things that's ta- thrown around the department you know we all have bits from Talkabout and that Room Fourteen book and that's about it like but as you say maybe there's not that many resources out there even"

Participant No.3: Focus Group No. 4
Pages 33-34: lines 1635-1642

EXTRACT 7.14

"There's a mix of of I think quality em some you you can adapt and and use like the Socially Speaking kinda thing is okay but it its em more for teachers there's very little I think out there for speech therapists to use usually what we do is go into the catalogues and try if there's a new programme order it have a look of it and see what bits we can use em"

Participant No.1: Focus Group No. 3
Pages 19-20: lines 872-879

EXTRACT 7.15

"but you often kinda find yourself picking from different em manuals different resources different ideas sometimes we've no resources or manuals we just kinda make up stuff ((laugh)) you know and hope it works em"

Interview No. 7
Page 11: lines 454-457

In Extract 7.16, the participant identified a lack of confidence about her skills in the area of pragmatics (i.e., "**we don't feel that skilled to be able to work in it**"). The use of "**we**" perhaps reflected an impression of the profession as a whole lacking skills, rather than the skill deficit being the individual clinician's responsibility. The participants often identified gaps in their own and the profession's clinical skills and resources in the context of clinical pragmatics, accentuating the perceived limits of SLT competence in this area.

EXTRACT 7.16

"it's [Pragmatics] a strange area in that its open ended and diverse and there no clear cut boundaries about who works on it and who doesn't work on it who shouldn't work on it em...and and and also that we don't feel that skilled to be able to work in it em but because we work in a team we're lucky because we work in a team we're lucky we can ask the others for their resources and their suggestions"

Interview No. 7
Page 10: lines 427-433
Pages 10-11: lines 446-449
[Words in brackets have been added]

Providing intervention in situations in which clinicians doubted their own skill level and/or their professional competence was a challenge for the participants. In Extract 7.17, the participant implied that she considered herself to be ill-equipped (i.e., "**completely out of my depth**") when working with particular clients. Pulling back and avoiding intervention (i.e., "**I pray they DNA**")[92] was her preference, in light of her concerns about her perceived level of competency.

EXTRACT 7.17

"Oh my god it's so much harder to have a fifteen year old or a sixteen year old or seventeen year old crying in front of me as opposed to like a eight nine ten I'd feel completely out of my depth if I had a teenager or even doing a formal assessment like much more on edge and you know like cos I'm just not used to dealing with them either...I think if we get a referral in and he's like fifteen or sixteen like a lot of the time I and off he'd go so so that's what I I think oh gosh what am I gonna to do with you and I go he's never going to come in any way I pray they DNA now and I go and that's plus it's you know it's an area that I'm uncomfortable"

Participant No.2: Focus Group No. 4
Pages 41-42: lines 2022-2047

[92] "DNA" is an abbreviation of "Did Not Attend" which may be used to indicate that a client did not attend a scheduled appointment without prior notification of their non-attendance.

Instances in which the boundaries of the Speech and Language Therapist's role was transgressed (e.g., by offering interventions which were outside of the clinician's remit) were also identified as necessitating a discontinuation of SLT inputs. Extracts 7.18-7.21 illustrate two divergent reasons for withdrawing intervention. A lack of technology (Extract 7.18) was juxtaposed with the crossing of professional boundaries (Extract 7.19 and Extract 7.21) as reasons for withdrawing intervention.

Participant No. 2 in Extract 7.18 implied that the area of "**counselling**" was within her professional remit, but that she required additional "**training**" and up-skilling in this area. The participant in Extract 7.21 pointed out that SLTs did not require additional training as they had been suitably "**equipped**" to provide this certain level of "**counselling**" interventions. Providing SLT inputs which transgressed a particular level of "**counselling**" work was considered to be practising outside of the professional boundary of the Speech and Language Therapist, and could not be continued as the clinician had been perceived as "**kinda taking on the role of psychologist**", as in Extract 7.21. (Section 7.2.2.2 below deals in more depth with the notion of using professional role boundaries, as opposed to drawing on professional skill and tool deficits, for delimiting the provision of intervention).

EXTRACT 7.18

"Hm I think we need more training and counselling skills I suppose...no but if it comes into it you know"

Participant No.2: Focus Group No. 4
Page 16: line 763

EXTRACT 7.19

"But we're not counsellors either"

Participant No.3: Focus Group No. 4
Page 16: line 764

EXTRACT 7.20

"No but if it comes into it you know"

Participant No.2: Focus Group No. 4
Page 16: line 765

EXTRACT 7.21

"I know we did do like counselling as part of our degree but I think um the skills that we are equipped to counsel we are using and we don't like do you get me moving into that counselling psychology role and I mean we've long enough waiting lists and enough to deal with without turning round and kinda taking on the role of psychologist because there's no psychologist available you know"

Participant No.1: Focus Group No. 4
Page 16: lines 766-776

A potential for disparity in practice was also highlighted in the previous extracts. The participant in Extract 7.18 implied that continuing to providing intervention in the area of "**counselling**" was indicated as part of her role, but that it was untenable due to her identified lack of skill. However, the data in Extracts 7.19 and 7.21 suggested that other participants would have discontinued intervention in this same instance, as they conceptualised this level of "**counselling**" intervention as being beyond their disciplinary role and responsibility. Variability in practice patterns could result from instances in which the presence of *Uncertainty* and a lack of guidance resulted in the clinicians making individual decisions regarding clinical practice and the boundary of their role.

The Limits of Individual and Collective Professional Skills and Knowledge property captured how a lack of training, tools and skills were used to construct a profile of the Speech and Language Therapist (both as individual clinicians and as a profession) as being professionally ill-equipped to provide intervention in the area of clinical pragmatics.

7.2.2.2 The property of *Employing Role Boundaries as Limits*

> **"I kinda had to take a step back and go okay I'm not equipped to give you any kind of advice or even to talk to you about this"**
>
> Participant No.1: Focus Group No. 4
> Page 17: lines 810-811

Participants used the boundaries of their role as a method for delimiting the provision of SLT input. When intervention was perceived to transgress the role boundaries of the clinician, practitioners were validated in disengaging from intervention. It was posited that clinicians should not continue to offer intervention which went beyond their remit. Data which reflected the *Employing Role Boundaries as Limits* property portrayed how participants, rather than identifying themselves as being under skilled or lacking in technology (as in the property of *The Limits of Individual and Collective Professional Skills and Knowledge* discussed above), highlighted the fact that other professionals possessed more appropriate tools and skills to provide supports in particular clinical situations.

Discontinuation or taking a "**step back**" from intervention could occur in instances when intervention involved the giving of "**advice**" or even talking about an area outside of the SLT remit, as in Extract 7.22. Often the participants highlighted an alternative profession as being better placed in dealing with intervention from which the clinician was withdrawing. In Extract 7.22 below, the participant identified the clinical issues as being more appropriately dealt with by another professional (namely with "**some kind of psychology input**"). Defining a clinical issue as

being outside of the professional remit of the Speech and Language Therapist distanced the practitioner from having a professional responsibility for that particular clinical issue.

EXTRACT 7.22

"Yeah diagnosis of Asperger's for years but didn't I suppose they only came to the forefront in school and as long it was very interesting cos I got mum to fill in a profile outside the door and him to fill it in with me and they were just two completely different profiles I was going it's like looking at two different children em well not a child he's a young adult like ((laugh)) you know em but his insight was amazing like he was able to tell me how he he had difficulties going into- how he hated school first of all like and that that's where I kinda had to take a step back and go okay I'm not equipped to give you any kind of advice or even to talk to you about this cos I'm gonna get myself into a hole whereas he was very he wanted to talk about it and he didn't didn't enjoy school and I just thought this child just had five years in secondary school and didn't enjoy a minute of it....and I just thought he's such- you know if he had some kind of psychology input earlier on he would have been able to leave school happy"

Participant No.1: Focus Group No. 4
Page 17: lines 802-815
Page 17: lines 819-821

The area of clinical pragmatics was presented in the data as an area which involved working with combinations of different phenomena across many domains of functioning. The property of *Employing Role Boundaries as Limits* highlighted that some of these phenomena might best be addressed by a Speech and Language Therapist, while others might not. When domains were highlighted as needing clinical support but which were considered to be outside of the Speech and Language Therapist's remit, other professionals were often nominated as being clinically responsible for providing support. Certain phenomena (notably socio-emotional difficulties) were highlighted as phenomena which SLTs were not trained or equipped to deal with. Extract 7.23 illustrated how working clinically with certain phenomena, namely "**anxiety**" and "**self esteem**", required skills and technology other than those possessed by someone in the role of Speech and Language Therapist. These socio-emotional issues were perceived to be outside of the remit of the Speech and Language Therapist and within the remit of other professions, which were explicitly named as "**psychology**", as below.

EXTRACT 7.23

"we did find em when we were doing the social skills groups that em the chil-a lot of the children with social skills difficulties they had they had like anxiety as well and self esteem issues and we just didn't feel that we could address all those issues did we we thought you know psychology would em be good"

Participant No. 2: Focus Group No. 4
Page 2: lines 59-63

The many domains which became relevant when working clinically with pragmatics led the participants, at times, to actively question the extent of their professional obligation to provide intervention. As highlighted in Chapter 6, a lack of clarity around the boundaries of the SLT role was evident as one facet of *Uncertainty* in the data (i.e., the facet of *Uncertainty* captured by *Emphasising a Lack of Clarity Regarding the Role of the Clinician)*. An illustration of this facet of *Uncertainty* can be seen in Extract 7.24. Here, the data highlighted *Uncertainty,* regarding the SLT role in supporting particular intervention goals.

However, when role boundaries were used to delimit the work of the Speech and Language Therapist they were coded as a response to *Uncertainty*. In response to *Uncertainty,* the participant in Extract 7.25 noted a need to recruit other professionals in order to provide intervention (i.e., "**I don't think it's our role singly**"). Thus, the instance in Extract 7.25 illustrates how a clinician justified pulling back from being the primary and sole provider of intervention, in light of *Uncertainty*, by using role boundaries.

EXTRACT 7.24

"that just brings up those issues of you know should we just be supporting them at their like I was talking about earlier today like at their self esteem making sure they're connected in the community they've got opportunities all those types of things and is that our role? I dunno I just sort of-"

Participant No. 2: Focus Group No. 1
Pages 46-47: lines 2121-2126

EXTRACT 7.25

"I don't think it's our role singly I think the kind of examples you're giving are its passable but I I'd be much more comfortable doing that as part of a team"

Participant No. 5: Focus Group No. 1
Page 47: lines 2128-2132

Decreased SLT responsibility for providing the total package of intervention in the area of clinical pragmatics was also evident in the data. Clinical pragmatics was positioned as a "**multidisciplinary**" enterprise, as in Extract 7.26. Skills and knowledge which were attributed to other professionals (such as Psychologists or Occupational Therapists) were called upon to support the Speech and Language Therapist in providing efficacious intervention. In this extract, offering "**effective**" intervention in the context of clinical pragmatics required the input of a team of people. Without the support of other professionals, interventions were conceptualised as ineffective. As previously discussed, interventions which were considered ineffective were often discontinued.

EXTRACT 7.26

"I think that's why a multidisciplinary approach is so important cos you need parents on board you need teachers on board you need you know it's not just a it's a sp-spe uh specific area it's really not just just for speech and language therapy so I suppose back to being effective or not it is for a certain area but not without the support of others"

Participant No. 1: Focus Group No. 4
Page 29: lines 1422-1432

Specialist knowledge and skills possessed by different disciplines were frequently noted as being required in order to clarify and characterise the nature of the presenting problem in the area of clinical pragmatics. In Extract 7.27, multidisciplinary perspectives were suggested in order to reveal the true nature of "**difficulties with cohesion**".

EXTRACT 7.27

"One of the potential benefits of interdisciplinary co-operation in this area would be improved understanding of how to determine whether a person's difficulties with cohesion originate from a lack of knowledge and exposure, from cognitive disability, from language disability or from problems more akin to psychosis or social/emotional dysfunction."

Working with Pragmatics
(Anderson-Wood & Rae-Smith, 2001, p. 12)

The way in which clinical issues were identified and defined enabled the clinical issue to be allocated to a particular practitioner. The way in which clinical issues were defined appeared to be flexible in the data. Translating a clinical issue into the arena of a particular professional involved conceptualising the clinical issue as being the result of difficulties in particular domains. For example, if reduced eye contact was conceptualised as an impairment of non-verbal communication skill, then this impairment could be dealt with by a Speech and Language Therapist. If the same behaviour (i.e., reduced eye contact) was understood to be a sign of emotional withdrawal, the behaviour could then be allocated to practitioners from Psychiatry or Psychology for intervention.

The domains which bore the impact of an impairment also influenced which clinicians might be involved in intervention. For example, pragmatic language difficulties could be viewed as contributing to or resulting in behavioural difficulties and consequently this issue could then be allocated to professionals who deal with the domain of behaviour, such as Psychology. Alternatively, when pragmatic language difficulties were associated with ramifications in the domain of communication, these clinical issues were often considered the province of the Speech and Language Therapist.

Conceptualising clinical issues within profession-specific domains endorsed a particular profession in clinically engaging with a particular client regarding a particular issue. A decision to pull back from offering intervention could be supported by casting a clinical issue in a particular light. Withdrawal of SLT input could also be influenced by the domain in which a clinical issue was identified and defined, as in Extract 7.28. Here, the participant commented that there could be a lack of clarity in terms of the appropriate diagnosis and underlying impairment of some of the children she worked with. Different diagnostic labels could result in diverging clinical pathways for a client.

EXTRACT 7.28

"I find the management plan for children like that very difficult because I find that we're sometimes going back and forth between services and asking for reassessments of children because we're wondering well are they on on the autistic spectrum you know those those high functioning children who are just you know those border line children em so I w- so that really impacts on the management of those cases I think because we're not certain about things like this and we're we're going okay well maybe we should be referring them on or maybe we'll just kinda accept that it's a language based difficulty and we'll keep them and work with them but then are we missing something so there's this kinda tussle all the time between not wanting to highlight something that might not be there but at the same time wanting to cover you know all the bases and make sure that you're not missing some kind of bigger need you know"

Interview No. 4
Page 3: lines 103-124

One of the potential clinical pathways discussed in Extract 7.28 could be captured by the property of *Employing Role Boundaries as Limits* (i.e., the withdrawal of SLT input and passing the client onto another professional for diagnostic clarification, because the Speech and Language Therapist considered another professional to posses more relevant skills and/or knowledge). This option involved conceptualising the clinical issue as being outside the remit of the Speech and Language Therapist and subsequently intervention was discontinued.

Extract 7.28 above also highlighted that an alternative clinical pathway was open for the clinician to pursue. As a result of diagnostic uncertainty, the clinical issue could also have been recast as being within the remit of the Speech and Language Therapist. By construing the clinical issue as a "**language based**" concern, the client could be retained on the caseload of the Speech and Language Therapist, with the result that the client could be granted continuing access to SLT intervention.

Some participants highlighted how offering intervention focusing on particular areas and skills had been traditionally associated with particular professionals. The longstanding pairing

between certain professions and certain skills, domains and/or impairments had set historic precedents for how practitioners worked.

A pattern of respecting role boundaries as they had been laid down by historical precedent was notable in the data. Clinicians were able to support decisions to withdraw intervention if an impairment was considered to fall under the traditional remit of another professional. For example, in Extract 7.29 impairments within the domain of "**phonological awareness**" were conceptualised as being part of "**the teacher's job**". A "**lack of clarity**" had led to the traditional precedents and historic role divisions dictating the scope of SLT practice, according to the participant, as in Extract 7.29.

EXTRACT 7.29

"I don't know is it a lack of clarity or a lack of willingness to embrace the role but then the two are I suppose they're interlinked I'm thinking of phonological awareness as an analogy we can't get into that that's the teacher's job you can only be effective in dealing with phonological awareness if you're working alongside the teacher with their literacy you know would say there's tonnes of evidence to point to how important it is to assess phonological awareness how it permeates across the oral written divide how as speech and language therapists we've as much responsibility to look at written language as we have oral language you know like when when children are at the written stage you know people come up with eh what's what's the word I'm looking for em ((4 second pause)) oh I can't think of it a reason or a principle or a philosophy so that they continue to do what they do you know so ((°laugh°))"

Interview No. 8
Pages 13-14: lines 644-669

Participants often explicitly delineated the boundaries of their work using specific topics or areas of functioning. In Extract 7.30, the participant noted how her remit extended to the "**communication side**" of things, while her Psychology colleague worked "**promoting the psychological side**". In this way, the participant established a forerunner for stepping back from assuming full responsibility for clinical activities outside of her remit.

EXTRACT 7.30

"the groups we run are for people on on the spectrum totally and you know there's deficits in the communication side of things and deficits in the cognitive side or the the affect the em emotion kinda the rigid thinking and all that side so eh I think because the nature of the disorder is is like that kinda we'll like trying to target multiple areas through the group eh typically kind of I I would be promoting the communication side of the group and the psychologist would be promoting the psychological side"

Interview No. 3
Pages 2-3: lines 96-108

Perceptions of transgressing role boundaries resulted in the clinician being encouraged to disengage from the provision of intervention. In Extract 7.31, one participant described how in some of her work in the area of clinical pragmatics she had provided intervention that focused on the management of "**anger**". It became apparent from her colleague's response (in Extract 7.32), that there was disparity between clinicians at where they drew the boundary line of their role, which implied some variation in conceptualisations of the scope of SLT role. The participant in Extract 7.32 asserted that her colleague had been "**technically**" offering interventions outside of her area of remit, by focusing on "**managing anger**". There was a strong implication that the interventions offered by the therapist focusing on "**managing anger**", should have been discontinued, as these interventions were not perceived to be within the Speech and Language Therapist's remit. The participants used the topic of "**managing anger**" to allocate this clinical concern to another profession and to disclaim that there was a need for SLT input in this instance.

EXTRACT 7.31

"Well cos there was this child the mum said in we did we did kind of a module on managing anger and she said she that she did notice the child you know doing some of the strategies like counting to ten and different things so you know"

Participant No. 2: Focus group No.4
Page 23: lines 1090-1092

EXTRACT 7.32

"But like that in itself like managing anger is that Pragmatics that that's more- that's more that's more behavioural psychology should be you know that's technically more something that a a behavioural psychologist implements you know"

Participant No. 3: Focus group No.4
Page 23: lines 1096-1104

Professional boundaries and clinical responsibility could be dictated by the domains in which a clinical issue or problem was arising. *Employing Role Boundaries as Limits* portrayed how role boundaries could be used to demarcate the remit of a clinician.

7.2.2.3 THE PROPERTY OF *THE INFLUENCE OF ORGANISATIONAL AND LOGISTICAL ISSUES*

"but I think in a in a kind of gen- acute kind of general medical ward you just- there is isn't the time"

Participant No. 4: Focus group No. 6
Page 28: lines 1382-1383

The SLT profession was situated by participants as being influenced by the policies and procedures operating at an overarching managerial or organisational level. Factors related to

organisational policy and procedures (e.g., the priorities identified by an organisation in which a SLT service was embedded) shaped SLT practice. Day-to-day logistical issues[93] pertaining to the running of a service were identified as impacting and partly dictating the scope of interventions offered. When these issues impacted on SLT input and coloured how *Uncertainty* was managed, they were conceptualised as *The Influences of Organisational and Logistical Issues* property.

Organisational issues such as the type of organisation in which SLT interventions were delivered, also impacted on the delivery of SLT input and fashioned the content and priorities of intervention. Different types of organisations were identified as having different overarching roles (e.g., curative versus supportive) and different treatment aspirations (e.g., medical stability versus community integration). The intervention targets of the clinician often had to be aligned with the priorities of an organisation in which an intervention was being provided.

Resourcing issues (such as a lack of time) in conjunction with the overarching organisational aims of a setting (such as discharging clients from hospital and sending clients back to their own homes) were highlighted as preventing clinicians from focusing on pragmatics in their interventions. In Extract 7.33, the setting of the intervention precluded long-term engagement with the client, as the service offered in this setting was "**acute**". In Extract 7.34 the "**priority**" of the organisation (i.e., going "**home**") was highlighted. The primary focus on sending clients back to their own homes was used to support a suggestion that work in the area of clinical pragmatics was not indicated or relevant, as it did not directly contribute towards the organisation's primary aim. The quick through-put of clients within an acute hospital setting, in order to achieve the priority aim of the organisation, was highlighted as precluding the possibility of SLT input focusing on the area of clinical pragmatics.

EXTRACT 7.33

"But yeah no but I think in a in a kind of gen- acute kind of general medical ward you just there is isn't the time"

Participant No. 4: Focus group No. 6
Page 28: lines 1382-1383

EXTRACT 7.34

"and it probably their everybody's least priority...you know you can go home with a pragmatic impairment you can't go home with a peg feed or well or you can go home you know a NG tube or whatever it is whereas"

Participant No. 2: Focus group No. 6
Page 28: lines 1385-1389

[93] The phrase "logistical issues" has been used to capture aspects of service delivery (such as planning, implementation and coordination of services offered within an organisation) which are typically carried out and arranged by those in adminstrative or managerial positions, rather than by clinicians directly.

As well as global organisational priorities being a significant influence on decision-making, the data revealed that logistical issues and arrangements within certain settings prevented SLTs offering intervention in the area of clinical pragmatics. In certain settings, logistical issues impacted on clinical decision-making resulting in intervention being focused on particular areas or phenomena. Logistical issues, such as the way in which clients were physically arranged in a setting (as illustrated by the data in Extract 7.35, "**sitting by their bed just quietly...they're not mingling on a corridor**") also impacted on the areas identified as targets for intervention.

EXTRACT 7.35

"plus on the acute wards their probably sitting by their bed just quietly they don't not like the they're not mingling on a corridor in rehab or a dining room where you notice a lot of the nursing staff mightn't even notice that they have a problem....and it's so structured your day it's not like you have to ever look for anything its you're sat up at half seven for your breakfast at eight you're washed between half eight and it's so laid out it they the patients themselves wouldn't have any say in changing things"

Participant No. 1: Focus group No. 6
Page 28: lines 1391-1395
Page 28: lines 1402-1406

Resourcing issues pertaining to a lack of clinical time, mounting waiting lists and inadequate funding were also evident within the concerns of participants. These resourcing issues differed from concerns about the absence of tools, training and skills (deemed to leave the Speech and Language Therapist professionally ill-equipped to work in the area of clinical pragmatics) which have been discussed in Section 7.2.2.1. The types of resourcing issues being presently discussed pertained in particular to the logistical tools that were deployed to clinicians in order for them to provide intervention (such as caseload size or organisational care pathways).

In Extract 7.36 below, resourcing issues such as a lack of time, were highlighted as precluding clinicians from working on the area of clinical pragmatics. Attending to pragmatics during intervention was restricted by limitations in clinical time and resources.

EXTRACT 7.36

"I think probably pragmatics and social skills could take up a large part of our caseload em if we had the resources ((laugh)) and the time for it ((laugh))"

Participant No. 3: Focus Group No. 5
Page 2: lines 79-80

Extract 7.37 was taken from an extended discussion about how generalisation of intervention targets was perceived to occur more readily when intervention was couched in real life activities and the everyday context of the client. Despite the participants being aware that this was most

likely to be the most efficacious form of intervention, resource restrictions meant that enacting intervention in this manner was not always "**feasible**".

Extract 7.38 portrayed how the participants were precluded from approaching clinical activity in the way that they wished to due to logistical factors. A lack of "**freedom**" and "**resources**" impacted on how SLT service was delivered, according to the data in Extract 7.37. Resource-related, logistical factors precluded the clinician from being within the client's everyday setting outside of the clinic, and were cited as one of the "**limitations of our work**".

EXTRACT 7.37

"the generalisation of the skills outside is always going to be a problem particularly with this client group because sometimes they'll overgeneralization or sometimes they'll they need the situation it needs to be situation specific em so we would try as much as possible to bring it into the real situation so now I'm slightly talking about something i- it's a different programme we're running at the moment but we involve everybody then in that so if a situation it arises they are facilitated to know how to address it with the person so that there's real here and now if you like input being provided....when feasible and I wouldn't say that we can always do that"

Participant No. 1: Focus Group No. 5
Page 11: lines 503-515
Page 11: lines 522-524

EXTRACT 7.38

"and a lot of the intervention we're doing is in eh formalised setting like a group or one to one here or possibly to make some recommendations to the teachers in school em but then we're not really doing our intervention there in the yard or there in the class there at the at the dinner table em so there is there isn't a direct kinda of if we're doing the training in the yard and then trying to see what the outcome is in then in the yard then it's it's much more of a direct process whereas we're doing the training and the coaching in in a group situation and then hoping that that will transfer to other situations em I suppose that's the limitations of our work that kind of we don't have all of the freedom or resources to be in in the everyday situations"

Interview No. 3
Page 8: lines 364-381

The property of *The Influences of Organisational and Logistical Issues* pertained to how organisational and managerial decisions, as well as logistical constraints during the day-to-day running of SLT clinics, were identified as influential on clinical practice in the face of *Uncertainty*.

7.2.2.4 *The Limits of the Profession:* SUMMARY

In addition to organisational influences on how intervention was realised, as discussed above, the provision or non-provision of intervention was also influenced by a perceived lack of collective and individual clinical skills, tools and training. In conjunction to these patterns observed in the data, disciplinary boundaries were also drawn upon to support the clinician in establishing when SLT intervention could and could not be provided. Thus, the category of *The Limits of the Profession* captured reasons why a clinician could not offer intervention due to a perceived limit of clinical skills and tools, the limits of perceived professional boundaries and organisational policies.

7.2.3 *Shrinking Remit:* SUMMARY

In this chapter, the sub-core category of *Shrinking Remit* was explicated and illustrated. The concept of *Shrinking Remit* emerged from the data as a collection of responses to *Uncertainty* which were characterised by the discontinuation or non-provision of intervention.

The category of *The Limited Impact of Intervention* pertained to a sceptical stance being taken regarding the efficacy of intervention, particularly in light of chronic conditions, and thus portrayed situations in which SLT interventions should not be provided. Interventions which were considered to be ineffective were discontinued, while the perception of chronic and persisting clinical conditions were highlighted as being beyond the reach of SLT and, as such, also resulted in the withdrawal of SLT input.

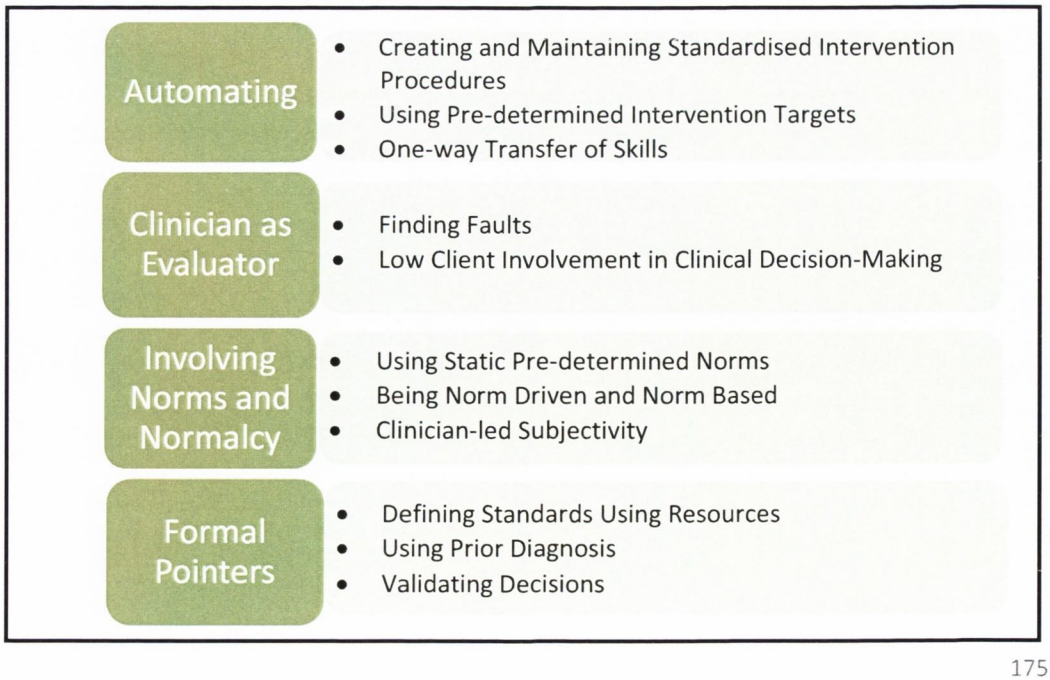
The category of *The Limits of the Profession* captured how situations in which a Speech and Language Therapist could not provide intervention in the area of clinical pragmatics were evident as patterns in the data linked with *Uncertainty*. A perceived lack of collective and individual skill, technology and competency were used to highlight that intervention could not be provided. Additionally, the participants drew on their role boundaries to delimit the work they carried out. Organisational and logistical issues (such as overarching service priorities and resourcing issues) influenced how the participants made decisions regarding engaging and disengaging from intervention. All of these variables interacted and impacted on clinical decision-making about the provision and, significantly, the non-provision of SLT interventions, in response to *Uncertainty* in the context of clinical pragmatics.

CHAPTER 8. RESPONSES TO *UNCERTAINTY* IN THE DATA: *CONTAINING UNCERTAINTY THROUGH HOMOGENISATION*

8.1 THE SUB-CORE CATEGORY OF *CONTAINING UNCERTAINTY THROUGH HOMOGENISATION*: INTRODUCTION

The concept of *Containing Uncertainty through Homogenisation* emerged from the data to capture responses to *Uncertainty* which were hallmarked by the provision of uniform packages of intervention. *Homogenisation* refers to how the entire process of intervention was made uniform by the standardisation of a variety of variables within the clinical process (including intervention targets, intervention structure, content of intervention and the clinical profiles of individual clients). Low levels of client involvement were recruited in clinical decision-making and the clinician played a defined and evaluative role during intervention in the context of *Uncertainty*. Intervention was operationalised as the one-way transfer of skills, behaviours and knowledge from a knowing clinician to a lacking client. The notions of norms and normalcy were the backdrop on which all things pragmatic were hung. Clinicians employed test scores, prior diagnoses and other criteria to support clinical decision-making and to guide the selection of intervention candidates and intervention targets.

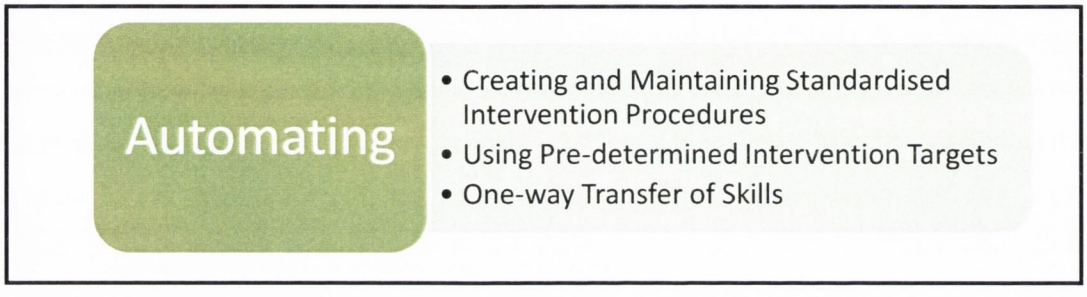
FIGURE 17: THE SUB-CORE CATEGORY OF *CONTAINING UNCERTAINTY THROUGH HOMOGENISATION*: ITS CATEGORIES AND PROPERTIES



8.1.1 THE CATEGORY OF *AUTOMATING*

Automating portrayed how clinicians crafted a well-defined and rigid approach to intervention, in response to *Uncertainty*. The category of *Automating* portrayed the mechanisms used for establishing and maintaining generic forms of intervention including the establishment of generic clinical profiles and the enactment of intervention which focused on the transfer of skills and knowledge and teaching of pre-determined intervention targets to clients.

FIGURE 18: THE CATEGORY OF *AUTOMATING* AND ITS PROPERTIES



8.1.1.1 THE PROPERTY OF *CREATING AND MAINTAINING STANDARDISED INTERVENTION PROCEDURES*

> **"when we're d-doing up the groups here okay social skills difficulties so he goes into a social skills group"**
>
> Participant No. 1: Focus Group No. 4
> Page 19: lines 935-938

In an effort to contain and manage *Uncertainty*, participants resorted to offering homogenised interventions to clients. Standardised interventions could be offered to clients only once a uniform presenting problem or clinical issue was uncovered or established. *Creating and Maintaining Standardised Intervention Procedures* captured how client concerns were translated into generic issues and how standardised intervention was maintained by drawing on uniform intervention tactics and content.

The use of universal forms of intervention to deal with standardised clinical concerns emerged recurrently from the data, as a response to *Uncertainty*. The reasons the client attended the SLT clinic were transformed into a generic clinical issue (e.g., "**have difficulties with em their social skills**") which could be subsequently managed by implementing broad and uniform interventions, as in Extract 8.1. Here, participants raised concerns about employing generic views of clinical issues. Slotting clients into pre-defined intervention groups (i.e., "**social skills groups**")

was noted as contributing towards the likelihood that accurate and effective intervention was not being provided. It was suggested that the client "**mightn't be benefitting from**" uniform intervention targeted during generic groups (such as group therapy focusing on "**difficulties with social skills**"). Thus, as in Extract 8.1, the use of generic clinical profiles was posited as neglecting clients' individualised "**profiles**", yet these generic clinical profiles enabled the provision of generic form of intervention.

EXTRACT 8.1

"even if they have you could say two kids could be here now and you could say they both have difficulties with em their social skills but they could be two totally different profiles and mix of different skills and even I think we find like when we're d-doing up the groups here you're like okay difficulties with social skills he goes into a social skills group but that might not be the right place either for them for them because they mightn't be benefitting from them"

Participant No. 1: Focus Group No. 4
Page 19: lines 933-941

It was evident in the data that by categorising clients using superficial terms, the differences between clients could be neutralised somewhat. Diffuse terminology (such as "**social skills difficulties**") could be used to cover a wide variety of clients. The use of generic terminology homogenised the client. Once the clients were seen to fit a particular standardised profile, it became feasible to offer a generic, profile-specific type of intervention, as opposed to a client-specific type of intervention.

The structural format of intervention was one feature of therapy which was recurrently standardised. In Extract 8.2 the use of a routine or standard format for enacting intervention (i.e., via "**groups**") reflected a uniform way of approaching "**most...pragmatics work**" in the clinic.

EXTRACT 8.2

"on a daily basis em I think most of our pragmatics work would be we try to do it in groups"

Interview No. 3
Page 2: lines 61-62

The data also illustrated that, as well as specifying a generic structure through which intervention should be mediated, activities and tasks which comprise intervention could also be specified in a standardised way. In Extract 8.3 below, definite intervention tactics and methodologies were provided in considerable detail in order to specify "**Contexts for working on pragmatics**" For example, one context specified was using "**Musical activities**". Here, intervention activities were identified in particular detail. Embedded within this specification of intervention structure and

content were implicit goals such as facilitating a client to "**improve turn taking and meaning-related intonation**".

EXTRACT 8.3

"Contexts for working on pragmatics: Musical Activities....

Use song and musical instruments to improve turn taking and meaning-related intonation. Try to encourage co-operation and enthusiasm in the activity rather than the singing ability of individual clients.

Record sounds (or use a commercially available audio tape) and see if clients can guess what might have made the sound.

Try musical activities with clients who are withdrawn. They can help them to 'blossom'.

Use popular sings on tape as 'ice-breakers' and sources of enjoyment. This can help improve group cohesion and co-operation. Tapes designed for children are sadly neglected as therapy tools. They are often linguistically, rhythmically or socially useful and children of all ages and level of ability find them attractive and memorable."

Working with Pragmatics
(Anderson-Wood & Rae-Smith, 2001, p. 100)

In the data, in Extract 8.4 below, a specific intervention content and sequence in which this content was to be approached was provided by the *Socially Speaking* resource (Schroeder, 1996). Intervention content was determined by the programme in that it provided topics to be covered and a set list of skills to be learned during therapy, as well as supplying guidelines on the structure and activities to be used during intervention. Often by specifying the content of therapy (i.e., activities, topics, skills and behaviours to be covered), intervention goals were implied. Indeed, oftentimes intervention content and goals were presented as synonymous.

Initially, if following the specifications of this resource, intervention was steered towards working with the client to facilitate him in learning about how to "**take turns, make eye contact, place their body in the correct position**" and "**ask questions and show interest in and awareness of others**". Also specified was the order in which intervention targets should be approached. The prescriptive fashion in which this resource was expected to be implemented, left little room for approaching intervention in a flexible or personalised way.

EXTRACT 8.4

"The programme covers an academic school year, and is divided into three units.

Unit One – Let's communicate

Unit Two – Let's be friends

Unit Three – Let's practise

It is important to follow through each term as each unit after the first builds on to the previous one. The basic skills taught in Let's communicate are fundamental for developing the more sophisticated skills needed in Let's be friends and Let's practise. For example, when teaching how to make friends, it is important that the pupil is able to take turns, make eye contact, place their body in the correct position, ask questions and show interest in and awareness of others. These are skills taught in the previous unit."

Socially Speaking
(Schroeder, 1996, p. viii)

Instigating a standardised, procedural way of working with clients managed *Uncertainty* to the extent that a set and systematic way of intervening was established. Thus, *Containing Uncertainty through Homogenisation* disregarded *Uncertainty* and imposed certainty on intervention in the form of a standardised template for therapy. In Extract 8.5, the participant discussed how students found it extremely challenging to accept the existence of *Uncertainty* in clinical practice. Here, a desire for a standardised approach to intervention was noted when the participant commented on how SLTs in training often sought "**recipe**" style procedures for intervention. Prescriptive procedures were posited as a solution in the face of "**unclear**" clinical situations.

Furthermore, Extract 8.6 illustrates that standardised packages of clinical care were actively sought out by consumers of SLT services. Here, the participant highlighted how other professionals and parents pursued a standard "**list**" of phenomena which specified all of the "**topics**" to be covered during intervention. It was presumed that a uniform and pre-fabricated approach to intervention existed and could be provided by the Speech and Language Therapist.

EXTRACT 8.5

"they [SLTs in training] find it really hard because they want the book that shows you how to do it [intervention] and they want the recipe and I think it drives them mad like particularly we'll say with the XXX years I have one scenario where they get a videoed clip of a child who is who was very complex and it's very unclear what's going on from a speech point of view so they would have several hypotheses from you know dyspraxia to phonological disorder to em dysarthria you name it and they just they can't han- they can't hand- it they find it very difficult rather to handle the fact well it is unclear and that actually it may never become clear"

Interview No. 1
Page 15: lines 725-739
[Words in brackets have been added]

EXTRACT 8.6

"what parents usually or schools come come back with is okay we've covered a few topics but we've run out of ideas what have I not covered or do you have can you provide me a list or is there a book I can use that's that's a very common question is there a book which will give me a list of topics or is there a checklist I can use em I suppose it relates to the nature of the whole area that we know there's a lot in it but

maybe it doesn't come to mind straight away you really have to think about it and you really have to look up the all the different aspects all the different mini topics"

Interview No. 3
Page 11: lines 524-538

Many of the instances in which the *Creating and Maintaining Standardised Intervention Procedures* property emerged also overlapped and co-occurred with data coded as instances of *Using Pre-determined Intervention Targets*. As in the examples above, in addition to the standardisation of intervention format or structure (i.e., as in group versus one-to-one therapy), the actual activities and tasks to be focused on (i.e., the content of therapy) could also be specified as being universal and uniform across clients. The enactment of standardised forms of intervention was heavily associated with the use of pre-existent intervention targets, and often a blurry line existed between intervention content and goals.

In extract 8.7, a set list of skills is proposed as intervention targets. In Extract 8.8 below, we see how a set, generalised intervention procedure was coupled with the specific, pre-determined intervention targets. Specifying the content of intervention in such prescriptive detail, in terms of the activities and tasks that comprise intervention, as in Extract 8.8, facilitated a generic goal of teaching "**eye contact**" to be realised.

EXTRACT 8.7

"This unit looks at the basic skills of communication.....Skills taught in this unit are:

» greetings
» eye contact
» showing an interest
» turn-taking
» awareness of physical attributes
» listening
» sitting appropriately and keeping still
» asking/answering questions
» using the voice effectively
» compliment."

Socially Speaking
(Schroeder, 1996, p. 3)

EXTRACT 8.8

"SESSION 1: Eye contact

1 Greetings

2 Introduction

This is the point at which to introduce the circle time and to discuss the aims for the term. See introduction, page viii.

3 Game-Winking

All the pupils are in the circle, except for one who goes outside. A leader is nominated and that pupil becomes the winker. When the pupil outside comes back into the group, they must stand in the middle of the circle and try to guess who the winker is. Meanwhile, the winker makes eye contact with the other pupils and winks at them. If they are winked at they must pretend to fall asleep. When the winker is discovered, they go outside and the procedure is repeated.

4 Discussion

The teacher introduces the role of being a good listener and asks what the pupils think being a good listener involves. Brainstorm ideas.

5 Role play and questions

The teacher asks a pupil to tell him/her about their family. While the pupil is talking the teacher looks away, avoiding all eye contact.

What am I doing wrong?

How does the speaker feel?

How do I do it correctly?

6 Pupil activity

The pupils role play with a partner, asking each other, 'Who is in your family?' Both take turns, looking/not looking. In pairs, they role play one situation in front of the rest of the group. The rest of the pupils must decide whether they were good listeners or not so good and say why.

7 Worksheet-My eye

The pupils each write a sentence about what a good listener does with their eyes. They then look at their own eye in a mirror and colour the worksheet appropriately.

8 Compliments"

Socially Speaking
(Schroeder, 1996, p. 9-10)

Creating and Maintaining Standardised Intervention Procedures portrayed how generic approaches to intervention with set structure and content were provided following the generation of generic clinical profiles. By providing intervention which had universally applicable activities and tactics, therapy was homogenised. Using generic intervention content in terms of topics, activities and tasks to be covered in therapy across all clients enabled and maintained a focus on generalised intervention targets which will be discussed below in greater detail. Uniform, and often prescriptive, methods of mediating intervention were evident as one way in which *Uncertainty* was reduced and managed in the clinical context

8.1.1.2 THE PROPERTY OF *USING PRE-DETERMINED INTERVENTION TARGETS*

"you distil the bare minimum of something into okay pragmatics is about relevance inappropriateness topic shifting etcetera"

Interview No. 1
Page 7: lines 317-320

As noted above, the property of *Using Pre-determined Intervention Targets* often co-occurred with instances of the property of *Creating and Maintaining Standardised Intervention Procedures*. However, as *Using Pre-determined Intervention Targets* emerged as such a significant part of how intervention was standardised, it was conceptualised as a property in its own right. Intervention goals and targets were pre-determined, in that they were generated prior to meeting an individual client and as such could be imported and re-used with a variety of clients who were considered to be similar. At times, pre-determined intervention targets appeared to be grounded in a theoretical approach or framework. However, in much of the data an underlying theoretical framework was implicit (not stated) or absent in supporting the decisions made about focusing on particular intervention targets

When intervention in the area of clinical pragmatics was synonymised with a set list of skills which the clinician taught to the client during intervention, the code of *Using pre-determined Intervention Targets* emerged. The potentially exponential nature of pragmatics was suggested as one reason why clinicians might have attempted to "**distil**" the area of pragmatics into a generic list of skills (Extract 8.9). In order to "**get a kind of a handle**" on pragmatics, a list of pre-determined skills and topics was used (e.g., "**relevance inappropriateness topic shifting etcetera**") which provided the clinicians with a well-defined and more manageable focus for intervention. The way in which SLTs attempted to "**distil the bare minimum**" of pragmatics into a set list of skills, thus provided a compact and clinically manageable conceptualisation of pragmatics which could be employed to fabricate definitive and generic goals. Limiting and defining pragmatics in this way provided a clear focus and structure for intervention in the face of potential knowledge gaps due to the "**massive**" volume of knowledge which the clinicians were expected to possess.

EXTRACT 8.9

"because and I don't think it's you know malicious or whatever I think it's just well like not like it's like they're trying I imagine if its you're working full time and it's the the what a speech and language therapist is expected to know is massive so it's like this you distil the bare minimum of something into okay pragmatics is about relevance inappropriateness topic shifting etcetera and you get a kind of a handle on it and as well I suppose they there's the there's no I think we like the the security of the test and there isn't really a test for it you know the kind of it's not like you can test receptive language

we'll say for example so I think there's al- and it's possibly a scary area I think in that respect"

Interview No. 1
Page 7: lines 313-329

As well as reducing the volume of potential intervention goals in the area of clinical pragmatics, the generation of set generic targets provided a more definitive trajectory for intervention. Extract 8.10 was embedded within a discussion about the challenges of measurement in relation to SLT practice and clinical pragmatics. In this extract a perceived lack of knowledge was highlighted about how best to initiate therapy. Here, it was suggested that not knowing "**where to start**" when working with a given client might be combated if participants had a definitive list or "**hierarchy**" of generic intervention targets to draw on for guiding the direction of intervention. The participant in Extract 8.11 commented that possessing pre-specified intervention goals would enable clinicians to work in a uniform way through a progression of goals with clients, in order to "**make it seem better**". Not knowing which phenomena should be targeted during intervention or "**what's the thing that's going to make it seem better**", led the clinician to suggest that having a pre-determined chain of skills to focus on would structure intervention, and be beneficial. Employing pre-determined intervention targets was presented as a time efficient way of working in light of *Uncertainty*.

EXTRACT 8.10

"knowing where to start....what's the hierarchy of....what's the the em-"

Participant No. 2: Focus Group No. 6
Page 21: lines 1046-1051

EXTRACT 8.11

"what's the thing that's going to make it seem better like will it be their turn taking will it be their eye contact will it be their tone of voice or their you know their prosody w- just what em and there's so many things that we probably wouldn't have time to start at the first the first one and give it six weeks and see okay that's yeah he's still a bit odd now we'll go on this one"

Participant No. 1: Focus Group No. 6
Page 21: lines 1052-1060

Having pre-determined intervention targets entailed that intervention was approached with an increased level of certitude in terms of intervention content and trajectory. In Extract 8.12, it was noted that clients were allocated "**specific**" intervention aims. However, these aims were definite rather than "**specific**" (in the sense of being client-specific), evoking an illusion of individually or personally-defined goals.

EXTRACT 8.12

"Each pupil will have a specific social aim, as in 'Let's be friends', but this aim will be targeted for a week and will be evaluated during the following session. The weekly aim will be written on a voucher that will be copied; an example is provided in Session 1. One copy will be taken home and the other displayed in the classroom so that the pupil is encouraged to try to achieve the skill in both situations.

For example, Alice's aim is to ask appropriate questions. Over the week both home and school will support Alice in achieving this aim. If others at home and school feel she has achieved this aim satisfactorily, the vouchers are then signed so that in the following session she can swap the vouchers for a sticker to go on her assessment/evaluation chart. If not, she tries again for the following week."

Socially Speaking
(Schroeder, 1996, p. 103)

The "**aim**" referred to in Extract 8.12 above stemmed from the generic evaluation/assessment framework provided within the *Socially Speaking* resource (Schroeder, 1996, pp. 106-108), as illustrated in Extract 8.13 below. As such, the intervention the client would receive was guided towards meeting the prefabricated aims dictated by the resource (e.g., "**I know my telephone number**") not by the client. Thus, the social use of language could be reduced to a set of discrete objective criteria which the clinician could support the client in learning.

Using Pre-determined Intervention Targets was a property which captured a pattern of employing intervention aims which were already fabricated prior to the client and clinician meeting. Having pre-specified intervention goals provided a definite focus for intervention which may have been otherwise absent in the context of *Uncertainty*. Concentrating interventions on pre-determined intervention targets enabled clinicians to standardise their intervention and to impose order and structure on their interventions in the uncertain area of clinical pragmatics.

EXTRACT 8.13

"Let's Practice

Assessment/evaluation

Pre-unit **Post-unit**

	Skills	**I need help**	**I can do this in the classroom**	**I can do this out of the classroom**
	Telephone **I know my telephone**			

	number **Date**			
	I know how to answer the phone **Date**			
	I know how to ask for someone on the telephone **Date**			
	I know how to give a message to a person **Date"**			

Socially Speaking
(Schroeder, 1996, p. 106)

8.1.1.3 THE PROPERTY OF *ONE-WAY TRANSFER OF SKILLS AND KNOWLEDGE*

"I like the idea of us kinda of going around between groups and kind of coaching or modelling"

Interview No. 3
Page 7: lines 319-320

The property of *One-way Transfer of Skills and Knowledge* captured how the practitioner was positioned as a teacher of skills, behaviours and knowledge which passed unidirectionally from the clinician to the client. The clinician's role was thus clarified, simplified and condensed.

The clinician was regularly positioned as assuming a role of teacher, imparting her knowledge (e.g., about how to accurately enact behaviours which were the targets of intervention) to the client. Extract 8.14 below was taken from a discussion about the role of different multidisciplinary team members in the context of clinical pragmatics. The participant highlighted the way in which her clinical role involved "**coaching**" and "**modelling**" in order to facilitate clients in acquiring particular skills. The clinician's role was operationalised as one in which intervention targets were "**taught**".

EXTRACT 8.14

"so as to so to so speak distribute the work evenly and we we're both taking responsibility for for different parts of the group em we use a lot of role play in the group yeah and we think personally I would try to get the children to work say in pairs but in parallel so em you have say three groups of two working at the same time and I like the idea of us kinda of going around between groups and kind of coaching or modelling em I think my colleague the psychologist more likes the scenario where two children are kind of performing to to the rest of the group so essentially we reach a compromise and do a bit of both....like it's an asp- an aspect of communication which other children acquire naturally and typically it's not taught that we're trying to teach something which is so so natural and so difficult to define and difficult to see eh I think like the area in itself is harder than other areas"

Interview No. 3
Page 7: lines 311-325
Page 9: lines 419-423

The way in which intervention was recurrently depicted as a teaching-based process emerged incidentally from the data, reflecting a taken-for-granted way in which the clinicians worked. Extract 8.15 illustrated how the work of SLTs was equated with "**teaching**". The synonymous use of "**therapy**" and "**teaching**" suggested situating the therapist as a teacher. Facilitating changes in the skill levels of client by the process of "**teaching/therapy**" was situated as one way for clinicians to enact the role of SLT.

EXTRACT 8.15

"Introduction

Development of the programme

The Social Use of Language Programme (SULP) was developed very much from a practical standpoint. In her work as a speech therapist, the author became aware of the need for a structured method of work to help clients to use language skills in a social context; to interact socially with other clients; to be more aware of themselves and others; to be able to use their language skills to meet the demands of everyday living.

SULP gives a framework for assessing and organizing teaching/therapy to allow a building of skills with the long-term target of achieving these broader aims. It was developed initially for teenagers with moderate learning difficulties and has been used successfully with several groups of children aged between 10 and 16 years. It also has application for other client groups where speech and language may be affected, for example, by specific developmental language disorder, hearing impairment, psychiatric disorder and severe learning difficulties. "

Social Use of Language Programme
(Rinaldi, 1992b, p. 1)

The property of *One-way Transfer of Skills and Knowledge* pertained to how clinical activities were positioned synonymously with teaching. The role of the clinician was to transfer her knowledge and skills to the client.

8.1.1.4 *AUTOMATING*: SUMMARY

The category of *Automating* pertained to how intervention was reduced to a generic process following the generation of uniform clinical profiles as captured by the property of *Creating and Maintaining Standardised Intervention Procedures*. The use of standardised intervention format, content and goals, as captured by both *Creating and Maintaining Standardised Intervention Procedures* and *Using Pre-determined Intervention Targets*, resulted in homogenised forms of intervention being enacted. As part of this standardised approach to intervention, in the context of *Uncertainty*, the clinician assumed a teaching role as portrayed by the property of *One-way Transfer of Skills and Knowledge*.

8.1.2 THE CATEGORY OF *CLINICIAN AS EVALUATOR*

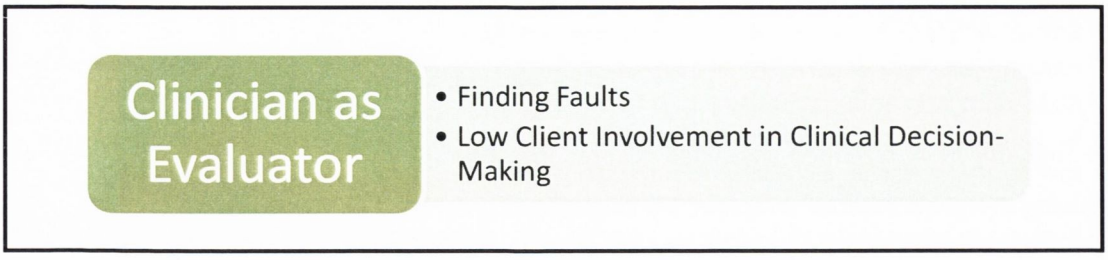
The category of *Clinician as Evaluator* captured how clinical activities were positioned as revolving around the appraisal of clients and their behaviours, skills and knowledge. Evaluation was situated as being integral to role of the Speech and Language Therapist. The potential for over-analysis and misrepresentation of a client's ability, through an autocratic and myopic evaluative focus, emerged as a concern for some participants in light of the evaluative nature of their work.

The evaluated behaviours, skills and knowledge of clients were used by clinicians to create an outline of the phenomena which required SLT input. Clients were not recruited to input into clinical decision-making. Important intervention-defining decisions (such as which goals should be selected or how the outcome of intervention should be specified) were made primarily by the clinician.

The *Clinician as Evaluator* category often emerged in tandem with the category of *Involving Norms and Normalcy*.[94] Evaluations were often explicitly subjective, as they were influenced by the clinicians' own versions of normalcy. Additionally, evaluations were informed by guidelines and standards which were available in the literature.

[94] The category of *Involving Norms and Normalcy* will be discussed in Section 8.1.3.

FIGURE 19: THE CATEGORY OF *CLINICIAN AS EVALUATOR* AND ITS PROPERTIES



8.1.2.1 THE PROPERTY OF *FINDING FAULTS*

"I'm bringing it into their level of consciousness you know that is a problem this is something that you do and that this is something that maybe needs to be targeted"

Interview No. 5
Page 6: lines 289-293

The property of *Finding Faults* emerged to capture the clinician-led identification of aspects of clients' skills, behaviours and knowledge (i.e., "**something that you do**") as being problematic in an effort to identify intervention goals, as in Extract 8.17. As noted, evaluation emerged from the data as a significant part of the activity of the SLT. The purpose of evaluation was generally to highlight the areas in which SLT interventions were required, and evaluations tended to highlight areas deemed inadequate and lacking. Data emerged to highlight that participants were often concerned by the fact that they found themselves exposing deficits and difficulties as a routine part of their work.

Finding Faults is distinct from the property of *Being Problem Based and Solution Focused* (which will be discussed later under the sub-core category of *Stretching Remit,* in Chapter 9), in that the client was not recruited in the process of identifying problems or concerns. Thus, *Finding Faults* reflected how evaluations were made unilaterally without client consultation.

The one-sided nature of identification of errors was noted in Extract 8.16. Here, the participant noted how appraisal occurred, in her experience of SLT intervention, via the clinician "**bringing it into their level of consciousness you know that this is a problem this is something that you do and that this is something that maybe needs to be targeted em**"

EXTRACT 8.16

"it's kind of a it's a real nebulous sort of area to work on I think and even when you're writing it up I find even when you're writing up well what actually did I do there it's hard to pin it down sometimes yeah I really do find that with pragmatics....and also em in terms of the insight you know if the person doesn't have insight I'm always slightly well particularly with the adults say the head injury clients I would be slightly concerned sometimes that I'm I'm bringing it into their area or I'm bringing it into their level of

consciousness you know that this is a problem this is something that you do and that this is something that maybe needs to be targeted em"

Interview No. 5
Page 6: lines 275-282
Page 6: lines 285-293

Extract 8.17 highlighted how clinical activities were manipulated to uncover difficulties, exposing *Finding Faults* as a taken-for-granted aspect of the clinician's role. Here, the participant highlighted the area of assessment as one which was a challenge to her. The particular aspect of assessment which challenged her was the fact that the informal assessment materials she used were not taxing enough for some of her clients, and consequently the assessment process failed to identify any errors or difficulties. It was implied that while certain clients did not demonstrate errors in the reception of non-literal language in the structured testing situations (i.e., that clients "**cop onto it**" during the informal assessment procedure and do not fail the assessment) yet that these same clients often displayed similar patterns of impairment in less structured, everyday situations. Thus, because of their failure to expose faults, certain informal assessments were deemed "**not good enough**" for use in the SLT clinic.

EXTRACT 8.17

"then we'd use the CCC-2 as we said em but even I'd devise these kinda informal things like em for the older ones em like a em a boy walks into the kitchen and he sees a cake that the girl has made and the em the boy says that cake looks delicious what do you think he really wants to say you know all those indirect things you- or if a girls says I've got thousands of DVDs why did she say that she has thousands you know the but often there not good enough either because the kids with autism the high functioning ones cop onto it but if if its happening in the yard and their kids- their friends are using exaggeration or sarcasm or indirect stuff they don't get it then so pragmatics is is so context dependent that's what makes assessment so hard I think"

Interview No. 7
Pages 23-24: lines 1017-1035

Evaluation for the purpose of *Finding Faults* was such an inherent part of the clinical work of SLTs that it was noted that there was a propensity for SLTs to take this aspect of their role too far—by being "**too microscopic**". An emphasis on evaluation in the SLT context could result in the over-analysis the skills, behaviour and knowledge of the client and potentially uncover faults where none existed, (as noted in Extract 8.18 below). This overanalyses could lead the clinician to mistakenly assume clinical significance, and identify phenomena as being faulty, in an "**incorrect way**".

EXTRACT 8.18

"yeah yeah now I suppose having said that as well I would be wary of speech and language therapists and I include myself in this kind of over analysing things that we observe you know....but because you know this child has some problems you might be interpreting behaviours in a in a incorrect way...maybe I it's just me ((laugh)) I need to be a little bit cautious em about not being too microscopic about it"

Interview No. 4
Page 15: lines 750-753
Pages 15-16: lines 758-761
Pages 15-16: lines 768-771

Echoing concerns about the SLTs' propensity to over-analyse, were concerns from clinicians about the potential of phenomena such as "**personality**" or a "**family eh way of interacting**" to be classified as deviant, following SLT evaluation, as seen in Extract 8.19.

EXTRACT 8.19

"Yeah and then I suppose there's the the piece about how much of is part sometimes when it's very subtle if how much of that is a part of the child's personality or maybe like a family eh way of interacting or communicating at one side and then if it sort of say clinical or something but is it clinical enough to explore that further or to bring other people on board and all then it opens up all of that yeah sometimes that's difficult to to know and how much is our responsibility I suppose to em you know open that up"

Participant No. 6: Focus Group 1
Pages 4-5: lines 169-188

Finding Faults portrayed how intervention often revolved around exposing faults. Extract 8.20 contained an illustration of intervention in which pragmatics was considered to be a clinical focus (i.e., "**I'm thinking of one case in particular of a of a young girl...who linguistically was great but pragmatically was really really off**"). In this instance, the clinician's activities centred on not only recording the behaviours deemed "**inappropriate**", but actively eliciting these behaviours in that the clinician "**was like putting her in all these situations**". "**Inappropriate**" behaviours were elicited during therapy in order to highlight and accentuate the deficits the client faced, with the goal of facilitating change by trying to demonstrate to the client that she was incompetent in the area of pragmatics (i.e., "**it was really tough sessions cos I was like putting her in all these situations and videotaping her and then getting her to watch it back and rate herself and all the rest and she just couldn't see it**"). At the end of this extract, the clinician highlighted that she was somewhat unsure of the efficacy of this approach to intervention (i.e., "**so I don't know about our intervention or method of intervention whether it's the the correct way you know**").

EXTRACT 8.20

"most of the time it's like your word against their word do you know you're doing this wrong and it's like well and the person goes well I don't think I am well I think you you know it's like well how do you...you know I've found that very difficult and depending on the personalities and then I'm thinking of one case in particular of a of a young girl similar age to me who was in a car accident who linguistically was great but pragmatically was really really off em doing really inappropriate things on the wards em walking into people's rooms without knocking and they'd be mid changing and and you know really was her pragmatics was going to be the one thing was going to stop her getting back to to normal and independent living em so we were doing loads of work with her and it was really tough sessions cos I was like putting her in all these situations and videotaping her and then getting her to watch it back and rate herself and all the rest and she just couldn't see it so I don't know about our intervention or method of intervention whether it's the the correct way you know"

Participant No. 2: Focus Group No. 6
Pages 11-12: lines 531-564

In the data which represented the property of *Finding Faults*, the clinical role was one which was situated as being heavily involved with the process of appraisal. Evaluation was repeatedly focused on locating problems and exposing difficulties, with a view to using these faults as areas to be addressed during intervention. The participants highlighted concerns about the proclivity for the over-analysis of the skills, behaviours and knowledge of clients in light of the evaluative nature of the Speech and Language Therapist's role. The clinician was situated as the primary evaluator, while the client's perspective was not meaningfully included in the evaluation process in much of the data, as will be discussed in Section 8.1.2.2 below.

8.1.2.2 THE PROPERTY OF *LOW CLIENT INVOLVEMENT IN CLINICAL DECISION-MAKING*

"When teaching meta-pragmatic awareness the clinician does the following:

1 identifies specific deficits in the communicative performance of clients;

2 explains to clients why these are causing problems"

Working with Pragmatics
(Anderson-Wood & Rae-Smith, 2001, p. 107)

The dimension of *Low Client Involvement in Clinical Decision-Making* portrayed how the ultimate authority in terms of clinical decision-making (e.g., selecting and evaluating intervention targets) rested with the clinician. Client involvement in decision-making was either not elicited or remained low. In many instances in the data, the client's perspectives or opinions were not sought. Also evident in the data was the recruitment of client involvement in clinical decision-

making in a less than equitable manner, so that the client had minimal influence in guiding the clinical process in a meaningful way.

Extract 8.21 below displays an instance illustrating how the client's perspective was omitted from the clinical process. The section of the *Working with Pragmatics* resource from which Extract 8.21 was taken focused on an approach to "**facilitation and training**" named "**Metapragmatic Awareness Training**" (Anderson-Wood & Rae-Smith, 2001, p. 92). Here, "**deficits**" are identified and then subsequently used as targets for intervention. The prominence of identifying "**deficits**" in the clinical process was captured by the property of *Finding Faults,* as previously discussed in Section 8.1.2.1. The clinician was also advised to tell the client why particular phenomena were designated as being problematic (i.e., "**causing problems**") and then the clinician was instructed to provide occasions for the client to "**practise**". There was little involvement of the client's perspective in clinical decision-making as the client was simply told what the focus of intervention would be, as in step 2 below: "**the clinician...explains to clients why these are causing problems**". The clinician's perspective was situated as the defining perspective in selecting intervention targets.

EXTRACT 8.21

"When teaching meta-pragmatic awareness the clinician does the following:

1 identifies specific deficits in the communicative performance of clients;

2 explains to clients why these are causing problems;

3 provides opportunities to practise;

4 gives constructive feedback on the clients' performance or on the performance of characters in plays or stories or on television.

If the client has no true disability, but is failing to perform satisfactorily for reasons such as lack of awareness, habit, lack of helpful experience, or lack of confidence, improvement can be rapid. If, on the other hand, the client is unable to function in the desired manner, more basic approaches such as the pragmatic skills training approach may be needed."

Working with Pragmatics
(Anderson-Wood & Rae-Smith, 2001, p. 107)

At times, the data revealed that the client's perspective was elicited only if the client was deemed to possess a particular level of skill or to meet other criteria (such as being of a particular age). The decision to recruit the client's perspective often appeared to be made at the discretion of the clinician. As noted in Extract 8.22 below, the clinician was accorded with the responsibility of deciding on the "**suitability**" of involving the client as an active voice in the assessment process.

Here we see that some people were judged as being unable to contribute to the clinical decision-making process in a valuable way. Non-clinical perspectives were not always positioned as providing "**accurate**" information. The clinician was positioned as having the final say on identifying the most trustworthy people for providing information during assessment. Thus, the clinician was accredited with the ultimate responsibility in regulating the involvement of client perspectives in the clinical process.

EXTRACT 8.22

"Where a caregiver is present but his or her suitability to provide accurate information is questionable, then the starting point for working with the caregiver, if and where appropriate, may well be at a level other than that suggested by the CAPPA and will be determined by clinical judgement. It is important to acknowledge that the caregiver may not always be the most accurate observer, a factor reported by Orange (1991) in work with families of people with cognitive decline"

Conversational Analysis Profile for People with Aphasia
(Whitworth, Perkins & Lesser, 1997a, p. 5)

Within the property of *Low Client Involvement in Clinical Decision-Making*, the client's perspective and opinions were not necessarily required for intervention to be enacted. For example, in Extract 8.23, the client was given the opportunity to highlight areas "**which they perceive to be of the most importance**". However, this information was not to be used for enabling the client to input into clinical decision-making but rather was to be used to explore the client's "**Self/other awareness**". The guise of recruiting client opinion masked another method for evaluating client skills.

EXTRACT 8.23

"Self/other awareness interview

The interview is divided into two parts. In Part 1 the client is first asked to describe him/herself. This gives the client the opportunity to express the aspects of themselves which they perceive to be of the most importance. The teacher/therapist then asks the client questions which tap more specific information about their appearance, hobbies, strengths, weaknesses, feelings and opinions.

The same format is used in Part 2 of the interview where the client is asked for information about a best friend. This information gives some indication of how aware the client is of others around him or her. The same questions can be asked about members of the client's family."

Social Use of Language Programme
(Rinaldi, 1992b, p. 18)

Also evident in the data were instances in which client opinions were elicited and recruited, but were not accorded with equal status to the opinions of the clinician during clinical decision-

making. Client opinions and perspectives were recruited in a post-hoc fashion, (e.g., they were sought during the later stages of intervention), after much of the clinical decision-making had occurred and after the course and trajectory of intervention had been established by the clinician.

An example of how clients' perspectives were recruited but were limited to choosing between intervention options chosen by the clinician or specified by a resource is provided in Extract 8.24 below. Client perspectives were solicited for an evaluation of "**progress**", but were restricted to commenting about progress in terms of the issues identified as problematic by the resource. Thus, the focus of intervention was dictated by the resource and this limited the way in which clients could meaningfully contribute to clinical decision-making.

EXTRACT 8.24

"Assessment

Each unit has its own assessment and evaluation sheet. This identifies all skills that are taught in the unit. These sheets are designed to be discussed and evaluated with the pupil and they are written in an easy-to-understand form especially for this purpose. Before the unit is studied, ideally the pre-unit assessment column should be filled in, based on observation of the pupil in a group situation (e.g., playtimes, class discussions etc.). The pupil should be marked as:

C – Competent

H – Needs help.

After the unit has been taught, together the teacher and pupil evaluate the progress made, identifying areas of strength and areas that need improvement."

Socially Speaking
(Schroeder, 1996, p. x)

When clients' perspectives were elicited, any disparity which emerged between client and clinician opinion was often viewed with suspicion. Differences from the clinical perspective were often perceived as errors on the part of client. In Extract 8.25, the resolution of disagreements between the clinical perspective (i.e., observations made during conversation analysis carried out by the clinician) and the client's perspective (i.e., as voiced in the interviews with the client and/or their conversational partner) were discussed. Resolution was achieved by the clinician's opinion being given the final say and maintaining a position of authority. The conversational analysis section of this resource, (which is completed by the clinician) was used as a way to validate or legitimise non-clinical perspectives by generating a "**realistic picture**" of the communication difficulty or difference in question. The therapists' completed conversational analysis was compared with the information supplied by the client and/or conversational partner in order to check the accuracy of the information supplied by them. It was the clinician who was considered best placed for specifying the most "**realistic**" account of the clinical issue. Thus, the data below

provides an example of an instance of recruiting but limiting the extent of authority given to clients' perspectives.

EXTRACT 8.25

"The CAPPA provides information from the converging sources of the reports by the conversational partner and the person with aphasia and the conversation analysis. Where the interview is conducted with both partners, either separately or together, important information is gained from the perceptions of both partners, which enables a more comprehensive assessment of the interaction than if only one of the partners interviewed. Given the linguistic difficulties of the person with aphasia and Orange's (1991) work with families of people with cognitive impairment that has highlighted a number of factors that may prejudice family members' perceptions of real communicative change, corroborating evidence is sought through analysis of conversational data. Analysis of a 10-minute extract of conversation, therefore, provides objective complementary information. In total the CAPPA provides information on a number of issues....A high percentage agreement between the interviewee/s' reports and the conversation analysis indicates that there is a realistic picture of the consequences of aphasia on their interaction, providing a sound basis for management.

A high percentage conflict between the interviewee/s' reports and the conversation analysis suggests that the person with aphasia and/or the conversational partner may be underestimating the difficulties that aphasia causes in the interaction. The therapist will need to consider whether this is an issue that needs addressing. If underestimation of difficulties gives rise to breakdown in conversation (e.g. failure of the conversational partner to recognize comprehension impairments), education may be necessary. Qualitative information collected from both the interview and the CA will need to be drawn upon. A high percentage of absence of evidence from the conversation analysis for items reported by the interviewees may arise due to the limited size of the sample collected or the sampling conditions."

Conversational Analysis Profile for People with Aphasia
(Whitworth et al., 1997a, pp. 47-48)

8.1.2.3 *CLINICIAN AS EVALUATOR:* SUMMARY

Evaluation in the context of clinical pragmatics coloured decision-making throughout the entire process of intervention. As such, the *Clinician as Evaluator* category captured how the role of the clinician was bound up with the process of appraisal and judgement. The property of *Finding Faults* portrayed how the evaluation of skills, behaviours and knowledge often resulted in the identification of deficits which were used to generate intervention targets. The data from which the category of *Clinician as Evaluator* emerged, portrayed limited client involvement in clinical decision-making and also captured how the clinician was situated as the dominant party in the clinical process. Specifically, the client's restricted involvement in clinical reasoning was captured by the property of *Low Client Involvement in Clinical Decision-Making*.

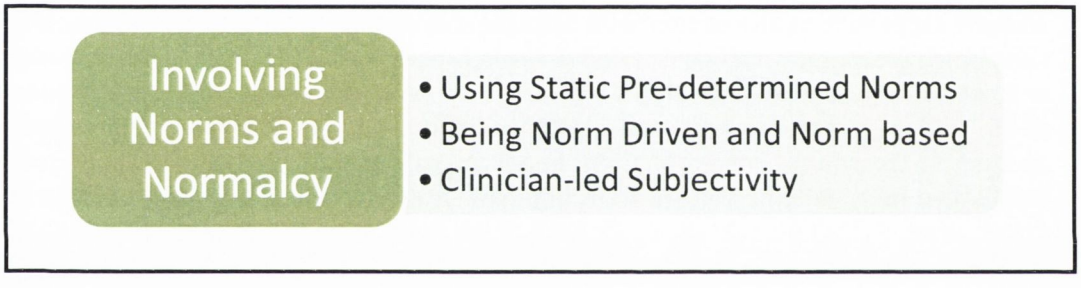
In light of the lack of theoretical frameworks for the clinician, to use to support her analysis and appraisal in clinical contexts, reliance often developed on personal and subjective

appraisals made by individual clinicians. The backdrop of norms and normalcy, against which evaluation frequently occurred, is the topic of the following section.

8.1.3 THE CATEGORY OF *INVOLVING NORMS AND NORMALCY*

Involving Norms and Normalcy portrayed how intervention was underpinned by concepts of normalcy. The category of *Involving Norms and Normalcy* reflected how prototypical and conventional versions of skills, behaviours and knowledge were perceived to be gold standards which could be employed as targets for intervention. The lack of extant, definitive norms saw the clinician draw on her own subjective perspectives and external, clinical perspectives to guide clinical decision-making involving the concepts of "normal" and cognate terms.

FIGURE 20: THE CATEGORY *OF INVOLVING NORMS AND NORMALCY* AND ITS PROPERTIES



8.1.3.1 THE PROPERTY OF *USING STATIC PRE-DETERMINED NORMS*

> **"In a formal situation you may sit face on and in an informal situation a person may sit at an angle towards the other person"**
>
> *Socially Speaking*
> (Schroeder, 1996, pp. 4)

The premise that set, standard ways of enacting intervention targets existed (in terms of particular definitive ways of performing, skills, behaviours and demonstrating knowledge) was revealed in the data. Regularly in the data, the notion of normal was assumed to be synonymous with a standardised or generic way of performing a particular skill or behaviour.

Intervention was often presented as focusing on the technicalities of how to perform various behaviours or skills. In teaching the client about pragmatics in this manner pragmatics was often reduced to a set of competencies, with static and specific universal formalities about how to enact each competency, as in Extract 8.26. Here, intervention was presented as the clinician teaching the clients in an objective manner, about how to demonstrate the "**basic skills of communication**" (such as how "**eye contact**" is "**generally**" realised). The presence of universal

and normal patterns of how to perform skills was implied within the data (i.e., "**Normally the speaker breaks eye contact momentarily when thinking**"). During therapy, guided by the *Socially Speaking* resource, prescriptive instructions about how to enact certain skills were provided to the client, via the clinician's use of the specifications of this programme (such as highlighting the "**correct distance**" between conversational partners to clients)

Extract 8.26 illustrated how specific and discrete skills were positioned as targets for intervention. Pre-specified intervention targets saw communication, as a whole, being reduced to constituent parts, constraining and containing what the clinician focused on when working clinically with pragmatics. A standardised and consistent way of approaching the teaching of "**the basic skills of communication**" was provided, in which perfecting the performance of individual constituent communication skills was enabled by assuming that universal and definitive ways of enacting these skills existed

EXTRACT 8.26

"Let's communicate

-introduction

This unit looks at the basic skills of communication, such as eye contact, turn-taking and sustaining conversation.....

1 Eye contact

Generally it is important to look people in the eye when talking to them, but differences in cultures must be ascertained before this is taught. Normally the speaker breaks eye contact momentarily when thinking and the listener tends to look for most of the time.

In this unit the pupils are continually encouraged to look at the speaker and at each other. Before talking the teacher should ascertain that all the children are looking and praise them for this.

2 Sitting appropriately and keeping still

It is important that pupils are aware of how close/far away they must place themselves from each other. Some may have no idea of what is a comfortable distance. They may place themselves too close or too far apart. Role play will help them find the correct distance, which is affected by cultural attitudes and personal preferences.

Generally, when talking to someone the body should be angled towards the other person. However, this does depend on the situation. In a formal situation you may sit face on and in an informal situation a person may sit at an angle towards the other person. Good posture is very important, as is sitting still."

Socially Speaking
(Schroeder, 1996, pp. 3-4)

The presentation of vignettes, role plays or hypothetical scenarios, in which the client was asked to demonstrate "good" and conversely "**bad**" versions of the intervention target, presumed that definitive good and bad ways of enacting intervention targets existed. In Extract 8.27, the client was asked to evaluate particular behaviours as being "**positive...negative**" or "**bad**", as part of intervention. The de-contextualised eliciting and practising of good versions of skills and behaviours was a common method utilised during intervention, evident in the data.

EXTRACT 8.27

"yeah there's some I can't remember what it's called I want to say in and out but it's maybe it's not that it's like a computer programme and it's a video settings and you watch a video and then afterwards you get the client to em look at the pragmatics of the interaction and highlight the positive things and the negative things and and you can click on they've got scenes at the bottom and you can click on that and you're supposed to you know where did he use bad turn taking or whatever and you've to they've got all these scenes at the bottom and you've got to click on them all em so"

Participant No. 2: Focus Group No. 6
Page 14: lines 662-671

The assumption that generic and set ways of enacting intervention targets existed, impacted on how the role of the clinician was realised within the data. When intervention was presented as a process of instruction focused on the enactment of skills or the demonstration of knowledge in a set standardised way, the clinician's role was conceptualised as being that of a role model, teacher and/or knowledge bearer. In Extract 8.28, the clinician's role was portrayed as focusing on the provision of information regarding uniform ways of enacting skills and performing intervention targets (such as terminating a conversation). For example, the clinician was instructed to provide a script for clients about how to perform conversational endings, in order to facilitate them in learning how to enact this skill (i.e., "**We must teach skills of ending conversation with farewells and conversational devices such as, 'Must go' and 'I'm running late'...**"). The clinician's work was focused on transmitting the technicalities of how to "do" pragmatics, to the client, in a standardised, objective and de-contextualised manner.

EXTRACT 8.28

"2 Initiating-terminating a conversation

This requires the skill of knowing when and how to initiate/terminate a conversation. Some situations are easier than others because they have a certain format to follow. For example, a telephone conversation is initiated by a greeting and terminated by a farewell. Other situations require initiating a topic that relates to a previous topic or giving a warning that the topic is going to change; for example, 'I know this off the topic but ...'

For some pupils terminating a conversation means just turning or walking away. This is not accepted by most people and can be seen as being rude. We must teach skills of ending conversation with farewells and conversational devices such as, 'Must go' and 'I'm running late', 'I'd best be off'."

Socially Speaking
(Schroeder, 1996, p. 102)

The data contained a pattern which reflected an assumption about the existence of an acceptable range of definitive ways of performing pragmatic skills and behaviours, as was portrayed by the property of *Using Static Pre-determined Norms*. When these types of phenomena were utilised as intervention targets, intervention was often presented as being focused on the teaching of particular skills, behaviours and knowledge in an objective manner. Correspondingly, the clinical role was realised as the de-contextualised teaching of objective knowledge and/or the provision of information and demonstrations (typically through simulated situations), about how to do all things pragmatic.

8.1.3.2 THE PROPERTY OF *BEING NORM DRIVEN AND NORM BASED*

"For those working with individuals who have pragmatic difficulties, it would be very helpful to know the range of normal pragmatic skills demonstrated at different ages"

Working with Pragmatics
(Anderson-Wood & Rae-Smith, 2001, p. 16)

Not only were set, norm-based ways of enacting skills and behaviours assumed to exist, but they were also used as the template by which clients were evaluated and intervention outcomes were orientated. In the data, norms were perceived as highly prized conceptual frameworks which underpinned and guided practice. Extract 8.29 below illustrated how norms were used as a paradigm or framework for approaching intervention. A "**principled**" approach to intervention was equated with an approach which was based on normal developmental trajectories. A "**sharp contrast**" between the lack of norms in the area of clinical pragmatics, and the presence of norms which were used to guide SLT input in other areas was highlighted. SLTs were posited as relying on definitive norm-based developmental trajectories in their work, reiterating the notion that SLT intervention and support was a norm based processes.

EXTRACT 8.29

"What Does Normal Pragmatic Development Mean?

For those working with individuals who have pragmatic difficulties, it would be very helpful to know the range of normal pragmatic skills demonstrated at different ages. At

present no means of reliably profiling pragmatic development exists. Despite numerous studies of particular aspects of pragmatic development, linguists, speech pathologists, and psychologists are far from understanding the overall picture or normal pragmatic development. This is in sharp contrast to knowledge of syntactic and phonological development, where a clear view of the normal progress of children has made possible a principled approach to the remediation of disorders of language development."

Working with Pragmatics
(Anderson-Wood & Rae-Smith, 2001, p. 16)

The need for norms as templates for guiding practice was also situated as problematic, in light of gaps in knowledge about how best to define normal, in that "**it's not as defined...you don't really know what's normal**" (Extract 8.30). The absence of an agreed normal developmental trajectory or a "**definite plan or sequence**" was presented a dilemma for SLTs in training, because they were not able to "**really know what's normal**". Clinicians in training were expected to learn about normal development and were facilitated in acquiring a template of "**normal...pragmatic skills**" by being sent on placement to non-clinical settings (such as "**normal preschool**"). Exposing student SLTs to norms as part of their training reflected the importance of norms. During clinical placements, which were completed early in their training, student SLTs were expected to learn about norms by observing normal behaviour in action, in order "**to see what normal is cos obviously you need to know...you need to know what normal I suppose pragmatics skills are**".

EXTRACT 8.30

"well like I think that I think that students find it hard well that would be my em I suppose the feedback I would get is is that em you know it is there's no structure there's and I know this is what happens is that when students when there is a definite plan or sequence then it's very clear they can take that in and yes have that but maybe when things are a little bit eh you know there isn't a it's not as defined then it's it- I think it's hard to get a grasp on it and actually figure it out cos then you don't really know what's normal or you- maybe you think it is but then some people say ah no I know people that do that.....you know like I think I think as well it comes down to experience if if a student on a placement meets I think is fortunate enough to meet a child with autism or say who has real social em interaction difficulties then you really can see that what is not normal as such do you know what I mean you know and I I not all students get that experience and I do think that then when you do know I think as well that's one thing but I think as well you have to have an idea of what's normal too so that if if students have access to like when they go on their fir- first year say in em say in XXX anyway when they go to they go to normal preschool in their first year for a full semester one morning a week for the whole semester to see what normal is cos obviously you need to know what this is this is the you need to know what normal I suppose pragmatics skills are but em so they get a good idea you know so they're observing"

Interview No.2
Page 7: lines 336-352
Pages 7- 8: lines 358-385

Clients' skills and behaviours were measured and evaluated against the template of "**normal**". Norms were used as a benchmark against which clinical significance could be measured. While some of the participants disagreed with the notion of set, prescriptive norms, the data which reflected the category of *Involving Norms and Normalcy* stressed and highlighted the pattern of attaching importance to norms evident in the data. The participant in Extract 8.31 highlighted the necessity of knowing what's "**normal**" in order to carry out the measurement which she saw as part of her clinical work. After a discussion in which the notion of norms was questioned by other participants, the participant in Extract 8.31 presented a revised concept of normal which was described as an "**acceptable range**". Phenomena which differed from the standard of normal were frequently assumed to be problematic in that they were not "**acceptable**". Consequently, deviances from normal were automatically assumed to be clinically significant and/or were positioned as intervention targets. As extant and pre-defined criteria, norms or normal ranges were situated as valuable clinical tools. Norm-based criteria were often drawn on as crucial clinical resources in order to evaluate the skills, behaviours and knowledge of the client and decide if these phenomena were "**acceptable**" (as opposed to being "**wrong**" or "**off**"), as in Extract 8.31.

EXTRACT 8.31

"I think before you can measure it you have to go know what's normal first because you we've nothing to measure it against...but then when it goes wrong we're all saying that we know when it goes wrong so there has to be an acceptable range cos when it's off"

Participant No. 2: Focus Group No. 6
Page 16: lines 788-792
Page 17: lines 811-815

As well as being used to identify clinical significance, normal enactments of skills, behaviours and knowledge were also utilised to generate intervention goals or outcomes. Norms were positioned as an aspiration for clients. The provision of models of normal behaviour was posited as being a clinically beneficial way of facilitating a client in attaining normal pragmatic skills, behaviours and knowledge during intervention.

Extract 8.32 below was taken from a discussion about selecting intervention candidates. It was thought that children who have received similar diagnostic classification may learn negatively (in terms of acquiring maladaptive behaviours) from each other. While Participant No. 2 noted that she felt it was beneficial for children with a specific diagnosis to meet and mingle, she also commented that the provision of normal role models might be clinically beneficial. The provision of opportunities to interact with "**normally developing children**", who "**model**" a

presumably normal way of performing or enacting all things pragmatic, was presented as one way in which intervention might be carried out with some clients in the extract below.

EXTRACT 8.32

"In a way though I thought it was nice for them to meet other children who were a bit like them you know because em wh- even in the group you could see they were all interested in the same kinda things computer games and you know there all the specific interests like so they did bond kind of on that level alright you know but em yeah it probably would help if they had some em kind of normally developing children as well to kinda like to provide the model"

Participant No. 2: Focus Group No. 4
Pages 6-7: lines 287-299

Clinicians were posited as being specialists in norms. SLTs were situated as being skilled in identifying behaviours as being normal or not. In Extract 8.33 below, the clinician was implicitly situated as being better equipped than "**the public**" at identifying normal behaviours.

EXTRACT 8.33

"But I suppose you would have different experience with parents perhaps you know em or or just members of the public that don't know anything about pragmatics might em you know judge something as being perfectly normal when really it's not you know"

Participant No. 5: Focus Group No. 2
Page 29: lines 1320-1326

The property of *Being Norm Driven and Norm Based* captured how recurrently norms were referred to as important benchmarks in practice. Norms, and cognate concepts, were used as templates against which clients' skills, behaviours and knowledge could be evaluated. Norms were also used as aspirational templates, influencing the design of intervention targets and outcomes. Often the aim of therapy was to facilitate the client in acquiring or developing normal versions of particular skills, behaviours and/or knowledge. Knowledge about pragmatic norms and normalcy were presented as a specialist and esoteric type of knowledge, which the SLT was skilled in using and applying in practice.

SLTs' opinions regarding norms, despite the concerns about the lack of research evidence to support the available norms as being considered robust, were valued as more trustworthy than non-clinical perspectives of the same. The pattern of prioritising clinical over non-clinical perspectives was captured by the property of *Clinician-led Subjectivity* discussed below.

8.1.3.3 THE PROPERTY OF *CLINICIAN-LED SUBJECTIVITY*

"often you're relying on your own common sense and em just going with what you feel might be the right thing to do at times"

Interview No. 5
Page 1: lines 40-41

Subjectivity was positioned as a characteristic of clinical decision-making in the area of pragmatics but it was also considered problematic, at times, in the data. *Clinician-led Subjectivity* captured how intervention was guided by the subjective opinions and perspectives of the clinician, while the subjective opinions and perspectives of the client were not actively sought, for informing clinical decision-making.

Gaps in resources and knowledge were recurrently linked with a reliance on the subjective opinions and perspectives of clinicians. Concerns were voiced about the involvement of "**common sense**" and "**going with what you feel might be the right thing**", implying that clinicians were not comfortable relying primarily on their own subjective perspectives to guide clinical decision-making, as in Extract 8.34.

Subjectivity was also involved in how the clinicians defined the norms they used in the clinic. In Extract 8.35, references to the influence of "**subjective judgement**" on clinical decision-making emerged in discussing the challenges of working in the area of clinical pragmatics. Here, the nature of decision-making was characterised as a personal "**judgement**" reliant on the clinician's "**own**" concept of "**normal**".

EXTRACT 8.34

"em also I suppose I'm always concerned about em or I'm often concerned about em the types of resources to use like there are some resources on the market but em there aren't there isn't a huge amount and em often you're relying on your own common sense and em just going with what you feel might be the right thing to do at times"

Interview No. 5
Page 1: lines 36-41

EXTRACT 8.35

"To a certain degree that's- your making a subjective judgement based on your own constructs on what's kind of normal you know...and culturally or whatever that may not be the family's construct so it's that influences it as well I think"

Participant No. 1: Focus Group 1
Page 5: lines 202-210

As above in Extract 8.35, Extract 8.36 captured how the clinician's own personal perspective and opinions were drawn on for clinical decision-making. Variations in clinical evaluations were linked

with this reliance on subjective clinical perspectives. For example, the data in Extract 8.36 illustrated how a concept such as "**acceptable**" when applied to behaviours such as "**eye contact**" could be used in a disparate manner by different clinicians.

EXTRACT 8.36

> **"I don't think you can have norms It's not something you have like what I would probably even if you think of three eh trained speech therapists if you were to ask between us if you were to put a rating scale down I might think it's acceptable to kinda just do a less eye contact let say than you might think might be happy with or my personal space I might like you but there are but there variations yeah"**

Participant No. 1: Focus Group No. 6
Page 16: lines 791-808

Extract 8.37 below also highlighted a potential disparity between clinicians and how they might interpret and apply pragmatics notions. Here, the participant highlighted the potential for inconsistency between how different clinicians used concepts from the area of pragmatics (such as "**topic maintenance**") to evaluate their clients. The way in which the behaviours, skills and knowledge of the clients were evaluated and classified could be influenced by the variable ways in which pragmatics notions were subjectively realised and applied by individual clinicians.

EXTRACT 8.37

> **"maybe there's like anything you know even like an r what an r sound to me might be okay where to you it mightn't be a good r and I think kinda topic maintenance well I might think he's not too bad you might think oh gosh no that's completely off"**

Participant No. 3: Focus Group No. 4
Page 31: lines 1504-1508

Other data revealed a concern for the potential pathologisation of variation because of the reliance on subjective, clinician-led perspectives. The personal interaction style, behaviours, skills and knowledge of the clinician were used as the benchmark of "**normal**" against which the client was evaluated. Subjective, clinician-specific norms were presented as a significant influence on clinical decision-making (i.e., "**there's a tendency to think that the way you do it is the right way to do it**"), as in Extract 8.38. This extract illustrates a concern about how differences or variation from a clinician's subjective norm (i.e., "**our nice little neat version of how it should be**") could be conceived as deficient, pathological or clinically significant.

Clinical classifications and decision-making regarding clinical significance emerged as being influenced by the subjective opinions of the participants. Participants recurrently highlighted the "**subjective**" nature of the concepts of "**normal...abnormal...borderline**" which

were used in the clinic, as in Extract 8.39. *Clinician-led Subjectivity* pertained to how subjective evaluations were used to guide decision-making and classification (e.g., "**normal**" or "**abnormal**").

EXTRACT 8.38

"because well I do think there's a tendency to think that the way you do it is the right way to do it so that thing you must look at me to signal interest I suppo- and I remember reading Temple Grandin's book I think it's thinking with thinking with pictures and she talks about how for some people with autism it's actually painful to look at another person and you're like god I never knew that and then you think of oh my god what I have been doing ((laugh)) you know and that but I think that's again a broader issue for speech and language therapy in general outside of pragmatics it's like well what are we trying to do here what are we i- because if you think about it in another way isn't impairment part of the entire spectrum of human experience so why are we trying to make it all fit into our nice little neat version of how it should be"

Interview No.1
Page 20: lines 973-991

EXTRACT 8.39

"and because it is so subjective when you're reporting it to parents family or other people it is really difficult to say whether it's like you said normal abnormal on the borderline whatever cos there is no assessment of what is normal cos it is so variable"

Participant No. 2: Focus Group No. 1
Page 5: lines 216-221

The participants' concerns about the subjective nature of terms (such as normal) in light of *Uncertainty*, did not result in these concepts being abandoned. These concepts continued to emerge in the data to guide clinical decision-making.

The sheer breadth of phenomena which could potentially be included for consideration in the area of clinical pragmatics enabled the area to be used as a broad platform for exploring and labelling a wide variety of behaviours, skills and knowledge. Phenomena from macro (e.g., considering the client's social networks or employment status) and micro (e.g., considerations of specific skills) levels of analysis permeated the data as evidence of difficulty in the area of pragmatics. Both marco and micro level phenomena were treated as indicators of clinical significance. The pattern of using a wide variety of indicators from a range of domains has been discussed previously and can be seen in the criteria used as indicators of pragmatic language difficulties, as per Figure 12 in Chapter 6.

In Extract 8.40, one survey respondent answered the following question: "**Q 7. What features lead you to suspect Pragmatic language difficulties in an adult or child?**", by evoking a list of phenomena which pertained to a wide variety of domains of analysis. Indicators of "**Pragmatic language difficulties**" (as stated in Question No. 7 and 8 on the Questionnaire) were taken from macro levels of overall social functioning (i.e., "**if have no friends**"). Micro levels of

analysis of the enactment of specific skills and behaviours (i.e., "**avoidant eye contact**" and "**unusual pitch**") were also taken to indicate difficulty in the area of pragmatics. The lack of an overt theoretical paradigm, in which the participant couched her list of indicators of pragmatic language difficulties, left the process of identification of intervention candidates and targets vulnerable to the influence of each clinician's own perspectives. Evaluations containing loose and potentially subjective terms (e.g., "**unusual...excessive...good**" Extract 8.40) implied the presence of subjectivity in the construction of clinical categories (such as pragmatic language difficulty).

EXTRACT 8.40

> **"From meeting the child-avoidant eye contact, unusual pitch, not answering questions in way expected, answering tangentially, excessive talking-rambling, switching topic too fast-disorganised narrative, can't understand their news-story despite child having good articulation and ability to use simple and complex sentences if have no friends, or have behaviour problems"**

Questionnaire No. 9

Extract 8.41 illustrates how interpretations of skills, behaviours and knowledge which were potentially quite subjective (such as, "**odd behaviours**") were used to identify either intervention goals or to identify a client as requiring intervention. The presence of "**odd behaviours**", in light of a diagnosis of "**right hemisphere syndrome**", was taken to imply that pragmatics was an area of clinical concern. In the data, *Formal Pointers* (as discussed in the Section 8.1.4 below), such as extant diagnosis, often emerged in tandem with subjective indicators of clinical significance.

EXTRACT 8.41

> **"in that particular week they have their problem over a couple of tutorials and it focuses on an individual with right hemisphere syndrome and talks about her odd behaviours and that gets them on the path of thinking about pragmatics and what's appropriate and what's not"**

Interview No. 6
Page 3: lines 138-142

In the data, the clinician's subjectivity appeared to be favoured so that the clinician was the only party in the clinical process whose subjectivity was valued and utilised as a resource. This type of unilateral subjectivity was exposed as an implicit or taken-for-granted aspect of decision-making as captured by the property of *Clinician-led Subjectivity*. However, many participants explicitly referred to the one-sided nature of their clinical evaluations as being deleterious.

8.1.3.4 *Involving Norms and Normalcy*: Summary

Involving Norms and Normalcy was a category of the *Containing Uncertainty through Homogenisation* which captured how norms and cognate terms were such a prominent influence on the clinical process. Intervention often involved the use of norms as templates for evaluating the client and for identifying the outcome of intervention. Norms were frequently defined in a subjective manner by the clinician. Although the subjectivity evident in clinical decision-making was highlighted, at times, as being problematic, the clinician's subjectivity was prioritised and utilised as a resource, while the subjective perspective of the client was often marginalised or neglected.

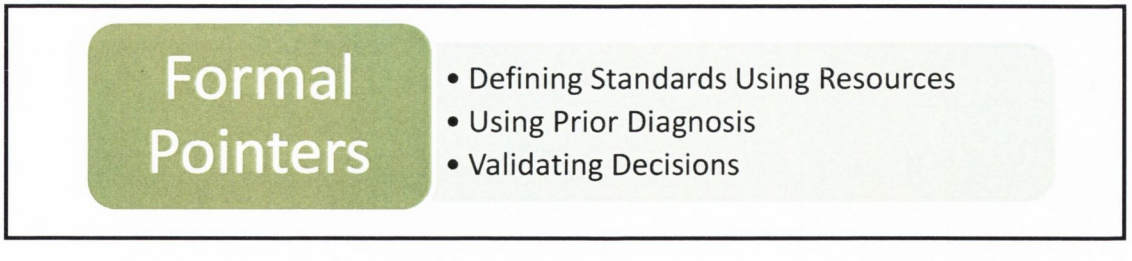
8.1.4 The category of *Formal Pointers*

Norms were not only influenced by a clinician's subjective constructs (pertaining to her own personal notions of typicality or normalcy), as noted in the discussion above. Norms and cognate terms were also based on the information put forward by published resources and commercially available materials.

Formal Pointers is a conceptual category pertaining to how phenomena external to the clinician were drawn on to guide and validate clinical-decision-making in the context of *Uncertainty*. In this study, examples of *Formal Pointers* included: criteria specified by resources, assessment results, reports from other professionals and extant diagnoses.

The category of *Formal Pointers* does not include the recruitment of client perspectives, as a resource during clinical decision-making. Information from sources outside of the clinician (such as, extant resources) was used to inform, support and validate clinical decision-making in place of relying entirely on the clinician's own perspective or drawing on the client's perspective.

Figure 21: The category *of Formal Pointers* and its properties



8.1.4.1 THE PROPERTY OF *DEFINING STANDARDS USING RESOURCES*

> **"Unasterisked ratings indicate normal conversational management, and it is not necessary to ask the supplementary questions"**
>
> *Conversational Analysis Profile for People with Aphasia*
> (Whitworth et al., 1997a, p. 23)

The property of *Defining Standards Using Resources* captures how *Formal Pointers* (such as, assessment results) were used to set criteria for the evaluation of clients and the specification of intervention targets. For example, evident in some of the data analysed were criteria guiding how the clinician might interpret observations and reports or the behaviours, skills and knowledge of a client.

The data in Extracts 8.42 and 8.43 captured how "**normal**" could be defined, according to the criteria specified by the resource. Clinical attention was steered towards the exploration of behaviours identified by the resource as not meeting their standard of "**normal**',' as in Extract 8.42. Behaviours which were deemed not to meet this resource's specifications of normal were assumed to be clinically significant and problematic (although, in this resource the client's opinion was solicited to evaluate how problematic a particular behaviour was). The user of this resource was advised to explore particular behaviours (i.e., those identified as not "**normal**") in greater detail by uncovering how the behaviour was dealt with, and how much of a problem the behaviour was considered to be, by the person being interviewed. The behaviour was then rated as being problematic on a scale (of 0-2). Thus, these guidelines structured how a clinician might interpret the behaviours of the client in order to manufacture a clinical focus in accordance with the prescriptions of "**normal**" specified by the resource.

The data in Extract 8.43 illustrated how a commercially available resource provided prescriptive instructions on how to define specific examples of "**normal conversational management**" (such as maintaining "**topic**"), while explicit descriptions of how behaviour which did not meet the specifications for being considered "**normal**" might manifest was also provided by this same resource (i.e., "**Evidence of failure to maintain topic will take the form of...**").

EXTRACT 8.42

> **"5. If the frequency rating elicited IS NOT marked with an asterisk, go straight to the next numbered question. Unasterisked ratings indicate normal conversational management, and it is not necessary to ask the supplementary questions.**
>
> **6. If frequency rating elicited IS marked with an asterisk, ask the supplementary parts (a), (b) and (c) of the question, as shown below.**
>
> **a) "*How do you deal with this*?" (or similar wording) (Record response in the space provided.)**

b) "*What happens when you do this?*" (Record response in the space provided.)

c) "How much of a problem etc...? look at the lower part of the card. Do you consider that it is not a problem, a bit of a problem or a big problem?"

Conversational Analysis Profile for People with Aphasia
(Whitworth et al., 1997a, pp. 23-24)

EXTRACT 8.43

"Evidence of failure to maintain topic will take the form of the absence of major turns that contribute to the development of a topic. This may be in the form of reliance on minimal turns to participate in conversation (as in the example for Q.22) or in the introduction of new topics by either conversational partners for which there is little topic development. For example... "

Conversational Analysis Profile for People with Aphasia
(Whitworth et al., 1997a, p. 41)

As discussed previously (see Section 8.1.3) clinical work was often situated within a framework of norms and, hence, could be considered norm based and norm driven. The resource in Extract 8.44 below provided a "**tentative outline**" of norms to inform practice. The weight of norms was highlighted when norms (such as "**developmental guidelines**") were positioned as being "**urgently needed**" for guiding clinical practice. Criteria such as developmental guidelines provided an outline which could be used to structure the observations of the clinician. Clinical significance was defined by behaviours, skills and knowledge which fell short of meeting the criteria specified by the resource.

EXTRACT 8.44

"Describing Pragmatic Development

The authors' knowledge of clinical decision making leads us to think that, without some developmental guidelines, clinicians are likely to be expecting too little or too much of clients and are also likely to be reluctant to accept that what appear to be infantile forms of behaviour may be developmentally appropriate. This is unfortunate since, for some individuals, acceptance has been found to foster communicative development more effectively than corrective approaches (Smith & Leinonen, 1992). For this reason we have taken a decision to include a sketchy and tentative outline of what urgently needed research may possibly confirm to be the normal pattern of events in the unfolding of pragmatic abilities. Short of postponing publication for several years, or omitting consideration of development, this appears to be our best option."

Working with Pragmatics
(Anderson-Wood & Rae-Smith, 2001, p. 17)

The provision of structured templates which outlined the anticipated development of a particular disorder were also evident in the data. Thus, resources specified both normal and disordered development. For example, the presentation of a "**predictable pattern**" of the types of

behaviours deemed to be representative of particular disorders, such as "**Semantic-Pragmatic Language Disorder**", is illustrated in Extract 8.45. Here, an assumed pattern of behaviour and skill development, which was expected to unfold in the behaviours of an individual labelled with a specific diagnosis, suggested that a standardised expression of a particular disorder was anticipated. In Extract 8.45, a chronological sequence of identifiable disorder characteristics (such as being an "**undemanding baby**") was provided and could be used as a template from which a clinician could evaluate a child's behaviour and construct a profile of "**Semantic-Pragmatic Language Disorder**" via reports and observations about a client.

EXTRACT 8.45

"What are the Significant Characteristics of a Semantic-Pragmatic Language Disorder?

Children with a semantic-pragmatic language disorder appear to have a significant degree of difficulty processing information in the ways already discussed. This affects how their linguistic skills develop in certain characteristic ways. There is a predictable pattern to the development of their verbal and non-verbal skills, which may be simplified into four stages (ages given are approximate).

Stage 1: Birth to Age 2

Communication skills

It is unlikely that a communication disorder would be recognized in a very young baby, but parents of children with a semantic-pragmatic disorder often comment that their child was an undemanding baby and was quite passive. He may have cried if in discomfort or when hungry, but not for attention. He may not have enjoyed eye contact with others or engaged in early cooing and babble turn-taking sequences to converse. He may also have been unwilling to join in with 'peek-a-boo' or other such games.

Other areas

Parents may also remember that even as a baby their child was upset by changes in routine, or by unfamiliar places or people. For instance...

Stage 2: Age 3-5

Communication skills

Children usually start to develop spoken language at around nine to 18 months. As mentioned before, the development of vocabulary and grammatical skills is based mainly on an ability to make concepts about the world. As this happens, words and phrases of increasing complexity are generated. As well as this, children also remember whole phrases without usually understanding every word in them. It seems that children with a semantic-pragmatic language disorder mainly use this latter method.

Other areas

By this stage children with semantic-pragmatic language disorder may have developed certain strong likes and dislikes which may not be very apparent until he is exposed to new experiences, such as going to a playgroup."

Semantic-Pragmatic Language Disorder
(Firth & Venkatesh, 1999b, pp. 19-20)

In presenting a template of how pragmatic difficulties might manifest, resources provided a set of indicators which could be used clinically to identify an individual as a candidate for intervention. In Extract 8.46, a compilation of "**characteristics**" across a wide variety of domains were specified as being linked to or associated with "**Pragmatic impairment**". Indeed, the resource explicitly noted that the purpose of this list of "**characteristics**" was to facilitate how certain "**features are recognized**" as being indicative of or associated with "**Pragmatic impairment**".

EXTRACT 8.46

"Characteristics of Pragmatic Impairment

The following lists have been derived from the literature on pragmatic dysfunction. We have arranged the characteristics found in the literature into four main groupings: expressing communicative intents, conversational management, problems of presupposition, and pragmatic comprehension and knowledge base. Clearly, anyone individual will exhibit only *some* of these features.

Expressing communicative intents

Does not attract attention to self.
Does not point (no deixis).
Seldom initiates interaction.
Does not make intent clear Echolalia (immediate or delayed).
Perseveration....

Conversational Management

Problems with basic interaction skills...
Poor turn taking (fails to take own turn, does not allow turns, pauses too long or overlaps)....

Weakness in conversational repair: failure to request clarification; failure to signal non-comprehension; failure or inadequacy in supplying clarification; poor spontaneous repairs (such as apologies)....

Problems of presupposition (awareness of what might be assumed to exist in the minds of other people)

Ignoring the listener's perspective when speaking
'Tactlessness'
Provision of more or less information than is needed.

Pragmatic comprehension and knowledge base

Apparent difficulty in making sense of the world
Difficulty in making inferences: appreciating the significance of words and events....

The following personal characteristics have also been noted and are thought by some writers to relate directly to pragmatic (and possibly semantic) impairment. We would prefer not to make this assumption since cognitive impairment, emotional discomfort or environmental factors might equally well be responsible.

Obsessive interests

Idiosyncratic style
Gaucheness
Shyness
Inflexibility
Non-cooperativeness
Preference for 'off-task' activities.....

The present authors have noted several other commonly occurring features in people whose pragmatic abilities are impaired (however; the above reservations still apply):

Aggressiveness
Timidity
A tendency to indulge in or to attract, teasing, or bullying
Jealous and competitive attitudes
Misunderstanding of competitive situating
Excessive dependence
An appearance of opting out or not making any effort

Further features mentioned in the literature could be viewed as *explanations* for some of the behaviours listed in the four groups. Much of the literature in which these features are mentioned lacks rigour. However, we have decided to include them in an effort to assist future researchers who are not familiar with the field. We also hope that there may be some benefit to interdisciplinary co-operation if the features are recognized."

Working with Pragmatics
(Anderson-Wood & Rae-Smith, 2001, pp. 29-30)

The property of *Defining Standards Using Resources* illustrated how sources external to the clinician were used as templates and aids during clinical decision-making, particularly in identifying intervention candidates and targets.

8.1.4.2 THE PROPERTY OF *USING PRIOR DIAGNOSIS*

"the right hemisphere guys"

Participant No. 4: Focus Group No. 6
Page 3: lines 103-104

The property of *Using Prior Diagnosis* was recurrently captured in the data, portraying how extant diagnoses were used to indicate that pragmatics would be an area of clinical concern. Associating particular diagnostic labels and certain aetiologies with particular difficulties which were deemed pragmatic in nature reflected a leaning towards accepting that particular profiles (or particular behavioural phenotypes) were inevitably linked with certain impairments. By *Using Prior Diagnosis* as *Formal Pointers* a consistent and tidy way of identifying clients and candidates for particular types of intervention was generated in the context of *Uncertainty*.

The use of prior diagnosis as a way of identifying candidates as being pragmatically impaired, or being likely to have difficulties in the area of pragmatics, is illustrated in Extract 8.47. In this data, the presence of a "**right hemisphere**" pathology was associated with "**very definite pragmatic problems**".

EXTRACT 8.47

"I I suppose when I'm thinking of like clients and things people with right hemisphere language problems who really y- they're the ones it's so hard to do that kind of work with but who stand I think out over and above some of the other people that we would see as adults as having pragm- very definite pragmatic problems....em I suppose I haven't well haven't done I haven't done as much TBI work as you would have done em but I did work in mental health for a long time and there we did allot of stuff on pragmatics so I think that where the bit for me for adults where it really kind of came up oh yeah this is major area to do do with to to look at but not so much I feel with the acquired clients apart from the ones I've experienced are the right hemisphere guys"

Participant No. 4: Focus Group No. 6
Page 2: lines 62-71
Pages 2-3: lines 95-104

Linking and associating particular impairments and patterns of behaviour together provided a way of predicting the occurrence of certain difficulties or deficits and this appeared to bolster certainty. Extract 8.48 illustrated, for example, linking the presence of "**psychosis**" with "**severe pragmatic difficulties**". Even prior to meeting a client, a clinician could begin to formulate hypotheses about likely patterns of impairment and behavioural characteristics based on the diagnosis of the client. In extract 8.48, a hierarchy of severity of "**pragmatic difficulties**" was presumed to be linked with the extant diagnosis a client had been given.

EXTRACT 8.48

"Severe pragmatic difficulties

People with autism and some types of psychosis.

Moderate pragmatic difficulties

People on the autistic continuum, for instance those with Asperger's syndrome.
People diagnosed as having 'semantic-pragmatic disorder' or 'high level language disorder'.
Some institutionalized people
Undiagnosed people regarded as communicating poorly or 'oddly'.
Some people with learning difficulties whose particular cognitive limitations affect pragmatics.
Some right hemisphere stroke patients....

Mild pragmatic difficulties

It is important to note that these mild pragmatic difficulties can be encountered in the absence of any pathology. Most of us will experience some difficulty in communicating successfully at some time in our lives.
Any of us experiencing a breakdown in communication with another person and not being able to repair it smoothly.
People who want to improve their management skills.
People who lack conversational 'know-how'. (This can include people with or without a history of language disorder or dysfluency.)"

Working with Pragmatics
(Anderson-Wood & Rae-Smith, 2001, p. 35)

Utilising diagnostic categories and particular disorders as methods for predicting which clients required intervention that focused on pragmatics meant that intervention targets and candidates could be selected with minimal client input. Decision-making about the focus of intervention was partly dependent on the particular diagnosis a client had been given (i.e., "**there are certain conditions disorders diseases whatever you want to call them that will incorporate work with pragmatics**") as in Extract 8.49. Rather than specifying intervention in a case-by-case manner, *Using Prior Diagnosis* captured how almost in advance of meeting a client the focus of intervention could be predicted to some extent.

EXTRACT 8.49

"now obviously in paediatrics and adults there are certain conditions disorders diseases whatever you want to call them that will incorporate work with pragmatics and pragmatic disorders....so for example one of the em one of the em problems in third year focuses on right hemisphere syndrome of course pragmatics is a big factor in right hemisphere syndrome so"

Interview No.6
Page 2: lines 84-89
Page 3: lines 126-129

The property of *Using Prior Diagnosis* captured how clinical diagnoses were used to predict particular patterns of behaviours and subsequent clinical needs.

8.1.4.3 THE PROPERTY OF *VALIDATING DECISIONS*

> **"I know he has severe difficulties but I don't know how to broach that one cos I've nothing to really back up what I'm saying"**
>
> Participant No. 1: Focus Group No. 4
> Page 39: lines 1894-1897

One important function of *Formal Pointers* was that they provided a source of validation for clinicians' decisions in light of *Uncertainty*. In order to validate and instil confidence in clinical decisions, *Formal Pointers* were used to legitimise and substantiate clinical reasoning, hence the emergence of the property of *Validating Decisions*.

Formal assessment was, for some participants, a highly regarded way of supporting decision-making and disseminating information in the area of clinical pragmatics. Without *Formal Pointers* (such as, prior diagnoses) a vulnerability or lack of robustness in decision-making was implied in the data. The participant in Extract 8.50 noted that she had "**nothing to really back up what I'm saying**" because of a lack of "**formal assessment**" which could be used.[95]

EXTRACT 8.50

> **"But at least with that you have like a formal assessment to go like look here this is the normal this is what he's getting like whereas with pragmatics you're kinda going I know he has severe difficulties but I don't know how to broach that one cos I've nothing to really back up what I'm saying"**
>
> Participant No. 1: Focus Group No. 4
> Page 39: lines 1893-1899

Formal assessment results and standardised scores enabled the participants to support and confirm their clinical decision-making and fostered a sense of confidence about the decisions that clinicians made. Extract 8.51 below highlighted how scores (such as, those supplied by formalised assessment procedures) protected the clinician, enabling the clinician to feel "**safe**" and thus bolstering confidence in clinical decision-making.

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[95] The use of various phenomena (such as second opinions and standardised test results) as "back ups" to substantiate and validate clinical decision making, in the face of uncertainty has also been found in other studies (Elliott, 2007, p. 72).

EXTRACT 8.51

"em they can do absolutely great on the CELF preschool....you know cos there's no connected speech whatsoever you know its words fill in the blanks you know it it's just silly em I mean it does what it does but it's not a comprehensive language assessment and its definitely not a comprehensive communication assessment em so that's really challenging and you need to be I think you need to be confident in your own abilities to stand over decisions about a child but you know a lot of people just from experience are not- you know t-they wouldn't have that confidence em...and then then yeah yeah it's really safe and you know everyone loves scores parents love scores teachers love scores we love scores too ((laugh)) but em you have be really careful of it I think really need to you know I think this is an area we really need to look at"

Interview No. 4
Pages 18-19: lines 902-930

Formal Pointers offered some certainty in light of *Uncertainty*. Participants highlighted the supportive function of *Formal Pointers* in identifying and justifying intervention goals, as can be seen in Extract 8.52. The validation offered by assessment results and pre-defined norms (i.e., "**test score.... scores in comparisons to norms**") was highlighted in the following piece of data. The perceived inadequacy of therapist's own clinical perspective (i.e., "**just my opinion**") was juxtaposed with the external indicators of clinical concern identified, in this instance, by the formal assessment "**scores**" and deviations from set established norms.

EXTRACT 8.52

"but I remember one time we had a father in and he just would not accept that there were pragmatic language difficulties and and the child was talking in an american accent and I em I was giving feedback saying that you know he has quite an american twang and he doesn't really look at you and blah blah blah and the dad the dad was just saying em no he doesn't have an american twang and sure I don't always look at people and I don't always change my facial expressions whereas if you were able to come out with kind of scores in comparisons to norms it it probably would have been easier for that dad to accept it em because it was just my opinion rather than a a test score em and I know that was part of his overall difficulty with accepting the child's issues and s- stuff like that but em it's just a hard area to to define"

Interview No. 7
Pages 2-3: lines 79-96

The use of particular technologies (such as formal assessment tools and diagnoses) enabled the clinicians to communicate clearly about clinical decision-making and also buttressed the clinical conclusions made by participants. In Extract 8.53 below "**normed**" and "**quantitative**" scores, facilitated the clinician in defending her clinical reasoning, and also facilitated her in persuading another person that the participant's clinical judgements were robust and valid (i.e., "**just purely to try and get someone on board**").

EXTRACT 8.53

"yeah I've I have to actually admit I haven't actually used it in its entirety but just just ideas from it and they're quite useful but not as an assessment in itself um CCC2 I've used just purely to try and get someone on board em i.e. another professional that might like scores more than my descriptions that sounds awful doesn't it....It's normed it's it's quantitative in in that's it's normed which I found really relevant but the good thing about it that I liked about it was that I got the teacher to fill it out as well and some of the things that I'd actually described to her she em I don't think she'd actually listened to ((laugh)) and she saw them on the profile and went ah yeah that what he is and I was like I told you that like you know a few months ago"

Participant No. 2: Focus Group No. 1
Page 41: lines 1852-1858
Page 41: lines 1864-1879

Validating Decisions was a property of *Formal Pointers* which pertained to how, sources external to the clinician, were used to support and validate clinical decision-making in an uncertain area.

8.1.4.4 *FORMAL POINTERS*: SUMMARY

Formal Pointers portrayed the use of sources external to the clinician for a variety of reasons, including supporting clinical decision-making in the face of *Uncertainty* as noted by the property of *Validating Decisions*. The property of *Defining Standards Using Resources* captured how criteria for evaluating clients and for structuring intervention (such as norms) were gleaned from sources external to the clinician, in order to guide clinical decision-making in the context of *Uncertainty*. The property of *Using Prior Diagnosis* pertained to the use of extant diagnoses, in the data, for predicting which clients might be eligible as intervention candidates and for identifying intervention targets.

8.1.5 *CONTAINING UNCERTAINTY THROUGH HOMOGENISATION*: SUMMARY

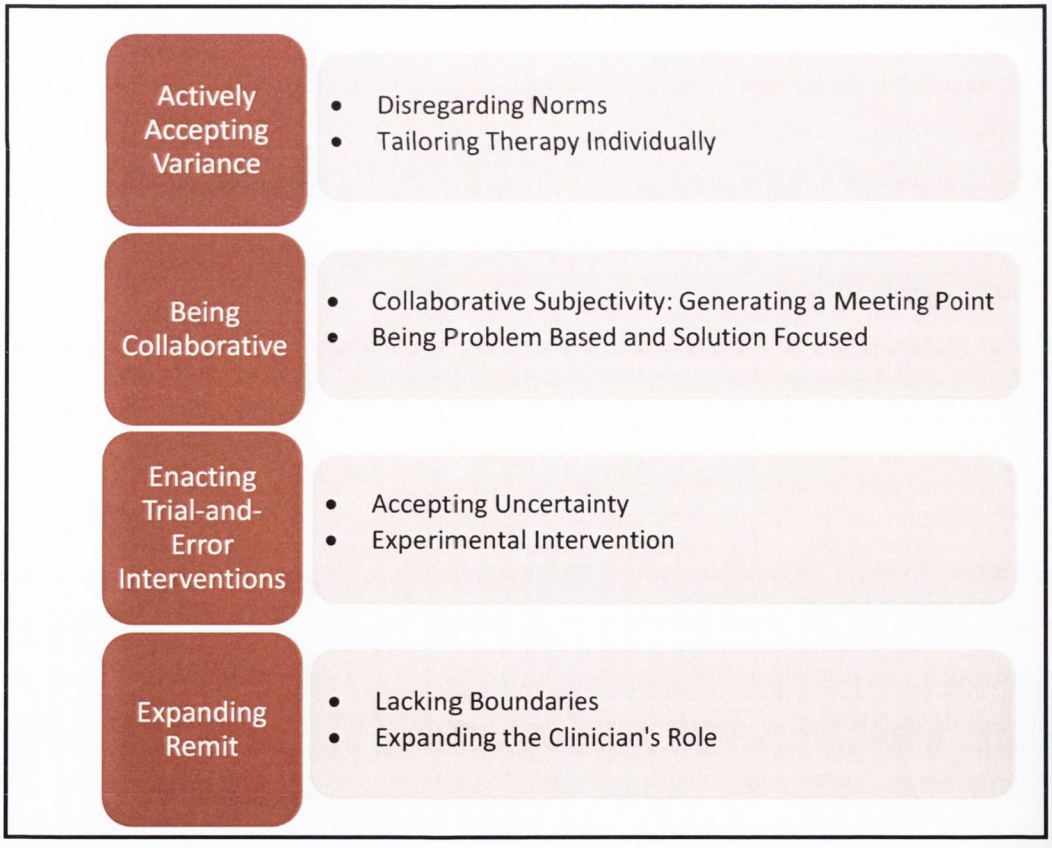
Containing Uncertainty through Homogenisation was a response to *Uncertainty* characterised by the creation of a standardised profile of clinical needs in order to subsequently approach intervention with universal and pre-determined structure, content and intervention targets. There was limited or no client involvement in clinical decision-making. The clinician's role was intrinsically evaluative and it was the clinician who was the primary authority with regards to clinical decision-making. Decision-making was supported by sources external to the clinician (such as resources, formal assessments and extant diagnoses), which were drawn on to validate and buttress clinical decision-making and which enabled the provision of homogenised intervention. Client skills, behaviours and knowledge were evaluated against a backdrop of norms and normalcy. Norms were generated by the use of guidelines found in the clinical literature environment and/or were informed by the clinician's own subjective benchmarks of normalcy.

CHAPTER 9. RESPONSES TO *UNCERTAINTY* IN THE DATA: *STRETCHING REMIT*

9.1 THE SUB-CORE CATEGORY OF *STRETCHING REMIT*: INTRODUCTION

Stretching Remit emerged from the data as a conceptual category, which captured responses to *Uncertainty*, hallmarked by the clinician assuming an expansive and flexible clinical role. In addition, acceptance of clinical uncertainty, heightened levels of clinician-client collaboration in relation to clinical decision-making and increased levels of clinical tolerance of variance, reflected how clinicians had recast their role in the area of clinical pragmatics in response to *Uncertainty*. Figure 22 presents a diagrammatic representation of *Stretching Remit.*

FIGURE 22: THE SUB-CORE CATEGORY OF *STRETCHING REMIT*: ITS CATEGORIES AND PROPERTIES



In *Stretching Remit,* the clinician and client jointly identified intervention goals which were achieved through a solution focused approach to intervention. The adoption of a personalised,

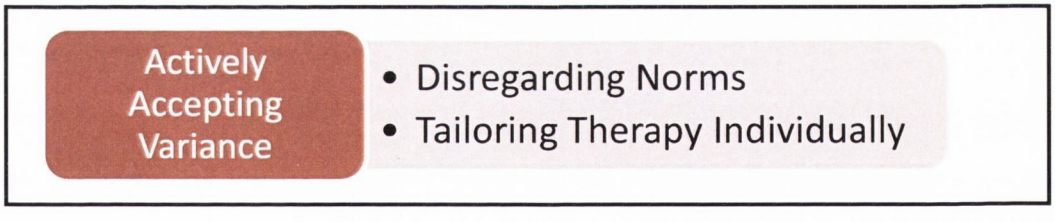
trial-and-error approach to intervention enabled the clinician to work in a client-specific and flexible manner. As such, *Stretching Remit* portrayed an approach to intervention characterised by a modifiable intervention trajectory. The Speech and Language Therapist adapted both the content and trajectory of intervention to meet individual client needs and to complement individual responses to SLT input.

An increased willingness to position unconventional behaviours, skills and knowledge exhibited by the client as non-pathological was also a hallmark of the *Stretching Remit* concept. In addition to a wider array of variance being clinically tolerated, another characteristic of the concept of *Stretching Remit* included an expanded acceptance of *Uncertainty*.

9.1.1 THE CATEGORY OF *ACTIVELY ACCEPTING VARIANCE*

Actively Accepting Variance was a category of *Stretching Remit* which pertained to the way in which diversity was embraced during intervention. This category also captured how intervention was tweaked and tailored individually, in light of an acceptance of variation. The notions of norms and normalcy were not used to guide practice. Impairment was not viewed synonymously with clinical significance. Differences in knowledge, skill and behaviour were recast as being representative of general human variation and diversity.

FIGURE 23: THE CATEGORY OF *ACTIVELY ACCEPTING VARIANCE* AND ITS PROPERTIES



9.1.1.1 THE PROPERTY OF *DISREGARDING NORMS*

"so what is normal you know?"

Participant No. 6: Focus Group No. 1
Page 16: line 719

Unlike the concept of *Containing Uncertainty through Homogenisation*, the concept of *Stretching Remit* reflected a premise that pre-fabricated norms should not inform or influence intervention, in light of *Uncertainty*. Differences from the norm were not taken to automatically indicate clinical significance, as extant, pre-defined norms were not regarded as being particularly trustworthy or robust notions in the realm of clinical pragmatics. Additionally, some of the difference or variation

evident in the skills, behaviours and knowledge of clients was taken as being a reflection of the wide variation of skills, behaviours and knowledge evident in the population at large, as opposed to being representative of impairment or pathology patterns.

Data which emerged reflecting the property of *Disregarding Norms* questioned the appropriacy of using norms as a paradigm for clinical practice, in the context of *Uncertainty*. As in Extract 9.1, participants positioned the concept of normal as problematic, "**so what is normal you know**". Doubts about how to best define normal emerged (and if, indeed "**normal**" could be defined in any definitive sense). In Extract 9.1 the existence of multiple perspectives on normalcy and the idea of individually or personally defining the concept of normal were posited (i.e., "**that's his normal**"). By extension, there was a tacit implication that incorporating alternative standards (such as individually-defined norms) into clinical practice may be indicated. In the data there was evidence of defining criteria (such as what is it to "**cope**" and what it is to be "**okay**") within personal frames of reference in response to a lack of pre-existing criteria for evaluating "**normal**". The use of static, pre-defined norm based paradigms was abandoned (e.g., "**but if if he can cope with it and if you know he- there's people that he understands then it's okay that that's his normal**").

EXTRACT 9.1

> **"That and the perception of what's normal you know as these kids grow up and get older they they'll find people who they do click with and who they do think alike and that little child I was talking about there's another child in the class and they just get each other you know and they can talk to each other in a way that the rest of the kids don't really know what's going on but they understand each other and there's that thing that you sort of know that he'll he'll fin- you know you know that as life goes on he'll find people who he gets- so what is normal you know if it's not my normal but if if he can cope with it and if you know he- there's people that he understands then it's okay that that's his normal"**

Participant No. 6: Focus Group No. 1
Page 16: lines 705-725

The existence of *Uncertainty* due to a lack of definitive and uniform developmental trajectories entailed that pre-defined norms were not reliable concepts for clinical use, as noted below in Extract 9.2. The lack of "**research**" in the area of clinical pragmatics precluded clinicians drawing on pre-defined norms to inform practice. Also the skills, behaviours and knowledge deemed pragmatic were presented as being vulnerable to "**cultural differences**", as in Extract 9.3. Cultural variation of pragmatics notions and a lack of research indicating what could be considered "**normal**" were presented as reasons why the area of clinical pragmatics might not be amenable to set, standardised norms. Thus, they were not used to guide clinical practice.

EXTRACT 9.2

"there isn't a lot of research done in it and how what level of eye contact is considered normal and what level of topic maintenance"

Participant No. 2: Focus Group No. 6
Page 6: lines 292-294

EXTRACT 9.3

"and and is there I suppose I suppose there must be cultural differences in that and and I mean from living in XXX and living here there's very definite different pragmatics things that people do that you wouldn't do in certain environments and whereas here it's perfectly fine"

Participant No. 4: Focus Group No. 6
Page 6: lines 295-302

The idea of individual variation was used to dismantle and vanquish the stability of extant generic norms, as concepts for informing practice. In Extract 9.4 individual variation and consequent diversity was accepted. Here, definitive norms were positioned as being difficult to identify, if not indefinable, via the process of "**assessment**" because of individuality in the area of clinical pragmatics. The "**personal**" nature of pragmatics echoed an acceptance of the individualistic or "**slightly different ways**" in which pragmatic skills, behaviours and knowledge were demonstrated by people, as in Extract 9.5.

EXTRACT 9. 4

"it is really difficult to say whether it's like you say normal abnormal on the borderline whatever cos there is no assessment of what is normal cos it is so variable em I find that really hard"

Participant No. 2: Focus Group No. 1
Page 5: lines 217-224

EXTRACT 9. 5

"and also the whole pragmatics area is such a- it's so it's quite personal and sensitive and em every- I know there are certain social norms but then everybody does things in slightly different ways...and then generally everybody is doing them fine"

Interview No. 5
Pages 6-7: lines 302-309

Participants frequently highlighted that a wide variety of ability and skill levels existed in the general population in terms of the phenomena (e.g., skills, behaviours and knowledge), which they considered to be pragmatic. An acceptance of variation and diversity enabled viewing unconventional skill sets, behaviours and/or knowledge as being unproblematic. Unconventional skill sets, behaviours and/or knowledge were not automatically considered clinically significant due to the vague line between "**normal pragmatics**" and "**impaired pragmatics**" (Extract 9.6).

EXTRACT 9.6

"I was like okay well and I was explaining what a pragmatic impairment was and how it's characterised and everything and they were like oh my god I know so many people...like that so there is an element of that it's not always something that you acquire and that some people are just like that so what's normal pragmatics and what's impaired pragmatics"

Participant No. 2: Focus Group No. 6
Page 6: lines 282-289

Actively Accepting Variance was achieved in part by *Disregarding Norms,* when static and strict standards such as archetypical average ways of demonstrating communication skills or performing language behaviours were viewed sceptically. Extract 9.7 illustrates how "**different interaction styles**" were assumed and therefore were not automatically considered clinically significant. Over-analysis, based on an assumption that differences indicated impairment and clinical significance, was positioned as being likely to pathologise diversity, according to the participant in Extract 9.7. By drawing "**attention**" to variance and neglecting to recognise natural, everyday variation (i.e., the fact that "**people have different interaction styles people communicate in different ways**"), the clinician might fail to see variation as being legitimate and potentially non-pathological.

Assuming the existence of standardised norms in the area of clinical pragmatics was posited as potentially deleterious in the face of natural variance. Accepting variance prevented the clinician from identifying phenomena as being clinically significant when they were not genuinely problematic for the client. Extract 9.8 also illustrated how the searching behaviours of clinicians (e.g., "**look[ing] under every stone sometimes sometimes for it [difficulties]**" [Words in brackets have been added]) were viewed critically as being somewhat "**academic**". Over-analysis of behaviours could be combated by holding a neutral assumption about the impact of impairment and recasting impairment as diversity. A disregard of norms and an acceptance of diversity was illustrated in Extract 9.8, when the participant commented that "**you know some people are quirky it's okay to be quirky**".

EXTRACT 9.7

"And sometimes you are I suppose because we're looking at things so closely not that we find things that aren't there but I suppose we draw attention or put importance on things that aren't necessarily causing huge issues you know people have different interaction styles people communicate in different ways and if they didn't land in our clinic because of other stuff that's kind of going on would they land if you know"

Participant No.4: Focus Group No. 1
Page 6: lines 248-258

EXTRACT 9.8

"Yeah it is more subtle like you have to kind of jig around I would go as far to say look under every stone sometimes sometimes for it....yeah sometimes you wonder is it just academic is it more you know is it actually making more to trouble to talk about this and to bring it up and you know you know some people are quirky it's okay to be quirky"

Participant No. 1: Focus Group No. 1
Pages 29-30: lines 1327-1330
Pages 29-30: lines 1344-1348

As an example of how variance and diversity of communication or interactional styles were accepted, the clinician in Extract 9.9 drew on the client's own standards to inform clinical decision making and the setting of intervention goals. In lieu of extant, pre-defined norms, client-specific conceptualisations of "**acceptable**" and the client's particular level of skill or ability (in this instance, prior to having a stroke) were recruited to guide clinical decision-making (i.e., "**for your outcome afterwards is you start off with what they were before and then see get it as close to or whatever is acceptable for them**"). The lack of robust, pre-existing norms was combated by accepting that a variety of skill, behaviour and knowledge could be considered as being "**acceptable**" in order to define an "**outcome**" for intervention.

Disregarding Norms also reflected the use of personally-defined benchmarks to supplement and/or usurp existing universal norms. Thus, clinical significance and the need for intervention in light of client difference from extant norms were not assumed. In Extract 9.9, after extant norms were used to identify the presence or absence of impairment, an evaluation of the clinical significance of the impairment was carried out by drawing on clients' perspectives. Impairment in and of itself was not problematic.

Evident in the data in Extracts 9.9 and 9.10, was the use of individual, client perspectives in defining how impairment impacted on the client, rather than the use of pre-defined universal ratings of severity (where severity was increasingly proportional to increasing levels of impairment). The client's own "**pre-morbidly**" typical interactional or conversational style (i.e., "**conversational management that may differ from what was pre-morbidly normal for those interlocutors**") were used as a baseline for exploring the clinical significance of impairment.

EXTRACT 9.9

"Cos I suppose with our caseload if somebody comes in and they have a stroke and they're aphasic they're not going to be exactly what they were before anyway so I suppose as well when for your outcome afterwards is you start off with what they were before and then see get it as close to or whatever is acceptable for them at that stage same as with their language"

Participant No.1: Focus Group No. 6
Page 9: lines 423-428

EXTRACT 9.10

"Transfer the frequency rating for each question from Part A. This has a score from 0 to 2 (written on the Interview Form), where 0 equates with normal conversational management and 1 or 2 equates with conversational management that may differ from what was pre-morbidly normal for those interlocutors.

Transfer the severity rating for each question from Part A. For questions where it has not been necessary to ask the supplementary questions because of normal conversational management, the problem severity rating is entered as 0 (not a problem)."

Conversation Analysis Profile for People with Aphasia
(Whitworth et al., 1997a, p. 26)

Disregarding Norms captured how individual variation was assumed, while the existence of static, extant, uniform norms was situated as problematic. Extant norms were either unavailable (due to a lack of research) or were deemed unsuitable for clinical use. An acknowledgement about the exponentially disparate ways in which variables (such as culture and context) influenced each interaction and shaped how participants performed pragmatic skills and behaviours, contributed to the doubting stance taken by participants about the suitability of pre-fabricated, uniform norms as aspirations and evaluations for guiding practice. Individually-defined norms were used in lieu of pre-fabricated generic norms. Thus, unconventional behaviours, skills and knowledge were considered in a neutral manner and were not presumed to be problematic.

9.1.1.2 THE PROPERTY OF *TAILORING THERAPY INDIVIDUALLY*

"there's often no set route you know there's no em prescription really you know it's very individual"

Interview No.2
Page 17: lines 812-814

Tailoring Therapy Individually captured how personally-defined intervention was enacted in place of using universal, extant packages of intervention. The data revealed that many of the participants deemed the application of pre-specified generic programmes of intervention as being inappropriate in light of *Uncertainty*. An acceptance of diverse and person-specific manifestations of normal in the area of clinical pragmatics, determined that intervention had to be guided by these unique specifications. Intervention targets were generated on a case-by-case basis, as were the methods with which intervention goals could be achieved.

In Extract 9.11, intervention in the context of pragmatics was likened to intervention in the context of fluency, it was described as lacking a "**set route**", and not being "**straightforward**".

The lack of standardised uniform intervention programmes was highlighted as "**there's often no set route you know there's no em prescription really you know it's very individual you know**". Intervention was realised by generating personal intervention plans which respected diversity and reflected a non-uniform approach to intervention, resulting in the creation of "**a management plan for an individual that suits that individual**".

EXTRACT 9.11

"and I find that I notice with that and maybe in one sense maybe a bit like eh pragmatics in some respects because there's often no set route you know there's no em prescription really you know it's very individual it's em there's so many variables....but I always say to the students you know like say that if they do like structure and they like okay this is the area of the brain that's affected and it's bang bang bang bang bang this is what's going to be the impairments and then this is how we treat bang bang bang lovely I said you're gonna absolutely hate the stuttering ((laugh)) em part of it because it is so not like that because it's all just trying to find this you know eh find a management plan for an individual that suits that individual because there's so many variables now maybe for pragmatics I know I'm kinda gone off the point a bit you know but maybe for pragmatics there are so many variables and it can be then hard to make a decision you know and maybe then it is a kind of eclectic approach pulling from different like you know your Talkabout or your Workbook for Pragmatics or taking from Floortime or you know what I mean so there's probably yeah a big mix not as straightforward yeah"

Interview No.2
Pages 16-17: lines 809-814
Pages 17-18: lines 842-868

Clinical decision-making in the context of pragmatics was situated as complex for a number of reasons. The need to generate intervention packages which were personalised was often emphasised in the data as one of the factors contributing towards the complexity of working with pragmatics clinically. In Extract 9.12, one of the challenges of approaching pragmatics in the clinic was related to the lack of definitive, pre-determined programmes of intervention, in that "**there's no therapy programme that works for everyone**". Clinically working with pragmatics was situated as complex and "**hard**" because of the necessity for individually-defined intervention. The absence of readymade intervention packages which might "**work**" with clients was taken to imply that there was a need to tailor intervention in a person-specific or individual manner.

EXTRACT 9.12

"it's so hard to kinda it's so hard to even work with pragmatics and because it's so individual to each person there's no therapy programme that works for everyone or there's no everything has to be adapted and so"

Participant No. 3: Focus Group No. 5
Page 4: lines 160-166

The lack of a direct link between diagnosis and intervention motivated the participants to view individual programmes of intervention as being superior to pre-defined, generic packages of therapy. The absence of a "**black and white**" straightforward relationship between a diagnosis and the ramifications that an impairment or diagnosis might have, for any particular client, was highlighted in Extract 9.13. The complexity of the way in which impairment could manifest highlighted how impairments interacted with other variables and phenomena to produce, in essence, a unique problem for each client so that "**every client you get will be different**". This uniqueness of communication disorders entailed that intervention had to be tailored to each client. As such, *Formal Pointers* (such as prior "**diagnosis**") were limited in their use for identifying and specifying intervention targets and methods in advance, as noted in Extract 9.13 below.

The fact that a definite pre-specified "**link**" between impairment and responses to impairment (such as compensatory "**strategy development**") could not be predicted was highlighted in Extract 9.14 below. The individualised way in which impairment could be accommodated and managed by each client was used to highlight the importance of taking a case-by-case or "**individualized**" approach to intervention. The non-uniform influences and contributory factors involved in how and why "**communication difficulties**" manifested contributed to the creation of a heterogeneous profile for each client, necessitating personally-defined intervention.

EXTRACT 9.13

"and em it's good to give them an experience of that while their undergrads because we tell you can tell them til you're blue in the face it's not black and white every client you get will be different the diagnosis may be the same but that means nothing you know like you you have to be ready for that and plus everybody comes in with usually a complication of lots of things not just like one particular thing and that freaks them out especially theoretically but then when they're on placement they see why"

Interview No.6
Page 17: lines 831-841

EXTRACT 9.14

"In addition, Perkins (1995b) has shown that there is no one-to-one link between the nature of the underlying linguistic impairment and the strategies that aphasic people and their conversational partners develop to deal with the communication difficulties. These findings indicate that there is a need for an individualized approach to strategy development that takes into account the unique pattern of underlying linguistic impairment."

Conversational Analysis Profile for People with Aphasia
(Whitworth, et al. 1997a, p. 7)

Individually-defined intervention was enacted by generating specific and unique goals for each client. Even in situations in which intervention was delivered using superficially generic methods,

(such as via "**group**" therapy), the outcomes of intervention for each client differed as seen in Extract 9.15 below. Generic goals and needs were not assumed.

EXTRACT 9.15

"and then I suppose the the benefits that different individuals get from a group would be you know specific and they would be different for each child em I suppose it leads us as well to the aspect of measuring outcomes which is not not that easy to do"

Interview No. 3
Page 5: lines 205-211

Tailoring Therapy Individually entailed that decision-making was carried out in cognisance of the fact that each "**case**" was different, as in Extract 9.16. In light of a lack of pre-defined standardised intervention packages, part of the clinical role was to explore the multiple options available for intervention, for each client. Clinical decision-making was guided by thinking about which tools and approaches would be most appropriate for each individual client. Thus, selecting intervention approaches and materials to "**assess and treat**" was done with awareness that "**every case is different**", as indicated in the data in Extract 9.16.

Extract 9.17 illustrated the notion that no two interventions could be considered the same because the factors which became relevant to intervention changed with every client. In essence, no two clinical issues could be considered identical and as such the Speech and Language Therapist was behoved to respond to each unique "**pragmatics problem**", in a personalised manner. The Speech and Language Therapist provided intervention which would be "**slightly different every time**". Personalised approaches to intervention accommodated the fact that a unique range of variables (such as "**different set of circumstances...different triggers**") was relevant during intervention in the area of clinical pragmatics.

EXTRACT 9.16

"one of their learning issues might be how do I assess and treat this client you know with this particular problem say its pragmatics they have to go and find the literature on it and so eight of them could come back with a different article and then they discuss then say well would this work for that person or was that published in a really good journal or you know have we seen those people's names before are they ref- have they big reference lists you know they'd be- that's what they have to do to make that decision and apply it to a specific case cos again they also need to be aware of the fact that every case is different so with any kind of disorder I imagine pragmatics is the same but with any kind of disorder em knowing what the options are critically evaluating them and working out what's most appropriate for that client"

Interview No.6
Page 11: lines 515-533

EXTRACT 9.17

"em yeah because even if you've encountered the problem before it's a very it's obviously a very different person and a very different set of circumstances and obviously maybe different triggers to that pragmatics problem that you didn't encounter the last time and so your intervention is probably going to be slightly different every time"

Interview No. 5
Pages 5-6: lines 245-256

Tailoring Therapy Individually portrayed an approach to intervention which was underpinned by the assumptions that the expression of impairment, and the response to impairment varied and as such were individual to each client.

9.1.1.3 *ACTIVELY ACCEPTING VARIANCE*: SUMMARY

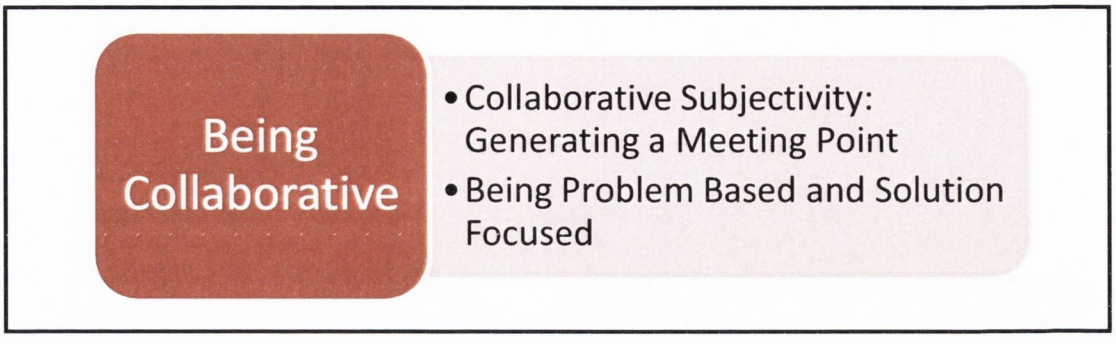
The category of *Actively Accepting Variance* captured how participants de-emphasised the role that extant static norms played in informing and guiding practice in the area of clinical pragmatics. Diversity and variance were assumed to be the key characteristic of how skills, behaviours, knowledge and impairment manifest in the area of clinical pragmatics, as in the property of *Disregarding Norms*. The property of *Tailoring Therapy Individually* captured how intervention was realised in a personalised manner.

The positioning of pre-defined norms as not being reliable or trustworthy for clinical use, in light of *Uncertainty,* and the existence of a wide range of acceptable variance left the clinicians having to turn to alternative sources of information to guide clinical decision-making. The manner in which other sources of information, such as the perspectives of clients, were used to inform clinical decision-making will be discussed in the following section.

9.1.2 THE CATEGORY OF *BEING COLLABORATIVE*

High levels of client involvement in clinical decision-making was one of the hallmarks of the *Stretching Remit* concept. The category of *Being Collaborative* reflected how clients' subjective and non-clinical perspectives were accorded value and authority during the clinical process. *Being Collaborative* captured approaches to intervention in which the clinician and client identified intervention goals which focused on jointly-defined trouble spots and problems in the client's everyday world.

FIGURE 24: THE CATEGORY OF *BEING COLLABORATIVE* AND ITS PROPERTIES



9.1.2.1 THE PROPERTY OF *COLLABORATIVE SUBJECTIVITY: GENERATING A MEETING POINT*

"we only worked on it because that was what the parents said they wanted to work on"

Interview No. 7
Page 10: lines 419-420

Collaborative Subjectivity: Generating a Meeting Point portrayed the creation of a shared perspective for informing and guiding practice. The property of *Collaborative Subjectivity: Generating a Meeting Point* captured how the perspectives of clients were situated as valid and valuable evidence for clinical decision-making. Once client opinions and perspectives were accessed, they were embedded into the decision-making process.

In Extract 9.18, we see how the client's perspective was accorded value and power. The client's outlook was elicited and used to define the content of intervention and to guide the selection of intervention targets (i.e., "**we only worked on it because that was what the parents said they wanted to work on**"). It was implied that the role of the clinician was extended to include a "**broad**" range of goals in order to meet the personal needs of the client. The lack of clarity and definition regarding "**what you should work on or not work on within pragmatic language**" was combated by recruiting client perspectives in clinical decision-making. An absence of certainty and consensus regarding appropriate intervention content and targets in the area of clinical pragmatics was dealt with by drawing on the perspectives of the client about these matters. In light of *Uncertainty,* clients' perspectives became increasingly valuable as a robust evidence source for guiding practice.

EXTRACT 9.18

"and when we were talking about how we'd been working on emotional regulation and anger management one of the therapists said em she was working in child psychiatry herself and she commented that how how broad our groups were and I think that's another area of pragmatics that there's there's kinda no boundaries on it in terms of w-

what's what you should work on or not work on within pragmatic language we only worked on it because that was what the parents said they wanted to work on and nobody else on the team is doing it ((laugh)) so we kinda thought well we better''

Interview No. 7
Page 10: lines 413-423

Client perspectives were valued and could be recruited in decision-making in order to develop ''**rationally motivated intervention**'', as in Extract 9.19 below. Identifying the ''**knowledge and perception**'' of the client was positioned as being necessary for ''**rationally motivated**'' therapy, highlighting a value being placed on the perspectives and opinions of clients. The fact that the ''**important**'' job of goal setting was posited as one which should be carried out in conjunction with clients and their families echoed the value which had been accredited to non-clinical perspectives, as in Extract 9.20.

EXTRACT 9.19

''CONCLUDING REMARKS

The CAPPA is not intended to be prescriptive in terms of management. It is designed to provide accurate information on the specific conversational strengths and weaknesses of the person with aphasia and the conversational partner, the knowledge and perception of these from both perspectives, and the strategies already being employed in the interaction. It is suggested that this will provide a firm basis for the therapist to develop rationally motivated intervention, which is client-led, incorporating the knowledge and skills that both conversational partners have already developed, the communication strengths of the person with aphasia and the therapist's professional knowledge of language and communication. The unique interaction between the conversational partner and the person with aphasia, their history and their needs, promotes a partnership approach to intervention.''

Conversational Analysis Profile for People with Aphasia
(Whitworth et al., 1997a, pp. 50-51)

EXTRACT 9.20

''but I think like goal setting's like really important like I think it should be that the professionals and the parents meet you know every year and come up with IEPs and you know that doesn't really happen so''

Participant No. 2: Focus Group No. 4
Page 29: lines 1435-1437

When intervention was approached without pre-fabricated intervention goals, the clinician could explore what meaning an impairment or unconventional skills, behaviours and/or knowledge had for the client. The subjective and ''**everyday**'' experience of impairment became an important focus and influenced clinical decision-making in the context of ''**a lot of uncertainty**'' as in Extract 9.21. In Extract 9.22, the way in which clinicians and clients worked in a collaborative manner by involving the client's perspectives (such as a ''**parent's point of view**'') in decision-making

revealed a value being placed on subjective perspectives, in situations which were "**complex**" and "**layered**".

EXTRACT 9.21

"yeah yeah yeah because I think we are you know just from having to kind of liaise with other people and I think we are really skilled in that area and that we don't necessarily trust ourselves even though there's a lot of uncertainty I think we have have good well I think what's absolutely key here is that we have finely tuned observation skills and I think that's all you need really in a way you know because then you're setting the scene and you've got a a- and I think we're really good skills in kind of communicating well hopefully with parents ((laugh)) em so you know if you're able to observe things really well and you're able to kind of tease out with parents as well in kind of everyday situations I think you've you've got a really good basis there for an assessment piece you know"

Interview No. 4
Page 15: lines 723-740

EXTRACT 9.22

"I suppose I think just so- the whole thing is so complex and so kinda layered em and I can see from a parent's point of view the practicalities of the matter and being in school and having to access the curriculum or whatever but obviously then the making the friends side of is obviously going be a concern as well you know"

Interview No. 1
Page 9: lines 445-452

Accrediting the client with authority, by recruiting their opinions and perspectives in clinical reasoning, enabled the clinician to partly counteract concerns about clinical decision-making being clinician-led and biased. The clinician and client worked to find a shared perspective from which intervention could be defined and consequently enacted. The utilisation of clients' perspectives was also considered valuable in light of the perceived natural variance that existed in the general population with regards to skills, behaviours and knowledge in the area of pragmatics. Involving client opinions and perspectives decreased the likelihood that diversity of skills, behaviours and knowledge might be pathologised. Exclusive reliance on clinicians' perspectives could result in the pathologisation of diversity and the generation of "**problems**" by misrepresenting variance as clinical significance, as suggested in Extract 9.23, in that a clinician could "**start looking for and seeing problems where there are none you know**".

In Extract 9.23 the topic of reconciling differences between the perspective of client and clinician was discussed. The participant suggested finding a collaborative space or "**meeting point**" of perspectives to enable the joint planning of appropriate intervention in the face of *Uncertainty*. A shared perspective could be used to inform clinical decision-making in that "**we em give our understanding of you know why it's important or you know and we try and understand**

where he is coming from and is there is there a meeting point". This data illustrated the use of multiple perspectives in order to identify what "**really matters**", in light of a lack of clarity about how best to identify and specify intervention content and trajectory. This collaborative goal setting ensured that therapy would not be focused on phenomena which only the clinician perceived to be problematic.

EXTRACT 9.23

"what does Schlegoff is it Schlegoff or somebody oh exchange points I'm not I can't clearly remember but you know that we interrupt each other stop etcetera etcetera so so just keep in mind what what we all do every day so that you don't start looking for and seeing problems where are there are none you know ((laugh)) em but then going back to that thing you mentioned that question you asked which I think is really really valid so he didn't see the point of small talk so you know so we can have a conversation with him whereby we em give our understanding of you know why it's important or you know and we try and understand where he is coming from and is there is there a meeting point and i-if he understood how it might be perceived by others would it matter to him would that make him change his perspective and if it did well then maybe we'd work on it you know and I mean talking about in that case I was talking about adolescent you know of sixteen or seventeen and like yeah maybe his mum was bothered but he's sixteen or seventeen ((laugh)) well he you know you've kind of what he wants really matters you know so there's a a but that's a juggling act I don't think there's hard and fast rules here"

Interview No. 8
Page 17: lines 824-851

Involving clients at various stages of the intervention process from assessment to evaluation rendered the process of clinical decision-making a collaborative one. Recognising the value of clients' subjective perspectives in specifying intervention goals and outcomes entailed recognition of the limits of a clinician's perspective, as one which necessitated supplementing, vis-à-vis the subjective expertise of the client. Intervention regarding the "**vague concept**" of pragmatics was realised by recruiting client opinions and perspectives, as in Extract 9.24. Non-clinical subjectivities were enrolled for identifying intervention targets (i.e., "**ascertaining what exactly they want**"). Client and parent viewpoints were also sought for defining the outcomes of intervention (i.e., "**having them back and then doing evaluations from both the parents' and the children's perspectives**"). Using multiple and non-clinical perspectives enabled the clinician to overcome the *Uncertainty* of the "**vague concept**" of pragmatics, in clinical practice.

In light of *Uncertainty*, the clinician could no longer remain the primary authority in identifying intervention goals. This retreat from authority facilitated a value being accredited to subjective and non-clinical evidence in the area of clinical pragmatics. Thus, *Uncertainty* created a platform for the client to enter the clinical process as an important and skilled participant. In order to "**tighten up**" clinical practice in the area of clinical pragmatics, subjective perspectives

were sought for specifying intervention, which resulted in providing intervention that "**worked much better**", as noted below in Extract 9.24.

EXTRACT 9.24

"em no it's usually okay because we ask the parents well previous to that we would have just decided ourselves which I think is not the best way to go if you're looking for generalisation and carryover and if you want the parents to be on board its worked much better by telling the parents we only have 6 things to work on what em what do you feel are the the most important things for your kids....yeah I think the hardest thing about it is that it's [pragmatics] such a vague concept and ((3 second pause)) what we're trying to do is tighten it up a bit and make it more def- definable by having the the em question by having the parents in first and ascertaining what exactly they want and then doing the group and then having them back and then doing evaluations from both the parents' and the children's perspectives so trying to get it but that's from a therapeutic point of view from the the assessment is still em a bit subjective in a way...yeah therapy is becoming more of the easier bit"

Interview No. 7
Page 13: lines 542-551
Pages 22-23: lines 978-995
[Words in brackets have been added]

Combining the subjectivities of the client and clinician in response to *Uncertainty* was one of the hallmarks of the *Collaborative Subjectivity: Generating a Meeting Point* property. However, recurrently a caveat which contained and limited the amount of authority accorded to the clients' perspective emerged in the data. The authority accredited to client perspectives was not always equal to the authority granted to the clinician, who at times appeared to retain the sway of power in clinical decision-making. Variance was evident across the property of *Collaborative Subjectivity: Generating a Meeting Point* in terms of the extent to which subjective and non-clinical perspectives were involved in clinical decision-making.

Participants questioned the reliability of client and parental opinion for identifying which issues were clinically significant. For example, parents were sometimes assumed to be unable to accurately perceive the difficulties being experienced by their children and to overestimate the skills of their children. For example in extract 9.25 below, the participant made allusions to an absence of "**insight**" possessed by parents in relation to their own child's social skills. The participant explained how this lack of "**insight**" became exposed when the same checklist was completed by teachers and by parents, who the participant felt tended to be unaware of the challenges their child faced. A participant from the same Focus Group followed this comment by discussing parents' tendencies to think their children were doing "**fine**", in relation to more general "**across the board**" speech and language development, but yet when assessment was carried out by the SLT a very different picture of the same children's speech and language

development was revealed. Thus, parents were implied as being less than accurate judges of their children's speech and language development at times in the data.

EXTRACT 9.25

"I suppose the teachers view is kinda more normal that's the way a child really mixes in a group for the rest of his life and like that just kinda highlights parents you know the the their lack of insight in a way in a certain sense I find the it very very rarely reflects the same those two rating scales"

Participant No. 3: Focus Group No. 4
Page 38: lines 1855-1860

EXTRACT 9.26

"I think that's important even just across the board for speech and language like you know parents come in going ah XXX's not doing too bad and then you do a formal assessment and you're like where do you start with him like"

Participant No. 1: Focus Group No. 4
Page 38: lines 1863-1867

It was also evident in the data that restrictions were placed on clients which impacted on their level of participation in clinical decision-making. The juncture at which clients' opinions and perspectives were sought often impacted on how much of an influence the client's perspective could have on the intervention. For example, asking the client for their perspective after intervention had been delivered restricted the client to evaluating the intervention, rather than actively defining and shaping the process of intervention.

An example of how client opinions could be solicited, but in a limited way, is illustrated in Extract 9.27 below, taken from the "**self-assessment rating scale**" of the *Talkabout* resource (Kelly, 2001, p. 9). This assessment scale highlights how client opinions were sought, but that they were restricted to commenting on specific goals identified by the resource. As such, although opportunities which were available for clients to contribute to clinical decision-making these were limited.

The data suggested that high client involvement in clinical decision-making was more likely to be recruited from adolescents and adults than children. Clients with more sophisticated and complex skills were often positioned as being more "**able**" to input into clinical decision-making, as noted in Extract 9.28. Individuals with unconventional skill sets, people with significant levels of impairment, people who lacked insight into their clinical profile and children were often positioned as being unable to input meaningfully into clinical decision-making. In Extract 9.28, the child's age and the nature of the child's "**difficulty**" were situated as dictating the suitable of recruiting their perspectives within the clinical decision-making process.

EXTRACT 9.27

What are you like at the following?	never good	not very good	quite good	very good	I don't know
Talking to a friend when we are on our own					
Talking to friends in a group					
Talking to someone in authority, eg. a policeman, a boss					
Talking to new people that I meet					
Listening to people that are talking to me					

Talkabout
(Kelly, 2001, p. 9)

EXTRACT 9.28

"cos if the child is seven you know you'd be hoping that they well if that's if their only difficulty is pragmatics that they'd be able to talk to you about what are the issues or what's why they don't have friends or what is it that you know we don't know about the child's circumstances"

Interview No.2
Page 9: lines 435-443

In Extract 9.29, the absence of client "**insight**" was linked with the limited authority accorded to the client's perspective. The lack of awareness (i.e., "**he had no idea about this change at all absolutely none**") possessed by the client had resulted in a lack of meaningful intervention outcomes being achieved, as the participant noted in hindsight. Clinical decision-making in this instance was guided by a clinical (i.e., "**staff**") perspective, while the voice of the client was omitted from this process, in that "**everyone was prioritising this...all the staff yeah this is what this man needs this is what we're going to do for him you know**". In light of the lack of impact which the intervention provided, the clinician reflected in hindsight that the withdrawal of SLT input had probably been indicated in this case. Intervention discontinuation had not occurred, as the clinician felt unable to cease intervention (i.e., "**not being able to say hang on I'm gonna stop this now**"). The client's perspective (i.e., "**you know there was no benefit to him and he kept reinforcing this he was like but I don't care it won't change my life**") was not permitted in clinical decision-making. The clinician's voice held the sway of decision-making power and this unilateral

form of decision-making resulted in intervention being provided which was of "**no benefit**" to the client.

EXTRACT 9.29

> **"I I had one guy who had a TBI and lived alone em and who whose family had said he would he would have been as they probably tar- termed it a bit off or a bit unusual pre morbidly but this was a huge exacerbation and he was to the point of unbearable at this point em and so everyone was prioritising this and that and because it was in XXX it was like speech therapy you know the the all the staff yeah this is what this man needs this is what we're going to do for him you know he needed physio and the everything else as well but em he had no idea about this change at all absolutely none and I suppose just th-the learning the lesson of insight and that you know his resistance to therapy was phenomenal also probably it was part of the brain injury you know ((laugh)) but just learning that to know when to stop you know to know to to and I suppose I was basic grade and I wouldn't have had the confidence to say I'm not going to be able to make a difference to this man and but he's he would have taught me that to know what factors you need before you can say okay I I'm gonna engage with this and this person will engage and we should see some improvements whereas with him I was just jes- it was awful he hated me at the end do you know what I mean but it was cos of my lack of experience and not being able to say hang on I'm gonna stop this now yeah yeah yeah yeah and and also there was no benefit for him to change he lived alone em very isolated in in the community he had a set routine every day you know there was no benefit to him and he kept reinforcing this he was like but I don't care it won't change my life and at the time I was thinking but you should care cos you're this and this and this so those just learning that I suppose but m- was more as me as a clinician learning that"**

Participant 2: Focus Group No. 6
Pages 24-25: lines 1203-1236

With reference to the *Containing Uncertainty through Homogenisation* concept, the notions of norms and normalcy which underpinned practice were defined subjectively by the clinician and/or by drawing on external resources (such as prior diagnoses or commercially available intervention resources). When the concept of *Stretching Remit* emerged from the data, it was evident that a jointly generated subjectivity was being used by the clinician and client as a space in which the nature of the clinical concern was defined. This collaboratively established subjectivity often influenced all aspects of the intervention process from the selection of intervention targets to the measurement of clinical outcomes. Client's opinions and perspectives were elevated to positions of authority (although the extent of this authority varied as previously discussed) and were used to combat *Uncertainty.* In order to establish what kind of intervention would be the most meaningful and effective for any given client, the personal perspectives of individual clients were sought and accepted as valid clinical evidence.

Intervention focused on trouble sources and problem spots which were embedded in the client's everyday life (rather than automatically focusing on impairment), as identified by the client and clinician together, as is discussed in the following section.

9.1.2.2 THE PROPERTY OF *BEING PROBLEM BASED AND SOLUTION FOCUSED*

> **"okay maybe that was a little bit strange but I mean is it affecting life in any way like it mightn't be so therefore I mean it's not really a problem"**
>
> Interview No. 4
> Page 17: lines 829-832

A lack of predefined intervention targets led the clinician and client to look elsewhere to define the focus of therapy. *Being Problem Based and Solution Focused* captured how non-clinical perspectives were recruited in order to outline trouble sources or problem spots, as targets for intervention and SLT supports. Unconventional skills, behaviours and knowledge were not taken in and of themselves as being problematic. The client's everyday life was the arena in which the clinicians attempted to locate trouble spots in order to facilitate the client in generating intervention goals in relation to clinical pragmatics.

As there was a lack of definitive approaches that could be used in the context of clinical pragmatics (i.e., "**there isn't a cook book**"), participants resorted to identifying the "**practical**" ways in which they could facilitate clients in working on some of their "**main concerns**" and attending to what the client deemed the "**biggest issue**", as in Extract 9.30. A practical emphasis on identifying a problem and subsequent solutions (i.e., "**what are we going to do about it**") reflected one facet of how intervention was approached in a solution focused manner, in the context of the *Stretching Remit* response to *Uncertainty*.

The tendency of clinicians to centre their attention in a solution focused way was also exposed in the data, as in Extract 9.31. This extract was taken from a discussion about the challenges of goal setting in the area of pragmatics. The clinician discussed how she had resorted to utilising the client's everyday context and drew on the client's parents and teachers to identify "**issues**" that were problematic. The identified problems then became the focus of intervention. Goal setting was focused on finding the "**biggest issues for them at home or things that are coming up for them in school**", while the aim of intervention was then related to "**alleviating those problems**".

EXTRACT 9.30

"yeah I think as well because everybody who comes in the door is completely different that you have to have- there isn't a cook book for okay phonological disorder this is what you do but then like everyone who comes in is totally different so you have to work out well what is it that's most appropriate in this situation and maybe that you have to be no pun intended more pragmatic ((laugh)) when it comes to well what are we going to do what are we going to do about this....practical and yeah yeah exactly in terms of well what's what are the eh main concerns here what's the biggest issue what's gonna be the biggest impact and well what are we going to do about it"

Interview No. 1
Page 14: lines 679-687
Page 14: lines 690-695

EXTRACT 9.31

"well well I suppose you'd be getting a lot of help from from their social context you know in terms of their parents and the things that are the biggest issues for them at home or things that are coming up for them in school and see if you can go some way towards alleviating those problems a little bit em"

Interview No. 5
Page 9: lines 430-434

Intervention targets were not identified by focusing on phenomena that differed from a conventional norm. Intervention targets were generated by the clinician and client jointly identifying a particular problem. In Extract 9.32 it was the effect or impact of an unconventional or "**strange**" behaviour which characterised it as being clinically significant and worthy of intervention. The ramifications of an unconventional behaviour on "**life**" were recruited to establish what was problematic for the client and for defining intervention targets.

Assessment scores were used to inform intervention but were not the prime influence on clinical decision-making, so that "**from the outset we try to take those scores out of the picture a little bit**", as in Extract 9.32. The focus of intervention revolved around how the clinician could offer supports in light of trouble spots (i.e., "**what's going wrong...in everyday situations**").

In the later section of Extract 9.32 below, the participant highlighted how impairment and severity level as identified by formal assessments were not the dominant indicator of intervention need. Candidates for intervention were not identified based on assessment scores alone (i.e., "**scoring criteria**"). The "**need**" and focus of SLT inputs was not dictated by "**scoring criteria**", but involved determining what was problematic for the client and jointly generating solutions.

EXTRACT 9.32

"and also like well does it actually matter like is it well I mean okay maybe that was a little bit strange but I mean is it affecting life in any way like it mightn't be so therefore I mean it's not really a problem you know so not not getting too academic about it either cos I think it's an area that that maybe because it's not something you're fixing and its

maybe a more long term difficulty you don't want to get too academic about it because it's more about real life and its more about is it causing a problem....when they come to us for assessment we do all informal activities with them em and we make goals based on those informal activities you know together with obviously the information from the formal but we would try to s- I suppose in our in building our relationship with the parents from the outset we try to take those scores out of the picture a little bit and you know in order to kind of reinforce that message that we're not trying to cure this we're not trying to reach a certain level on a test em we're trying to look at well what's going wrong how can we make it better you know in in everyday situations you know that's really worked very well....we have the exclusionary information from their IQ and their SLT assessment but then trying to get the inclusionary stuff and what it allows us to do is to- see previously ((laugh)) if we assessed a child and they managed to get like seventy one ((laugh)) we were supposed to not take them cos they weren't severe even though they were probably so now we've kinda gotten away from that so now we can use our own judgement about that we try to rate them I mean it doesn't always work out like we need to develop it further we need to get rating scales so we're being equitable about it I mean most kids who are referred are appropriate so it it doesn't come up that often but sometimes there's a child who's just you know functionally they're doing great and they just don't need this service so we're able to then kind of say no and em but equally we're able to say yes to the kids who might not meet a scoring criteria but yet are are have huge needs em so it's more real"

Interview No. 4
Page 17: lines 828-841
Page 26: lines 1299-1314
Page 27: lines 1344-1368

Being Problem Based and Solution Focused portrayed how aspects of everyday life which were deemed to be problematic by both the client and clinician became the focus of intervention, rather than aiming intervention automatically at unconventional or impaired skills, behaviours and knowledge. Intervention did not target pre-fabricated goals, but rather was solution focused.

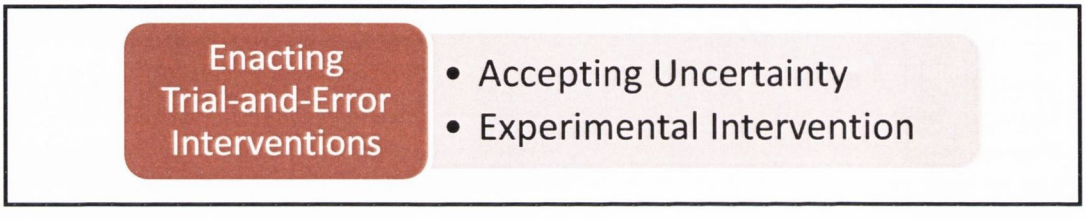
9.1.2.3 *BEING COLLABORATIVE:* SUMMARY

Gaps in clinical knowledge and limits in clinical ways of knowing pragmatics were tackled by valuing subjective and non-clinical knowledge in order to guide and inform intervention. The property of *Collaborative Subjectivity: Generating a Meeting Point* portrayed how a shared perspective between client and clinician was created in order to guide intervention. As such, the client's opinions and perspectives were recruited and valued in the process of clinical decision-making. The use of everyday contexts and non-clinical, subjective evidence to identify intervention targets was portrayed by the property of *Being Problem Based and Solution Focused*. In combination, these properties reflected a focus on solutions, rather than deficits, and the generation of a common understanding of intervention goals, as captured by the category of *Being Collaborative.*

9.1.3 THE CATEGORY OF *ENACTING TRIAL-AND-ERROR INTERVENTIONS*

Enacting Trial-and-Error Interventions captured how participants accepted some level of *Uncertainty* in their clinical practice and consequently adopted an experimental approach to intervention. A lack of definitive intervention goals and set approaches to achieving intervention targets was also portrayed by this category of the *Stretching Remit* concept. An experimental approach to intervention involved testing out different interventions to see which one was the most suitable for each individual client.

FIGURE 25: THE CATEGORY OF *ENACTING TRIAL-AND-ERROR INTERVENTION* AND ITS PROPERTIES



9.1.3.1 THE PROPERTY OF *ACCEPTING UNCERTAINTY*

"once you accept the uncertainty it's like well that's like that's just the way it is"

Interview No. 1
Page 14: lines 670-671

In acknowledging *Uncertainty* as a common and "**inherent**" aspect of clinical practice, as in Extract 9.33, *Uncertainty* was accepted and was treated as an everyday and mundane aspect of clinical practice. Extract 9.33 illustrated acknowledging uncertainty as being "**just the way it is**" when it comes to SLT practice. Thus, the participant combated becoming stagnated or overwhelmed by a lack of certitude in clinical practice by *Accepting Uncertainty*. Subsequently, clinical work continued to be provided (i.e., "**you try something**" or "**let's do something**"), as in Extracts 9.33 and 9.34 respectively. Thus, *Uncertainty* was not inimical to effective or meaningful clinical practice. *Uncertainty* was a variable which was present in the background of all clinical decision-making.

EXTRACT 9.33

"I would find myself with the students that I deal with now saying well uncertainty is like an inherent part of speech and language therapy and once you can accept the uncertainty and like what if I haven't quite accepted it myself ((laugh)) and do you ever really accept it but that once you accept the uncertainty it's like well that's like that's

just the way it is and you try something and if it works it works and if it doesn't it doesn't but then you kinda feel like of jesus I should have a better ((laugh)) rationale than let's try it and see what happens you know"

Interview No. 1
Page 14: lines 667-675

EXTRACT 9.34

"like maybe we are certain about that maybe we're certain about the uncertainty and we're certain about the reality of that uncertainty do you know what I mean that's getting a bit philosophical but maybe it's not- never going to be that certain and we just kind of but actually we know what we're doing we're going okay everyday situation let's have a look what is the functioning like now let's do something about that"

Interview No. 4
Page 30: lines 1500-1513

In Extract 9.35, a variety of approaches were advocated. The *Uncertainty* which existed over which intervention approaches worked best was referred to in a positive light, as a "**healthy controversy**". The lack of a definitive consensus about which intervention approach might be the most effective created a situation in which no one intervention could be prescriptively recommended. Rather than seeing this lack of certitude as problematic, the availability of multiple intervention options was positioned as a clinical choice. *Uncertainty* had been recast in a positive light.

Making choices from a variety of available options was situated as a usual part of a clinician's role, in terms of having to select between different "**techniques**" and approaches to intervention, as in Extract 9.36. Here, the acceptance that "**there may not be one right way to do something**" positioned a lack of certainty as an inevitable and manageable facet of the clinical process. In Extract 9.36, clinicians in training were educated about *Accepting Uncertainty*, in order to prevent them from becoming stagnated by the fact that *Uncertainty* was inherent to the clinical process and there was not "**one way to treat this**".

EXTRACT 9.35

"There is healthy controversy over whether a behaviourist approach to working with clients with pragmatic or social skills difficulties is effective or not (Matson & Ollendick, 1990). Given that no single approach to therapy has received unanimous recognition as being the most effective method, and that very little work has been done comparing the effectiveness of different approaches, it is too early to advocate just one."

Working with Pragmatics
(Anderson-Wood & Rae-Smith, 2001, p. 65)

EXTRACT 9.36

"but certainly provide them [SLTs in training] with the fact that there may be people coming from different angles and in many cases there may not be one right way to do something so even they need to know that they can't go out to the real world expecting

that there's one way to treat this there's one way to treat that and that's it that there are lots of techniques out there one may be better than another....you know so I think if anything we'd be doing them a disservice if we said this is the one way to do something and we are almost making that decision for them whereas we need to train them to be aware you will always have lots of options but it's up to you to pick the right one"

Interview No. 6
Pages 10-11: lines 489-513
[Words in brackets have been added]

Uncertainty was posited as not being a factor which should prevent clinicians from providing intervention and from "**having a go**", as in Extract 9.37. Acknowledging *Uncertainty*, but drawing on other skills and resources, such as "**good management principles**", enabled the clinician to continue to provide intervention in the face of *Uncertainty*. Acknowledging Uncertainty and the use of these other clinical resources enabled the clinician to construe *Uncertainty* as a challenge which could be surmounted.

EXTRACT 9.37

"I suppose the other thing I talked at the start about lack of tools etcetera em confusion in the literature em some speech and language therapy w- scoping far too much far more than than is really pragmatics for example etcetera etcetera but that should not preclude people from having a go as long as they use good management principles and maybe use a dynamic assessment approach and and that's something else I should have said this in in relation to assessment if if there was ever an area where assessment approach was more needed and kind of a responsiveness to intervention perspective rather than trying to tick all the boxes and get all the answers at the start pragmatics is really it"

Interview No. 8
Pages 17-18: lines 853-872

In Extract 9.38 *Uncertainty* manifested as a lack of clear information about aetiology, diagnostic category and other contributory factors (regarding "**a child who is who was very complex and it's very unclear what's going on ... I can describe what I'm seeing and I dunno why it's there and I dunno altogether what it means**"). Despite the presence of *Uncertainty*, intervention could still be provided. The participant posited a response to *Uncertainty* characterised by both properties of the category of *Enacting Trial-and-Error Interventions*. The acknowledgement and integration of *Uncertainty* (i.e., *Uncertainty* regarding diagnostic clarity "**it actually may never become clear and but that doesn't matter in a way**") as a normal part of clinical practice was an illustration of the property of *Accepting Uncertainty*. The way intervention was provided, which was based on an experimental and modifiable approach (i.e., "**cos you would try something to im- to impact on intelligibility and if it works it works**"), was captured by the property of *Experimental Intervention*, discussed below in Section 9.1.3.2.

EXTRACT 9.38

"they find it really hard because they want the book that shows you how to do it and they want the recipe and I think it drives them mad like particularly we'll say with the second years I have one scenario where they get a videoed clip of a child who is who was very complex and it's very unclear what's going on from a speech point of view so they would have several hypotheses from you know dyspraxia to phonological disorder to em dysarthria you name it and they just they can't han- they can't hand- it they find it very difficult rather to handle the fact well it is unclear and it actually may never become clear and but that doesn't matter in a way cos you would try something to im- to impact on intelligibility and if it works it works and that isn't that the important thing but they do find yeah that the uncertainty very difficult to to handle and they yeah they want the book....and I can completely appreciate that cos because I think it takes a lot of confidence to actually be able to go right I can describe what I'm seeing and I dunno why it's there and I dunno altogether what it means but this is what I suggest we do"

Interview No. 1
Page 15: lines 725-745
Page 15: lines 753-760

Accepting Uncertainty was a property of *Enacting Trial-and-Error Interventions*[96] which pertained to how *Uncertainty* was acknowledged as just another variable in the clinical mix. As such, *Uncertainty* was integrated into the clinical process as a manageable, and indeed mundane rather than extraordinary, aspect of clinical practice.

9.1.3.2 THE PROPERTY OF *EXPERIMENTAL INTERVENTION*

"it's trial and error and if it works great"

Interview No.7
Page 11: lines 450-452

The data revealed a pattern, named *Experimental Intervention* that captured how intervention often involved experimentation with different therapeutic approaches and clinical tools in light of *Uncertainty*. Intervention was modified in response to the impact and result of using different clinical tools or intervention approaches in any given instance. Thus, intervention was presented with a modifiable trajectory.

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[96] As an example of in vivo coding, the use of "**trial and error**" emerged in the data in this study, to describe how intervention proceeds in response to *Uncertainty,* for example, when a participant commented: "**I think because there is nothing out there it's it's a trial and error thing most of the time**" (Focus Group 5: Participant No. 1, Page 8: Lines 346-350). This term captured the experimental and case-by-case approach to intervention evoked, and the high levels of monitoring that took place when participants could not be certain about the intervention approach they had chosen and could not guarantee or predict intervention outcomes. Thus, the taken-for-granted meaning in this phrase was exposed and verified as a pattern that occurred repeatedly in the data. Thus, *Enacting Trial-and-Error Interventions* emerged later as a selective code in this study.

Extract 9.39 was an extract which was taken from a lengthy discussion about diagnostic uncertainty in relation to a particular group of children whom the participant considered to be "**borderline children**" (Interview No. 4, Page 5: line 110). These children were so termed by the participant, as they were perceived to fall between currently accepted diagnostic categories. The participant also highlighted the potential for variation in practice in the context of a lack of diagnostic clarity. There was a possibility that different professionals might have diagnosed the children in question divergently. In talking about how the participant intervened with clients, in situations like this, it was notable how a tentative and speculative approach to intervention was specified, as when the clinician noted her "**tendency...to work with them you know see how things go**".

EXTRACT 9.39

"yeah I mean in a service like this we get a lot of children like that you know so em you know it's it's it's kind of at any one time we'll have at least five or six who'll be in that kind of category em and my tendency is just to work with them you know see how things go"

Interview No. 4
Page 5: lines 227-233

The property of *Experimental Intervention* captured how a modifiable and flexible approach to intervention was performed. The data portrayed how intervention was modified in accordance to how well the intervention met individually-defined goals. The pattern of adopting an experimental approach to intervention, in response to *Uncertainty*, also illustrated how clinicians mixed and matched their clinical tools and intervention approaches in order to try and uncover which of these would enable clinicians to meet the intervention targets identified with a particular client.

The lack and unsuitability, of pre-defined and prescriptive targets (such as "**developmental kind of set of of targets**", as in Extract 9.40) resulted in intervention being approached without a set idea of the content and trajectory. After collaboratively defining targets with clients, the clinician focused on developing solutions to impact on "**what's going wrong**" for the client, as in Extract 9.40. Consequently, if initial intervention attempts failed, intervention could then be revised (i.e., "**let's try this instead**"). This modifiable intervention trajectory reflected a notion that there was no set, standardised intervention approach which was suitable for using when dealing with clinical pragmatics.

EXTRACT 9.40

"I would always try to just take it from the child's life you know to to work with the parents and try and set goals em just based on everyday situations really em so you're

not following like a development- well I'm not following a developmental sequence or a developmental kind of set of of targets plus kinda basing it on what well what's going wrong now can we have any impact on it okay let's try this you know and it's a lot of I suppose I would find it's a lot of problem solving and going back and going actually no that's that's not going to work let's try this instead and you know''

Interview No. 4
Page 11: lines 536-550

A perceived lack of skill and knowledge was one facet of how *Uncertainty* manifested within the data, as in Extract 9.41. Here, the participant explicated how she used the resources available to her in a "**trial and error**" fashion when implementing intervention, in light of her perceived lack of skill. Intervention in the area of pragmatics was characterised as being unpredictable and not amenable to universal, rigid or "**prescriptive**" specifications.

In Extract 9.41, intervention was dependent on the unique contributions which clients and their significant others made. The varied and person-specific nature of intervention in the area of clinical pragmatics (in that "**pragmatic language therapy...depends on the child and the parents and and then it depends on the dynamics in the group**") echoed the positioning of *Uncertainty* as an inevitable aspect of clinical practice in this area. Modifying and adapting resources in response to what "**works**" was one of the ways in which intervention was enacted in a trial-and-error manner (i.e., "**it's trial and error and if if it works great**"). A standard response to intervention was not assumed. Case-by-case approaches to intervention which were adopted in the presence of *Uncertainty* were considered experimental, as the clinician could not anticipate what goals would be selected and which intervention approach would work best for any given client in advance of embarking on therapy.

EXTRACT 9.41

"and and also that we don't really feel that skilled to be able to work in it em but because we work in a team we're lucky that we can ask the others for their resources or for their suggestions but usually it's just we do the reading on it and devise games around it and then it's trial and error and if if it works great but you often kinda find yourself picking from different em manuals different resources different ideas sometimes we've no resources or manuals we just kinda make up stuff ((laugh)) and hope it works em em....yeah cos its not prescriptive do you know whereas some forms of speech and language therapy are quite prescriptive and but pragmatic language therapy is more experiential or something it depends on the child and the parents and and then it depends of the dynamics in the group cos some of them could not handle working on eh coping with losing in games if there are other children there cos em it would just set them off completely so yeah its very much trial and error and see how you go and see how the group get on with each other and then you bring in all your other skills and the parents' objectives and and hope that it somehow works"

Interview No.7
Pages 10-11: lines 446-457
Pages 18-19: lines 802-818

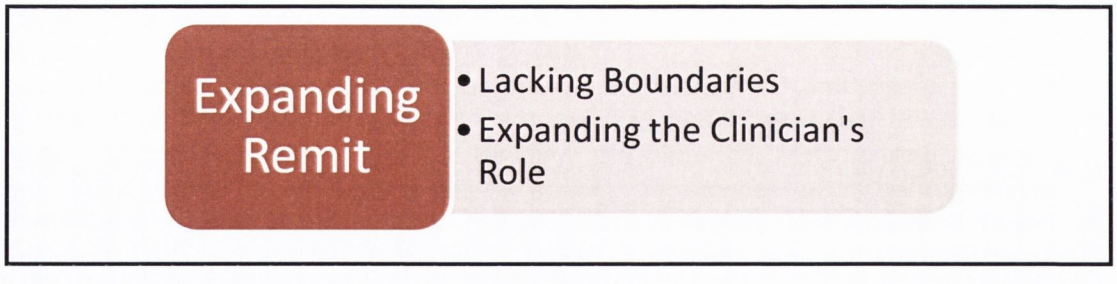
9.1.3.3 *Enacting Trial-and-Error Interventions*: summary

The category of *Enacting Trial-and-Error Interventions* captured how participants acknowledged some level of *Uncertainty* in their clinical practice and subsequently adopted a tentative, experimental approach to intervention. The property of *Experimental Intervention* captured how intervention involved the trialling of different therapeutic approaches and clinical tools, modifying intervention as was necessary. *Uncertainty* was deemed a mundane, rather than exceptional, aspect of clinical practice which had to be integrated into the clinical process, as captured the property of *Accepting Uncertainty*. Thus, effective clinical practice was not considered inimical to the presence of *Uncertainty*.

9.1.4 The category of *Expanding Remit*

The category of *Expanding Remit* captured how trial and error approach to SLT intervention was enabled by the way in which a broad clinical role was adopted in the context of *Uncertainty*. *Expanding Remit* was a fourth category of *Stretching Remit* that captured how the role of the clinician was considered to be broad and flexible. In order to work on the wide variety of goals which resulted from collaborative goal setting with the client, the clinician's role was expansively defined. The two properties of *Expanding Remit* (i.e., *Lacking Boundaries* and *Expanding the Clinician's Role*) were two sides of the same coin. *Lacking Boundaries* portrayed how clinicians did not prescriptively specify or ring fence the exact nature of their clinical remit, while *Expanding the Clinician's Role* captured how participants embraced a broad and variable role.

Figure 26: The category of *Expanding Remit* and its properties



9.1.4.1 THE PROPERTY OF *LACKING BOUNDARIES*

> **"I think that's another area of pragmatics that there there's kinda no boundaries on it in terms of w- what's what you should work on"**

Interview No. 7
Page 10: lines 416-417

Participants defined their remit broadly in relation to the area of clinical pragmatics. In order to approach intervention in a case-by-case manner without pre-specified intervention targets or trajectory, the intended impacts of interventions and the domains in which SLTs offered supports became broad and variable. The clinical role of the Speech and Language Therapist was positioned as one which was not amenable to strict delimiting and, thus, had to be defined without definite boundaries, as captured by the property of *Lacking Boundaries*.

The way in which the SLT role was defined without definite limits entailed that clinical intervention could be carried out divergently and according to the specifications of each client. In Extract 9.42, the participant highlighted how the content of her intervention was disparate in comparison to the interventions of other clinicians (i.e., "**one of the therapists said em she was working in child psychiatry herself and she commented that how how broad our groups were**"). As the focus of intervention was identified in collaboration with clients (as illustrated when the participant in Extract 9.42 notes that "**we only worked on it because that was what the parents said they wanted to work on**"), intervention was likely to vary across the profession.

EXTRACT 9.42

> **"and when we were talking about how we'd been working on emotional regulation and anger management one of the therapists said em she was working in child psychiatry herself and she commented that how how broad our groups were and I think that's another area of pragmatics that there's there's kinda no boundaries on it in terms of w- what's what you should work on and not work on within pragmatic language we only worked on it because that was what the parents said they wanted work on and nobody else on the team is doing it ((laugh)) so we kinda thought well we better"**

Interview No. 7
Page 10: lines 413-423

In attending to "**what matters**" to the client, the content of intervention was guided by the client, as in Extract 9.43. The clients' perspectives guided clinical decision-making and even overruled the clinicians' desires and proclivity to focus on particular phenomena (e.g., "**you may desperately want to treat their naming disorder**") during intervention. Valuing client perspectives and allowing clients to define intervention meant that the client shaped the clinical focus and correspondingly the clinician's role to some extent. In Extract 9.43 the participant highlighted how clinicians had an "**ethical**" duty to attend to the needs of the client, as indicated by the client.

Subsequently, a broad palette of phenomena could be attended to in the clinical work of the therapist, ranging from focusing on "**quality of life**" to "**well being**" and "**self esteem**", as noted below.

EXTRACT 9.43

"if they [the client] don't see any problem with their pragmatics and they don't want to work on their pragmatics and they're quite happy with the way things are then ethically what do you do so that's what we kinda try to get across to the students as well like all of those kinds of eth-ethics and morality and autonomy and decision making and all that kinda of thing advocacy what's functional for the client you know you may desperately want to treat their naming disorder but if they just don't care but they wanna work on their speech intelligibility that well you know we have an ethical obligation moral obligation client obligation to focus on what matters to them and what matters to their quality of life and their feeling of well being and self esteem and all the rest of it"

Interview No. 6
Pages 25-26: lines 1266-1286
[Words in brackets have been added]

In order to provide intervention in the uncertain and "**wishy washy**" area of pragmatics, clinicians had adopted a wide remit, as in Extract 9.44. Borrowing and incorporating resources from a broad spectrum of areas, particularly in the service of meeting a wide range of collaboratively defined intervention goals, was evident in the data. In Extract 9.44, one way in which clinicians realised this widened remit was illustrated by how different clinical perspectives were incorporated into practice (such as divergent and multiple "**ideas of development**") in response to the absence and/or unsuitability of evoking a universal account or "**set pattern**" of development in this area.

EXTRACT 9.44

"you know like say with morph- with syntax and em morphology and speech like that all there's a developmental stage or a sequence and you can easily plot and map and of course we all like that and the students definitely need that but then when pragmatics really doesn't it's very I dunno you might say you know wishy washy or you know there's no kinda set pattern as- there are aspects that you can look for....I'd look a lot at emotional and social development I'd kinda draw a lot from the disabilities background like em you'd have Stanley Greenspan you know he would talk a lot about like well he's got a checklists and everything for different years for emotional and social development and it looks at the care giver and the em the child or the client so I would em probably use that to structure like his his ideas of development"

Interview No. 2
Page 5: lines 201-213
Pages 5-6: lines 238-254

Lacking Boundaries also captured how a broad consideration of the SLT role could be supported by clinicians being "**open**" to overlapping with the work of other disciplines, as in Extract 9.45. Working in the area of clinical pragmatics was considered to particularly highlight a natural

"**overlap**" in the clinical work carried out by differing disciplines. In extract 9.45, keeping an "**open mind**" enabled the participant to see that other disciplines may have "**good things to to contribute**" to intervention in the context of clinical pragmatics.

EXTRACT 9.45

"and I mean social work they do a lot around helping people be able to to say no and stand up for themselves and do all of those other sorts of things that they mightn't nes-classify as pragmatics you know necessarily but I mean there there's I think there's I think keep an open mind and see how things go and if people have em got good things to to contribute to it I think it's important all too often there's too much overlap and people see it as one person's role or the other and sometimes you just can't view it that way because there is so much overlap"

Participant No. 1: Focus Group No. 5
Page 16: lines 771-784

The *Stretching Remit* response to *Uncertainty* captured how participants accepted the client as a co-decision maker. However, this acceptance resulted in participants having to expand their remit, by working on a wider variety of goals and working across many domains in order to attend to collaboratively-defined intervention targets. *Lacking Boundaries* emerged as a property of the category *Expanding Remit* to capture how clinicians did not ring fence the exact nature of their role, but considered their roles broadly in the area of clinical pragmatics.

9.1.4.2 THE PROPERTY OF *EXPANDING THE CLINICIAN'S ROLE*

"you would be thinking god is this really a speech and language therapy role but the more I thought about it the more I thought no well it is cos it's communication based really a lot of it"

Interview No. 5
Page 4: lines 188-192

The property of *Expanding the Clinician's Role* conceptualised how clinicians embraced rather than shunned an expansion of their remit. In Extract 9.46, the participant highlighted, during a discussion about the role of the Speech and Language Therapist, how she has been in situations in which she had to consider if her actions were within her remit. On reflection, by relating clinical activities to the area of "**communication**", the clinician concluded that mediating arguments in the schoolyard could be conceptualised as being within the SLT remit. Broad views of the SLT role were embraced to facilitate a wide palette of intervention being offered as dictated in collaboration with the client. Similarly, in Extract 9.47, the participant highlighted that the

"**broad**" nature of pragmatics necessitates that SLTs embrace a wider role and that they should "**input**" into more general "**programmes**" and clinical activities.

EXTRACT 9.46

"I suppose sometimes em I'm I would have often wondered is this my role to do this em particularly in the language class say em after a break time or whatever if there was em arguments in the yard you'd find yourself god you could be caught up in discussing the ins and outs of it for you know a good while after break and you would be thinking god is this really a speech and language therapy role but the more I thought about it the more I thought no well it is cos it's communication based really a lot of it and em when I teased it out I did I did come up with the conclusion that it it was my role"

Interview No. 5
Page 4: lines 179-196

EXTRACT 9.47

"and it goes back again to what is pragmatics actually where the pragmatics is just so broad ((laugh)) you know we're looking at turn taking we're looking at people's opportunities to contribute conversation and passiveness and assertiveness and things you really it depends on what area like where you are if you're like you a social worker like working on people saying no or looking at you know at behaviours that are going to put them at risk or whatever then yes but like I I do st- I do think that a speech and language therapist should probably hold the role you know have the at least have the input into into programmes that are going happening"

Participant No. 2: Focus Group No. 5
Pages 16-17: lines 787-800

The assumption that facilitating a one-way transfer of norm-based, pre-specified knowledge and behaviours was the clinician's role (i.e., as in the response of *Containing Uncertainty through Homogenisation*) entailed that the clinician assumed the role of teacher, role model and/or provider of knowledge. With reference to the concept of *Stretching Remit*, the clinician's role was less strictly defined and was in some sense re-defined afresh in a collaborative way when the clinician and each client jointly identified intervention goals. The role and remit of the Speech and Language Therapist was stretched in light of the *Uncertainty* about how best to intervene in the area of clinical pragmatics. Broad definitions of "**communication**" enabled clinicians to take an inclusive and "**broad**" stance on what might fall within their remit, as in Extract 9.48.

EXTRACT 9.48

"I'd say in relation to the education side of it [SLT] em that em I would see it [Pragmatics] really as a fundamental part of speech and language therapy in terms of our remit in relation to communication in its broadest sense em and then in relation to let's say the actual therapy per se I would see it as critical as well in terms of again communication in a very broad sense and maybe in relation to things like em eh moving away from kinda like theory side of things but looking let's say for example I did Floortime training recently and I thought to myself oh yeah like that really is like they're talking about the affect or the emotional element and I thought yeah that's something

that really isn't actually considered in say speech and language and I'm not sure if the emotional aspect is actually a pragmatics issue but it is I think in terms of how you respond to how you take your turn in the conversation or in the interaction how you respond to what the other person has initiated we'll say for example''

Interview No. 1
Page 1: lines 18-35
[Words in brackets have been added]

9.1.4.3 *EXPANDING REMIT*: SUMMARY

The property of *Lacking Boundaries* pertained to how clinicians defined their remit broadly and without rigid and strict borders. *Lacking Boundaries* was complemented by the property of *Expanding the Clinician's Role* which specifically echoed how the clinicians accepted, rather than rejected, an expansion of the role and remit. *Expanding Remit* emerged as a category of *Stretching Remit* which captured the way in which participants were open to a broader role, enabling them to recruit and respond to increased levels of client involvement in clinical decision-making when working in the area of clinical pragmatics.

9.1.5 *STRETCHING REMIT*: SUMMARY

The response to *Uncertainty* portrayed by *Stretching Remit* was hallmarked by increased levels of client-clinician collaboration, as reflected in the recruitment of high levels of client involvement in clinical decision-making throughout the clinical process. Subjective and non-clinical perspectives were accredited high value and were consequently drawn on to inform and guide clinical practice. In doing so, the clinician and client jointly generated intervention targets which were solution focused.

As client perspectives were drawn on to inform intervention, standardised and pre-specified criteria (such as extant norms) were not utilised in practice. Intervention was sculpted according to the personalised evaluations and outcomes generated from collaborating with each client, in place of structuring intervention towards meeting pre-defined intervention targets.

Uncertainty was deemed to be a mundane and manageable aspect of clinical practice. The personalised nature of intervention entailed that it was an intrinsically uncertain process, with a lack of definitive guarantees that any one intervention would work for any given individual. As such, intervention proceeded along in a trial-and-error fashion. A lack of strict boundaries on the clinical remit of the SLT and an acceptance of a broad remit facilitated the provision of this personalised and client-led form of intervention by the Speech and Language Therapist.

9.2 *RESHAPING REMIT*: SUMMARY

A brief summary of *Reshaping Remit* is provided here prior to exploring this theory against the relevant literature in the following chapter. In this study, the theory of *Reshaping Remit* emerged to capture how participants responded to their main concern of *Uncertainty*. Participants managed *Uncertainty* by *Reshaping Remit* in accordance with three main strategies. In dealing with *Uncertainty*, the strategy *Shrinking Remit* could be employed by acknowledging and evoking *The Limited Impact of Intervention* and *The Limits of the Profession.* Additionally, the strategy of *Containing Uncertainty through Homogenisation* explicated patterns in the data as responses to *Uncertainty*, which involved *Automating, Involving Norms and Normalcy*, using *Formal Pointers* and assuming a stance of *Clinician as Evaluator*. The final strategy in *Reshaping Remit* was *Stretching Remit*, which involved *Actively Accepting Variance, Being Collaborative, Expanding Remit* and *Enacting Trial-and-Error Interventions.*

CHAPTER 10. THE SEQUELAE OF OBVIOUS AND INHERENT CLINICAL UNCERTAINTY

10.1 CLINICAL UNCERTAINTY

10.1.1 INTRODUCTION

The overarching aim of this study was to explore the main concern of the SLT community with regards to clinical pragmatics and SLT practice. This study uncovered *Uncertainty* as the main concern of the participants, as discussed in Chapter 6. Subsequently, the theory of *Reshaping Remit* emerged from the data, as explicated in Chapters 7-9, to conceptually account for how *Uncertainty* was responded to in the context of SLT practice and clinical pragmatics.

The current chapter explores how *Uncertainty* and its management, as it emerged in this study, sits conceptually with previous research in the area of clinical uncertainty and clinical uncertainty management. Section 10.1 of this chapter introduces the topic of clinical uncertainty. Here, the manner in which clinical uncertainty has been represented in the literature will be compared and contrasted with the nature of *Uncertainty* specified during data analysis.

Section 10.2 deals with the literature which has suggested standardisation as a response to clinical uncertainty, while Section 10.3 highlights how personalisation has also been suggested in the literature as a mechanism for responding to clinical uncertainty. Sections 10.2 and 10.3 also discuss standardisation and personalisation as responses to *Uncertainty* by relating these extant notions to the patterns of responding to *Uncertainty* uncovered in the current study.

The presence of uncertainty in the context of clinical practice is not a novel research finding. Clinical uncertainty has been discussed across a number of different disciplines, but has been most widely studied within the area of Health Sciences, by the discipline of Medicine (as noted by Penrod, 2001). Clinical uncertainty has also received significant attention within the Social Sciences literature, from sociologists of health and illness, who treat clinical uncertainty as a legitimate topic in its own right (e.g., Gabe et al., 2004).

Although clinical uncertainty has been noted as a significant issue within the literature of the Health Sciences and within the literature of Social Sciences, these two bodies of literature often appear to conceptualise clinical uncertainty differently. Within much of the literature of the Health Sciences, clinical uncertainty has been recognised as an issue which results from gaps in knowledge (e.g., Lloyd, Rose & Fenton, 2006). On the other hand, the literature from the Social

Sciences has tended to deal with clinical uncertainty as a wider palette of concerns touching on issues beyond straightforward gaps in "clinical knowledge" (e.g., Fox, 2000; Griffiths, Green & Bendelow, 2006).

The broad-based literature of the SLT community has tended to sway on the side of the Health Sciences literature in recognising uncertainty as a discrete issue of knowledge gaps (e.g., Bernstein Ratner, 2011). However, within the SLT-related literature there has also been some recognition of uncertainty as a wider range of issues that permeates many aspects of clinical practice, highlighting the complex nature of SLT practice (Kamhi, 2011a, 2011b; Nelson 2011). However all in all, clinical uncertainty has received relatively little research attention with regards to SLT practice.

10.1.2 Clinical uncertainty as a heterogeneous "family of problems"

As the purpose of this chapter is not to review the literature on clinical uncertainty but to discuss the findings from this study against a relevant body of literature, a full discussion of how clinical uncertainty has been represented in the literature was not indicated. However, in this section a brief summary of how clinical uncertainty has been approached within the literature is provided to contextualise the discussion in the remainder of this chapter, about the sequelae of uncertainty in clinical practice.

Although uncertainty is a well-established topic of inquiry in some corners of the literature, uncertainty has been interpreted and represented in manifold ways and via a number of divergent analytical angles, leading Babrow, Kasch and Ford (1998, p. 2) to note that: "Given the pervasiveness of uncertainty in illness experiences and the range of analytical lenses that have been applied to it, there is no surprise in noting that conceptual analyses have been quite varied." It has been suggested that clinical uncertainty has not been treated as a coherent concept, leading to it being treated inconsistently in the literature in that "uncertainty has been used as a catch-all term. It has been used to characterize diverse phenomena, and has not always been subject to sufficient conceptual scrutiny or empirical inquiry" (Atkinson, 1995, p. 110).

To date, explorations into clinical uncertainty have predominantly drawn on the perspectives of medical practitioners (e.g., Bovier & Perneger, 2007) or have sought the perspectives of those accessing medical, health care services (e.g., Blanch, Hall, Roter & Frankel, 2009; Martin, Stone, Scott & Brashers, 2010; Mishel, 1988, 1990).

Efforts to shed light on clinical uncertainty from the outlook of those who provide health care services have centred on exploring uncertainty in relation to the process of clinical decision-

making as Cranley, Doran, Tourangeau, Kushniruk & Nagle (2009) noted in a recent literature review of clinical uncertainty. From a practitioner perspective, uncertainty has also been defined in terms of a lack of predictability and has been associated with concepts such as risk and the resultant communication of harm versus benefit of medical interventions (as noted in Politi, Han & Col, 2007).

From the client's perspective, uncertainty in illness has been defined in relation to the meaning, and lack thereof, which an individual experiences during an illness or an illness related situation (Mishel, 1981). In the research exploring clinical uncertainty from the perspective of people who access health care services, the views of people living with chronic illness are disproportionately represented in comparison to other health care service users (for example, Charmaz, 1991; Mishel, 1999). This disproportionate focus on people with ongoing illness may be related to the unpredictable nature of many chronic illness trajectories. Long-term illness experiences are likely to be characterised by an irregular and even erratic illness trajectory which no doubt contributes to a sense of uncertainty for those navigating these types of illness experiences, as noted by Brashers, Neidig & Goldsmith (2004).

Thus, to date, clinical uncertainty has been viewed as a heterogonous family of problems in the literature. As a family of problems, uncertainty has been explored from a variety of different perspectives using a range of methodologies and a variety of conceptual frameworks.[97]

Despite clinical uncertainty being discussed as a heterogeneous concept in the literature, a pattern is notable in how uncertainty has been conceptualised. In the literature, clinical uncertainty is frequently positioned as either an obvious, knowledge-based issue or as an issue more pervasive to and indeed inherently part of clinical practice. In the current study, an intricate interaction between facets of *Uncertainty* was revealed in the data highlighting that all instances of *Uncertainty* echoed, to greater and lesser extents, the obvious and inherent character of *Uncertainty*.

As discussed in detail in Chapter 6, *Uncertainty* emerged in the data as a multifaceted concept that contained four overlapping and interacting facets. The overlapping and multifaceted nature of *Uncertainty* precluded the identification of responses to *Uncertainty* as being particular to certain facets of *Uncertainty*. Thus, *Reshaping Remit* is positioned as a typology of responses to all forms of *Uncertainty* evident across the entire data set. The data did not reveal that obvious or

[97] Further examples of conceptual frameworks used to explore clinical uncertainty include how uncertainty has been explored by decision theorists in relation to probability and prediction (e.g., Luce & Raiffa, 1957) and as a state of mind resultant from ambiguous cues within the literature on stress and coping (e.g., Lazarus & Folkman, 1984).

inherent *Uncertainty* was managed consistently by the use of any one particular response or strategy.

However, some facets of *Uncertainty* captured in the data positioned *Uncertainty* as having primarily an obvious or inherent character. In the data, the obvious nature of *Uncertainty* emerged when uncertainty was considered to result from gaps in knowledge, while the inherent nature of *Uncertainty* was revealed when *Uncertainty* was situated as an inevitable and omnipresent issue impacting on many aspects of clinical practice. To recap briefly from Chapter 6, the facet of *Uncertainty* named *Presenting Pragmatics as an Unformulated Body of Knowledge* predominantly echoed concerns which reflected the obvious nature of *Uncertainty*. This facet of *Uncertainty* was chiefly concerned with *Uncertainty* as an issue pertaining to an incomplete knowledge base and knowledge gaps. The facet of *Uncertainty* termed *The Intangible Nature of Pragmatics Notions* considered *Uncertainty* as a pervasive issue related to the elusive and indefinable nature of pragmatics notions, which was associated with all parts of the clinical process and, as such, principally echoed *Uncertainty* as an issue inherent in clinical practice in the area of clinical pragmatics. The remaining two facets of *Uncertainty* (namely *Emphasising a Lack of Clarity Regarding the Role of the Clinician* and *Uncertainty as a Lack of Trust in the Clinical Practices of the SLT Community*) captured concerns reflective in more equal measures both the obvious and inherent nature of *Uncertainty*.

In order to discuss the multifaceted nature of *Uncertainty* and the responses to *Uncertainty* emergent in the data against those evident in the literature, the obvious and inherent nature of *Uncertainty* has to be discussed separately below—as the literature often deals with these concerns as completely unrelated and separate issues. This fracturing of *Uncertainty* will highlight how failing to consider clinical uncertainty as a multifaceted phenomena, with a simultaneously obvious and inherent nature, can result in the generation of responses to *Uncertainty* which are incomplete and superficial.

10.1.3 Obvious clinical uncertainty

In the data, the most ostensive and blatant instances of *Uncertainty* (of the four facets of *Uncertainty* which emerged) were captured by the concept of *Presenting Pragmatics as an Unformulated Body of Knowledge* relating to the way in which the data revealed *Uncertainty* as a direct result of gaps in the clinical pragmatics knowledge base. These gaps in knowledge and the subsequent lack of guidance emerged as a highly palpable source of *Uncertainty* in the data.

The facet of *Uncertainty* captured by *Presenting Pragmatics an Unformulated Body of Knowledge* particularly echoed the obvious nature of clinical uncertainty which is portrayed in the

literature of the Health Sciences. The consideration of clinical uncertainty as an issue arising primarily from knowledge gaps can be linked with the earliest research into clinical uncertainty.

EARLY STUDIES OF CLINICAL UNCERTAINTY

Following the groundbreaking work of Talcott Parsons (1951), three specific types of uncertainty were identified in Fox's (1957) seminal study of clinical uncertainty in medical training.[98] Clinical uncertainty arose for medical trainees in relation to the sheer volume of medical knowledge which they had to conquer. Secondly, the actual gaps in medical knowledge represented another facet of clinical uncertainty for medical trainees. A third type of clinical uncertainty stemmed from a failure to differentiate between personal knowledge deficits and gaps in medical knowledge. These three facets of clinical uncertainty became a standard template by which clinical uncertainty was characterised and explored in later research. Fox's original description of clinical uncertainty depicted uncertainty as arising from three distinct sources, which were all related to the issue of "medical knowledge", in that:

> The first results from incomplete or imperfect mastery of available knowledge of the lore of medicine. The second depends upon the limitations in current medical knowledge. There are innumerable questions to which no physician, however well trained, can as yet provide answers. A third source of uncertainty derives from the first two. This consists of difficulty in distinguishing between personal ignorance or ineptitude and the limitations of present medical knowledge.
>
> (Fox, 1957, pp. 208-209)

Other work by Fox has explored clinical uncertainty in the context of physician-researchers (Barber & Fox, 1958; Fox, 1958; Fox & Swazey, 1975) and has also attended to the ethical ramifications of clinical uncertainty (Fox, 1974, 1976, 1996). While some of Fox's work has dealt specifically with patient responses to uncertainty (e.g., Fox, 1958), most of her work has been focused on how practitioners respond to clinical uncertainty. Fox's (1957) initial characterisation of uncertainty has had an enduring (as noted in Gerrity, Earp, DeVellis & Light, 1992), yet often criticised (Atkinson, 1984, 1995), influence on how clinical uncertainty has been studied, with critics claiming she instigated a focus on clinical uncertainty as an issue primarily relating to knowledge gaps.

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[98] Here, in her semenal study of clinical uncertainty Fox (1957) focused on eleven physicians in training via observation, diary analysis and by conducting interviews with these medical students and some of their classmates. Fox (1957) like many of those engaged in early studies of clinical uncertainty, focused her explorations on the area of medical training in particular. Throughout her work, Fox has considered the response of medical students to clinical uncertainty as being "harbingers of some of the key ways in which many physicians handle uncertainty" (Fox, 2000, p. 410).

EQUATING CLINICAL UNCERTAINTY WITH GAPS IN KNOWLEDGE

The process of constructing and maintaining the knowledge which underpins clinical practice had only, until relatively recently, been minimally considered in a critical way. Focusing on gaps in clinical knowledge, rather than examining the nature of, construction and use of knowledge, has often remained the primary way in which clinical uncertainty has been explored in contemporaneous studies also. For example, clinical uncertainty is often dealt with as predominantly arising from "the limits of scientific evidence or from an individual's lack of knowledge" (Blanch et al., 2009, p. 300). This restricted view of clinical uncertainty can be compared with views of clinical uncertainty as something which emerges from multiple sources in relation to a greater variety of phenomena, such as "limited medical knowledge, unpredictability of the natural course of disease and of the patients' responses to treatment and variability in the physicians' and patients' values" (Bovier & Perneger, 2007, p. 632). Treating clinical uncertainty as solely an issue of knowledge gaps reflects only some facets of *Uncertainty* emergent in the data in this current study and, as such, echoes the obvious nature of *Uncertainty* only.

Many studies of clinical uncertainty neglect to explicate or specify the nature of uncertainty. Generally, clinical uncertainty is not something which is explicitly and directly discussed as a topic in its own right, within the SLT literature environment.[99] For example, a recent search of some of the most prominent SLT related journals for articles which directly reference clinical uncertainty in their titles resulted in a minimal return of articles. [100]

SLT is a relatively young profession, as noted in Chapter 1. Perhaps unsurprisingly, in light of the relative youth of the profession, an underdeveloped knowledge base is frequently bemoaned (for example, Pring, 2005, p. 212). This presence of knowledge gaps, across the entire spectrum of SLT practice, has parallels with the obvious nature of *Uncertainty* which emerged in this study (in particular the facet of *Presenting Pragmatics as an Unformulated Body of Knowledge*).

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[99] However, as noted by Dollaghan (2007), the SLT literature environment is vast, spanning many different disciplines and various specialties, which has resulted in an absence of a unitary body of literature that can definitively be considered to be the SLT literature environment.

[100] Back issues of SLT-related journals were searched electronically online on 21/06/10, using both the full phrase "clinical uncertainty" as well as using the words "clinical" and "uncertainty" with the boolean operator AND, to search through article titles. Thus, a search of article titles in *The International Journal of Language and Communication Disorders*, from 1918 to the present resulted in the retrieval of 0 records. An identical search was performed on back issues of *American Journal of Speech Language-Pathology; Journal of Speech, Language and Hearing Research; Language, Speech, and Hearing Services in Schools;* and *Contemporary Issues in Communication Science and Disorders*, from 1936 to present, resulting in the retrieval of 1 article. This search was then repeated across all of these sources searching only for "uncertainty" in article titles. This search resulted in the retrieval of 1 title in *The International Journal of Language and Communication Disorders* and 5 articles across the following journals; *American Journal of Speech Language-Pathology; Journal of Speech, Language and Hearing Research; Language, Speech, and Hearing Services in Schools;* and *Contemporary Issues in Communication Science and Disorders*.

Specifically within the literature on clinical pragmatics, uncertainty reflective of the obvious nature of *Uncertainty* has been noted with regards to the paucity of the knowledge base for guiding SLT practice (Adams, 2008). Additionally, a lack of consensus in relation to effective intervention approaches and terminology use (Cummings, 2007a; Perkins, 2000) is well acknowledged within the literature of clinical pragmatics. These forms of clinical uncertainty which are most saliently referred to in the literature, of clinical pragmatics, position clinical uncertainty as an issue chiefly resultant from knowledge gaps and a scarcity of research and resources.

In the data, the obvious nature of *Uncertainty* emerged as a concern for participants. For example, in Extract 10.1, gaps in the literature environment provided an impetus for that author to develop an intervention resource. *Uncertainty* about how to "**help clients**" emerged as a direct consequence to the lack of a "**method**" for guiding intervention. In introducing the *Social Use of Language Programme,* the author commented that:

EXTRACT 10.1

"in her work as a speech therapist, the author became aware of the need for a structured method of work to help clients to use language skills in a social context; to interact socially with other clients; to be more aware of themselves and others... "

Social Use of Language Programme
(Rinaldi, 1992b, p. 1)

However, additionally in the data *Uncertainty* emerged simultaneously as a more complex concept with an obvious and inherent nature, as previously noted. For example, *Uncertainty* was perceived to be integral to clinical practice, in that it was part of the "**reality**" of clinical work in the area of "**communication**" as well as being related to gaps in the SLT knowledge base, so that:

EXTRACT 10.2

"the first one [type of uncertainty] is is a reality of the situation the nature of communication you know...but I think as well there is uncertainty because there is a lack of evidence there's a lack of- yeah there's definitely a lack of evidence"

Interview No. 4
Page 31: lines 1536-1542
[Words in brackets have been added]

10.1.4 INHERENT CLINICAL UNCERTAINTY

Uncertainty emerged in the data as a pervasive and inevitable facet of working clinically in the area of pragmatics. Factors such as the situationally variant nature of, and the influence of personal values on, constructs from the area of mainstream pragmatics translated into problems when employing pragmatics notions in clinical practice. *The Intangible Nature of Pragmatics Notions* emerged from the data, as a facet of *Uncertainty*, to capture how pragmatics was perceived as an amorphous area with concepts which were impossible to specify in a definitive or universal manner. As such, clinical pragmatics was presented as an area marred by *Uncertainty* and even beyond certainty.

In the current study, facets of *Uncertainty* merged and interacted. For example, indicators of obvious *Uncertainty* (such as participants noting that clinical pragmatics had an underdeveloped research base) and inherent *Uncertainty* (such as participants highlighting the person-specific nature of pragmatics notions) combined to generate a perceived lack of trust in SLT inputs consistently working well and being effective in the area of clinical pragmatics. Thus, the inherent nature of *Uncertainty* radiated in part from the non-uniform character of pragmatics notions and the unpredictable nature of intervention in the area of clinical pragmatics. As such, *Uncertainty as a Lack of Trust in the Clinical Practices of the SLT Community* captured a perceived lack of trust which participants held in relation to SLT interventions effecting meaningful changes for clients in the area of clinical pragmatics.

A LACK OF CLARITY ABOUT THE ROLE OF THE SLT

The inherent nature of *Uncertainty* permeated many aspects of clinical practice so that clinicians found it difficult to specify clinical targets and outcomes, measure intervention progress and so on. Indeed, the *Emphasising a Lack of Clarity Regarding the Role of the Clinician* facet of *Uncertainty* emerged to capture the challenges clinicians faced in clearly defining their role on account of the pervasive issue of *Uncertainty* in SLT practice in the area of clinical pragmatics. For participants, specifying the exact issues on which to focus intervention was a tricky process which remained uncertain and vague. The scope of their role was ambiguous as clinical pragmatics was considered to be a "**real nebulous sort of area to work on**" (Interview No 5, Page 6: line 275). Thus, clinical uncertainty was an issue which emerged distributed across the entire clinical process, not just in relation to selecting intervention tools or during discrete moments of clinical decision-making.

While participants drew on policy and precedents set in their own local settings, for providing guidance and constraints on the scope of duties they carried out in their roles as SLTs,

the advice issued by professional associations rarely emerged in the data as a resource for seeking clarity about the SLT role. Organisations such as the Irish Association of Speech and Language Therapists (IASLT) and the Royal College of Speech and Language Therapists (RCSLT) have generated resources outlining the scope of SLT practice which make reference to the area of pragmatics (for example, IASLT 2005, p. 6). However, the frameworks provided by these organisations in the form of documents outlining the "speech and language therapy scope of practice" (IASLT, 2005, p. 3), professional standards (RCSLT, 1996) and those specifying clinical guidelines (RCSLT, 2005) did not emerge explicitly in the data as offering constraints on practice or clarity about the role of the SLT.

THE LIMITS OF CLINICAL KNOWLEDGE: UNCERTAINTY IN THE PRESENCE OF ROBUST CLINICAL KNOWLEDGE

The literature has noted how much of current clinical knowledge comprises theory which often fails to fully account for or resolve many of the complex challenges pertinent to health, illness and well-being which arise in clinical practice (Malterud, 2001). In the data, it transpired that participants struggled with how they could best apply theory in daily clinical practice, exposing the detached and intangible nature of theory and theoretical advances. Pragmatics was an area in which theory was difficult to translate into practice, resulting in *Uncertainty* as a permanent issue, not necessarily aided by advances in theory per se.

Often in the data, the area of pragmatics was situated as intangible because clinical theory failed to capture the actual problems challenging clients and clinicians. Clinical knowledge and theory were positioned as being detached and, at times, worthless in everyday practice. The failure of theory and clinical knowledge to account for and resolve *Uncertainty* in the area of clinical practice echoed the inherent nature of *Uncertainty* which emerged in the data. *Uncertainty* was not a simplistic issue which could be completely resolved by the application of knowledge and theory in that "**I know you can look up the theory and everything behind things but a lot of the time the practical ideas of things around pragmatics are quite useful**" (Participant No. 1: Focus Group No. 2 Page 31-32: lines 1431).

The literature has also identified clinical uncertainty existing not just in relation to knowledge gaps, but also as a broader issue pertaining to a variety of ambiguities arising throughout the entire clinical process. Light (1979, 1980) highlighted how different types of uncertainty emerged at different points of the clinical process and noted how these were dealt with in a variety of ways. Light (1979) exposed uncertainty regarding instructors, diagnosis, treatment and client responses to intervention presenting alongside the existence of obvious uncertainty related to gaps in medical knowledge. Light (1979, p. 313) uncovered various "forms

of control" for explicating how these different types of uncertainty were managed in different ways by psychiatrists in training.[101]

Advances in clinical knowledge have brought about fresh paradigms for looking at and working with health, illness and well-being (Kelleher, Gabe & Williams, 2006). Alternative disciplines and novel approaches to intervention recognise health, illness and well-being along different, and at times divergent perspectives highlighting the transient and evolving nature of clinical knowledge: "As alternatives to established clinical practices have been given a more significant voice in a variety of forums...the presuppositions which establish a clinical phenomenon as 'knowable' rest on increasingly shaky ground" (Rafalovich, 2005, p. 306). Participants, in the present study, also noted the lack of stability in knowledge as a source of *Uncertainty* in the SLT clinic, as the knowledge base was not a static source of definitive guidance but something which was "**shifting all the time**" (Interview No. 4, Page 24: lines 1203). Theory from the complexity sciences (Stacey, 1996; 2011; Stacey, Griffin & Shaw, 2000) has provided a framework which suggests that clinical practice may be better viewed as an intrinsically uncertain practice. That is, that clinical practice is enacted in a middle ground between stability and instability—a context hallmarked by a lack of total agreement and certainty known as the "zone of uncertainty" (Plesk & Greenhalgh, 2001, p. 627). Thus, modern day clinical practice has been positioned as an essentially complex and uncertain practice for a number of reasons which will be further discussed below.

Clinical intervention was once restricted to focusing on acute care and the eradication of disease, but there has been a "dramatic shift away from acute care to chronic care and caregivers often manage illness or combinations of illnesses rather than cure disease....sickness is not just a temporary status...chronic illness may become a permanent part of their identity", as noted by Charles, Gafni and Whelan (1997, p. 682). As such, clinical intervention now has a wider set of aims and focuses on increasing quality of life as well as attempting to save it. The advancement of biomedical techniques, resulting in an increasing population of people who have long-term or chronic illness, has brought to the fore discussions about the nature, aims and limits of effective clinical intervention. Issues arising from the interaction between knowledge, values and beliefs in clinical decision-making have also been exposed in light of the often elusive nature of many of the clinical outcomes targeted today (Muir Gray, 1999).

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[101] For example, Light (1979) noted that one way of coping with the "kinds of uncertainty" which emerged in relation to "treatment" was to "emphasize technique", while uncertainty related to "client response" could be managed by trying to "maintain a dominant relationship" and/or by attempts to "keep clients ignorant and uncertain" (Light, 1979, p. 313).

Clinicians are now faced with moral and ethical issues, as well as purely technical issues, because of their involvement in defining and evaluating many aspects of well-being and quality of life as issues of health. Modern day clinical work has a wide remit and has cast its net over many areas of everyday life in which it would previously have had little or no jurisdiction (Conrad, 2000, 2007). Thus, clinicians now deal with uncertainties which are obvious (such as attending to technical issues and knowledge gaps) and also face uncertainties which are distinctly inherent to clinical practice (such as measuring and defining quality of life, managing risk and evaluating effectiveness against shifting and multiple cultural, social and political landscapes). Correspondingly, Fox described the complex nature of uncertainty, increasingly evident in modern clinical practice, as reflecting the "critical problems of meaning and 'ponderably imponderable' questions about the 'whys' and the mysteries of life and death that are at once integral to medicine and that transcend it" (Fox, 2000, p. 410).

The challenges experienced in qualifying and specifying pragmatics notions during intervention in the area of clinical pragmatics, represented by *The Intangible Nature of Pragmatics Notions* facet of *Uncertainty*, mirrors some of the literature which has acknowledged that matters of health, illness and well-being are non-universal and personally defined. The literature which has exposed the limits of clinical or bio-medical concepts[102] to fully define and evaluate health, illness and well-being (and consequently, evaluate health care services) echoes many of the issues emergent from the data relating to the inherent nature of *Uncertainty*.

The data exposed *Uncertainty* as an inevitable issue in clinical practice because of the fact that clinical practice dealt with phenomena which were beyond certainty. Intervention in the area of clinical pragmatics involved concepts (such as the concepts of normal or acceptable) which were related to the beliefs and values of both clients and clinicians. As such, these concepts could not be definitively and objectively specified as participants noted when discussing the person-specific nature of some of these concepts: "**so what is normal you know...it's not my normal...that's his normal**" (Focus Group No. 1: Participant No. 6, Page 16: lines 719-725). The emergence of *Uncertainty* has drawn attention to complex and nuanced issues which can often result from the blurry lines and interaction between facts, beliefs and values in present day clinical practice. Thus, *Uncertainty* was situated as an inevitable aspect of clinical work. In the data, it transpired that participants regularly dealt with issues of a philosophical and moral nature,

[102] In this thesis clinical and/or bio-medical concepts are those which are based on the views expressed in the clinical knowledge base, as dicussed in the glossary, rather than drawing on other sources of knowledge. These forms of knowledge have been suggested as being held in partticularly high regard by the clinical professionals (Atkinson, 1995).

as issues of *Uncertainty*, rather than experiencing *Uncertainty* as a purely linear and technical challenge.

In the literature, more critical stances towards clinical uncertainty have exposed a taken-for-granted assumption of certainty which clinical knowledge had been imbued with. Indeed, Fox's earliest work has been criticised for focusing on practitioners' acceptance of uncertainty, when in fact it transpired that, rather than being trained to embrace uncertainty, physicians were being trained to disregard uncertainty and were orientated towards certainty (Atkinson, 1984). This disregard of uncertainty has been linked with clinicians' proclivity to maintain authority and control during clinical practice (Davis, 1960; Light, 1979).

Davis (1960) noted how uncertainty was utilised as a mechanism for avoiding emotive and potentially challenging conversations with family members of children, receiving treatment for poliomyelitis. Davis (1960) highlighted that issues other than knowledge and gaps therein were relevant to a full exploration of clinical uncertainty, as when he stated that his work aimed to:

> temper to some extent the predominantly cognitive emphasis that the issue of uncertainty has received in medical sociology, as if all that passed for uncertainty or certainty in the communication between doctor and patient were wholly a function of the current stage of scientific and clinical knowledge
>
> (Davis, 1960, p. 47)

The more recent research exploring clinical uncertainty has continued to question the assumed certainty which has been placed on clinical knowledge. Indeed, Talcott Parsons predicted the paradox that increases in clinical knowledge would exacerbate, rather than lessen, the issue of clinical uncertainty: "One of its effects, like that of all scientific advance, is to increase awareness of the vast extent of human ignorance, even in the most sophisticated fields of applied science." (Parsons, 1951, pp. 449-450) For example, the conceptual fissure between micro-level research (specifically at the level of genes) and the social reality in which it has to be implemented has yet to be bridged, as noted by Fox (2000, p. 413), who discussed this as an "intellectual gap that exists between medicine and molecules".

Others have also identified clinical practice as an essentially uncertain enterprise and have suggested that some of the underlying frameworks for clinical practice maintain a disregard for uncertainty. For example, Bursztajn, Feinbloom, Hamm and Brodsky (1990, p.xxvi) have noted that much clinical practice is founded on a "mechanistic" premise that illness and health can be understood with a sense of certainty, and correspondingly clinical practice has become orientated towards certainty, in place of probability which they contend would be more appropriate.

UNDERSTANDING INHERENT *UNCERTAINTY* BY DRAWING ON COMPLEXITY THEORY

The body of literature drawing on complexity theory seeks to understand complex systems (such as brains, cities or organisations) and specifically challenges deterministic, mechanical frameworks as appropriate paradigms for understanding action and change (Stacey et al., 2000). There is a growing interest in applying concepts from complexity theory in an effort to understand action and change in clinical practice (e.g., Griffiths, 2007; Griffiths et al., 2010; Nelson, 2011). One particular strand of thinking emergent from complexity theory will be briefly focused on here namely complex responsive processes which is founded on concepts from natural sciences, sociology, social psychology, systems thinking and draws heavily on the work of Kant, Hegel, Mead and Elias (Stacey, 1996, 2011; Stacey et al., 2000).

Complexity theory emerged, but represents a significant and radical departure, from systems thinking in an attempt to understand action and change as the result of agents engaged in adaptive and responsive processes which are fundamentally uncertain (Stacey et al., 2000, pp. 56-84). Systems thinking attempts to understand change and action by viewing agents as elements embedded in whole structures or mechanisms orientated towards homeostasis. Thus, it has been posited that change and action in organisations could be understood by analysing discrete units or agents separately, in an effort to make sense of the whole (e.g., von Bertalanffy, 1968). In contrast, complexity theory emphasises the reflective, interactional and responsive nature of change and action, while problematising the notions of predictability, linear cause and effect and rigid boundaries between agents as accurate ways of understanding organisational life (Stacey et al., 2000).

Complexity theory seeks to understand complex systems as layers of interacting adaptive processes. As people and health care organisations are examples of such systems, complexity theory provides metaphors and concepts which resonate well with the practice of heath care. So although not explicitly a framework for understanding clinical practice, complexity theory has had an increasing presence in the literature of health care (e.g., Mowles, van der Gaag & Fox, 2010; Griffiths 2007). Two core concepts from complexity theory are a rejection of cause and effect linear relationships in understanding action and change, and the notion of the zone of complexity (an area hallmarked by both stability and instability) as the place in which change happens and in which there is the possibility for creative and innovative solutions. These concepts will be briefly outlined in the following paragraphs in tandem with a consideration of inherent nature of *Uncertainty* emergent in the data.

Self-organisation is a "central concept of causality in complexity theory" (Stacey et al. 2000, p. 13). People in organisations are thus viewed as active, adaptive, self-organising agents responding to their environment by following simple internalised rules rather than obeying

centrally imposed rules. As such, self-organisation is positioned as the cause of both stability and change in organisations.

Stacey (1996, p. 55) noted that complexity theory has premised patterns of "archetypical" behaviour as being emergent from interactions between people (or any active "agent") and as such these patterns are not predictable but are better viewed as a "potential" or a "disposition". Thus, a particular pattern of action is not completely predictable as a direct effect of any one cause, in a linear sense, but can be viewed as a "possibility that is enfolded in a set of rules of interaction" (Stacey, 1996, p. 55). This understanding of change implies a rejection of the notion of linear cause and effect which underpins many frameworks for understanding action and change in human behaviour specifically and more generally underlies much of scientific thinking. This has interesting ramifications for evaluating the use of complexity sciences in health care research—as researchers cannot make claims about direct links between their interventions and changes noted in the data (e.g., Mowles, van der Gaag & Fox, 2010). However, changes made to the interaction between agents (such as people) are thought to facilitate the production of "completely new archetypes by developing new rules that govern the interactive games we play with each other" (Stacey, 1996, p. 55).

When this non-linear approach to understanding action and change in clinical practice is taken, it is easy to see how a more iterative and contextual understanding of causality, as proposed in complexity theory, might resonate with a multi-party, dynamic and situated consideration of clinical decision-making. Additionally, this non-deterministic approach to understanding action and change may be particularly useful in trying to understand clinical practice in the area of complex behavioural interventions in which there may be a myriad of interacting factors influencing multiple and individualised outcomes.

Indeed, in recognising SLT's status as a complex behavioural intervention it could be suggested that continuing to uphold linear cause and effect thinking, in relation to the area of clinical pragmatics, might aggravate some of the concerns emergent as *Uncertainty* in the data. In the data, *Uncertainty* was characterised by an unstable knowledge base, a lack of clarity about the scope of the clinician's role and remit, a lack of certitude regarding the efficacy of interventions and a presence of elusive and non-universal pragmatics notions in the area of clinical pragmatics. Many of these issues highlight the complex nature of SLT practice in relation to clinical pragmatics and imply that a deterministic cause and effect framework may fail to capture the complex challenges of effecting change in clinical practice in this area. Using a linear cause and effect approach to understanding clinical action and change, in the context of these concerns, does not reconcile any of these issues and could well exacerbate the issue of *Uncertainty.*

Complexity theory also puts forward the notion of a zone of complexity that is paradoxically neither completely certain nor completely chaotic and instable. This paradoxical set of circumstances has been suggested as offering a useful model for understanding clinical practice. For example, Plesk and Greenhalgh (2001, pp. 627-628) have framed clinical practice using ideas from complexity theory saying:

> Not all problems live in the zone of complexity. Where there is high level of certainty about what is required and agreement among agents (for example, the actions of a surgical theatre team in a routine operation) it is appropriate for individuals to think in somewhat mechanistic terms and to fall into their pre-agreed role....Few situations in modern health care, however, have such a high degree of certainty and agreement...

While as clinicians, "our learnt instinct...is to troubleshoot and fix things—in essence to break down the ambiguity, resolve the paradox, achieve more certainty and agreement, and move into the simple system zone" it may be more accurate to recognise and accept the complexity in which most clinical practice is embedded in (Plesk & Greenhalgh, 2001, p 627). Thus, drawing on concepts from complexity theory for developing an understanding of the paradoxical and complex state in which clinical practice occurs may be a useful tool for identifying solutions to current challenges. Importantly, complexity theory also presents a new framework for understanding how practitioners "get things done", despite these challenges (Stacey et al., 2000, p. 4).

Crucially, complexity theory positions clinical uncertainty as an opportunity as well as a challenge. Zones of complexity—"states far from equilibrium, often characterized by difference, conflict and crisis"—are viewed as positive settings in which responsive, creative and innovative change can be brought about (Stacey et al., 2000, p. 18). The facets of both obvious and inherent *Uncertainty*, (such as a lack of certainty about the knowledge base and efficacy of SLT practices in the area of clinical pragmatics, a lack of clarity and agreement about the scope of the SLT role and how best to define pragmatics notions in clinical practice), exposed in the data in the current study, certainly resonate with the notion of the zone of complexity.

In the data, theory and the external evidence base were not always positioned as holding answers to *Uncertainty* and as such other sources of knowledge and other strategies for managing *Uncertainty* emerged as patterns in the data. This lack of value placed on theory highlighted that approaches to managing *Uncertainty* which focused exclusively on *Uncertainty* as an issue of knowledge gaps, neglected to attend to the full suite of issues emergent as *Uncertainty*. Thus, the distributed and multifaceted nature of *Uncertainty*, which resonates with the notion of clinical practice as a complex practice, was resolved by a typology of responses captured by *Reshaping Remit*. Correspondingly, patterns of responding to *Uncertainty,* discussed in Chapters 7-9,

highlighted creative and novel ways of facilitating clinical practice in one of SLT's zones of complexity (namely SLT practice in the area of clinical pragmatics).These responses revealed that innovative and creative strategies were being used by clinicians to combat *Uncertainty* and get things done in a complex area of practice. Reponses to uncertainty in the literature, which are relevant to a discussion of the data, highlight standardisation and personalisation as two mechanisms for managing uncertainty. Standardisation as a response to clinical uncertainty will be discussed below in Section 10.2.

10.2 RESPONDING TO CLINICAL UNCERTAINTY WITH STANDARDISATION

Following on from approaching clinical uncertainty as a phenomenon resulting chiefly from gaps in knowledge, standardisation has emerged in the literature as a response to clinical uncertainty. Standardisation has surfaced as a potential answer to the problem of "uncertain knowledge" in clinical and non-clinical realms, as pointed out by Timmermans and Angell (2001, p. 344) who have stated that "standardization has become an attractive but contested solution to manage uncertain knowledge". Section 10.2 will consider why standardisation might be viewed as an incomplete solution to the *Uncertainty*.

10.2.1 EVIDENCE-BASED PRACTICE AS A RESPONSE TO CLINICAL UNCERTAINTY

Standardisation is a shared aim of both evidence-based practice (EBP) and one of the responses to *Uncertainty* in the data namely *Containing Uncertainty through Homogenisation.* When clinical uncertainty is primarily considered to be a direct result of gaps in knowledge, the filling of these knowledge gaps becomes a potential solution to uncertainty. EBP is based on an assumption that the systematic application of scientific knowledge has the potential to combat clinical uncertainty as Armstrong (2007, p. 73) has suggested, EBP can be viewed as a "control strategy claiming to reduce uncertainty by identifying effective (and efficient) interventions and by removing ineffective treatments from clinical practice". Correspondingly, EBP has been positioned as a framework for facilitating clinical decision-making and changing practice patterns in the context of clinical uncertainty, in that "evidence-based medicine deals directly with the uncertainties of clinical medicine and has the potential for transforming the education and practice of the next generation of physicians" (Evidence-Based Medicine Working Group, 1992, p. 2424).

Today, EBP finds itself in a prominent position as pointed out by Timmermans and Mauck (2005, p. 19) "it is difficult to exaggerate the resonance of EBM in contemporary health care. Many observers have elevated EBM to a new international health care paradigm". Indeed,

founders of EBP from the field of clinical epidemiology (Evidence-Based Medicine Working Group, 1992), following Kuhn (1962), made the original suggestion that that EBP represented a "new paradigm" (Evidence-Based Medicine Working Group, 1992, p. 2421). Thus, currently, EBP sits in a resonant but contested position (Pope 2003) which has advocated strongly for a reframing clinical knowledge as "evidence" for guiding practice. EBP assumes that a reduction in variation in health care services can be achieved when evidence from external research bases are applied to individual instances of clinical decision-making. Application of knowledge in this manner is posited as ensuring that only interventions which have been proven to be effective, by EBP standards, will be used in health care services.

Despite the prominent position of EBP, and the valiant impetus for EBP (i.e., that only interventions which have been proven to work well should be offered to clients accessing health care services), the current practice of EBP has attracted strong opposition. EBP has been seen as an attempt to monopolise decision-making in the areas of health, illness and well-being. Critiques of EBP have suggested that if the effectiveness of specific interventions, and health care services in general, are defined according to strict EBP criteria, then the particular hierarchies of research design, endorsed by EBP, will dictate the nature of quality and effectiveness in health care services. This dominance of certain forms of evidence has been viewed as problematic, as the hierarchies of research design advocated by EBP (and the knowledge that these specific methodologies create and endorse) have been seen to exclude other ways of knowing health, illness and well-being (Morse, 2006). EBP's stance of prioritising particular forms of knowledge by suggesting particular procedures for developing, applying and evaluating this knowledge, has led some to claim that hegemony of objective scientific thinking is being perpetuated by EBP (Higgs & Titchen, 1998; Street, 2001).

However, it may be worth noting here that a low uptake of EBP has been identified in studies of clinical decision-making in specific clinical settings (as in Gabbay & Le May, 2004) and in discussions about the wider clinical community (Haines & Donald, 1998; Timmermans & Mauck, 2005). As such, the strong presence of EBP in the rhetoric of the literature may not necessarily be echoed at the cold face of clinical practice. Additionally, being cognisant of the original principles and the historical context in which EBP emerged may be helpful when reflecting on why and how the EBP paradigm has come to this resonant position and changed the landscape of decision-making in clinical practice.

THE CONTEXT OF EBP'S EMERGENCE

EBP arrived at a time when clinical decision-making was guided almost exclusively by expert opinion and individual practitioners' personal clinical experiences. This was deemed problematic when it transpired that expert practitioners did not necessarily agree on how health care should be practiced. Correspondingly, significant variation in clinical practice patterns and the skewed provision of certain medical procedures began to surface as serious concerns in the literature (Wennberg & Gittelsohn, 1973). In this context, EBP emerged as a way of enabling practitioners to identify and generate consensus about the most effective and beneficial forms of health care practice.

As such, some have suggested that EBP materialised directly in response to the reliance on expert opinion and the passing down of knowledge and practice patterns from senior to junior health care personnel. Additionally, a landscape of decreasing trust in the medical profession and calls for regulation and value for money from funders of health care services placed pressure on these once unquestioned professionals—to justify the power and control they had been accorded in society (Freidson, 1970; Hunter, 2006; Light, 2000). Therefore, in many senses an overhaul of the experience driven, expert-led approach to decision-making in clinical practice was needed and EBP arose as potential way of responding to this need. As Lambert (2006, p.2634) has succinctly pointed out in her measured anthropological reflection on EBP, from the 1960s onwards clinical decision-making was steered towards a "more 'science-based' approach" in light of a rising acknowledgement that: "doctors are not infallible and that many medical interventions have historically been based on tradition or preference, unsupported by any evidence of benefit other than the conviction of the administering practitioner".

Additionally in looking to the historical context in which EBP emerged, it is noteworthy that EBP came about at the same time as a dramatic increase in the amount of information, in the form of an expanding research and publications environment, available to practitioners. Thus, EBP also functioned as a tool for supporting practitioners in condensing and translating research into practice in the context of this information explosion. Previous to EBP, the passing down of knowledge and practice patterns from senior to junior professionals dominated clinical training. This approach to clinical education was suggested as leading to long delays in the most up to date research reaching the cold face of clinical practice (Haynes & Haines, 1998). Thus EBP, and the methodologies it sanctions for appraising research, have also been presented as ways of making the most current research information accessible and useful to practitioners (e.g., Egger, Smith, & Altman 2001).

It may also be salutary to note here that original incarnations of EBP were not intended to exclusively guide clinical decision-making. It should be noted that despite its current ubiquity in

the literature of the Health Sciences, the originators of EBP did not claim EBP to be a panacea for all clinical decision-making or for the management of clinical uncertainty. Initiators of the EBP model presented it as something which should to be integrated with other methods for informing clinical decision-making as noted by some of the founding members of the EBP framework, in the quote below:

> "If, in the final analysis, the practice of this 'science of the art of medicine' is to do more good than harm to patients and clinicians, five additional ingredients must be added to the study of this book. First, its elements must be integrated with those of the other basic sciences, such as morphology, physiology, and biochemistry, as they are applied; were the approaches presented here to constitute the sole scientific basis for clinical action, we would simply be substituting a new tyranny of unachievable methodological rigour for the old tyranny of untouchable clinical art"
>
> (Sackett, Haynes, Guyatt & Tugwell, 1991, pp. xiv-xv)

THE PRACTICE OF EBP: PROCESS OR PRODUCT?

EBP, although not intended as a method for guiding all instances of clinical decision-making, when applied to individual instances of clinical decision-making has been proposed as a staged process. The "full-blown" realisation of EBP, specified by Straus et al., (2005, pp. 3-4), involves five specific steps comprising question formation (step 1), finding evidence (step 2), and evaluating the evidence which has been found (step 3). These initial stages are then followed by the integration of evidence with clinical experience and client preferences for the purpose of managing an individual clinical problem (step 4). The EBP process ends with step 5 of "evaluating our effectiveness and efficiency in executing steps 1-4 and seeking ways to improve them" (Straus et al., 2005, p. 4).[103]

When employing the staged process of EBP to instances of individual clinical decision-making, the fourth and "toughest" stage of EBP process (Barratt, 2008, p. 408) aims to cohere the external research evidence with both the client's preferences and the clinician's expertise. This fourth step is notoriously underdeveloped, as noted from both a client and practitioner

[103] However, when reflecting on their own clinical practice Straus et al. (2005) have noted that more partial applications of EBP are also indicated, particularly in instances in which less typical clinical problems present. Omitting more than one of the EBP steps, entails that a partial EBP approach has been taken. For example, "first is the 'doing' mode in which at least the first four steps are carried out. Second is the 'using' mode, in which searches are restricted to evidence resources that have already undergone critical appraisal by others, such as evidence summaries...Third is the 'replicating' mode, in which the decisions of respected opinion leaders are followed...For conditions we encounter everyday...we need to be 'up-to-the-minute' and very sure about what we are doing, Accordingly we invest time and effort necessary to carry out both steps 2 (searching) and 3 (critically appraising), and operate in the 'doing mode'....For conditions we encounter less often....we conserve our time by seeking out critical appraisals already performed by others....For the problems we're likely to encounter very infrequently....we 'blindly' seek, accept and apply the recommendations we receive from authorities in the relevant branch of medicine"(Straus et al., 2005, pp. 4-5).

perspective (Lockwood, 2004; Satterfield et al., 2009; Straus & Jones, 2004). Sparse guidance exists on how to operationalise this integration, of all three forms of information during step 4, particularly when compared to the volume of literature which is available guiding practitioners about how to realise the first three steps of the EBP process (Dollaghan, 2007).

Indeed, one of the most salient criticisms of EBP is that in following the EBP approach external research is accorded the highest value in the clinical decision-making process, as it "forms a point of departure for treatment and management decisions" (May, Rapley, Moreira, Finch & Heaven, 2006, p. 1025). This prioritisation of external evidence may clash with the rising attempts to enact patient-centred health care services (Armstrong, 2007). Consequently, EBP has been criticised for rendering subjective and non-clinical perspectives of clients "to the domain of consumer satisfaction research" (Kovarsky & Curran, 2007, p. 56).

EBP aims to reduce clinical uncertainty by applying the most current evidence to support clinical decision-making. However, increasingly EBP has become associated with the application of static and standardised clinical products or intervention. This narrow realisation of EBP does not dovetail with the earlier principles underlying the EBP model (Evidence-Based Medicine Working Group, 1992; Sackett et al., 1991). Originally, EBP was heralded as the integrated use of current high-quality research evidence and other crucial information (including a clinician's experience and information elicited from the client) to support clinical decision-making. The original, less myopic interpretation of EBP positions EBP as a series of actions or as Justice (2008, P. 324) has noted as a "*process* in which the clinician is engaged as she or he systematically gathers and integrates information (i.e., evidence) from a variety of resources including scientific evidence, prior knowledge, and client preferences, to arrive at a decision".

In its currently popular, but misinterpreted guise, EBP has become narrowly interpreted and consequently realised as a method for universally and prescriptively sanctioning certain interventions. This limited view of EBP has generated an inclination towards the standardisation of health care service provision (Timmermans & Angell, 2001). Some of the issues this narrow interpretation of EBP evokes will be discussed in the following section. There are some similarities between this restricted interpretation of EBP and the patterns of standardised clinical practice noted in the data as responses to *Uncertainty* (namely *Containing Uncertainty through Homogenisation*). Correspondingly, a discussion about the challenges and concerns which might be associated with realising this narrow view of EBP and subsequently enacting standardised forms of clinical intervention will follow. This following discussion supports the overall argument that static, standardised forms of clinical practice may not be the most promising responses to *Uncertainty*.

10.2.2 A SHARED FOCUS ON STANDARDISATION: *CONTAINING UNCERTAINTY THROUGH HOMOGENISATION* AND EVIDENCE-BASED PRACTICE

EBP and *Containing Uncertainty through Homogenisation* are far from synonymous. However, EBP provides an extant notion which has been useful for exploring the response of *Containing Uncertainty through Homogenisation* on account of their shared proclivity towards standardisation, as a mechanism for responding to clinical uncertainty. Specifically, the narrow interpretation of EBP as a "destination rather than a process or a way of doing the work we do" (Bernstein Ratner 2011, p. 78) reflects the possibility of viewing EBP as a call for standardised clinical practice. As discussed in the last section, a narrow view of EBP clashes with some of the original tenets of EBP (as outlined by Evidence-Based Medicine Working Group, 1992; Sackett et al., 1991).

Here, issues associated with standardised, generic clinical practice such as the generation of standardised clinical problems, the assumption of universal and standardised notions relating to health, illness and well-being and viewing client perspectives as tantamount to preferences (as distinct from viewing client perspectives as knowledge) will be discussed. Considering these issues enabled reflection on both the patterns in the data named *Containing Uncertainty through Homogenisation* and the narrow view of EBP as responses to *Uncertainty*.

10.2.2.1 GENERATING GENERIC CLINICAL PROBLEMS

The category of *Automating* (from the sub-core category of *Containing Uncertainty through Homogenisation*) portrayed how *Uncertainty* was responded to with standardised intervention procedures which followed trajectories orientated towards universal and pre-determined intervention targets. These uniform types of intervention could be provided pending the establishment of generic clinical profiles for individual clients. In the data, the categories of *Involving Norms and* Normalcy and *Formal Pointers* captured how particular phenomena (such as published norms and prior diagnoses) were used to depersonalise the client and transform their personal issues or concerns into generic ones. Thus, the endorsement of standardised clinical profiles and consequent uniform packages of intervention are common to both *Containing Uncertainty through Homogenisation* and narrow views of EBP.

The first step of the EBP process involves the use of a "well-built" foreground clinical question which guides clinical decision-making by sculpting the questions being asked of the evidence along particular dimensions (as specified in Richardson, Wilson, Nishikawa & Hayward, 1995, p. 12).

Developing a foreground question converts clients' concerns into clinically answerable question(s) which guides the evidence search and subsequent clinical decision-making. Thus,

individual concerns can be transformed into more generic and uniform problems. For example, the "PICO" format is one commonly advocated way of generating a foreground question within the EBP approach, using the structure of "Patient/Problem, Intervention, Comparison" and "Outcome" (Straus et al., 2005, pp. 16-17). Often a diagnostic category, in combination with general clinically relevant characteristics (such as age) are used to identify the "Patient/problem" element of the foreground question (e.g., children with Asperger's Syndrome, adults 2 years post stroke and so on) (Richardson et al., 1995). As such, the clients' concerns are converted into clinical concerns in order to explore the external evidence about which interventions have been proven to be effective when used with diagnostically similar clients. Thus, the decision-making process is hung on the client's diagnosis.

While it may be naive to suggest that all forms of deductive reasoning (i.e., reasoning from the general to the specific) are not usable or useful in clinical decision-making, the way in which EBP has operationalised and developed its form of deductive reasoning forces the clinician to generate a standardised clinical profile from an individual problem. The diagnosis becomes a fulcrum for decision-making and intervention planning as the specific dimensions outlined by proponents of EBP along which a clinical problem or focus is defined encourages the clinician to frame the issue in generic and purely clinical terms. Bio-medical concepts, diagnoses and generic but clinically relevant characteristics (such as gender or age)[104] are used as a lens through which an individual is depersonalised and transformed into a client. Consequently, the clinician can match a generic client profile to an existing form of intervention, developed for individuals with similar diagnoses or clinical profiles, from the external evidence base. The generic clinical profile may be a particularly problematic notion, in an area such as clinical pragmatics, were a lack of robust diagnostic tools and more importantly individual variation are well acknowledged (e.g., Adams, 2002).

10.2.2.2 The fallacy of the standard client

The absence of typical, textbook clients in everyday practice has been recognised by Naylor (2001, p. 523) who noted, in relation to medicine, that "typical patients are far from typical". This notion of client individuality was also evident in the data, where the fact that "**every case is different**" and "**everybody who comes in the door is completely different**" was highlighted—pointing to the non-uniform nature of clients and their concerns in the area of clinical pragmatics (Interview No. 6, Page 11: line 529 and Interview No. 1, Page 14: line 679, respectively).

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[104] As an example of how restricted and generic phenomena may depersonalise an individual and transform the client into a generic clinical entity, consider how a PICO foreground question is unlikely to include a client's occupation or hobbies yet these aspects of a client's life are likely to colour how health, illness and well-being (and indeed intervention and recovery) are understood by an individual (Kiefer, 2008).

The presence of heterogeneity has often been noted with regard to SLT diagnostic groupings, stemming from both the "complex" nature of communication and the variable ways in which communication disorder emerges and impacts on different individuals (Dodd, 2007, p. 120). "Communication health" and "communication disorders"[105] cannot be readily reduced into strictly biomedical phenomena (Kovarsky, 2008). As Doyle (2000, p 231) explicated, there are multiple contributions to the complex and heterogeneous nature of communication "problems":

> The presenting symptoms of persons with communication problems can be diffuse and can involve complex relationships between component communication skills. The fact that an individual's communication is intimately linked to their particular life setting complicates the picture.

Clinical criteria are often limited in that they define health, illness and well-being along standardised and primarily bio-medical dimensions. As communication disorder is influenced by context and cannot be equated with a definitive objectifiable phenomenon, a wide variety of context-dependent and indeed person-specific phenomena may be necessary to fully specify the nature of any given communication disorder. The personal and divergent ramifications of communication disorder have been drawn on to highlight that there may always be a considerable heterogeneity within diagnostic categories used in the context of communication disorder. As such, it has been suggested that both subjective and objective data should be drawn on when evaluating clinical inputs in the realm of SLT practice (Duchan & Black, 2001; Simmons-Mackie & Damico, 2001).

Significant client heterogeneity within diagnostic groupings in the context of communication disorder (as noted in Pring, 2004) is one reason why certain methodologies, favoured by EBP, which rely on definitive diagnostic groupings may not be amenable for use within the discipline of SLT (Dodd, 2007). Thus, methodologies which are prioritised by EBP (i.e., large controlled clinical trials and/or the synthesis of these large trials involving a homogeneous population, as discussed by Straus et al., 2005) may neglect to provide guidance which can be easily translated to instances of individual clinical decision-making in the area of SLT practice.

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[105] The notion of "communication health" is used in this thesis to capture the SLT cognates of health and well-being of which there are very few extant examples. A notable exception is the concept of "communicative competence" introduced by Hymes (1966) in response to Chomsky's structuralist stance which prioritised linguistic structure (Chomsky, 1969). Communicative competence is a term which has been developed and drawn on by many others (e.g., Foster, 1990). There is a dearth of extant concepts to use when describing the absence of communication disorder, perhaps reflecting the intangible nature of "good" or "healthy" communication or the propensity for clinical accounts of communication to focus on incompetence (Duchan, 2004; Kovarsky & Duchan, 1998). The commonly used term "communication disorder" is used simplistically as the SLT cognate to illness throughout this thesis.

Additionally, in the SLT context diagnostic categories are far from having well-established stability (Dodd, 2007; Pring, 2004). Some of the diagnostic categories which are pertinent to the area of clinical pragmatics (such as SLI and PLI) have been shown to be particularly unstable. When traced over time, individuals have been shown to move between diagnostic categories (such as, ASD and SLI) considerably (Conti-Ramsden, Simkin & Botting, 2006; Rutter, 2008). Thus, the heterogeneity within current diagnostic groups in the SLT context makes reliance on large controlled trials as the primary method for evaluating intervention problematic. Problems arise as large controlled trials may often require client homogeneity in order to be enacted and assume client homogeneity in their recommendations.

From an EBP stance, appraising the quality of evidence has become increasingly linked with the research methodologies used in the generation of evidence. An ongoing debate remains regarding the hierarchy of methodologies valued within an EBP framework (e.g., Weinberger et al., 2001). However, a general consensus remains that Randomised Controlled Trials (RCTs) are a "gold standard" of methodology producing the highest quality evidence for "establishing effects of an intervention" (Straus & McAlister, 2000, p. 839). Hierarchies for rating external evidence (e.g., Chalmers. et al., 2010, Phillips et al., 2009) are increasingly prevalent. These hierarchies are situated as tools for grading evidence, guiding the reader to appraise evidence on the basis of research methodology.

The importation of these evidence hierarchies into all clinical fields, including SLT, has been deemed problematic (Fey, 2006; Pring, 2004). Translating research from large groups of people to individuals is challenging, as findings which may hold true for a population of people cannot always be assumed to be true in all particular individual instances (Rockhill, Kawachi & Colditz, 2000). The evidence generated via large-scale studies produces guidelines based on populations of clients, not individual people. This population-based orientation of evidence can make converting research results during individual instances of clinical decision-making difficult (Griffiths et al., 2006).[106] Indeed, it has been suggested that the challenge of translating evidence to individuals accounts in no small part to the inevitable or "inherent" presence of uncertainty in health care: "However, robust the research, clinicians face the dilemma of applying this to individual patients. This is the uncertainty inherent in the nature of medical evidence." (Griffiths, Green & Tsouroufli, 2005, p. 511)

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[106] For example, if an intervention is shown to have desirable effects for 8 out of 10 people, on which it was trialled, the clinician still remains unable to specify definitively if any given individual client will be one of the 8 out of 10 people for whom the intervention will generate desirable effects or if an individual client will be one of the 2 out of 10 people for whom the intervention will have less than or even undesirable effects. Griffiths and colleagues (2006, p. 1079) posit that this is due to the way in which intervention effectiveness and efficacy tends to be presented as an "estimate of probability" in research that involves large-scale clinical trials.

A tension resulting from trying to achieve both high levels of external validity and internal validity[107] has been noted as another challenge in drawing on EBP's currently sanctioned hierarchy of methodologies for evaluating clinical research—particularly in light of the complex nature of many clinical interventions (Cartwright, 2007). Low levels of external validity may often be resultant from having to control for a wide variety of variables (as is often necessary for complex behavioural interventions).[108] Thus, in order to evaluate an intervention, according to gold standard of RCT, large numbers of potentially influential variables may have to be controlled for rendering the research extremely low in external validity (as noted in Brackenbury, Burroughs & Hewitt, 2008, p. 86). As such, large-scale clinical trials, premised on the existence of standardised or uniform clients and contexts, may not be the most appropriate way of exploring and evaluating all types of clinical intervention.

EBP's penchant for drawing on the results of large-scale clinical trials for informing individual instances of clinical decision-making, with regards to intervention in particular, may be particularly incongruous with the inherent nature of *Uncertainty* in the context of SLT practice and clinical pragmatics.

This section has discussed the essentially unique nature of each client and how this makes drawing on and applying uniform and standardised forms of evidence to inform practice problematic. While there are undoubted benefits of grouping together large numbers of individuals for research purposes, and exploring similarities across individuals, it may be problematic to assume that instances of individual clinical decision-making can be fully informed by evidence generated in this fashion.

10.2.2.3 THE FALLACY OF STANDARDISED INTERVENTION

As well as doubts about existence of a typical or standardised client, as noted in the previous section, it has been suggested that the human and contextualised nature of clinical practice in health care settings entails that clinical knowledge cannot be applied in standardised fashion. Subsequently, it is posited that intervention cannot be performed identically across different

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[107] Internal validity reflects the extent to which the results of a study are considered to be "formally valid for the group enrolled in the study, but only for that group" (Cartwright, 2007, p. 12) while external validity reflects the extent to which the results of a study are applicable to individuals who were not part of the study (Dollaghan, 2007).

[108] Complex behavioural interventions are those which focus on complex, contextualised phenomena and which are characterised by an "absence of a single standard outcome measure that can encompass the complexity of the disorder" (Carding & Hillman, 2001, p. 646). For example, voice therapy in SLT has been deemed as being a complex behavioural intervention because of its distributed, contextualised nature, in that: "The human voice is a complex phenomenon that involves anatomical structures, physiological mechanisms, acoustic output-the voice we hear and associated psychosocial factors that are unique to each person" (Carding & Hillman, 2001, p. 646).

settings. The heterogeneity of communication health and disorder, as well as SLT's status as a complex behavioural intervention, entails that SLT interventions may be difficult to enact in a standardised way.

As noted by Fourie (2009), SLT is mediated within the context of a clinician-client therapeutic relationship and, as such, may be particularly vulnerable to intervention procedures becoming locally revised within the dynamic setting of the therapeutic relationship. As the generation of evidence from large clinical trials relies on the existence of both typical patients and standardised interventions, it may not be the most suitable method for producing evidence to guide practice (in recognition of the locally divergent ways in which clinical practice can be realised). The therapeutic context in which SLT interventions are mediated makes uniform and identical intervention unlikely across different therapeutic dyads.

Indeed, it has been suggested that even seemingly prescriptive clinical interventions are likely to be re-appropriated and revised each time they are enacted. It has been pointed out that stringently standardised medical procedures and protocols (such as CPR)[109] evolve and transform in their application and use and, as such, can never be performed as truly standardised procedures (Timmermans & Berg, 1997). The concept of "local universality" has been developed to capture the way in which standardised procedures become modified and revised within their local contexts of use (Timmermans & Berg, 1997, p. 295). The data in the current study also contained instances which suggested that even relatively standardised procedures (such as the use of formal standardised assessments) were amenable to divergent realisations and local variation. In the literature, it has been suggested that the expressed purpose of a SLT procedure (e.g., for disseminating information about progress or for support in seeking additional educational or clinical resources) could influence the procedure, in this case impacting on the type of information contained in reports written by SLTs (Duchan, 1998).

One aspect contributing to the complexity and variance of SLT interventions is that they may require long durations in order for intervention to take effect or consolidate. For example, in many areas of practice (such as SLT interventions in the area of child language or intellectual disability) intervention may occur over a period of months or even years (for example, Girolametto, Weitzman & Greenberg, 2003). The duration of intervention entails that outcomes are vulnerable to extraneous influences and the synergistic interaction of a large number of

[109] In two case studies studying how an oncology protocol and the Cardio Pulmonary Resuscitation (CPR) protocol were used in clinical practice, the authors highlighted the way in which these seemingly standardised protocols were influenced by the prior knowledge of the user of these procedures. The authors also demonstrated how these procedures evolved, and were implicitly revised, in response to local contexts of practice in which they were used (Timmermans & Berg, 1997).

variables. Additionally, SLT interventions may often consist of multiple programmes and overlapping goals, as pointed out by Duchan and Black (2001, p. 38):

> Many therapies are multifaceted and different therapies may be administered simultaneously, making it difficult to determine what it is that is affecting change. How does one differentiate the short and long-term effects of one among several programs being administered simultaneously?

The distributed and contextualised nature of communication disorder, and the state of theoretical plurality in the area, has seen incongruous conceptualisations of communication and language being used across SLT practice (Duchan, 2004). The complexity of intervention in the area of communication disorder may partly explain the lack of consensus regarding clinical outcomes used by clinicians and researchers. At times, the outcome measures used in research have been positioned as incompatible with those employed during clinical practice. For example, Apel suggests that clinicians and researchers have been using divergent definitions of "language" and that this has led to barriers in translating research findings into practice and he has noted a need for the establishment of a "shared definition of language" to inform practice and research, particularly in relation to the issue of clinical outcomes (Apel, 1999, p. 100).

This need for consensus may be particularly great, in light of the cacophony of definitions of pragmatics available in the area of clinical pragmatics, as discussed in Chapter 2. The contextual dependency of communication disorder is particularly relevant to a discussion of clinical pragmatics. Many definitions of pragmatics, as discussed in Chapter 2, highlight the area of pragmatics as being particularly sensitive to aspects extrinsic to an individual. Thus, clinical outcomes for SLT interventions may be located across a wide range of disparate sites ranging from, for example, environmental changes, community engagement, as well as measuring changes to internal client competency levels.

Clinical outcomes, in the context of communication disorder, are not always amenable to being defined in terms of isolable objective phenomena. In the SLT context, outcomes may focus on phenomena such as esteem, participation and identity, as well as measuring reductions in impairment (e.g., van der Gaag et al., 2005). As such, outcomes in SLT are not always easily measured as reductions in levels of impairment (Duchan & Black, 2001). There are complex and non-universal mixes of variables which interact to produce clinical outcomes during SLT interventions. Communication disorder has a variable and subjective reality because of the way in which sequelae of communication disorder uniquely impacts on any given individual. Thus, outcomes of SLT interventions must take the subjective reality of communication disorder into account. Correspondingly, Simmons-Mackie and Damico (2001, p. 23) have noted that: "living

with a communication disorder is a subjective experience! Capturing this subjective experience through insider perspectives is critical to meaningful intervention".

The mechanism of EBP has been deemed an inappropriate one for guiding clinical decision-making in the area of complex behavioural interventions (McConachie, 2002). The status of SLT as a profession which deals with complex behavioural interventions, (as noted by Law and Conti-Ramsden, 2000) may also suggest that EBP, when it is narrowly defined, may not be an entirely suitable approach for guiding clinical decision-making in the SLT context.

Intervention for communication disorder often revolves around the provision of a palette of different therapies, as noted by Doyle (2000, p231), who has highlighted that "there is often a range of potentially suitable approaches to the treatment of many communication problems". Indeed in the data, one way in which *Uncertainty* was managed, as conceptualised by the response of *Stretching Remit*, saw clinicians draw on a wide variety of disparate interventions dictated by the non-universal nature of communication disorder. Here, individual preferences and the unpredictable response of clients to intervention were accommodated and incorporated into clinical decision-making and were used to inform choice of intervention from a wide range of intervention tools and techniques.

An example from the literature, which shows the heterogeneous nature of communication disorder, clients and intervention has been supplied by Pring (2004) echoing many of the points discussed in sections 10.2.2.1-10.2.2.3. Pring (2004, p. 292) has noted widespread heterogeneity in the context of SLT intervention and aphasia which suggests that assuming generic clinical problems, standard clients and standardised interventions may well be problematic as when he stated that "people with aphasia vary and it is improbable that all or even a majority will respond to any one therapy. Therapists know this and use different therapies with different clients but with little evidence to guide them".

10.2.2.4 Standardisation as an incomplete response to clinical uncertainty

As noted above, the non-standardised way in which communication disorder emerges, for each individual client, and the complex and distributed nature of SLT intervention entail that standardised approaches to clinical practice may be difficult to enact in the area of SLT. Thus, generating generic and universal approaches to intervention, as endorsed by EBP and as conceptualised by *Containing Uncertainty through Homogenisation*, may not be entirely suitable within the context of *Uncertainty* in relation to SLT practice and clinical pragmatics.

In the data, a reliance on standardised forms of intervention was the hallmark of data indicating the pattern of *Containing Uncertainty through Homogenisation*. However, these forms

of intervention were not always deemed appropriate and some participants noted how they reduced or even stopped providing SLT inputs which were standardised as they considered these forms of intervention not to be effecting valuable change. The category of *Shrinking Remit* portrayed how the non-provision of intervention became a legitimate response to *Uncertainty* when it was perceived that SLT input could not promote meaningful change or that the intervention needed was beyond the remit of the SLT. For example, the participant in interview No. 4 noted how she had pulled back from providing standardised group packages of intervention (in the form of "**social skills groups**") because she perceived this form of intervention to be of limited value: "**I would have done the usual like social skills groups and all that sort of stuff em but I don't do that kind of thing anymore I just don't think it's effective**" (Interview No.4 Page 24-25: lines 1196-1220). When personalisation and flexibility were not present during intervention, it was implied that intervention was often ineffective in the data.

The original principles of the EBP clearly suggest that personalisation should play a role in clinical decision-making. Indeed, the notoriously elusive forth stage of the EBP process provides a mechanism which seeks to reduce homogenisation by attempting to personalise the generic forms of evidence (valued within the EBP framework) and interpret this evidence specifically in light of each individual instance of decision-making. Thus, the EBP approach insists that client values and preferences are integrated into the clinical decision-making process unlike patterns of managing *Uncertainty* captured by *Containing Uncertainty through Homogenisation* which had no such mechanism for personalisation.

The EBP approach to personalising generic, external forms of evidence by integrating this form of evidence with the clinician's expertise and the values and preferences of the client has not always been received warmly and has been deemed insufficient (Lockwood, 2004). Central to these critiques is the notion that EBP exhibits a "failure to consider the patient views", as Lambert (2006, p. 2635) noted. As client perspectives are not recruited until Step 4, in the EBP process, it has been suggested that clients' perspectives are drawn on only for choosing between intervention options crafted and chosen by the clinician. Thus, it is assumed that the clinician knows which are the most suitable intervention options to present to the client, rather than looking to explore the client's knowledge and expertise, in any great detail, regarding his own health, illness and well-being prior to picking options for intervention.

It is this neglect of client perspective that has come to hallmark a narrow interpretation of EBP—as the application of universally sanctioned clinical interventions. A restricted interpretation of EBP is one which does not view EBP as a series of actions aiming to integrate the most recent scientific evidence with the client's and clinician's experience and knowledge about health, illness and well-being. This restricted, product-orientated view of EBP fails spectacularly to meet the

original tenets of EBP expressed in seminal texts (Evidence-Based Medicine Working Group, 1992; Sackett et al., 1991). However, the narrow realisation of EBP may meet other needs such as cost efficacy and reducing clinical uncertainty by assuming that the application of scientific thinking can answer definitively all of the complex questions emergent during clinical practice (Armstrong, 2002).

When one source of information, such as specific forms of the most recent research evidence, is so dominant in the clinical decision-making process that other important forms of evidence and information are quashed then a standardised, de-personalised form of clinical decision-making ensues which both clashes with the initial tenets of EBP and is open to all of the problems of standardised clinical practice-as have been discussed in this section. Basnett (2001), explicitly speaking as both a client and clinician, has highlighted the need for both well evaluated and multiple forms of evidence:

> An important tool for making judgements about health care interventions, at a programme and an individual level, is clinical effectiveness of evidence-based medicine....As I say, in principle, I have no problem with this approach. If there is a choice, I would rather have treatments that have been shown to "work well". However, there are difficulties. In this context, I am most concerned about the evidence on which judgements are based and who is making the judgements. The evidence is largely based on clinical trials in which the outcomes measured are often decided by physicians or other health care professionals, although some quality-of-life measures are being included.....Thus, particularly for disabled people, where intervention is often not related to an acute life-threatening event but is longer term, the outcomes need to be subtler and include what users want from treatments....Until that happens, much of the evidence is incomplete and is dominated by physicians' perspectives.
>
> (Basnett, 2001, p. 458)

The original spirit of EBP reflects a process of information sharing and gathering which called for the inclusion, not dominance of current research evidence in clinical decision-making. Following this principle, EBP could only warrant a valuable addition to clinical decision-making practice. After all, it is undeniably appropriate that the most recent and robust clinical evidence should play a part in clinical decision-making. However, a narrow interpretation of EBP has enabled the current dominance of certain types of knowledge (typically authored by clinicians and clinician-researchers) in decision-making preventing other important forms of evidence such as evidence of feasibility, appropriateness and last but certainly not least evidence of meaningfulness from being heard (Pearson, Field & Jordan, 2007).

In light of *Uncertainty*, exposed in this study, the profession of SLT may benefit from thinking carefully about how they might widen and balance their conception of evidence and EBP to include a wider variety of knowledge sources as valid evidence (Roulstone, 2011). Current

critiques of the practice of EBP, highlight how it has become somewhat derailed from its original principles, and offer valuable lessons for the SLT community about how they might realise EBP in a way which more closely reflects some of the original tenets of EBP (as specified by Evidence-Based Medicine Working Group, 1992; Sackett et al., 1991). Indeed, lessons from SLT's use of the EBP framework, in view of the call for SLT to work with both the objective and subjective realities of communication health and disorder, have the potential to make interesting contributions to the EBP debate—particularly in light of the growing acknowledgment that providing health care services is a far more complex and layered practice than once assumed (Mowles, van der Gaag & Fox, 2010).

In this section, the inadequacy of standardised approaches to the management of *Uncertainty*, which demonstrate a blinkered focus on clinical uncertainty as an issue of knowledge gaps only, have been discussed with reference to the complex character of *Uncertainty*, emergent from in the data. Strategies which only respond only to obvious, knowledge based forms of clinical uncertainty (such as a narrow interpretation of EBP) fail to understand the complexity of modern clinical practice and thus fail to alleviate the challenges of *Uncertainty*. The presence of inherent *Uncertainty* (i.e., uncertainty as an inevitable and pervasive clinical issue involving an interaction between beliefs, values and knowledge) evokes a broader view of clinical uncertainty and necessitates a broader and more layered response. More complete responses to clinical uncertainty will be suggested below in Section 10.3.

The data contained recognition of the omnipresence and inevitability of *Uncertainty*, even in the context of robust external research evidence, which highlighted that there was more to clinical uncertainty than gaps in knowledge. Thus, obvious forms of *Uncertainty* did not represent a complete concept of clinical uncertainty. *Uncertainty* was an issue which extended far beyond a consideration of gaps in knowledge and highlighted the complex, dynamic and distributed nature of clinical practice. These issues will be discussed in more detail in the following section in relation to personalisation and clinical decision-making.

10.3 RESPONDING TO CLINICAL UNCERTAINTY WITH PERSONALISATION

As a response to clinical uncertainty, personalisation clashes in many ways with standardisation as discussed in Section 10.2. Section 10.3 will highlight how a personalised approach to health care might offer useful ways of working in the context of *Uncertainty*.

The literature has increasingly recognised a need for valuing subjective perspectives as legitimate clinical evidence and a need for more collaborative forms of clinical practice which, in this section, will be positioned as key elements for personalising intervention. Certain categories in the data (particularly, those associated with the sub-core category of *Stretching Remit*) share similarities with some of the discussion in the literature about these key elements of personalised intervention. Thus, it will be suggested that personalising intervention may be a particularly appropriate way of responding to clinical uncertainty in light of the nature of and response to *Uncertainty* emergent in this study.

10.3.1 PERSONALISING INTERVENTION

Much of the literature does not make explicit reference to clinical uncertainty when it discusses issues that in are particularly relevant to the notion of *Uncertainty,* as it emerged in this study. In particular, the issues and concepts which have been recognised in this study as instances of inherent *Uncertainty* have not always been recognised as issues pertinent to clinical uncertainty in the literature. [110] The literature which is particularly relevant to our discussion here highlights a need for integrating objective and subjective knowledge to guide clinical decision-making, a need for joint decision-making between the client and clinician and a need for recruiting including lay perspectives in order to enrich clinical views of health, illness and well-being. These suggestions for understanding and modifying clinical practice will be discussed as responses to *Uncertainty* because they echo some of the patterns of *Uncertainty* management noted in the data, particularly in relation to the concept of *Stretching Remit.*

10.3.1.1 RECRUITING SUBJECTIVITY IN DEFINING HEALTH, ILLNESS AND WELL-BEING

Stretching Remit captured a response to *Uncertainty* which accepted subjectively defined notions of communication health and disorder as being relevant when working with pragmatics clinically. As a response to *Uncertainty*, *Stretching Remit* portrayed how clinicians combated *Uncertainty*

[110] As previously noted, in the data, *Uncertainty* emerged as a multifaceted concern. In the literature, clinical uncertainty is often presented as either obvious *Uncertainty* (i.e., pertaining to gaps in knowledge) or as inherent *Uncertainty* (i.e., as an inevitable and pervasive issue in clinical practice stemming from the links between beliefs, values and knowledge in clinical practice).

when they supplemented clinical knowledge and guided uncertain intervention trajectories by drawing on their clients' subjective perspectives. Clients were accredited with a significant role in clinical decision-making, as their perspectives were viewed as important for specifying both the nature of the clinical concern and the subsequent intervention (for example, by defining the nature of the communication disorder, specifying clinical outcomes and evaluating intervention).

As *Uncertainty* was considered an issue integral to clinical practice in the data, subjective perspectives from the client were not just considered valuable but were considered indispensible for clinical decision-making. Subjective perspectives were used to augment the uncertain external clinical knowledge base in order to fully specify the nature of communication and communication disorder. For example, in place of having extant criteria (such as norms) to use for guiding intervention, participants noted that they sought information from the client themselves and their significant others. Participants noted, for example that talking "**to a family member**" to find out about what a client considered "**their normal**" communication style and skill level to be, enabled a clinician to identify intervention baselines and outcomes despite the absence of criteria for doing so in the literature of clinical pragmatics (Participant No 2: Focus Group No. 6, Page 2: lines 345-349).

The necessity for personalising clinical intervention by drawing on subjective perspectives in light of clinical uncertainty has also been noted in the literature. Katz's (1984) work has explored clinical practice, in the context of medicine, exposing the issue of clinical uncertainty as a central concern in the clinical relationship. Katz highlighted that a "healthy" life was a "ambiguous" concept in that it was variably and personally-defined (Katz, 1984, p. xliv). Correspondingly, Katz stressed that health, illness and well-being could not be understood in bio-medical terms alone. Katz (1984, pp. xliv-xlv) posited that these phenomena also have personal, psychological and social meanings for an individual which a clinician was not automatically privy to:

> To be sure, physicians and patients are united in their common pursuit of restoring patients to "healthy" life. Since that objective rarely can be fully achieved however, it remains an ambiguous one. To the extent it can be achieved it is attainable by many different and uncertain routes, each with its own benefits and costs. In the absence of any one clear road to well-being, identity of interest cannot be assumed, and consensus on goals, let alone on which paths to follow, can only be accomplished through conversation.

Clinical practice has traditionally been guided by a number of ethical principles including that of beneficence which behoves clinicians to act in the best interests of those accessing their services. However, Katz (1984, p. 6) noted that the principle of beneficence entailed an assumption that the clinician could independently define what was best for the client, because an

"identity of interests" had historically been presumed to exist between client and clinician. Katz's notion of identity of interests reflects how a shared understanding, regarding the nature of health, illness and well-being, had been presumed to exist a priori between a client and clinician. Thus, Katz noted there was an assumption that a clinician could independently identify what was best for the client in terms of medical treatment. In light of his rejection of the notion that a client and clinician shared an "identity of interests", Katz stressed the impossibility of maintaining the principle of beneficence (i.e., acting in the best interest of the client) without extensive information sharing and discussion between the clinician and client. Consequently, Katz called for high level of client involvement in clinical decision-making and a significant value to be accredited to client perspectives within the clinical process.

Katz also recognised uncertainty as an issue which was integral and inevitable in clinical practice. Katz urged practitioners to accept uncertainty as an persistent issue pertaining to phenomena beyond current knowledge gaps in medicine, as he saw uncertainty as something which would "beset" clinical knowledge, "for a long time", if not "forever" (1984, p. 205). In the penultimate chapter of Katz's (1984) influential book, he noted that the ubiquity and persistence of uncertainty necessitated the sharing of decision-making in clinical encounters. According to Katz, practitioners were obliged to develop a collaborative clinician-client relationship, which openly acknowledged the limits of clinical certainty. Indeed, he posited that advances in medical knowledge and corresponding reductions in uncertainty only facilitated clinicians in better knowing the technical limits of their trade and differentiating between this and the more inescapably uncertain and "unknowable" aspects of clinical practice (Katz, 1984, p. 205).

Acknowledging the limits of universal and generic ways of knowing health, illness and well-being clashes with the standardised approaches to intervention endorsed by both *Containing Uncertainty through Homogenisation* and a narrow interpretation of EBP. Standardised approaches to healthcare intervention often presume that there is a relatively certain (i.e., universal and stable) way of knowing health, illness and well-being. Katz (1984) and Bursztajn et al. (1990) both recognise uncertainty as a pervasive and inevitable facet of clinical practice and have presented the concepts of health, illness and well-being (and their cognates) as being essentially individually defined. This stance highlights that standardised approaches to health care (if they are premised on unitary and generic concepts of health, illness and well-being) may be limited in dealing completely with clinical uncertainty.

If uncertainty is inherent to the area of clinical pragmatics, then a clinician can never truly know what the best course of clinical action for a given individual might be without engaging in open dialogue with a client to seek their views. Although differing terminology has been used, the inherent nature of *Uncertainty* explicated conceptually in the data which echoes with the concept

of identity of interests developed by Katz (1984, p. 6), has also been discussed in relation to the concept of disability and the notion of communication disorder.

10.3.1.2 THE FALLACY OF AN IDENTITY OF INTERESTS IN RELATION TO CONCEPTS OF DISABILITY

The literature on Disability Studies has increasingly pointed to the inadequacy of a unitary notion of disability. This "non-unitary"[111] stance on disability can also be taken as support for the need to enact personalised intervention when it comes to matters of health, illness and well-being. Initially a generic and unitary notion of disability cohered activists, authors and researchers and facilitated the birth of the disability movement. Thus, a unitary notion of disability has been deemed to have served its purpose of mobilising and uniting collective experiences of oppression and now has become somewhat superfluous (Vernon & Swain, 2002). Despite its initial adequacy and success, a unified concept of disability is deemed problematic, as has been noted by Davis (1995, 2006).

Disability has become increasingly accepted as a divergent and flexible concept relating to a wide spectrum of identities and situations, rather than being a stable and unified concept. In particular, following recognition of the social nature of disability, it has been highlighted that disability cannot be fully linked, in a static way, to definite physical phenomena (such as impairment). As a socially mediated yet embodied experience of oppression, disability can also be seen as a combination of different forms of situationally-dependent oppression which would preclude the adequacy of a unitary concept of disability (Vernon & Swain, 2002, p. 79).

Following the ideas of activists from the *Union of the Physically Impaired Against Segregation* (1976), disability is no longer considered to be an intrinsic and definite characteristic of an individual but rather it is thought to exist as a socially mediated process which is tied to and enacted on certain bodily states (Oliver, 1990, 1996). Disability has been defined as being "wholly and exclusively social" (Oliver, 1996, p. 35) and as such, the link between disability and impairment was severed completely by some commentators. Subsequently, disability was defined in terms of prejudice and discrimination (Barnes, 1992; Shakespeare, 1994) and as an issue separate to impairment (Oliver, 2004). However, some of these same authors have, more recently, re-attended to the link between bodies and societies (Shakespeare & Watson, 2002).

There is, however, a distinct lack of agreement about the extent of the link, if any, between bodily states and disability amongst writers in the area of Disability Studies (Crow, 1996; Oliver, 1999, 2004). Writers such as Thomas (2004) have noted that the complete separation of body and society has perpetuated a denial of legitimate suffering, by pointing out that the reality

[111] Following Davis's (2006, p. 240) "dismodernist" perspective on disability, I have used the term "non-unitary" to capture a notion of disability which highlights the divergent, unstable and contextual nature of disability.

of pain or the experience of everyday challenges cannot be explained away or reduced to being simply another layer of "purely linguistically constructed difference" (Thomas, 2004, p. 25). It has been suggested that a dualist split of body and society is perpetuated by considering impairment and disability as completely unrelated issues (Vernon & Swain, 2002). This separation has prompted Thomas (2004, p. 25) to call for "a theoretical framework that recognises the social influences in the science of biology and the irreducible biological foundations of the social". As such, it is noted that the body has a physical constituent which cannot be accounted for in purely social or cultural terms as well as acknowledging that culture and society are mediated and enacted in an embodied manner. Thus, a separation of impairment and disability continues to be an active and hotly debated topic in the literature. Vernon and Swain (2002, p. 87) have pointed out the paradox and challenge that a non-unitary notion of disability presents to the area of Disability Studies, in that "it is ironical that the very thing they are united on is also the very thing that leads to division between them-that is, 'identity and difference'...". Although, many authors in the area of Disability Studies appear to share a common view of disability as a social phenomenon, many of these authors also differ with regard to the way in which they see disability as being accounted for, exclusively, as a form of socially mediated oppression. For example, French (1993) discussed disability as a non-unitary concept, (and also that impairment cannot be eradicated by social changes only), when she noted that changes to the built environment which would accommodate a particular visual impairment might disable other people without visual impairment.

The need to highlight the ubiquity of impairment, rather than an assumed centrality of function, in definitions of normal has also been suggested as another reason why disability cannot be viewed as a unitary concept (Davis, 2006). Some authors have suggested (in a similar vein to the category captured by *Actively Accepting Variance* relevant to *Stretching Remit*) that there is a wide range of diversity in the general population. As such, impairment (rather than function or able-bodiedness) has been presented as being ubiquitous because "no one's body works perfectly, or consistently or eternally. We are all in some way impaired. Illness, as Antonovosky (1979) argues, is the human condition" (Shakespeare & Watson, 2002, p. 24). The everyday reality of variance and impairment has been posited as the most appropriate starting point for normal, rather than a myth of bodily perfection being assumed (Davis, 2006; Shakespeare & Watson, 2002). Function should not be considered a neutral concept to which all of nature is orientated and which sets the benchmark of normal as Davis (2006, pp. 240-241) has noted:

> In a dismodernist mode, the idea is not a hypostatization of the normal (that is, dominant) subject, but aims to create a new category based on the partial, incomplete subject whose realization is not autonomy and independence but dependency and interdependence. This

> is a very different notion from subjectivity organised around wounded identities; rather, *all* humans are seen as wounded...Protections are not inherent, endowed by the creator, but created by a society at large and administered to all. The idea of a protected class in law now becomes less necessary since the protections offered to that class are offered to all...normal parking becomes a subset of handicapped parking.....What is universal in life, if there are universals, is the experience of limitations of the body

A positioning of diversity and variance in skill, behaviour and knowledge as being more normal than the existence of a generic static range of the same implies that subjective perspectives may be necessary in order to accurately understand and recalibrate the nature of normal, as relevant to every individual. The "ubiquity" of impairment (Shakespeare & Watson, 2002, p. 24) implies that pre-specified benchmarks of normal in relation to communication health may also be inappropriate. Similarly, in the data *Stretching Remit* captured patterns reflecting an acceptance of multiple versions of normal and a clinical tolerance for variance.

It has been noted how challenges in the area of communication emerge divergently from person to person, and vary with situation to situation (Bunning, 2004), particularly when models which appreciate contextual influences are applied to the study of communication disorder, as demonstrated by Simmons-Mackie and Kagan (2007). Following the application of a unitary notion of disability to communication disorder, disorders of communication have been viewed as being, to varying degrees, a socially and contextually mediated form of oppression and not a direct ramification of particular impairment patterns (e.g., Pound & Hewitt, 2004). If communication disorder reflect not only a particular impairment pattern but also a socially and contextually mediated form of oppression then the true nature of communication disorder will need to be understood in relation to each individual's experience of the same and cannot be universally defined.

10.3.1.3 The fallacy of an identity of interests in relation to communication disorder

The personalised nature of health, illness and well-being as proposed by Katz (1984), has also been suggested within the realm of communication disorder. Kovarsky has pointed out that both communication[112] (Kovarsky & Damico, 1997) and communication disorder should not be considered discrete and independent entities which can be readily objectified or considered in separation from the context and subjective realities in which they exist (Kovarsky, 2008). Thus, subjective perspectives from the context in which both communication health and disorder

[112] Communication has been described as being dependent on both static (off-line), and context dependent, real-time phenomena or "a priori and on-line resources" (Kovarsky & Damico, 1997, p. 308).

manifest thus become necessary in order to fully understand their nature. Although different terminology has been used by Katz (1984) and Kovarsky (2008), Kovarsky has noted how a communication disorder cannot be accurately or fully defined without involving the subjective perspectives of the client. As such, Kovarsky's (2008) stance can be seen to echo Katz's (1984) rejection of a shared identity of interests between client and clinician, in the SLT context.

In the data, the personally-defined nature of communication health and disorder, in the context of clinical pragmatics, was embraced as part of the response to *Uncertainty* captured by *Stretching Remit*. The categories of *Being Collaborative* and *Actively Accepting Variance* portrayed how, in the context of *Uncertainty*, clinicians did not approach intervention with pre-specified norm-based criteria for identifying clinical targets and outcomes. Rather, clinicians worked on a wide range of outcomes, as specified by individual clients and their unique definitions of the clinical problem. As such, communication disorder and cognate terms were defined in a personalised way without assuming an identity of interests between client and clinician. By not endorsing standardised definitions (of communication health, communication disorder, impairment and so on in the area of clinical pragmatics) intervention was personalised. In light of the spectrum of definitions of pragmatics discussed in Chapter 2, some of which highlighted the contextualised nature of all things pragmatic, there may be a need to recruit information from the context (such as the subjective perspectives of the client and everyday context of the client) in defining problems when working with pragmatics clinically—dependent on how a clinician defined pragmatics. Thus, information from the context in which the communication disorder or clinical issue occurs may enable the Speech and Language Therapist to more fully understand the nature of the client's concern, in so far as this is possible.

In the data, the sharing of decisions was a key mechanism for how clinicians could focus a seemingly broad palette of SLT interventions along a more specific and definite intervention trajectory as portrayed by *Stretching Remit*. The lack of guidance available in the external evidence base was supplemented with guidance from the client, by viewing clients' subjective and non-clinical perspectives as being a legitimate, if not a crucial form of, evidence for the purpose of clinical decision-making. The important role that joint decision-making played, in responding to *Uncertainty* in the data, will be discussed with regards to existing joint decision-making models, in 10.3.2. However, prior to this, the need for flexibility in order to enact personalised forms of intervention will be briefly discussed below.

10.3.1.4 Flexibility

Enacting personalised intervention necessitates a flexible and modifiable approach to intervention and the abandonment of generic and uniform packages of intervention. Rather than assuming a universal and pre-defined set of criteria for identifying the trajectory and endpoint of intervention (as evident in the response of *Containing Uncertainty through Homogenisation*), *Stretching Remit* portrayed the pattern of generating intervention content and trajectory in a case-by-case fashion.

The data specified how different clients were assumed to have divergent expectations and needs from intervention. Thus, intervention was approached flexibly without set goals and targets. A personalised approach to intervention resulted from the manner in which intervention goals and outcomes respected and responded to diversity. Dissimilar clinical outcomes reflected each client's unique and personal situation and how they collaboratively defined their clinical concern with the SLT. This modifiable manner of working, as portrayed by the category of *Enacting Trial-and-Error Interventions,* demonstrated how flexible intervention supported clients and clinicians reaching divergent intervention targets in a range of ways.

The data also revealed that the scope of the clinician's remit was dictated in part by the intervention targets specified by the client. Adopting a wide and flexible assessment of the SLT role enabled intervention to be non-universal and personalised, in a case-by-case manner, as portrayed in the *Expanding Remit* category.

Flexible approaches to intervention could hypothetically extend to cover an exponential range of interventions if not curtailed. This expansive and flexible approach to intervention was honed along a definite, yet personalised intervention trajectory by accrediting the client with relatively high levels of authority in the clinical decision-making process. Additionally, the sub-core category of *Shrinking Remit* captured reasons why clinicians both should not and could not continue to provide intervention in the area of clinical pragmatics, thus delimiting their provision of intervention. The presence of a chronic, clinical condition or the inability of SLT inputs to effect change (as represented by the category of *The Limited Impact of Intervention*) were presented as reasons why SLTs should not continue intervention. Additionally, a lack of professional competencies (such as limits in a SLT's range of tools and skills and a recognition that other disciplines may be better placed to provide intervention in certain situations) as well as the influence of organisational policy (as was represented by the category of *The Limits of the Profession*) indicated situations in which SLTs could no longer provide intervention. Flexible ways of working, necessitated by the presence of *Uncertainty*, provided a platform in which joint decision-making between the client and clinician could occur, as will be discussed next.

10.3.2 THE NEED FOR JOINT DECISION-MAKING

Mechanisms for working flexibly and personalising intervention in response to *Uncertainty*, in the data, involved a heavy reliance on subjective evidence from the client. Joint decision-making between the client and the clinician (as opposed to clinician-led decision-making) facilitated the enactment of personalised approaches to intervention. Personalisation was enabled by joint decision-making as it allowed the clinician to access the subjective perspectives of the client which in turn were used to inform clinical decision-making.

10.3.2.1 JOINT DECISION-MAKING: INCORPORATING SUBJECTIVITY INTO THE CLINICAL PROCESS

Joint decision-making is one mechanism for incorporating subjective perspectives into the clinical reasoning process. The literature on joint, clinical decision-making repositions subjective evidence as a trustworthy and valuable resource in the clinical decision-making process.

Of the three responses to *Uncertainty* in the data *Stretching Remit* captured how subjective perspectives were put forward as a valid form of knowledge for guiding practice. Intervention was defined in accordance with the specifications generated in tandem by the clinician and client, thus suggesting the presence of joint decision-making to some extent. By disregarding static, pre-defined, norm based packages of intervention, SLT intervention could be tailored in a personalised manner but only when subjective perspectives were elicited from the client.

At times, the client's perspective was deemed necessary for fully specifying the nature of the clinical concern, evaluating intervention and defining clinical outcomes in the data. In some instances, clients' perspectives even became viewed as an indispensible source of clinical knowledge for combating *Uncertainty* and guiding intervention. However, client perspectives were not always considered indispensible or even equitable to the perspectives of the clinician. Client perspectives could be drawn on to variable extents and were accredited with differing levels of authority, dependent on the SLT's assessment of her role and the role allocated to the client. For example, accessing client perspectives was treated as a completely optional adjunct to the clinical process when *Uncertainty* was responded to by *Containing Uncertainty through Homogenisation.* Indeed, *Uncertainty* was managed by disregarding the subjective and personal nature of communication health and disorder thus imposing a clinician- or resource-led, universal intervention trajectory. These standardised forms of intervention saw the clinician retaining the sway of the power in defining and specifying the nature of the clinical issue, the nature of the intervention and the nature of clinical outcomes.

In the literature it has been suggested that clients' perspectives can be devalued when they are accorded the status of preference, rather than being seen to represent an indispensible form of knowledge necessary for clinical decision-making. When the client's perspective is viewed as being synonymous with preference, it is relegated to being "mere anecdotal information or consumer opinion" (Kovarsky, 2008, p. 48).

In the data, as in the literature, the authority and influence of clients' perspectives on intervention could be curtailed by treating the client's perspective as a preference rather than legitimate clinical knowledge. Extant mechanisms for joint decision-making in the literature have been criticised for incorporating client perspectives into clinical reasoning, as preferences only (Kovarsky, 2008; Kovarsky & Curran, 2007). Other criticisms of models of joint decision-making include the involvement of clients at the later stages of the clinical decision-making process. Existing models of clinical decision-making will be discussed in more detail below as methods for incorporating subjective perspectives into the clinical process.

10.3.2.2 Extant models of joint decision-making

A call for joint decision-making, in light of an acknowledgment of the complex and uncertain landscape in which health care services currently reside, is increasingly evident in the literature (e.g., Frantsve & Kerns, 2007; Henry, 2006). EBP has been proposed as one potential way of recruiting client perspectives in health care decision-making in light of the fourth step of EBP which instructs those adopting an EBP framework to integrate the "critical appraisal" of the external clinical evidence with "our patients' unique biology, values and circumstances" (Straus et al., 2005, p. 4). The manner in which client perspectives are incorporated at such a late stage into the clinical decision-making process reduces the client's role in clinical decision-making to choosing between the intervention options already chosen for the client by the clinician. When a client has been invited to participate in clinical-decision making by choosing from intervention options devised by the clinician, it has been suggested that joint clinical decision-making has not occurred, as the crafting of intervention options has not been "shared" (Price, 2009, p. 368).

It has been suggested that within the EBP framework clients' values and preferences are treated as separate to, and lesser than, forms of evidence gleaned from the external research base (Kovarsky & Curran, 2007). There is little recognition within the EBP approach that a client's subjective and personal perspectives are necessary for developing a full understanding of the issue that has brought the client to access a particular health care service. This attempt at joint decision-making is a far cry from incorporating clients' perspectives in order to generate an identity of interests and flesh out the nature of health, illness and well being. Thus, it has been

claimed that the voice of the client is excluded from clinical decision-making, as "patient narratives are not themselves usually regarded as 'evidence' within EBM" (Lambert, 2006, p. 2640).

Also the disproportionate amount of attention diverted to the development of steps 1-3 in EBP orientated literature (in comparison to the undeveloped fourth step where the client's preferences and unique predicament are incorporated into clinical decision-making) has been taken to suggest that, from an EBP perspective, this fourth step is not a priority during the clinical decision-making process. Other approaches which facilitate clients in participating in clinical decision-making, such as Shared Decision-Making (SDM) (Charles et al., 1997, p. 317; Charles, Gafni & Whelan, 1999; Edwards & Elwyn, 2009) have been suggested as mechanisms for realising the underspecified fourth step of the EBP approach to clinical decision-making (Barratt, 2008).

SDM has been positioned mid-way between informed consent and paternalism[113] as a model of clinical decision-making (Charles et al., 1997, 1999). SDM can be summarised as involving the patient in decision-making "*to the extent that they desire*" (Edwards & Elwyn, 2006, p. 317) through the stages outlined in Table 7 below:

TABLE 7: STAGES IN THE PROCESS OF SHARED DECISION-MAKING

"Stages and competences of involving patients in healthcare decisions" adapted from (Elwyn, Edwards, Kinnersley & Grol, 2000, p. 894)
Implicit or explicit involvement of patients in decision-making processes.
Explore ideas, fears, and expectations of the problem and possible treatments.
Portrayal of equipoise and options.
Identify preferred format and provide tailor-made information.
Checking process: understanding of information and reactions (e.g. ideas, fears, and expectations of possible options.)
Checking process: acceptance of process and decision-making role preference, involving the patient to the extent they desire to be involved.
Make, discuss or defer decisions.
Arrange follow-up.

So although 161 different definitions of SDM have been identified (Makoul & Clayman, 2006), the most common definitions draw on the characterisation of SDM originally specified by Charles et al., (1997) and later explicated by Charles and her colleagues as:

[113] Charles et al., (1997, 1999) specify the informed consent model of clinical-decision making, as the practice of the clinician transferring information and leaving the client to make decisions in an unsupported way, while paternalistic clinical decision-making reflects situations where the clinician shares little or no information, or decision-making responsibility, with the client (as originally specified by Parsons 1951, p. 311). However, Marteau (2009) has noted some concerns about the accuracy of Charles et al.'s (1997, 1999) positioning of informed consent and paternalistic models of clinical decision-making as binary opposites.

> At a minimum, both the physician and patient are involved in the treatment decision-making process.
>
> Both the physician and patient share information with each other.
>
> Both the physician and patient take steps to participate in the decision-making process by expressing treatment preferences.
>
> A treatment decision is made and both the physician and patient agree on the treatment to implement.
>
> (Charles et al., 1999, p. 652)

SDM should be employed flexibly as a group of principles, not as a verbatim procedure, in light of each particular scenario in which it is deployed (Elwyn, Edwards & Kinnersley, 1999). Thus, SDM is a flexible and dynamic process which is not amenable to being specified in a prescriptive manual or "standardized checklist" (Charles et al., 1997, p. 689).

The clinician's ability to offer choice and display "equipoise" ("that is, in certain clinical scenarios the doctor can have no clear preference about the treatment choice to make. This is where shared decision-making is most feasible. Legitimate choices exist") has been considered to be the hallmark of SDM (Elwyn et al., 2000, p. 895). Proponents of SDM identify the notion of "equipoise" as a key element for operationalising SDM (Elwyn et al., 2000, p. 895). Equipoise captures an acknowledgement that in some cases multiple options are available with no clear medical consensus about the best option. In these instances, SDM proposes that the client must be consulted to evaluate how differing options (and their consequences) would best meet the client's particular situation, expectations and wishes. As such, it seems that SDM does not highlight uncertainty as being a pervasive issue pertinent to all matters of health, illness and well-being but rather that there may be "certain clinical scenarios" in which the clinician cannot unilaterally identify one right choice for intervention.

As one of the most salient models of joint decision-making, SDM has been criticised as being atheoretical because it has not been based explicitly in decision-making theory (Becker, 2009).[114] It has been suggested that SDM does not accurately reflect how decisions are made in everyday clinical contexts (Hudson, 2009). Indeed, it has been suggested by drawing on naturalistic decision-making models that clinicians rely less on rational processes, but pull on

[114] Decision-making theories can be grouped into three categories; "normative, descriptive" and "prescriptive"(Becker, 2009, p. 45). Normative decision-making theories offer a theory driven account of how people think in idealised situations. The group of decision-making theories known as normative theories generally provide models of rational behaviour based on rules of logic (e.g., Baron, 1996). Descriptive theories focus on data-driven or "bottom-up" accounts of how people actually make decisions often drawing on information processing frameworks to explicate this process. Finally, "prescriptive" decision-making theories aim to facilitate the development of "good" decision-making by suggesting "how people should think in order to make the best decision" (Becker, 2009, p. 45).

implicit knowledge and enact other more tacit forms of reasoning in daily practice. These forms of implicit decision-making can clash with the views of the clinician and client as decision-makers who are often situated, from a SDM perspective, as rationally thinking and autonomous individuals (Rapley & May, 2009). Thus, SDM has been accused of leaning too strongly towards rational, cognitive models and is being increasingly questioned as an accurate and appropriate framework for modelling how clinical decision-making actually occurs (Becker, 2009; Hudson, 2009; Kamhi, 2011b; Rapley, 2008).

Following on from this, SDM has been criticised as neglecting to attend to the dynamic reality in which clinical decisions are made (Murtagh, 2009, p. 82). Others have situated clinical decision-making as being a distributed multiparty process (Rapley & May, 2009). Challenges in implementing SDM may have begun to expose the inadequacy of viewing clinical decision-making as a de-contextualised activity (Elwyn, O'Connor, Frosch, Volk & Feldman-Stewart, 2009). It has been suggested that in order to make changes to clinical practice, the distributed and collaborative nature of clinical work must be considered (Timmermans & Mauck, 2005).

Decision-making models which treat decision-making as discrete instances within a clinical encounter neglect to attend to the layers of context in clinical practice that colour how decisions are made (Berg & Goorman, 1999). Clinical decision-making may be more appropriately construed as a continuous action which is embedded within the fabric of a dynamic clinical encounter. In the data, the different specifications of SLT remit and role coloured how *Uncertainty* was managed. Thus, clinical decisions did not appear to be made in isolated instances but were embedded within the SLT's assessment of her role and the role of the client.

In line with the data, and with the perspective of Mattingly and Hayes Fleming (1994) and Rapley (2008), decision-making will be viewed in this thesis as a distributed action-orientated process which might be better captured by the term "clinical reasoning". Additionally, Mattingly & Hayes Fleming (1994, p. 4) recognised a broad range of influences on clinical decision-making including the personal and professional beliefs brought to clinical interactions in that:

> The conception of clinical reasoning we developed concerns not only *how* therapists think when treating patients, but also something about *what* therapists think about their practice *as* a practice....Thus this research project was not confined to the study of isolated cognitive processes that could be called problem solving. It was a project that encompassed the study of real people in their real everyday actions....clinical reasoning was studied as part of the whole therapeutic process from initial assessment to discharge. Because we looked at the entire process rather than focusing only on assessment, we developed an understanding of thinking in occupational therapy that is very different from that traditionally described in the medical decision making literature. We assumed from the start that clinical reasoning is a thinking process that happens over time, as therapists interact with patients, and that we needed, therefore, to understand and describe it as an unfolding process.

As previously discussed in this chapter, outside of a specifically clinical frame of reference Stacey (1996, 2011) has acknowledged that action and change do not occur in a linear fashion with readily identifiable causes and effects. Consequently, all action, including decision-making, can be viewed as emergent, stemming from constantly evolving and interacting agents who dynamically adapt and learn from their environments and interactions. Extrapolating from complexity theory, it has been suggested that much clinical decision-making occurs in the absence of high levels of agreement and certainty—within a zone of complexity (Mowles et al., 2010; Plesk & Greenhalgh 2001). Stacey and colleagues (2000, p. 188) have specifically highlighted action and change in organisations "as highly complex, ongoing processes of people relating to each other". Correspondingly, models of clinical decision-making may benefit from drawing on complexity theory and forefronting issues of complexity (such as uncertainty and the interpersonally and contextually embedded ways in which action and change occurs) to produce more accurate models of clinical decision-making.

The potential for SDM to deal fully with clinical uncertainty may be limited by both its failure to view uncertainty as integral to clinical practice and its treatment of decision-making as a de-contextualised clinical moment. The inherent nature of *Uncertainty*, emergent in the data, points to *Uncertainty* as a pervasive aspect across the entire clinical process. This insight into the multifaceted and distributed nature of *Uncertainty*, which arose from this study, highlights the need for a framework for joint decision-making which appreciates the dynamic and distributed nature of clinical decision-making in order to acknowledge and deal with the pervasive and embedded challenges and opportunities associated with *Uncertainty*.

Thus far, the distributed nature of clinical decision-making and an acknowledgement of the fallacy of a shared identity of interests between client and clinician have been discussed. These issues have been used to support a call for personalised approaches for dealing with *Uncertainty* the area of clinical pragmatics.

This personalisation of intervention also entailed a need to examine the value accorded to subjective perspectives in the clinical process. In the data, the presence of *Uncertainty* coincided with strategies involving the recruitment of subjective perspectives to qualify health, illness and well-being in non-uniform ways. Re-positioning subjectivity as a valuable resource for clinical decision-making exposed a need for seeking knowledge outside of the clinical realm. As such, the value of explicitly non-clinical client perspectives will now be discussed.

10.3.3 THE NEED FOR NON-CLINICAL PERSPECTIVES

The value of non-clinical perspectives lies in their ability to provide insight from outside a strictly clinical or bio-medical realm about the nature of health, illness and well-being in general and in relation to communication health and disorder more specifically. The external research base has been identified as providing a disproportionately bio-medical and thus limited, basis for understanding communication health and disorder (Kovarsky & Curran, 2007). Here, it will be suggested that, in the context of *Uncertainty*, the importance of involving non-clinical perspectives in the clinical process is heightened. Indeed, amongst the responses to Kamhi's (2011a, 2011b) commentary (which is almost unique in directly discussing the issue of clinical uncertainty in the SLT context), Nelson (2011) noted the need to locate SLT outcomes in the everyday non-clinical context of the client. This context is one which can only be accessed by seeking non-clinical perspectives by engaging in dialogue with the client in order to work towards an identity of interests.

In this section, the potential for non-clinical or lay perspectives to function as an additional form of knowledge in clinical decision-making will be discussed. The potential for non-clinical perspectives to contribute towards health care professionals' understanding of communication health and disorder and also towards the development of services in this area will be alluded to. Additionally, the limits of lay knowledge will also be outlined.

10.3.3.1 SUPPLEMENTING AND ENRICHING CLINICAL PERSPECTIVES

The presence of *Uncertainty,* which was both obvious and inherent to clinical practice, exposed unavoidable deficits in both the quantity and quality of expert clinical knowledge in the area of SLT practice and clinical pragmatics. Outside of the context of SLT, the failure for all aspects of the health, illness and well-being to be fully accounted for using bio-medical or clinical knowledge alone has been used to call the dominance of bio-medical perspectives on health, illness and well-being into question (Popay & Williams, 1996, p. 760).

Indeed, the inherent nature of *Uncertainty*, evident in the data, suggests that knowledge outside of the clinical realm may be useful for to specifying the nature of communication health and disorder for a given client. Drawing on Habermas's notion of life-world,[115] Kovarsky (2008) has highlighted that the true nature of a communication disorder is tied to the life-world within which

[115] "Life-world" is alluded to, following Habermas (1987), as the complex system of meanings which human beings allocate to the material context they inhabit as they experience it. Communication and language are important in constructing a life-world, as "without communicative participation through language where understandings, values, expectations and identities can be negotiated between individuals, there would be no life-world" (Kovarsky, 2008, p. 50).

it is embedded. As such, Kovarsky has proposed the use of personal narratives as a mechanism for accessing the life-world of an individual in order to more fully understand the nature of a given communication disorder (Kovarsky, 2008, p. 50). Others have also alluded to the power of narrative as a method for accessing personal and meaningful accounts of illness experiences (Greenhalgh & Hurwitz, 1999; Williams, 2000). Thus, considerations of communication health and disorder without reference to the subjective perspective of the client are incomplete, as "an exclusive reliance on objective data is at odds with the very nature of what it means to participate in the life-world and how communication disorders manifest themselves" (Kovarsky, 2008, p. 51). If the presence of inherent *Uncertainty* in the area of clinical pragmatics is to be addressed, personal subjective perspectives may need to be taken as a legitimate form of knowledge by the SLT community. The value of these perspectives lies in the fact that they provide information about the life-world in which communication health and disorder become realised and in essence exist. Therefore, these perspective can be viewed as providing reliable and accurate information about the nature of communication health and disorder.

In the context of *Stretching Remit,* communication health and disorder were not defined in purely clinical terms. The clinician and client collaboratively identified the trouble spots and problems in the client's everyday context in order to specify the nature of the communication disorder, identify the client's constructs about communication health and understand more fully the reason for which SLT services were being accessed. Seeking subjective evidence from the client's everyday context and unique situation was a key element of how the clinician blended her clinical skill and expertise with the expertise of the client in order to generate a meeting point of perspectives and knowledge. The expertise of the client was experiential, in that clients were positioned as the prime authority on their life-world in which knowledge about the nature of communication health and disorder could be accessed.

Much of the literature discussed already in this section (i.e., 10.3) can also be taken to highlight the need to draw on non-clinical perspectives when it comes to matters to health, illness and well-being. The literature on lay knowledge has particularly advocated for the inclusion of non-clinical perspectives and actors when it comes to defining, designing and implementing health care services (e.g., English, Merzel & Moon-Howard, 2010; Popay & Williams, 1998).

The literature of lay knowledge recognises that clinical and non-clinical perspectives as simply different ways of knowing health, illness and well-being (Herzlich, 1973). It has been acknowledged that all knowledge, including clinical or medical knowledge, is socially produced (Annandale, Elston & Prior, 2004) and additionally that blurry lines exist between medical and non-medical knowledge (Atkinson, 1995) with medical knowledge meaning divergent things to different people (Chapple, Campbell, Rogers & Roland, 2002). Rather than seeing non-clinical

perspectives as cultural products, lay or non-clinical perspectives are slowly becoming recognised as legitimate forms of knowledge in their own right (Gabe et al., 2004).

There has been a distinct value accorded to lay perspectives because of the firsthand experience of illness and well-being on which they are built (Williams & Popay, 2006). Lay expertise lies in the experiential accrual of knowledge, as Popay and Williams (1998, p. 410) have noted: "lay knowledge- the knowledge we all gain through the experience of living in this or that place or having experience of particular health problems". Client perspectives have been positioned as dense forms of evidence that capture the full meaning of health, illness and well-being by bringing together a wide range of factors. Lay knowledge is positioned as valuable as it provides a window into the everyday, subjective and complex context in which matters of health, illness and well-being emerge and are realised. As such, lay knowledge consolidates seemingly divergent factors and brings them together to offer a "holistic" picture of a health care or illness experience from an explicitly non-clinical viewpoint:

> The key characteristic of lay knowledge is that it is integrative and holistic: drawing on multiple factors in a syncretic but not indiscriminate fashion; bringing together "scientific" or other professional sources of knowledge and reflecting the ideological climate of the times, but also providing an incisive moral and political critique of them.
>
> (Gabe et al., 2004, p. 137)

Lay knowledge may thus countervail clinical uncertainty by supplementing, and revising if necessary, purely clinical and bio-medical ways of defining health, illness and well-being—which have been highlighted by the presence of *Uncertainty* as inevitably incomplete. It has been suggested that lay knowledge challenges medical knowledge in two ways:

> Firstly, they represent a challenge to the "objectivity" of expert "theories". They both contest the impartiality of expert knowledge compared with other forms of knowledge, and raise questions about the extent to which the process of objectification—upon which truth-claims of scientific knowledge depend—permits a proper understanding of health problems. Secondly, they challenge the authority of professionals to determine the way in which problems are defined in the policy arena.
>
> (Popay, 2006, p. 571)

In the data, *Uncertainty* in the area of clinical pragmatics was indicated when clinicians had to make distinctions between communication health and disorder. In the context of *Stretching Remit*, lay knowledge was drawn on in order to substantiate and clarify this distinction. Indeed, particular instances in the data demonstrated how lay perspectives were needed in order to generate an accurate evaluation of the skills, behaviours and knowledge being clinically assessed. For example, in one instance in the data the patterns of interaction which the clinician had

recognised as patterns of impairment were seen as effective interactional strategies by the parents of the child in question. In this instance, the ecological usefulness and non-pathological status of a particular pattern of interaction (i.e., how a child would "**fixate and and perseverate on a specific topic**" in order to engage with new people or mask comprehension difficulties) was proved by recruiting lay perspectives on this issue (Participant No. 1: Focus Group 2, Page 28: lines 1246). Thus, instead of to considering lay knowledge as a challenge to clinical knowledge, it may be more useful to consider the ways in lay knowledge can contribute to and support clinical knowledge, particularly in light of issues arising under the guise of *Uncertainty*. However, clarification regarding the exact status and the limits of lay knowledge as a form of clinical evidence may be needed and will be discussed in the following section.

10.3.3.2 Placing too heavy a burden on lay knowledge?

Questions about the limits of lay knowledge have been raised by many (e.g., Prior, 2003). The limits of lay knowledge have been linked with lay knowledge's status as a form of experiential knowledge which is constructed on concepts outside of biomedical theory. In the context of rising patterns of consumerism in health care (Conrad & Leiter, 2004), the potentially negative ramifications following a complete neutralisation of the boundaries between lay and expert knowledge in relation to decision-making responsibility and authority have been identified. Consequences include potential threats to ensuring effective and safe health care services while tokenistically professing claims of client participation and empowerment (Prior, 2003). For example, the rising popularity of cost efficient "self management" approaches in health care has been associated with a misinterpretation of the notion of the expert patient and a careless blurring of the differences between lay and clinical knowledge (Greenhalgh, 2009, pp 629-630).

In a more general discussion, (outside of health care but immediately relevant to it), concerns have been raised about what might happen if distinctions between lay and expert knowledge were fully dissolved—resulting in an "indefinite extension of technical decision-making rights" for everyone (Collins & Evans, 2002, p. 235). It has been pointed out that this kind of non-discriminate equality of knowledge could result in everyone being accorded equal opportunity and authority to make decisions on any issue or subject, which might well lead to chaos in society (Turner, 2001).

The discussion about how best to clarify the nature of and the boundaries between lay and expert knowledge continues to highlight that a simplistic equality between these different forms of knowledge may be a flawed approach. Debates about the function of experts and the authority they are accorded in society emphasises that experts (such as professionals working in health care services) have ever lessening levels of authority (Armstrong, 2007; Bury & Taylor,

2008). However, it has also been suggested that despite this decreasing authority, professionals are needed and are still serving useful functions in society vis à vis their specialist knowledge and expertise. Thus, it has been claimed that health care professionals can yet respond to the challenge of decreasing authority by evolving to greater levels of shared authority and autonomy while at the same time preserving some rights to maintain a specialist knowledge base (Kelleher et al, 2006).

The fact that specific "technical" expertise is possessed by specific health care professionals and that this may be necessary for defining and generating evidence in the realm of health care services cannot be denied. Indeed, advocates for incorporating non-clinical perspectives as clinical evidence have also stressed that SLT practice needs multiple forms of knowledge for evaluating clinical outcomes—not a dominance of one source of knowledge (Duchan & Black, 2001; Kovarsky, 2008). As such, non-clinical perspectives are envisaged "not to supplant more traditional, objective units of measurement but, rather, to enhance our ability to interpret the ecological validity of evidence, by listening to voices from our clients' life-world" (Kovarsky, 2008, p. 48). However, the dominance of the bio-medical, technical way of defining the quality of health care services maintains an authoritative presence in the evidence base and this has been interpreted politically as a testament to the continued oppression of a dominant group perspective over minority perspectives.

> The selection of measurement indicators is not only a technical process but also a political one...the ability of particular groups to define "quality" and the value base which they use to do it, will also determine the kinds of services which are thought to have "value".
>
> (Priestley, 1998, p. 187)

The task for health care professionals seems to be to learn how to acknowledge and harness the expertise of clients, an expertise which is thrown into particularly sharp focus in the context of *Uncertainty*, without neglecting to acknowledge the expertise developed by those working in health care services. Collins and Evans (2002, p. 271) discuss the issue of expertise in relation to decision-making in general and have pointed to the work ahead which is needed to clarify this issue: "The job, as we have indicated, is to start to think about how different kinds of expertise should be combined to make decisions in different kinds of science and in different kinds of cultural enterprise." This sharing of decision-making authority involves acknowledging the boundaries of specific forms of expertise resulting in a negotiated rather than a simplistic blended expertise. Without careful progression on this matter, a lopsided burdening of responsibility and authority and a tokenistic claim of power sharing could emerge.

While this thesis argues that *Uncertainty* presents an opportunity for working towards new notions of expertise, embedded in a negotiated and collaborative clinical relationship in relation to SLT, the challenges in doing so are acknowledged as being significant. Developing a framework for recognising and incorporating divergent types of expertise in decision-making is far from complete and presents a mammoth task, as Popay and Williams (1998, p. 410) have noted:

> Lay knowledge...is the least valued source of knowledge in modern societies permeated as they are with an all too often unquestioning acceptance of the might of science. Moreover, there is of course no unitary 'public opinion' but rather a multitude of voices waiting to be heard. And each voice may express multiple identities—they (we) can be patient and service provider, lay and professional, at the same time. Each of us is a member of different publics and speak from different perspectives at different times. Developing sustainable ways of involving the diversity of publics are difficult.

The task of incorporating and involving lay knowledge presents challenges, however expanding clinical knowledge and evidence to include a broader array of voices may hold particular promise for answering some of the challenges identified as issues of *Uncertainty* in this thesis.

10.3.3.3 Including non-clinical perspectives in intervention evaluation

Finally, it has been recognised that evaluating intervention should involve the perspectives of those who have received intervention. In an uncertain context, where both the obvious nature of *Uncertainty* (e.g., the presence of an incomplete evidence base) and/or the inherent nature of *Uncertainty* (e.g., doubts regarding the suitability of using universal, clinician-led perspectives in guiding intervention due to the simultaneously objective and subjective nature of communication health and disorder) exist, non-clinical perspectives may be important in specifying which interventions are valuable and how. Thus, as well as incorporating an individual's non-clinical perspectives into defining the content and trajectory of the intervention they are personally involved in, the role of lay knowledge in contributing to the general external evidence base may also need to be readdressed.

The dominance of bio-medical perspectives in identifying effective interventions and generating evidence has excluded people who are the end users of health care services in contributing to the evidence base and guiding clinical practice. Failing to involve people who have lay knowledge (i.e., firsthand experience) in using health care services excludes non-clinical perspectives from contributing towards the evidence base which informs health care service provision. Thus, the evidence base, and the services founded on this evidence base, may remain both skewed and incomplete (Basnett, 2001; Finkelstein, 2004).

Non-clinical perspectives offer clinicians a subjective translation of the objective changes, emergent as a result of intervention, while also exposing tacit and more subtle changes following

intervention. Lay knowledge has the potential to qualify and complement other forms of clinical evidence, particularly in light of the fact that SLT interventions may not always bring about external changes which can be objectively measured. As discussed earlier in Section 10.2.2.3, lay perspectives may be particularly important for establishing and validating clinical outcomes in light of the subjective nature of the experience of communication disorder. Others have noted that intervention outcomes cannot be equated proportionally with objective increases in skills or activities divorced from the meaning which is imbued into these increases by the client. Discussing this point from an Occupational Therapy perspective, Mattingly (1998) has talked about the need to attend to the less visible aspects of intervention that qualify it as meaningful and effective or "good therapy":

> Therapists are quite clear that healing cannot be equated with mere increase in skill or capacity to carry out a series of actions. The "something" that counts as good therapy has the (conceptually strange but intuitively sensible) properties of being both a set of public actions and an invisible set of emotions, feelings, judgements, and perceptions.
>
> (Mattingly, 1998, p. 168)

The personal and non-universal nature of communication health and disorder, and the person-specific experience of intervention, have been used to argue for the necessity of including subjective perspectives as legitimate forms of clinical evidence. The essentially person-specific nature of communication disorder establishes a need for supplementing objective forms of evidence because "explanations of effectiveness rooted only in objectivity run the risk of simply being wrong if subjective explanations are not also taken into account" (Kovarsky, 2008, p. 55).

At the very minimum, it would appear that non-clinical perspectives deserve a role in evaluating health care services. The incomplete nature of the evidence base resulting from the omission of client perspectives could also be seen, in practical terms, as a simple waste of resources. The value of individuals with experience of using health care services positions them as natural choices for inputting into the development of these same services. In the quote below, non-clinical perspectives are discussed as "valuable insights" and "resources". As such, lay perspectives about the experiences of health, well-being, illness and how these states have been ameliorated or otherwise through the provision of health care services, have been repositioned as valuable perspectives:

> Patients with chronic conditions are an under-utilised resources....They often have valuable insights into the management of their condition and health professionals with an interest in developing patient education resources need to ensure that work closely with groups of individuals who represent the eventual users of the end product.
>
> (Kennedy, Robinson & Rogers, 2003, p. 309)

The data also portrayed instances of involving clients in evaluating SLT interventions in the area of clinical pragmatics that enabled clinicians to develop SLT services in a positive manner. The provision of SLT inputs in the "**vague**" area of clinical pragmatics became less challenging when the clinicians spent time "**ascertaining what exactly they [clients] want**" and finding out about intervention outcomes by engaging clients in discussions about their intervention [Words in brackets have been added]. Thus, involving the clients in intervention planning and evaluation was one way in which clinicians developed their service in an uncertain area:

EXTRACT 10.3

"yeah I think the hardest thing about it [pragmatics] is that it's [pragmatics] such a vague concept and ((3 second pause)) what we're trying to do is tighten it up a bit and make it more def- definable by having the the em question by having the parents in first and ascertaining what exactly they want and then doing the group and then having them back and then doing and evaluations from both the parents' and the children's perspectives"

Interview No. 7
Page 22: lines 985
Page 23: lines 995
[Words in brackets have been added]

10.3.3.4 SLT AND EBP: LINKING CONCEPTIONS OF EVIDENCE WITH ETHICAL DECISION-MAKING

Like many other professionals, SLTs are being called on by consumers and funders to prove that the interventions they provide are efficacious and beneficial. EBP has become widely recognised as a crucial framework for supporting efficacious clinical decision-making in the SLT context, as Roddam and Skeat (2010, p. 11) have pointed out: "SLTs, like other healthcare professionals are experiencing pressures to demonstrate that they are providing effective and efficient services, and showing a strong commitment to EBP is integral to this". Indeed, the IASLT has referred to the use of "evidence" by SLTs in their code of ethics (2006, p. 7). With reference to a SLT's "responsibility to the community" the IASLT have stated that "a member must not promote or make unqualified statements regarding new therapeutic procedures that are not evidence based" and that "a member must strive to maintain and develop the provision of services in line with best practice and supported by evidence". However, despite this strong rhetoric, the amount of influence of EBP as a framework guiding everyday clinical decision-making in the context of SLT has been queried in the sparse research exploring EBP's uptake in relation to SLT practice. For example, surveys of practicing clinicians about EBP suggested that while EBP is valued by SLTs that it is not always drawn on for everyday clinical decision-making due to time constraints and other barriers (Vallino-Napoli & Reilly, 2004; Zipoli & Kennedy, 2005)

Despite these suggestions of a low uptake of EBP, the voice of EBP resounds loudly in the SLT literature environment (as noted by Kovarsky & Curran, 2007). As an illustration of EBP's influence it is notable that hierarchies for rating external evidence (e.g., Chalmers. et al., 2010, Phillips et al., 2009), developed by proponents of EBP, have been imported into the world of SLT (e.g., American Speech-Language-Hearing Association, 2004, 2005; Gillam & Gillam, 2006; Royal College of Speech & Language Therapists, 2005) with some objections and contentions (Fey, 2006; Kovarsky & Curran, 2007). However, it may be salutary to note that EBP was not generated specifically as a framework for SLT practice, but rather was imported into the world of SLT as "a term that our discipline has borrowed from medical research and practice" (Ingham, 2003, p. 197). As such, the SLT community has started to carefully consider, and modify accordingly, EBP as a framework for supporting clinical decision-making.

Dollaghan (2007) is a strong advocate of drawing on the EBP framework to inform clinical decision-making, although she also has identified a distinct need for modifying the framework of EBP before importing it into the SLT world. One of the modifications suggested by Dollaghan (2007) is that the EBP framework might be reconstructed in the form of an E^3BP framework. E^3BP is presented by Dollaghan (2007, p. 9) as a modified version of the EBP framework in which three sources of evidence are explicitly acknowledged as being of equal weight during the decision-making process so that: "The goal of E^3BP is to reduce uncertainty about a clinical decisions by using best evidence from external research, from clinical practice, and from a fully informed patient concerning his or her preferences." Dollaghan (2007) repeatedly touches on the issue of clinical uncertainty throughout her discussion of EBP in the context of SLT. Clinical uncertainty has been positioned as a healthy clinical stance necessary for implementing high quality clinical decision-making, as when she stated that "successful E^3BP has three preconditions" one of which is "uncertainty about whether a clinical action is optimal for a client" (Dollaghan, 2007, p.3). Thus, the presence of this type of clinical uncertainty is alluded to as a normal feature of everyday clinical decision-making, implying that clinicians are unable to decide if a given intervention is "optimal" for a given client without explicit recourse to all three of the knowledge sources outlined in the E^3BP framework.

Dollaghan (2007) also referred to wider ethical issues which become relevant when considering clinical decision-making in the context of SLT practice. Dollaghan (2007, p. 3) suggested that clinical decision-making should be informed by the "four principles that underpin clinical ethical reasoning beneficence (maximising benefit), nonmaleficence (minimizing harm), autonomy (self-determination), and justice (fairness)." In many ways, EBP has become viewed as the standard mechanism for operationalising the ethical principles of beneficence and nonmaleficence during clinical decision-making—by drawing on proof in the form of evidence to

ensure that the clinician is providing interventions which maximise benefits and do no harm to the client. However, a narrow interpretation of EBP (as discussed on pages 271-272 of Section 10.2.1 above) fails to live up to all of these ethical principles by blatantly contravening the principle of autonomy or self-determination. An understanding of EBP as a process, as posited in the original version of EBP, stresses the importance of client autonomy by highlighting the need for integrating a client's individual perspectives and unique situation into the clinical decision-making process. Broader views of EBP as a series of actions reliant on information gathering from multiple sources, active collaboration and power sharing between the client and clinician may facilitate clinicians upholding all of the ethical principles, outlined above, during clinical decision-making.

These types of ethical and philosophical issues are thrown into sharp focus in considering the impact of EBP on SLT as Beecham (2004, p.133) has noted in her "concerns" about "the SLP profession adopting EBP". Primary among Beecham's concerns are the issues of power and the profession's lack of clear understanding about the values and beliefs underpinning SLT practice, as when she stated "I would argue that we need to understand what we do in practice; and that this needs to be theorised" (Beecham, 2004, p.133). It appears that attempts to import the EBP framework into the SLT world, have highlighted the lack of understanding about the nature of SLT practice and have also highlighted related and unresolved issues about power and indeterminacy in SLT practice.

The narrow view of EBP, (equating EBP as the use of research to reach clinical decisions), diverts attention from important ethical issues such as examining what counts as valid clinical evidence and who sanctions this evidence—issues which have yet to be resolved. A narrow interpretation of EBP seems easy to import into clinical practice, whereas a true understanding of EBP, (founded on the original tenets outlined by the Evidence-Based Medicine Working Group, 1992 and Sackett et al., 1991) necessitates a much clearer understanding of the complex nature of clinical practice being reached: "Embedding EBP is more than just reading journals. There are complex factors about the individual and the context that impacts on how we access and apply evidence in our practice. These factors make EBP possibly one of the most challenging change initiative facing clinicians." (Skeat and Roddam, 2010, p.21)

EBP has had a significant influence on how SLTs think about their practice and how this practice is evaluated. The *Uncertainty* emergent in this study calls for a revision to the narrow interpretation of evidence and EBP, because as Roddam and Skeat (2010, p. 11) have noted "the definition of 'evidence' is much broader than just research data", so that a wider and more equitable pool of knowledge can be drawn on both for informing individual instances of clinical decision-making and developing the general SLT evidence base. Others have also suggested that

additional segments of knowledge need to be drawn on for developing a more balanced and robust notion of evidence. Some have suggested that evidence of appropriacy, feasibility and meaningfulness are needed as well as looking for evidence of effectiveness (Roulstone, 2011). The addition of other dimensions of evidence, such as information from the local setting in which an intervention is to be enacted has also been suggested as lacking in many of the narrow interpretations of evidence (Schlosser & Sigafoos, 2008). These additional dimensions of evidence enable EBP to be practiced, as it was originally intended, as a "a complex and highly individualized process" Justice (2008, P. 324). These broader views of evidence and EBP resonate with original spirit of EBP presenting EBP as a series of actions supporting the clinical decision-making process which is always embedded in a complex context.

Summary

In this chapter, the patterns of uncertainty management and the complex character of *Uncertainty* emergent in the data were explored in light of approaches to uncertainty management, available in the literature, hallmarked by standardisation and personalisation. This exploration included a consideration of EBP and the antecedents to its arrival as well as exploring the role of subjectivity and lay knowledge in clinical evidence and models of collaborative decision-making. In this chapter, it was argued that the EBP has morphed considerably from its original incarnation and that the original principles of EBP provide useful concepts for working in the context of *Uncertainty*. Additionally, suggestions were made for widening the definition of clinical evidence and for incorporating subjectivity and non-clinical perspectives into the clinical decision-making process in light of the important moral issues highlighted by *Uncertainty* and in light of the original tenets of EBP.

While subjective, non-clinical perspectives on health, illness and well-being were once dismissed as biased and inaccurate, they are increasingly being considered valuable forms of evidence, simply because of their subjective nature, so that:

> Now many of the most important patient outcomes, like patient choices before them, are valid *because* they are subjective. The most complete and meaningful assessments of health status are now seen to include the perspective of the patient. Medicine is thus turning away from the scientific ideal of fully objective or "perspective-less" assessments of disease and health.
>
> (Sullivan, 2003, p. 1595)

The emergence of *Uncertainty* with a simultaneously obvious and inherent nature in the data highlighted the significant potential that client perspectives might play in aiding professionals to tackle clinical uncertainty. Concerns about the quantity and quality of current clinical knowledge

as foundations for clinical practice suggest that clients' personal non-clinical perspectives may provide a rich, additional source of evidence for guiding practice in the context of *Uncertainty*.

The inherent nature of *Uncertainty*, in particular, suggests a need for moving away from standardised, and towards personalised, forms of intervention. Responses to *Uncertainty* (such as the responses conceptualised as *Stretching Remit*) which incorporated subjective perspectives and offered flexibly and personally-defined intervention may be the most complete responses to *Uncertainty*, because this response in particular would appear to address the obvious and inherent nature of clinical *Uncertainty*.

Most discussions of clinical uncertainty are divergent in terms of how the authors define the notion of uncertainty, although they are almost always unequivocal in how they present clinical uncertainty as being a negative or undesirable state or situation. However, an analysis of the data in the current study suggested that *Uncertainty* may present opportunities as well as challenges. Indeed, when clinical uncertainty is recognised as an issue with simultaneously obvious and inherent facets, as in the data, it becomes acknowledged as significant but mundane aspect of clinical practice. This normalisation of *Uncertainty* (i.e., viewing uncertainty as an inevitable part of clinical practice) presents an opportunity for revising the asymmetries between clinical and non-clinical perspectives, which have traditionally existed in the realm of health care, by recognising a real value in the perspectives and knowledge possessed by clients.

The following chapter will briefly discuss how the insight generated by this exploration of clinical uncertainty and its sequelae, in light of the emergence of *Uncertainty* and the theory of *Reshaping Remit,* might contribute to further study of uncertainty management and clinical pragmatics in relation to SLT practice.

CHAPTER 11. DRAWING ON *RESHAPING REMIT* TO BRIDGE THE "SWAMPY LOWLANDS" OF EVERYDAY CLINICAL PRACTICE WITH THE "HIGHLAND" OF THEORY

INTRODUCTION

As discussed in Chapter 10, the multifaceted and distributed nature of *Uncertainty* has been taken to imply that *Stretching Remit* may be the most thorough response to *Uncertainty* which emerged from the data. In particular, Chapter 10 highlighted how personalised approaches to intervention may accommodate most completely both the obvious and inherent nature of *Uncertainty*.

As such, the purpose of this chapter is to highlight how future research exploring uncertainty management in the context of clinical pragmatics and SLT practice might be "conceptually empowered" (Glaser, 1998, p. 17) by the theory of *Reshaping Remit*. The notion of conceptual empowerment refers to the way in which a grounded theory study produces fresh concepts and theoretical accounts which should be relevant and be useful to those in the substantive area being studied.

The title of this chapter echoes a division which Schön (1987, p. 3) makes between the "swampy lowland" (i.e., cold face of clinical practice with mundane and complex challenges and concerns) and the "high ground" of practice, where "research-based theory and technique" can be readily applied to solve problems. Indeed, it has been recognised that there are many aspects of everyday SLT practice that are not yet fully understood, or even documented, as noted by van der Gaag and Anderson (2005, p 1) who borrow Schön's analogy to comment that "there are many areas of SLT practice that remain relatively uncharted in the literature, and many of them would probably be found in Schön's lowlands".

Schön (1987) has posited a disparity between the knowledge that is valued in training institutions and the knowledge that informs everyday clinical practice. Schön (1987, p. 3) goes so far as to posit the existence of a "crisis of confidence" in knowledge due to the fact that professionals in training acquire knowledge that may not fully prepare them for the daily realities of professional practice. This chapter aims to bridge this division by exploring how a data-driven theory, developed from the analysis of data gathered about the swampy realm of everyday clinical practice, can inform the theoretical landscape of uncertainty management and clinical pragmatics in relation to SLT practice.

In this chapter, Section 11.1 discusses the importance of recognising the complexity of clinical uncertainty and exploring considerations of role in relation to uncertainty management.

The specific theoretical directions suggested by *Reshaping Remit* in relation to the theory of clinical pragmatics will be discussed in Section 11.2. Here, the appropriacy of contextualised and personalised approaches to clinical pragmatics, stemming from functionalist-inspired definitions of pragmatics, in light of clinical uncertainty will be discussed.

11.1 *RESHAPING REMIT* IN RELATION TO THE THEORY OF UNCERTAINTY AND UNCERTAINTY MANAGEMENT

11.1.1 THE STUDY OF UNCERTAINTY AS A MULTIFACETED AND DISTRIBUTED PHENOMENON MAY BE COMPLEMENTED BY ACKNOWLEDGING THE DISTRIBUTED NATURE OF CLINICAL DECISION-MAKING

The multifaceted and distributed nature of *Uncertainty* exposed in the data comprised a wide range of challenges which occurred in a situationally dependent manner across the entire clinical process. The distributed and multifaceted nature of *Uncertainty* which emerged from the data reflected how it impacted on a wide variety of aspects within clinical practice. Thus, clinical uncertainty may be better viewed as a continuous backdrop to practice, rather than a definitive moment in clinical practice. Acknowledging the distributed nature of *Uncertainty* calls for the study of clinical uncertainty to move beyond focusing on uncertainty as primarily an issue of knowledge gaps. As the following extract illustrates, *Uncertainty* emerged in this study at a variety of levels.

EXTRACT 11.1

"I mean parents expect you to know these things and it you know like it's difficult for us to understand we're really uncertain about it other professionals are really uncertain about it and then to try and communicate that uncertainty to a parent you know whose used to kind of operating like you know we're working in the XXX they're used to operating in this medical model where things are defined and things are definite or things are said to be definite anyway even if they're not and then to try to explain I mean the you know the number of times we've had the conversation about well it's difficult to say and its very unclear and the research is very un unclear and you know parents don't most parents don- aren't able buy into that like they just they think you know it's a b or c it's a broken leg or it's a broken arm and then going into this woolly sort of well you know with this and this and ((laugh)) sometimes we see this with kids and and you know they're all different as well em so again your back to its not a broken arm ((laugh)) it's not a broken leg so even something like SLI is very difficult for people to grasp and understand and then when you throw the pragmatics into the mix and you're trying to explain well what there's so many levels what is pragmatics how does it impact what kind of pragmatic difficulties does this child have what is the extent of them what does that mean for the child you know it's I think that's hugely challenging"

Interview No. 4
Pages 7-8: lines 332-371

As the illustration above in Extract 11.1 shows, *Uncertainty* is not an isolable phenomenon distinct to particular instances, but permeated clinical work and emerged across a variety of parties. Clinical uncertainty has been most frequently studied in relation to decision-making (as noted by Cranley et al., 2009) with clinical decision-making being viewed as an isolable discrete moment within the clinical process. Thus, the multifaceted and distributed nature of clinical uncertainty may be best complemented by drawing on notions of clinical reasoning (Doyle, 2000; Mattingly & Hayes Fleming, 1994; Mattingly & Hayes Fleming, 2000) and distributed clinical decision-making (Rapley, 2008; Rapley & May, 2009), instead of exploring clinical decision-making as an isolable, cognitive moment between clinician and client.

A brief exploration of some of the literature related to clinical uncertainty, as in Chapter 10, highlighted that clinical uncertainty has been presented as a divergent range of problems which exist across and at "different levels of context" (Brashers, 2007, p. 226). Despite some notable attempts (e.g., Penrod, 2001, 2007), many studies of uncertainty, and clinical uncertainty in particular, have failed to generate or draw on a coherent conceptual framework for specifying the nature of clinical uncertainty, in that "to date, there has been little recognition and no comprehensive and systematic analysis of the variations in meanings of uncertainty in illness" (Babrow et al., 1998, p. 2).

The way in which *Uncertainty* emerged in the current study, as both a distributed and multifaceted concept, revealed that *Uncertainty* could be viewed as a patterned yet disparate family of problems which stemmed from a range of overlapping and interacting concerns. In this study, recognising the simultaneously obvious and inherent nature of *Uncertainty* enabled a coherent conceptual explication of seemingly disparate manifestations of *Uncertainty*. By taking the multifaceted nature of *Uncertainty* into account, the distributed impacts which *Uncertainty* had on clinical practice were exposed. Acknowledging the multifaceted and distributed nature of *Uncertainty* may inform a more coherent handling of clinical uncertainty in future studies. In addition, studying clinical uncertainty against a backdrop of more distributed models of clinical decision-making may facilitate researchers in exploring the wide ranging pervasive influences that clinical uncertainty has on practice.

11.1.2 THE STUDY OF UNCERTAINTY AS A MULTIFACETED AND DISTRIBUTED PHENOMENON MAY BE COMPLEMENTED BY FLEXIBLE APPROACHES TO UNCERTAINTY MANAGEMENT

As *Uncertainty* in the area of clinical pragmatics arose as a multifaceted and distributed phenomenon integral to clinical practice, responses to *Uncertainty* may particularly benefit from accommodating to this aspect of its character. Correspondingly, there may not be one universal or uniform way to appropriately manage *Uncertainty*.

Additionally, it has been suggested by Babrow and Kline (2000) that it may be more useful to focus on coping with, rather than reducing, uncertainty. Prioritising standardised responses to uncertainty, as specified by *Containing Uncertainty through Homogenisation*, would appear to focus on eradicating *Uncertainty*, rather than integrating it into the clinical process.

The suitability of flexible and context-sensitive responses to uncertainty has been discussed in the literature in relation to areas other than clinical pragmatics. The fact that uncertainty may be best responded to in a situationally-dependent manner has been taken to substantiate the claim that any given response to uncertainty is likely to vary in its "appropriateness and effectiveness" dependent on the situation in which it is used:

> Because uncertainty is multilayered, interconnected, and temporal, the appropriateness and effectiveness of responses used to manage it are likely to vary across contexts and situations (see Babrow et al., 2000). These dimensions of the experience require that people develop responses sensitive to multiple goals and tasks. The layers of context suggest that people experience multiple sources of uncertainty at once, that manipulation of one type of uncertainty can impact (e.g. increase or decrease) uncertainties of other types, and that experiences of uncertainty are ongoing and changing features of life.
>
> (Brashers, 2001, p. 481)

Taken in combination, the situational dependence and highly contextualised nature of clinical uncertainty, the appropriacy of strategies for uncertainty management and indeed many of the definitions of pragmatics, discussed in Chapter 2, suggests that the role of the SLT should be contextualised and flexible. *Stretching Remit* thus, presents tentative suggestions for developing hypotheses for further exploration into how clinicians might enact a role which is flexible and sensitive to uncertainty.

Finally, as discussed in chapter 10, the body of literature known as complexity theory (Stacey 1996, 2011), may also provide some support for understanding *Uncertainty* as part of the dynamic and complex environment in which clinical practice occurs. As such, this body of literature may facilitate further investigations into how best to support clinicians to accommodate *Uncertainty* and make changes, if needed, to their practice patterns.

11.1.3 SOCIALISING CLINICIANS TO NORMALISE UNCERTAINTY

Responses to *Uncertainty* were identified in the data as distinct yet interacting patterns, partly differentiated by how clinical decision-making authority was shared between the client and clinician and the amount of flexibility with which intervention was approached and enacted. *Reshaping Remit* uncovered how the participants' consideration of their role shaped their responses to *Uncertainty*. The roles enacted by the clinicians also influenced the role that was allocated to the client during the clinical process.

Shrinking Remit conceptualised one pattern of responding to *Uncertainty* portraying reasons why intervention should not or could not take place, resulting in the discontinuation of SLT inputs. The other two responses to *Uncertainty* which were characterised by the provision of intervention (namely, *Containing Uncertainty through Homogenisation* and *Stretching Remit)* suggested that different conceptualisations or considerations of the role of the SLT influenced the way in which intervention in the area of clinical pragmatics was realised.

Thus, the theory of *Reshaping Remit* conceptually explicated how a consideration of role, underpinned by the concepts which were available in the substantive area of clinical pragmatics, impacted on how *Uncertainty* was managed. Role became a vehicle for realising pragmatics notions divergently. Thus, the issue of role as well as concepts and theory from the substantive area of clinical practice guided practice.

It has been noted that clinical practice is shaped by a variety of influences (including values, as noted by Byng, Cairns & Duchan, 2002; van der Gaag & Mowles, 2005). Clinical practice is not guided by technical knowledge alone (Higgs and Titchen, 2001; Mattingly & Hayes Fleming, 2000). Subsequently, attempts to understand clinical practice should consider a wide variety of influences, beyond merely focusing on technical expertise or the theory of a particular disorder. As Hyter (2007) notes below, as well as exploring how the "concepts" of pragmatics are defined, there is a need to explore the other elements drawn on during clinical practice, which influence how assessment and clinical intervention in the area of pragmatics occurs:

> Assessing pragmatic language skills is complex, given the variability of pragmatic aspects of language and their relationship with context and culture. Considerable work has been done since the "pragmatics revolution" in the late 1970s (Duchan 1984); yet, there is much work left to do. Some of this work includes evaluating the premises of assessment perspectives and purposes, the way concepts are defined, and the social theory clinicians and researchers use to make connections among concepts.
>
> (Hyter, 2007, p. 143)

The influence of role on uncertainty management in clinical practice may deserve further research consideration. For example, an open acceptance of uncertainty is well acknowledged in the

literature as a useful way of dealing with uncertainty in clinical practice. However, accepting uncertainty is also considered to be a behaviour which may need to be socialised into practitioners (Atkinson, 1984, 1995). Brashers (2007) has suggested that how people respond to uncertainty, in general, is associated with their appraisal of uncertainty. If the area of clinical pragmatics and SLT practice is integrally uncertain, appreciating this may enable clinicians to view uncertainty and its management as a normal part of their clinical role. Supporting clinicians to recognise *Uncertainty* as a significant yet mundane element in their work may decrease the almost taboo status that clinical uncertainty has become accorded with.

The fact that clinicians become socialised to disregard uncertainty during training has been a significant finding in the literature. Explorations in the area of clinical uncertainty have revealed how clinicians in training have been socialised to disregard uncertainty through both formal and informal or "hidden curricula" (Atkinson, 1984, p. 952).

The way in which medical knowledge is presented to student practitioners, as knowable facts, echoes a reductionist epistemological view characterised by high levels of certainty in that: "The philosophy of sciences embodied in the manifest and hidden curricula of most medical schools is not one which emphasizes the tentative, provisional nature of scientific knowledge." (Atkinson, 1984, p. 952) Consequently, the student practitioner becomes socialised to perceive gaps and limits in knowledge and/or uncertainties in clinical encounters as puzzles and conundrums which can be best solved by the application of scientific knowledge via clinical reasoning (Atkinson, 1984, 1995). Thus, a proclivity for trainees to be steered towards accepting clinical knowledge, as a certain rather than uncertain science, leads to a disregard of uncertainty.

Indeed, following Katz, it has been highlighted that SLTs are also to some extent socialised towards certainty and a disregard of uncertainty. Kamhi (2011a, p. 60) has noted that SLTs, like other clinical practitioners, have been taught to assume a particular amount of certainty in the knowledge they acquire in training in that "every profession, including speech-language pathology, has similar examples of educating students to believe that what they are taught is the best course of action".

The use of tools such as reflective diaries to encourage recognition and articulation of clinical uncertainty has been suggested as one way of facilitating clinicians in acknowledging uncertainty as an inherent aspect of clinical practice (Nevalainen, Mantyranta & Pitkala, 2010). Utilising small group discussions in which practitioners are facilitated in articulating and exploring clinical uncertainty has also been suggested as being a useful way in which an acceptance of uncertainty can be fostered (Sommers, Morgan, Johnson & Yatabe, 2007). It has been suggested that new attitudes to uncertainty may be mediated while clinicians in training learn how to use clinical tools, such as case presentations (Lingard, Garwood, Schryer & Spafford, 2003; Spafford,

Schryer, Lingard & Hrynchak, 2006). Additionally, it has been suggested that clinicians may need to be facilitated in recognising less blatant forms of clinical uncertainty in their own practice, as illustrated by French (2006).

Integrating the acceptance of uncertainty into the education of practitioners has been suggested for developing a culture in which uncertainty becomes subsumed as a natural element of clinical practice. Explorations involving the study of Social Workers, in training, have revealed how expressions of uncertainty in trainees were interpreted in a positive way "as a touchstone of competence, rather than a personal deficit meriting punishment" by educators (Spafford, Schryer, Campbell & Lingard, 2007, p. 171). These positive affirmations following expressions of uncertainty differed significantly from how uncertainty was responded to within the training of medical students and optometrists (Spafford et al., 2007; Spafford et al., 2006). Indeed, it was concluded that an acknowledgment of uncertainty as a positive reflection of advanced clinical thinking may result in an increased tolerance for uncertainty (Spafford et al., 2007). On a related point, it may be that clinicians in training may benefit from being supported to recognise different forms of clinical uncertainty. Part of this training may be learning how to differentiate between the inherent and acceptable forms of *Uncertainty* and those which are less acceptable (such as a clinician administering an intervention she has not been trained to deliver).

Uncertainty and its management have often been seen as being inextricably linked with how uncertainty is communicated in health care settings (Brashers, 2001, 2007). SLTs are almost uniquely placed in that the content of SLT interventions are often both mediated by, and constituted of, communication. Unsurprisingly, there is a growing acknowledgement of the importance of communication between client and clinician in the SLT context (Ferguson & Armstrong, 2004; Kovarsky & Duchan, 1997; Walsh, 2007). The acquisition of particular communication styles has been suggested as part of the process of SLT role acquisition in that: "Therapists are acculturated through training and clinical practice into a particular range of professional communication styles (like the use of IRF exchanges) that become bound up with professional identity" (Cortazzi & Jin, 2004, p. 478). As communication has also been considered an important mechanism for mediating uncertainty management, facilitating reflection on the communication styles of SLTs may provide a fruitful avenue for understanding and ameliorating how uncertainty is managed in relation to SLT practice.

Other channels through which SLT practice patterns and professional identity are acquired may also warrant further exploration. In particular, the lack of reference to guidelines issued by professional organisations detailing the scope of SLT practice was notable in the data. Resources such as professional standards (RCSLT, 1996), clinical guidelines (RCSLT, 2005) as well as documents detailing a code of ethics (IASLT, 2005) and the scope of SLT practice (IASLT, 2006)

were rarely cited by participants as influences on practice or the management of *Uncertainty*. Information sharing between professional organisations and practicing clinicians may be indicated as one way of specifically exploring how and why these documents are used. Considering the potential guidance to be found in these documents it may be that professional organisations would do well to promote their content and explore how much support these types of documents in their current form offer the profession of SLT.

Additionally, the data highlighted issues of importance for participants which were of a moral and philosophical nature that have not been prominent in the SLT literature. For example, IASLT (2005, p. 3) sum up the content of their document delineating the SLT "scope of practice" without referring in any great way to moral and philosophical issues and instead focus on the more technical aspects of SLT practice. Thus, the IASLT's (2005, p. 3) document outlining the scope of SLT practice by detailing the "breadth of professional practice offered within the profession and aims to outline populations served, contexts in which the service is provided, rationale for service provided and the modalities in which it is presented". It may be that professional organisations need to touch on the moral and philosophical issues such as those evoked by *Uncertainty* in addition to the other items more commonly included when discussing the SLT scope of practice.

The patterns of action captured in the data, as explicated by *Reshaping Remit*, portrayed how participants got things done in spite of and indeed in concert with the complex issues indicative of *Uncertainty* by modifying their role and the role of the client in the clinical process. Reflection on practice is one method for dealing with a general lack of certitude (Schön, 1983, 1987). Studies which reflect on the nature of SLT practice and the patterns that characterise it are only just emerging (for example, Bunning, 2004; Ferguson, 2009; Penn, 2004). These in-depth studies which aim to develop a better understanding of the process of SLT and explore the scope of the SLT role in terms of the beliefs, values and practice patterns may inform the development of a firmer and much needed consensus about how the role of the SLT should evolve (Beecham, 2004). In turn, clarity about SLT remit may emerge. Perhaps, an open dialogue about how the issue of clinical uncertainty fits into the SLT role from some of the professional organisations affiliated with SLT would facilitate clinicians developing consensus about how best to respond to this complex challenge as an speech and language therapist. It would be useful for clinicians and clinicians in training to have a common language and framework for talking about and dealing with clinical uncertainty, and in particular for knowing what types of clinical uncertainty are acceptable and when to seek assistance in this regard. Professional organisations may be particularly well placed to instigate a discussion of this nature and to generate some consensus across the profession.

Exploring how the role of the Speech and Language Therapist can best integrate and accommodate uncertainty needs to be addressed in future research. Clinicians in training may provide an obvious location for exploring clinical role formation (Ferguson & Armstrong, 2004). It has been suggested that clinicians in training are a useful site for exploring the "junior versions" of uncertainty management, demonstrated later by qualified practitioners (Fox, 1980, p. 7).

11.1.4 *RESHAPING REMIT* IN RELATION TO THE THEORY OF UNCERTAINTY AND UNCERTAINTY MANAGEMENT: SUMMARY

Reshaping Remit emerged as a conceptual account of the patterns and variance in the data which revolved around the participants' attempts to manage their main concern of *Uncertainty* in the context of clinical pragmatics. There was an association between the manner in which clinical roles were conceptualised by participants and how *Uncertainty* was responded to. Thus, uncertainty management may need to be addressed with clinicians in places where clinicians learn about, and are socialised into, their roles and professional identity, as "professional identity shapes attitudes and behaviours towards uncertainty" (Spafford et al., 2007, p. 173). The education of SLTs is an obvious setting in which foundations of the SLT role are laid (Ferguson & Armstrong, 2004). The educational setting may be one setting in which clinicians might be socialised to accept uncertainty as a mundane, everyday aspect of clinical practice. However, greater discussions of clinical uncertainty in the SLT related literature as a legitimate topic in its own right, may enable the profession to begin thinking about how uncertainty fits into their role as practitioners of a constantly evolving, ostensively and inherently uncertain, knowledge base.

Data analysis suggested that responses to uncertainty were based on an appraisal of the SLT role. It has been suggested that uncertainty is not always responded to by attempts to reduce uncertainty (Brashers, 2001, 2007). Indeed, *Reshaping Remit* captured patterns in the data which exposed how clinicians integrated and accommodated *Uncertainty* as another variable in their clinical practice as well as responding to *Uncertainty* by attempting to disregard or eradicate it. Therefore, developing concepts and a language for differentiating between acceptable and unacceptable forms of clinical uncertainty may support clinicians in dealing with clinical uncertainty and knowing when to seek assistance or discontinue intervention.

If the area of clinical pragmatics represents an area which is essentially uncertain for a number of reasons, including those suggested by the data and also by some definitions of pragmatics discussed in Chapter 2, then the theory of clinical pragmatics must begin to accommodate uncertainty. Below, the emergence of *Reshaping Remit* as a response to

Uncertainty in the area of clinical pragmatics will be discussed more specifically, with regard to the theory of clinical pragmatics.

11.2 *RESHAPING REMIT* IN RELATION TO THE THEORY OF CLINICAL PRAGMATICS

11.2.1 REFLECTING ON THE EMERGENCE OF *UNCERTAINTY* FROM AN EXPLORATION INTO THE AREA OF CLINICAL PRAGMATICS

What does it mean for the theory of clinical pragmatics that *Uncertainty* emerged in the data as the most salient concern for the participating members of the SLT community? Perhaps, it was not entirely surprising in light of the myriad definitions and lack of theoretical consensus, discussed in Chapters 2 and 3 that *Uncertainty* emerged as the participants' core concern in the area of clinical pragmatics. However, the presence of a definitional hangover from the lack of consensus in mainstream pragmatics, and the existence of an unformulated knowledge base in clinical pragmatics were not the only ways in which *Uncertainty* was revealed in the data. As well as knowledge gaps and a lack of consensus regarding best clinical practice, the data revealed other facets of *Uncertainty* which had not been previously documented in the literature of clinical pragmatics.

Uncertainty emerged in the data with a multifaceted character and as an issue pervasive in SLT practice in the area of clinical pragmatics. As such, approaches to pragmatics clinically may benefit from focusing on the use of pragmatic theory which enables a contextualised and flexible approach to intervention.

As discussed in Chapter 10, a personalised approach to intervention in the context of clinical pragmatics would appear to complement both the obvious and inherent character of the *Uncertainty* which emerged in this study. Indeed, it could be suggested that the inherent nature of *Uncertainty* was ignored by the standardised responses to *Uncertainty* which emerged in the data, namely *Containing Uncertainty through Homogenisation*. As *Uncertainty* emerged as an inherent part of the clinical process in the area of clinical pragmatics, this has been taken to suggest that set standardised approaches to clinical pragmatics may not be entirely suitable for the SLT context.

11.2.2 THE IMPORTANCE OF UNDERSTANDING HOW PRAGMATICS IS CONCEPTUALISED IN THE AREA OF CLINICAL PRAGMATICS

Understanding how SLTs conceptualise pragmatics is important, as exploring the concepts which underpin practice can help account, in part, for how and why certain practices become realised or operationalised (Duchan, 2004). As highlighted throughout the discussion of data analysis (i.e., Chapters 7-9), the clinicians' responses to *Uncertainty* were linked with how clinicians operationalised their role and the role that was allocated to the client during intervention. As discussed in Sections 11.2.2-11.2.3, the responses which emerged as variations of the SLT role within the area of clinical pragmatics contained echoes of the divergent definitions of pragmatics discussed in Chapter 2. In particular, the response of *Containing Uncertainty through Homogenisation* harmonises with definitions of pragmatics from a formalist perspective in which pragmatics is seen as a separate component of linguistic theory. It has been suggested that in some instances SLTs have tried to directly translate formalist-inspired definitions of pragmatics, (i.e., pragmatics is viewed as a segment of linguistic theory) into clinical practice. Thus, formal definitions of pragmatics have been converted into a clinical conceptualisation of pragmatics as a separate segment of an individual's linguistic competence (Perkins, 2005b, 2007). For example, Duchan notes how pragmatics has been treated as an isolable set of skills, reflecting a view of pragmatics as a separate section of the linguistic competence of an individual (Duchan, 2005, p. 211).

The response to *Uncertainty* in the area of clinical pragmatics captured by *Stretching Remit* complements functionalist-inspired definitions of pragmatics in which pragmatics is conceptualised as an overall organisational system for meaning-making and language use. Utilising either one of these types of definitions of pragmatics in a clinical encounter has been suggested to influence the kind of interventions which are accessed by the client:

> With emphasis on the formal aspects of pragmatics, treatment promotes the patient's successful use of the rules that characterize well-formed discourse structure. In the functional pragmatic approach, the patient's environment, communication partners and pragmatic communicative strategies are the primary focus of intervention.
>
> (Bloom & Obler, 1998, p. 19)

Thus, how clinicians define their role is partly tied up with the concepts they use in relation to the substantive area in which they carry out their clinical roles. Accentuating this point, in relation to conceptualisations of communication below, Gould (2009) alludes to the way in which clinical needs, outcome measurements and progress are specified can be linked with how "communication" is conceptualised:

> The key to understanding how speech pathologists conceptualize communication lies in understanding how speech pathologists as a profession deal with the notion of what constitutes effective communication. Typically speech pathologists identify communication as effective when both the speaker and the listener have executed their roles to an age expected level within the biological capabilities of the individual. The way speech pathologists talk about communication identifies their conceptualization of communication as primarily a biological process.
>
> (Gould, 2009, p. 59)

How pragmatics is defined, either as a component of grammar or as an overall organisational and contextualised interface for meaning-making using language, is particularly important because it may guide how SLTs work with pragmatics clinically. Thus, each of the three definitions of pragmatics from the spectrum of definitions outlined in Chapter 2 will be briefly revisited here in light of *Reshaping Remit*.

11.2.3 REVISITING THE SPECTRUM OF DEFINITIONS OF PRAGMATICS IN LIGHT OF EMERGENCE OF *RESHAPING REMIT* FROM THE DATA

Responses to *Uncertainty*, emergent from the data, have not been presented as direct manifestations of practice patterns or as working definitions of pragmatics used in clinical practice. Responses to *Uncertainty* were unquestionably complex and multifaceted and involved more than the importation of theory from the area of mainstream pragmatics into clinical practice. However, it became apparent, following a review of the literature of mainstream and clinical pragmatics, that the divergent patterns identified in the data emergent as responses to *Uncertainty* resonated with particular definitions of pragmatics.

PARALLELS BETWEEN DEFINITIONS OF PRAGMATICS AS A COMPONENT OF LINGUISTIC THEORY AND *CONTAINING UNCERTAINTY THROUGH HOMOGENISATION*

Definitions of pragmatics as a component of linguistic theory were discussed in Section 2.2.1 of Chapter 2. These definitions of pragmatics, steeped in formal linguistic thinking, represent a body of literature which is echoed by responses to *Uncertainty* characterised by a reliance on universal norms and the subsequent enactment of a standardised intervention trajectory drawing on these norms. Many of formalist-inspired approaches to language assume the existence of language as an abstract, de-contextualised product—a notion which lends itself well for developing universal linguistic targets as clinical endpoints. The patterns of action in the data which characterised the response to *Uncertainty* named *Containing Uncertainty through Homogenisation* such as *Creating and Maintaining Standardised Intervention Procedures, Using Pre-determined Intervention Targets, Using Static Pre-determined Norms* and *Being Norm Driven*

and Norm Based imply the existence of a generic range of skills, behaviours and knowledge which can be readily identified, evaluated and then targeted in therapy. A focus on language use as a fixed code, and subsequently as a phenomenon which is readily isolable from its context of use, enabled clinicians to focus intervention on tangible linguistic structures or specific behaviours.

In addition, the delimitation of the role context, evident in many definitions of pragmatics as a component of linguistic theory, could be used as support for focusing intervention on the skills, behaviours and knowledge possessed by an individual. So although, *Containing Uncertainty through Homogenisation* was not explicitly linked with particular theories or definitions of pragmatics from mainstream pragmatics, patterns of responding to *Uncertainty* in this manner have notable parallels with attempts to define pragmatics as an isolable set of skills or behaviours.

The low levels of client involvement in clinical decision-making portrayed by the category of *Clinician as Evaluator* also dovetailed well with theory which models language as a relatively context-independent code with a definitive surface structure. Approaching pragmatics as a component of linguistic theory was mirrored by pragmatics being treated as a specific set of skills and behaviours, isolable from their contexts of use, and which could be evaluated and taught by clinicians during intervention. For example, in extract 11.2 the participant discusses the issue of pragmatics being such a "**huge area**" while the participant in 11.3 responds by noting how she had dealt with the breadth of the area of clinical pragmatics by using a "**checklist**" which detailed specific ranges in relation to isolable skills such as "**eye contact**". Here, an underlying conceptualisation of pragmatics as a specific set of skills which could be evaluated along definite ranges was implied. Ideas underpinning definitions of pragmatics as an isolable component of linguistic theory appear to have been translated into considering specific skills and behaviours to represent the totality of pragmatics in clinical practice.

EXTRACT 11.2

also cos there's so many bits of it you know pragmatics covers as we were saying a huge area so how do you pu- and it's when you get everything together working together so how do you I don't know is the answer ((laugh))

Participant No. 2: Focus Group No. 6
Page 18: lines 885-888

EXTRACT 11.3

in groups we used to use like a checklist and used to have like eye contact and a range I just remember little circles ((laugh)) I've vague memories of this and both of us the two we usually ran a group in twos not necessarily two speech therapists you know you me and another mental health worker and then we'd rate them separately and see what are level of agreement was over a period and see whether both of us were the same

Participant No. 4: Focus Group No. 6
Page 18: lines 888-895

The pattern of equating pragmatics with a definitive list of skills and behaviours was notable in some questionnaire responses when participants were asked to detail how they would "**describe**" pragmatics, as in question No.3, illustrated in Extract 11.4. This reductionist approach to defining pragmatics as an isolable range of skills and behaviours is one which is perhaps perpetuated by many of the commercially available resources which are available to clinicians. Many of the available resources, particularly those designed to support the assessment process present pragmatics (and related terms such as social language use or conversational skills) as a discernible set of skills and behaviours, as illustrated in Extract 11.5. Here, a self-report interview schedule deconstructs "**conversations**" into a set of isolable behaviours which the client is asked to rate himself on along the dimensions of "**never good, not very good, quite good**" and "**very good**".

EXTRACT 11.4

Q 3. If you had to describe 'Pragmatics/Pragmatic Language' to another professional e.g. psychologist/psychiatrist, what would you say to them?

It's Communication above the sentence level – includes aspects such as intonation, proximity, body language, management of conversation, etc.

Questionnaire No. 16

EXTRACT 11.5

Conversations ... what am I like at them?

	never good	not very good	quite good	very good	I don't know
Listening					
Starting a conversation					
Taking turns					
Asking questions					
Answering questions					
Being relevant					
Repairing					
Ending a conversation					

Talkabout
Kelly, 2001, p.53

Responses to *Uncertainty* were undoubtedly complex and drew on elements other than definitions of pragmatics. However, the standardised response to *Uncertainty* in the area of clinical pragmatics, captured by *Containing Uncertainty through Homogenisation,* also conceptualised how clinicians envisaged their role as being tied up in the process of evaluation. Thus, evident in this response was the suggestions that clinical perspectives were the most robust and trustworthy form of knowledge in light of *Uncertainty*. These specifications, particular to the response of *Containing Uncertainty through Homogenisation*, regarding the evaluative and authoritative nature of the clinical role cannot be fully accounted for within the theory of mainstream pragmatics. However, definitions of pragmatics as a component of linguistic theory complement a standardised approach to intervention. Formalist-inspired definitions of pragmatics can be more readily employed for the generation of a circumscribed and definitive set of criteria (in the form of skills, behaviours and knowledge) which might be slotted into a standardised approach to practice in the area of clinical pragmatics.

PARALLELS BETWEEN DEFINITIONS OF PRAGMATICS AS THE USE OF LANGUAGE FOR CONTEXTUALISED MEANING-MAKING AND *STRETCHING REMIT*

The broad category of definitions of pragmatics in which pragmatics is defined as a contextualised process of meaning-making positions pragmatics as the crucial interaction between language and context, during language use, for the purpose of meaning-making. Defining pragmatics in this manner draws heavily on theories from the areas of Ordinary Language Philosophy and functional linguistics as discussed in Section 2.2.2., in Chapter 2. From this perspective, pragmatics is not equated with a definite range of skills and behaviours that can be prescriptively charted. Rather pragmatics is seen as an epiphenomenal process drawing on multiple skills, behaviours, stores of knowledge, people and context dynamically and responsively. The synergistic and epiphenomenal nature of pragmatics was suggested in Extract 11.2 on page 322, when pragmatics was alluded to as being: "**when you get everything together working together**". As Extract 11.6 illustrates, pragmatics was not always seen as a set of "**discrete**" skills in the data. Here, pragmatics is positioned as an overarching mediatory process interfacing between language and its use likened to a "**bubble**" in which all of language use is encapsulated.

EXTRACT 11.6

em but yeah people tend to work on those very specific discrete skills but it's not about those discrete skills that's pragmatics is not about discrete skills pragmatics is about taking everything in em it's like almost a bubble around the rest of language like that's intersecting with socialisation so it's it's it's really artificial to break it down

Interview No. 4
Page 25: lines 1222-1234

It is the situationally dependent and collaborative nature of pragmatics from definitions of pragmatics as a contextualised process of meaning-making that resound in particular with patterns of responding to *Uncertainty* captured by *Stretching Remit*. *Stretching Remit* advocated a contextualised and flexible approach to *Uncertainty* management in the context of clinical pragmatics. The co-constructed intervention trajectory developed between clinician and client as a response to *Uncertainty* implied that clinicians abandoned notions of pragmatics as a predictable and isolable set of skills, behaviours and knowledge and instead looked to the client and their everyday context for identifying trouble spots and specifying intervention targets. Approaching intervention in this client-specific manner led to the need for an experimental and modifiable approach to intervention. Thus, pragmatic theory founded on Ordinary Language Philosophy and functional linguistics provided an approach to defining pragmatics that merges particularly well with the client-specific, modifiable and essentially collaborative nature of responses to *Uncertainty* in the context of clinical pragmatics captured by *Stretching Remit*.

As discussed in chapter 2, in defining pragmatics as a process of meaning making, heavily reliant on context, a broad view of context was often called for. The importance of context and the wide view of context specified in these types of definitions of pragmatics offers interesting parallels to the ways in which clinicians found themselves drawing heavily on context in the data. The patterns indicative of *Stretching Remit* captured how SLTs explored the client's context in order to better understand the client, the reasons they came to access SLT supports and also to plan intervention (as portrayed in particular by the categories of *Actively Accepting Variance* and *Being Collaborative).*

Furthermore, the sub-core concept of *Stretching Remit* conceptualised how in responding to *Uncertainty*, clinicians enacted their role in a broad and flexible manner, drawing on the client's perspective as valuable knowledge for informing and guiding practice. Theories of pragmatics do not currently provide an account which can link these role specifications directly to any one theory of pragmatics. However, the context-sensitivity evident in functionalist-inspired definitions of pragmatics provides a platform for developing theory in clinical pragmatics which might complement a context-sensitive, broad and flexible SLT role and highlights the need for individually defined intervention in the area of clinical pragmatics.

PARALLELS BETWEEN DEFINITIONS OF PRAGMATICS AS A CRITICAL LINGUISTIC OUTLOOK ON LANGUAGE USE AND *SHRINKING* AND *STRETCHING REMIT*

The definitions discussed in Section 2.2.3 of Chapter 2 define pragmatics as a critical linguistic outlook on language use. Following Ordinary Language Philosophy and functional linguistic thinking, pragmatics is seen as a fresh and general perspective on all things linguistic. Particular attention is given here to the macro level impact of language use (with an often explicitly political or critical tone) in the life of the people and organisations in which language is used.

These definitions of pragmatics resonate in particular with two patterns of responding to *Uncertainty* namely *Stretching Remit* and *Shrinking Remit*. Firstly, the response of *Shrinking Remit* pertained to how participants pulled back from providing intervention. Here, instances in which intervention was not effective or was beyond the remit of the SLT were taken to contraindicate the continuation of SLT supports. At times, the positioning of intervention as being beyond the boundaries of the SLT profession (a pattern named *The Limits of the Profession*) resonated with definitions of pragmatics as a critical linguistic outlook on language use in that the problematic issue was construed as an issue of rights rather than one necessitating a clinical intervention. For example, In Extracts 11.7-11.9 the participants discuss children with "**pragmatic issues**" and highlight that at times rather than SLT intervention these children would benefit from a new array of social and educational opportunities including meeting "**people who are interested in the same things**" as in Extract 11.8. Thus, the issues evident in the clinic relating to pragmatics (such as "**eccentricity**") could not be resolved by the provision of SLT input and were situated as issues of opportunity and equality. Thus, participants may have been linking the notion of pragmatics with issues such as equal opportunities for all, in the context of divergent interaction styles, rather than viewing pragmatics as a specific set of skills. In Extract 11.9 a particular individual is alluded to as needing opportunities to meet new people and needing a "**new start**" in a setting such as university, as opposed to requiring intervention, in order to resolve the issues deemed pragmatic which brought this client to the SLT clinic.

EXTRACT 11.7

some of the kids I have like now whose got pragmatic issues I'd love to like fast forward to like ten years time and see what they're like

Participant No. 3: Focus Group No. 4
Page 25: lines 1202-1204

EXTRACT 11.8

but I'm certain some of them might cope better later on em cos you know when you were saying about that child that's going off to college I think some of those children might cope better in college environment a new environment you know more academic

probably more people yeah more people who are interested in the same things as them and.... Exactly I think ec- eccentricity becomes more kind of of the norm normal it's true it's true. So you know I think secondary school is definitely the hardest environment for these children cos it's so cliquey and you know

Participant No. 2: Focus Group No. 4
Page 25: lines 1206-1212
Page 25: lines 1216-1222

EXTRACT 11.9

Like his local his secondary school was in his local area and like growing up its very hard even like we talk chat like and some of the advice we would give is kinda after school activities and evening go out and join groups and all that there but if you're having such a hard time in secondary school and then you're going to a group that has the same kids that you're meeting in school you're not going to get any enjoyment out of that either em the good thing is em college kinda brings together people from all different areas not just the towns the specific areas yeah you do kinda get a new start

Participant No. 1: Focus Group No. 4
Pages 25-26: lines 1249

Stretching Remit captured how participants evoked a broad clinical role and worked towards a wide range of clinical outcomes. As in Extract 11.10, leaning on "**broad**" definitions of pragmatics were associated with patterns of adopting a wide and expansive role as was associated with patterns in the data indicative of *Stretching Remit*. The data below suggests that an expansive array of outcomes might be targeted by SLT supports (such as "**people's opportunities to contribute conversation....assertiveness**") as a direct reflection of a "**broad**' viewpoint on pragmatics. Thus, *Stretching Remit* portrayed a pattern of responding to *Uncertainty* that appeared to be underpinned by a more expansive definition of pragmatics, beyond equating pragmatics with a specific set of skills and behaviours.

In addition, the political undertone of targets such as "**assertiveness**" in Extract 11.10 above and supporting people to "**integrate into society**" in Extract 11.11 below (when the participant was talking about why she felt the area of clinical pragmatics was a "**priority**" in her work as a SLT), highlighted echoes of definitions of pragmatics as a critical linguistic outlook by evoking rights based issues in relation to citizenship and community as relevant concepts for informing intervention and guiding outcomes in the area of clinical pragmatics.

EXTRACT 11.10

it goes back again to what is pragmatics actually where the pragmatics is just so broad you know they're looking at turn taking they're looking at people's opportunities to contribute conversation and passiveness and assertiveness and things

Participant No. 2: Focus Group No. 5
Page 16: lines 787-792

EXTRACT 11.11

and it has such an impact em when you're dealing with people who are trying to integrate into society you know em the whole social use of language is so important from that point of view so it it it would be a priority area for us in our work

Participant No. 1: Focus Group No. 5
Page 16: lines 787-792

However, these explorations of possible links between how pragmatics is defined and how *Uncertainty* is managed in the context of clinical pragmatics and SLT practice are tentative and preliminary. Much more analysis and theorising would be needed to clarify these associations. In light of the nature of *Uncertainty*, exposed in the current study, one extant approach to clinical pragmatics which strongly references Ordinary Language Philosophy and functionalist approaches to pragmatics may hold particular promise for advancement of the theory of clinical pragmatics, as will be discussed in Section 11.2.4 below.

11.2.4 SUPPORT FOR DRAWING ON SITUATED PRAGMATICS TO INFORM CLINICAL PRAGMATICS

The variable and contextualised nature of *Uncertainty* and its management, as noted in much of the data and in the literature, is serendipitously echoed by the rising acceptance of context as a crucial influence in the area of pragmatics, as discussed in Chapter 2, and further discussed in this section.

One existing approach to clinical pragmatics which particularly emphasises the contextualised nature of pragmatics may already accommodate clinical uncertainty as a multifaceted and distributed phenomenon. Situated pragmatics is one approach to clinical pragmatics (briefly introduced in Section 3.1.5) which views pragmatics as a contextualised process of meaning-making using language.

Duchan and colleagues' "situated" definition of pragmatics couches linguistic competencies within the entire context in which they are used. Situated pragmatics stands in contrast to other more traditional, abstract approaches to pragmatics which have been considered, by Duchan (2000b), as being markedly componential. It has been suggested that when these componential definitions of pragmatics are employed, by clinical practitioners, pragmatics often becomes reduced to a subset of disparate skills and knowledge divorced from the situations and contexts in which they occur (Duchan, 1997).

The situated pragmatics framework locates its origins in Ordinary Language Philosophy and beyond. Thus, situated pragmatics draws from the functional tradition in linguistics as well as

the work of other "scholars of pragmatics in the early twentieth century" including a wide range of thinkers, from the areas of Psychology, Sociology, Philosophy, Anthropology and Education, such as Lev Vygotsky, John Dewey (Duchan, 1995, pp. 2-17) and George Herbert Mead (Duchan, 2000a). With the arrival of the pragmatics turn, a broader conceptualisation of pragmatics which viewed pragmatics as the entire process of language use, not as an isolable aspect of linguistic structure, was enabled. From such a stance, communication was related to the process of meaning-making across the entirety of the client's life-world and was no longer confined as the transfer of information from one source to another. For example, it has been highlighted that communication has been understood as a straightforward transaction of information, in terms of the "conduit metaphor", which has exerted a strong influence on clinical practice in the SLT realm (Duchan, 2004, p. 8). Duchan (2000b) considers communication in less transactional terms and views pragmatics as crucial in explicating how communication, as a dynamic and collaborative process of meaning-making drawing on context, happens.

> A second development of the pragmatic revolution embraced yet a wider expansion of the notion of communication. Meaning was seen to reside in situational contexts as well as in words and sentences....Some of us have called this event-based view of communication "situated pragmatics" to distinguish it from the more abstracted, isolated skill depiction of pragmatic meanings.
>
> (Duchan, 2000b, pp. 190-191)

Context is integral to a situated definition of pragmatics as language, and more specifically linguistic competence, can only be fully understood if it is studied within the context in which it occurs (Duchan, 2000a; Lund, 2000). Within a situated pragmatics approach, language structure and linguistic competence become only one aspect of communication which might be influencing the "success or failure" of communication and, thus, which might be the target of SLT interventions:

> Situated pragmatics investigates language structure as only one possible aspect of communication that contributes to the success or failure of communicative exchanges. Broader aspects of the interaction are also analysed for their influences on the exchange. These include such factors as the nature of the event and the social relationships of the interactants....situated pragmatics places the description of language within the specific context in which it is used.
>
> (Lund, 2000, p. 271)

Also important within a situated pragmatics stance is the dynamic nature of context, so that context is not considered as being amenable to pre-specification. Subsequently, intervention in the area of clinical pragmatics cannot be approached with pre-defined intervention targets which assume that certain aspects of context will be relevant intervention targets (Hewitt, 2000a). The

fact that pragmatics cannot be approached with a priori intervention targets, and indeed intervention tactics, echoes the need for a flexible case-by-case approach to intervention in the area of clinical pragmatics.

As noted in Sections 11.2.2-11.2.3, concepts of pragmatics influence how intervention in the area of clinical pragmatics is realised. Defining pragmatics by drawing on a more functionalist inspired approach to pragmatics shifts the clinical focus from providing interventions solely focused on linguistic competencies, to the provision of intervention that explores the entire context in which language is used and meaning is made. This recasting of pragmatics positions it as a priority and as such has implications for the clinical work of the SLT community, in that "The situated pragmatics approach has implications for altering our service delivery model by changing what we work on, who we work with, how we do our work and how we evaluate our successes" (Duchan, 1997, p. 1). Broader definitions of clinical pragmatics, which are sensitive to context, characterise the scope of clinical work along much wider lines and may enable clinicians to move away from "professional myopia" which has blighted the profession of SLT (van der Gaag, 1998, p. 88). This myopic view is characterised by the tendency of the SLT community to automatically locate the clinical issue or problem on which intervention is focused, within the intrinsic competencies of the client. Thus, situated pragmatics as a framework for clinical pragmatics calls for more distributed and context focused approach to intervention.

As such, proponents of situated pragmatics have made continuous calls to focus SLT interventions on the whole of a communicative event, and to conduct "event based analysis", rather than focusing clinical analysis on fractured aspects of an event, such as the client's behaviour and the client's performance of skills within an event (Lund, 2000, p. 267). Thus, the teaching of de-contextualised language structures can no longer be supported as the only focus or primary tactic of SLTs in the area of clinical pragmatics.

The entirety of context, including the socio-cultural reality and ramifications of communication and communication disorder, thus becomes relevant during SLT interventions (for example, Barrow, 2008; Duchan & Black, 2001; Lyon, 2004). Arenas (such as self-esteem, community participation, educational inclusion, and access to information) which had been considered as being traditionally outside of the purview of the SLT thus can become ripe platforms for couching and mediating SLT interventions from the situated pragmatics perspective.

A situated pragmatics focus on the entire communicative event has enabled the clinician to use intervention as a vehicle for exploring pragmatics notions as context-sensitive phenomena, rather than concentrating on the linguistic competencies of one participant who has been labelled the "client". Duchan (1984, 1995, pp. 133-139, 2000b), and her colleagues have been strong proponents for drawing on mainstream pragmatic theory in order to extend the SLT's myopic gaze

from individual competencies to entire events. They have also positioned pragmatics as a crucial aspect of how communication for the purpose of meaning-making, involving language, works.

Stretching Remit represents a response to uncertainty which leans towards functionalist-inspired definitions of pragmatics and, as such it points to the need to draw on Ordinary Language Philosophy and functional linguistic theory from mainstream pragmatics for future theorising in the area of clinical pragmatics. Definitions of pragmatics which conceptualise pragmatics as a contextualised (i.e., situation- and person-specific) process involving language use complement more thoroughly the nature of *Uncertainty* which emerged as problematic in the current data. In the data, the response of *Stretching Remit* appeared to deal more fully, at a conceptual level, with both the obvious and inherent nature of *Uncertainty*. The body of literature known as situated pragmatics may be a particularly useful resource for future research in the area of clinical pragmatics.

SUMMARY

In this chapter, the theory of *Reshaping Remit* has been considered along with the multifaceted and distributed nature of *Uncertainty* which emerged from the data, in order to specify further theoretical directions for investigation in the areas of uncertainty management and clinical pragmatics, in relation to SLT practice. Although, three patterns of responding to *Uncertainty* emerged from the data, *Stretching Remit* would appear to have particular potential for formulating a more complete response to *Uncertainty*, in the context of clinical pragmatics and SLT practice.

In the earlier part of this chapter clinical role formation was identified as an important platform for incubating awareness, and facilitating the development, of appropriate responses to *Uncertainty*. Additionally, it was suggested that a distributed consideration of clinical decision-making may be well-placed for dealing with the pervasive and multifaceted nature of *Uncertainty*. Thus, the analysis of concerns from the swamps of clinical practice has provided potential theoretical directions for further developing the theory of clinical pragmatics and uncertainty management, in relation to SLT practice.

CHAPTER 12. EVALUATING RESEARCH QUALITY

12.1 METHODS FOR EVALUATING AND MAINTAINING RESEARCH QUALITY AND RIGOUR

This study utilised Classic Grounded Theory (GT) as a methodology in order to explore the main concern of the SLT community with regards to their practice in the area of clinical pragmatics. The study will be evaluated in this chapter in relation to this aim.

Achieving and maintaining quality or rigour in research is a heavily debated issue that has no clear consensus (Seale, 2003). Criteria for evaluating the quality of research have been suggested which are universally applicable across methodologies (Hammersley, 1992) or specific to one methodology (e.g., Glaser, 1998; Glaser & Strauss, 1967). Additionally, particular criteria have been suggested as being applicable dependent on the quantitative (e.g., Duffy, 2005) or qualitative nature of a study (e.g., Lincoln & Guba, 1985; Pope & Mays, 2006). Criteria for appraising research quality which are advocated from a qualitative tradition generally relate to the notions of "credibility"' (Holloway, 2005, p. 166) and "transferability"[116] (Holloway, 2005, p. 169), rather than being specifically concerned with internal and external validity, which are cognate concepts for evaluating research quality employed from a quantitative research perspective. Somewhat complicating the issue of how best to evaluate research rigour, is a discussion around the division between qualitative and quantitative research, and whether this dichotomy is in any way a legitimate separation worth maintaining (Hammersley, 1990; Pope & Mays, 2006).

It has been noted that research within the qualitative tradition does not reflect a unified domain in terms of an accepted level of analysis or methodological agreement. Indeed, it has been noted that the "diversity" of methodologies and analysis carried out within the tradition of qualitative research may be greater than the diversity between quantitative versus qualitative research methodologies (Meyrick, 2006, p. 800). As a loosely related yet disparate domain, it has been suggested that researchers within the qualitative domain should draw on multiple paradigms and standards for appraising research rigour. Rolfe (2006, pp. 308-310) has suggested multiple approaches for evaluating the rigour of research:

[116] "Generalisability" has also been used to capture the notion of "transferability" (Lincoln & Guba, 1985).

> It would appear, then, that the *very idea* of qualitative research as a epistemologically or ontologically coherent paradigm is open to dispute....Rather than search for overarching set of criteria by which to judge the validity of qualitative research, we should perhaps acknowledge that there is a multiplicity of (so-called) qualitative paradigms, each requiring very different approaches to validity.

Although, GT is a general methodology that is amenable to both qualitative and quantitative data, this study drew on qualitative data.[117] For the purpose of this thesis, specific criteria from the area of Classic GT will be used to appraise research quality (Glaser, 1978, 1998, 2003; Glaser & Strauss, 1967). While there may be more than one set of criteria which might be both useful and appropriate for evaluating any given piece of research, the Classic GT criteria have been developed specifically to evaluate research which is focused on generating a theoretical account of participants' main concern. As this study aimed specifically to shed light on the concerns of the SLT community in relation to the area of pragmatics and clinical practice it was deemed appropriate to draw on criteria which had been developed expressly for evaluating research of this nature.

12.2 Evaluating research quality from a Classic grounded theory perspective

Classic GT has developed four criteria for evaluating quality, which will be discussed below in relation to this study. The four criteria of "fit, work, relevance" and "modifiability" were introduced by Glaser and Strauss (1967, p. 4) and can be used for evaluating Classic GT studies in that:

> Grounded theories have "grab" and they are interesting. People remember them; they use them. To achieve this use, we stated in DISCOVERY that a theory must have fit and relevance, and it must work....We have subsequently elaborated these criteria and added a fourth. A theory must be readily modifiable, based on ever-emerging notions from more data.
>
> (Glaser, 1978, p. 4)

[117] Qualitative data is defined as data which is not specified in purely numerical form. However, it is acknowledged that qualitative data can be viewed quantitatively and all quantitative data is based at some stage on a qualitative judgement (as discussed in Miles & Huberman, 1994, p. 40). Although, the qualitative-quantitative division between research data may be somewhat superficial, yet it is used in this thesis to highlight the non-numerical nature of the data.

12.2.1 FIT: GT SHOULD GENERATE DATA-DRIVEN CONCEPTS AND THEORY

Fit pertains to the extent to which a grounded theory conceptually reflects the data, as opposed to reflecting the assumptions or preferred theories of the researcher. As such, fit relates to the manner in which the concepts generated within a GT study are indicated by the data. Glaser (1978, p. 4) has pointed out that "by *fit* we meant that the categories of the theory must fit the data. Data should not be forced or selected to fit pre-conceived or pre-existent categories or discarded in favour of keeping an extant theory in tact [sic]" (Glaser, 1978, p. 4).

The development of theories which fit the data is facilitated by the use of GT procedures (such as constant comparative analysis and theoretical sampling). GT procedures attempt to facilitate the data in being the primary force in shaping the emergent theory. Thus, the theory which is generated fits the data because the emergent theory is systematically altered and modified in light of analysis and fresh data, until it becomes conceptually dense enough to be considered saturated. As discussed in Chapter 4, Glaser (2002) has noted that while all data is subjective and co-constructed, that strict adherence to Classic GT procedure renders the data more objective, in so far as this is possible, by counteracting the influence of extant concepts and researcher bias during analysis. However, the extent to which this objective rendering of data is possible through the application of GT procedures has been heavily debated (Thomas & James, 2006).

The heavy use of direct quotes from the data, as well as the researcher's demonstration of both her grasp and enactment of GT procedures, were displayed in earlier chapters in order to assure the reader of fit. The use of direct quotes in Chapters 6-9 illustrates the types of instances from which the theory, and its concepts, were developed. As such, it is hoped that the illustrative use of data will enable the reader to gain some assurance about how these concepts fit the data, without the reader being privy to the entire data set.

The use of audio recordings of data and transcripts of data is not necessarily advised by proponents of Classic GT (Glaser, 1998, pp. 107-113). The type of in-depth illustration of data, as included in this thesis, is not always considered necessary from a Classic GT perspective. In light of the author's status as a PhD candidate, and as a novice user of the Classic GT methodology, a considerable amount of illustration has been provided in order to demonstrate fit because, as Glaser (2003, p. 135) noted, "the amount of illustration dosage depends on the prospective audience: some need more and some less".

Attention to GT methods as criteria for evaluating quality has also been suggested as a way of examining a GT study for rigour (Elliott & Lazenbatt, 2005). Thus, in this thesis, the criteria of fit can be evaluated in light of the author's understanding of GT procedures, demonstrated in

Chapter 4, and the explication of how GT procedures were realised as presented in Chapter 5. In particular, quality assurance with regard to the fit of concepts and theory can be taken from the extensive examples of data provided in Chapters 6-9.

12.2.2 RELEVANCE: A GT SHOULD BE APPOSITE TO THOSE IN THE SUBSTANTIVE AREA UNDER STUDY

As GT centres on the study of the main concern of a group of participants, and how this is resolved, it is posited as a method which produces a theory that is of relevance to those in the substantive area being studied. Relevance is a criterion which pertains to the production of theory that captures what is going on in the data, in a meaningful and resonating way. Thus, relevance follows on from the generic aim of GT to facilitate "core problems and processes to emerge" from data (Glaser, 1978, p. 5).

The literature on the substantive area of clinical pragmatics, as discussed in Chapter 3, highlights particularly that there is a lack of consensus regarding clinical practice across this area. These claims that the area of clinical pragmatics is one characterised by an absence of consensus and disparity have arisen from reflections on the published research evidence available in the area of clinical pragmatics (e.g., Cummings, 2009, 2010b) and from reflections on personal practice and research in the area of clinical pragmatics (e.g., Adams, 2008). The data and analysis in this study have provided some support for the claim that discord and divergence, in the form of *Uncertainty*, is an issue in SLT practice in the area of clinical pragmatics. However, as noted previously, GT studies do not provide a representative or accurate portrayal of the data, in the descriptive sense (Glaser, 2003), but provide just one conceptual framework for explicating patterns in the data. Thus, the nature of *Uncertainty* and the responses to *Uncertainty*, captured conceptually by the theory of *Reshaping Remit*, as the participants' main concern, provides some tentative empirical and conceptual support to other accounts of disparity and uncertainty as a pertinent issue in the area of clinical pragmatics and SLT practice.

However, the theory of *Reshaping Remit*, if taken as a research finding, not only resonates with but also contributes to, extant knowledge in the literature regarding clinical pragmatics and SLT practice. As noted, *Reshaping Remit* resonates with the literature of clinical pragmatics in that it provides some support to the concerns noted in the literature that clinical pragmatics is an area which is marred by disparity, confusion and uncertainty. Additionally and importantly, *Reshaping Remit* also explicates conceptually the manner in which *Uncertainty* manifested and as such, draws attention to issues which have not always received much attention in the literature on clinical pragmatics. For example, the lack of evidence in the knowledge base of SLT community regarding best practice in the area of clinical pragmatics has been noted in the literature as

perpetuating the confusion and uncertainty in the area (Cummings, 2009; Perkins, 2007). However, a lack of clarity about the role of the SLT, emergent in this study, has not frequently been suggested in the literature as a form of, or a contribution towards, clinical uncertainty. Thus, the theory of *Reshaping Remit* is useful, as it provides a foundation for a more in-depth exploration of the issue of uncertainty in clinical practice.

Relevance has been achieved by the way in which *Reshaping Remit* conceptually explicates the nature and management of *Uncertainty* which both echoes and extends the discussion of clinical uncertainty evident in the literature of clinical pragmatics. As discussed in Chapter 11, shedding light on *Uncertainty* and *Reshaping Remit* has identified further directions for research in the area of uncertainty management and clinical pragmatics in relation to SLT practice. Although a relatively small study with limited generalisability, the data analysis here provides insight into the complexities of SLT practice. As the theory of *Reshaping Remit* provides indications for further research directions, and theorising about some of the complex challenges of SLT practice, it can be deemed apposite to the profession.

12.2.3 WORK: A GT SHOULD PROVIDE A COHERENT EXPLANATION OF THE PHENOMENA UNDER STUDY

Achieving the criteria of "fit" and "relevance" are considered prerequisites to achieving the criteria of "modifiability" and "work" (Glaser, 1998, p. 17). Work has been called a theory's "power to explain" (Glaser, 2003, p. 131) which results from the "impact of fit and relevance" (Glaser, 1998, p. 237). The criterion of work decrees that a GT should not present an abstruse representation of the data but rather should present a meaningful conceptual explication of the participants' main concern.

A theory possesses work when it can "account for most of the variation of behaviour in the substantive area" (Glaser, 1998, p. 237). The theory of *Reshaping Remit* provides an analytical account of divergent forms of behaviour which are all related to *Uncertainty* and its management. The theory coheres superficially divergent empirical patterns relating to intervention provision and non-provision, and the enactment of disparate varieties of therapy as being associated to the one process of uncertainty management. The way in which the diversity in the data at a descriptive level (i.e., in terms of the many instances on which the concepts are based), can be integrated conceptually points to the development of a theory which works.

Data analysis integrated the wide range of issues arising in the area of clinical pragmatics into the complex and multifaceted concern of *Uncertainty*. *Reshaping Remit* integrated responses to this concern by cohering patterns in the data as one multivariate theory. Again, the provision of

multiple instances of data, in Chapters 6-9, demonstrates how *Reshaping Remit* brings together a wide range of instances together into a meaningful theoretical account and can be taken as an indication that *Reshaping Remit* works.

12.2.4 MODIFIABILITY: A GT SHOULD BE FLEXIBLE BUT RESILIENT

Glaser highlights how the modifiable nature of GT should entail that a "theory can never be more correct than its ability to work the data" (Glaser, 1978, p. 5). The notion of modifiability reflects the premise that "there is no such thing as a 'wrong' theory....the theory gets modified by subsequent data" (Glaser, 1998, p. 237). Thus, a GT should be able to accommodate and integrate many instances of data and adapt to new data as necessary until it is saturated. The adherence to GT procedures of theoretical sampling and constant comparison, in particular, enabled the researcher to modify and alter the emergent theory in light of fresh data, as dictated by the insights generated from data analysis.

The submission of three separate applications to the relevant Research Ethics Committee provided permission, in this study, for the researcher to approach three different data sites with divergent data collection techniques. There was a progression from using questionnaires, then utilising focus groups and document analysis, to finally achieving theoretical saturation in the final data site using interviews (see Appendix 1). The final data collection tactic of interviewing enabled specific categories of the theory of *Reshaping Remit* to be conceptually fleshed out. Interviewing facilitated the researcher in probing participants about particular facets of *Uncertainty* and responses to *Uncertainty*, at a later stage, when these categories had been uncovered as significant analytic concepts from previous analysis. The way in which the theory was modified in response to new data until theoretical saturation was achieved is demonstrated by the details provided in Chapter 5 which specifies how the iterative data collection-analysis process was enacted by the researcher.

Again, an understanding of and, most importantly, a trail of how GT procedures were realised (discussed in Chapters 4 and 5 respectively) presents some reassurance that the researcher carried out data collection and analysis iteratively (in that they were simultaneous and they informed and influenced each other). Thus, the clear trail of how the constant comparative procedure was carried out provides support for modifiability and the claim that *Reshaping Remit* was a theory which was adapted and altered in line with the new theoretical insights gleaned from the data.

12.3 RESEARCH LIMITATIONS

12.3.1 RELIANCE ON CRITERIA SPECIFIC TO GT FOR EVALUATING QUALITY

Following on from a discussion of the adequacy of research quality, some limitations should also be noted. The appropriacy of relying on distinct research quality criteria developed for specific methodologies, as this study has done, is not ideal. It has been suggested that methodology specific criteria can lead to a circular form of quality appraisal, in which the quality of the methodology is defined on its own merits (Miller & Fredericks, 1999). Additionally, the development of criteria for judging quality which are specific to only one methodology creates the potential for development of exponential quality criteria. Correspondingly, multiple criteria for the evaluation of research rigour may lead to insularism, by fracturing the discussion of research quality into generally inaccessible methodology-specific discussions. However, as noted in the introductory discussion in Section 12.1, there is, as of yet, a lack of consensus about how best to reconcile the advantages and disadvantages of universal and specific criteria for evaluating research quality.

12.3.2 BEING A GT NOVICE

The absence of a Classic GT supervisor is often cited in the literature of GT as a challenge to carrying out GT research. However, while there are undeniable benefits to having supervision from an individual experienced in GT, GT is well recognised as a methodology which is experiential (i.e., in that GT can only be learnt by carrying out a GT study, Glaser, 2003). As a novice user of Classic GT, I learnt the methodology not only from doing, but from reading and engaging with other grounded theorists at seminars specifically focused on GT.[118] These seminars provided opportunities to learn from and trouble shoot with experienced grounded theorists and also to present and discuss the current study, as a work in progress, to those attending the seminar. Indeed, in some ways, utilising a methodology which had not been previously used by my supervisor facilitated the development of autonomy and enabled me to reflect on and consider non-GT perspectives and challenges regarding the GT methodology in general, and the Classic GT methodology specifically.

[118] In June 2009, the author attended a 3 day Classic Grounded Theory seminar facilitated by Dr. Barney Glaser. In June 2008 and June 2010 the author attended 2 day Grounded Theory seminars facilitated by Dr. Tom Andrews. In June 2008, the author also attended an introductory workshop on Grounded Theory facilitated by Dr. Agnes Higgins.

12.3.3 RESEARCHER BIAS

The process of explicating personal belief systems regarding the nature of reality and knowledge is commonly cited as a quality control mechanism in the world of research. Situating the researcher in this way is considered important for ensuring research quality by exposing potential leanings and biases (Creswell, 2007; Lincoln & Guba, 1985; Miles & Huberman, 1994). The statement of the philosophical underpinnings of this study, in Chapter 4, and the explicit acknowledgement of the author's status as a practising clinician in chapter 1, were deliberate attempts to make these stances explicit to the reader.

The issue of bias can also arise from the author's personal and professional affiliations. As a practising SLT, the author cannot claim to have entered the field without being aware of any of the literature in the area of clinical pragmatics or having preconceptions about the area of clinical pragmatics or SLT practice. When the author began this study, as a relatively recent graduate with less than 3 years experience as a practising clinician, her time as a practising SLT was relatively limited. However, as the study progressed challenges in separating self as researcher from self as clinician emerged. These challenges will be briefly discussed in this section as an acknowledgement of the inevitable influence that the author's status as a SLT had on the current study.

The author attempted to approach the data with an open mind and to avoid substantive reading in the areas of clinical uncertainty until later stages of the research when the theory had emerged. Indeed, the author had little or no contact with the literature of the sociology of heath and illness prior to engaging in a literature review for this thesis. The depth of reading which was required to develop an adequate understanding of the areas of mainstream pragmatics and clinical pragmatics, for the purpose of a literature review, differed from the type of literature review that might be demanded of clinicians in day-to-day practice, both in terms of depth and focus. The GT procedures of constant comparison facilitated the author in weeding out false leads and concepts which did not pattern out. Additionally, the process of memo writing constantly throughout the generation of data and analysis also facilitated the author in reflecting on and separating her concerns from those of the participants.

Indeed, one of the most valuable consequences of constant memo writing was the opportunity it afforded the researcher to reflect on her reactions to the emergent theory. It transpired that some of the issues emergent in the study resonated with the author's personal experience as a clinician. Thus, the process of memo writing was indispensible in untangling the author's personal and emotional reactions to the data from patterns of action evident in the data. For example, the author began to think about her own clinical practice in terms of some of the

emergent concepts and noted how, at times, patterns echoing the response of *Containing Uncertainty through Homogenisation* stirred uncomfortable responses in the author when she identified these as patterns evident in her own practice as a SLT. On reflection it transpired that there may be clashes between the values and beliefs brought to clinical practice by the author and some of the underlying values embedded in the data. As an illustration of the author's values and beliefs, it is worth noting that the author draws on theory founded on the social model of disability to inform her thinking and in turn her clinical practice (for example, Byng & Duchan, 2005; Davis, 1995, 2006; French & Swain, 2004; Goodley, 2004). In particular, this body of literature mirrors many of the author's values and beliefs about the nature of disability.

The author was forced to confront and reflect on the values and beliefs which underpin her clinical practice in order to generate a data-driven account. While Classic GT offers a package of procedures which facilitates the researcher in separating out patterns in the data from personal responses to the data, the author had to work hard at hearing the participants by maintaining a minimal role during data gathering and using the language of the participants and paraphrases of the same as well as drawing on concepts from the emergent theory to guide the process of data collection. During analysis, unpacking the patterns evident in the data from concerns the author had about clinical practice involved significant reflection through memo-writing and strongly adhering to the iterative process of data generation-analysis that is the hallmark of GT studies. Being explicitly aware of personal values and beliefs facilitated the author in attending to the patterns evident in the data and focusing on these to inform the emergent theory. However, Classic GT does not produce an objective, neutral account of the phenomena studied or an accurate reflection of the lived experiences of participants. Rather Classic GT renders empirical data to a conceptual level producing a careful theoretical account authored by the researcher not the participants. Thus, as an authored piece of work, the final account of the data must contain traces of the researcher's values and beliefs and cannot be presented as a neutral account of the data. The author contends that explicating personal values and beliefs and becoming personally aware of the same through memo writing fostered a certain distance between these personal values and beliefs and the patterns of action identified in the data. However, a total separation of beliefs, values and data is impossible once the inseparability of self as clinician and self as researcher is acknowledged as it has been done here.

Classic GT has been misunderstood as a methodology which purports to not involve any level of interpretation (Charmaz & Mitchell, 1996). However, this may be an exaggeration of the stance taken by proponents of Classic GT. Glaser (1999), has claimed that all data is subjective and co-constructed, as noted in Chapter 4, and that GT offers a package of procedures for prioritising the concerns of participants, as opposed to the concerns of the researcher. However, GT does not

deny that more than one latent pattern may be evident in the data, and that any GT will be just one conceptual account of one pattern of many in the data. Classic GT's end product cannot be accurate or "wrong", in the positivist sense (Glaser, 1998, p. 237). GT simply generates hypotheses and resultantly a GT is just one researcher's conceptualisation of patterns in the data, which are driven by the participants' concerns. GT does not claim to be the ultimate and only way to represent the data (Glaser, 2001, p. 5). There will always be alternative research methodologies amenable to making sense of the data that are valuable (Glaser, 1999).

12.3.4 *RESHAPING REMIT'S* STATUS AS A SUBSTANTIVE THEORY

If, as Kovarsky (2008) contends, any given communication disorder (beyond the area of clinical pragmatics) needs to be subjectively defined in a person-specific manner, as well as being objectively defined, the issue of *Uncertainty* might well be more pervasive across SLT practice. However, in order to explore this point, further research across wider data sites would be indicated. Theoretical sampling would be needed to facilitate the generation of data focusing on SLT practice in general, as opposed to focusing (as in this study) on one specific area of practice, namely clinical pragmatics.

It would also be interesting, following on from this study, to explore if *Uncertainty* and its management manifest in similar ways with other clinical practitioners from a wider variety of disciplines.

SUMMARY

This chapter has discussed the manner in which the four GT criteria for evaluating research quality (namely, fit, relevance, work and modifiability) have been met in this study. An understanding and adherence to methodological procedures, as well as leaving a clear trail of the same, was demonstrated in Chapters 4 and 5. The provision of instances of illustrative data, in Chapters 6-9, was an explicit attempt at demonstrating research quality, as discussed in this chapter. Additionally, highlighting the limits of this research exposes the author's emergent understanding of the process of research and facilitated appropriate and well-placed conclusions being reached. The following chapter is the final one; it will present the main conclusions of this thesis.

CHAPTER 13. CONCLUSIONS

INTRODUCTION

The structure of this final chapter is as follows. Section 13.1 summarises the study, while some methodological conclusions following the use of Classic Grounded Theory (GT) are presented in Section 13.2. Finally, Section 13.3 presents the main contributions of this thesis for the advancement of theory in the areas of clinical pragmatics and uncertainty management in relation to SLT practice, in terms of identifying directions for future research.

13.1 THESIS SUMMARY

The aim of this study was to explore the main concern of members of the SLT community with regard to clinical pragmatics and SLT practice. Data analysis revealed a typology of responses, conceptualised as *Reshaping Remit*, as a theoretical account explicating how the participants resolved their main concern of *Uncertainty*. This study shed light on a novel research area and provided some preliminary analysis and theorising with regard to *Uncertainty* in the substantive area of clinical pragmatics.

The introductory chapters aimed to set the scene in which this study was carried out by briefly discussing the impetus and context for this research in the first chapter, and then by discussing the development of, and main issues arising in, literature from the areas of mainstream and clinical pragmatics, (in Chapters 2 and 3). Following this, the methodological choice of Classic GT was justified and the manner in which this methodology was realised was presented in Chapters 4 and 5. Chapters 6-9 provided a discussion of data analysis and, correspondingly, presented the theory of *Reshaping Remit*. The case for including subjective, non-clinical perspectives as legitimate, clinical evidence for guiding SLT practice in the face of *Uncertainty*, was made by exploring the nature of *Uncertainty* and the theory of *Reshaping Remit* against the extant, relevant literature in Chapter 10. Chapter 11 provided tentative suggestions regarding further directions for research. Chapter 12 explored the issue of research quality in relation to this study and finally, the current chapter concludes this thesis.

13.2 METHODOLOGICAL CONCLUSIONS REGARDING CLASSIC GROUNDED THEORY

This thesis demonstrates that Classic GT can be used to shed light on novel areas of research, using multiple data sources and sites, to explicate the nature and resolution of concerns in clinical practice. While Chapters 2 and 3 demonstrated that the areas of mainstream and clinical pragmatics were areas which were marred by confusion and disparity, the methodology of Classic GT enabled the author to expose and model these concerns in a coherent fashion. Thus, Classic GT facilitated an in-depth understanding of the issue of *Uncertainty* and its management beyond what had been noted in the literature of clinical pragmatics.

In an era when the challenges of implementing changes in clinical practice have become increasingly recognised (e.g., May & Finch, 2009), the complex and intricate interactions of variables involved in enacting and making changes to clinical practice have been exposed (Gabbay & Le May, 2004; Mowles, van der Gaag & Fox, 2010; Timmermans & Mauck, 2005). Classic GT was a methodology which facilitated the researcher in being able to analyse data in order to account for complex and distributed latent patterns. Thus, Classic GT may be a useful tool for exploring implementation of changes to clinical practice, from a conceptual perspective in other clinical studies.

The nature of Classic GT, which involves both empirical and theoretical analysis, facilitated the development of research findings which interface between theory and practice and which are not unidirectional (i.e., from theory to practice). Indeed, Classic GT may provide an alternative methodology for developing Practice-Based Evidence (PBE) (as introduced by Horn and Gassaway, 2007, 2010). PBE is founded on the notion that research at the cold face of clinical practice can provide insight to the nature of effective and ineffective clinical practice. However, PBE is an emerging method for generating evidence of clinical outcomes which advocates particular methodologies.[119] Despite the apparently divergent epistemological positions taken in PBE studies and health care studies which are carried out using GT, a focus on exploring patterns in real life clinical practice with a view to uncovering more effective forms of practice can be both realised by these two methodologies.

In this study, the theory of *Reshaping Remit* captured certain patterns in the data which were mirrored, in the existing literature, by some of the most current and progressive attempts at uncertainty management in clinical practice (such as joint clinical decision-making and the abandonment of static, unitary concepts of disorder and disability) noted in the literature. Thus,

[119] The approach known as Practice Based Evidence captures the use of prescribed observational methodologies which aim to identify interventions that currently work well in clinical practice (Horn, DeJong, Ryse, Veazie & Teraoka, 2005). This is done by exploring data retrospectively for associations between variables in order account for intervention effectiveness in natural everyday clinical practice.

certain patterns of behaviour, conceptualised from patterns occurring on the ground in SLT practice, resonated and extended suggestions in the literature relevant to uncertainty management.

Following extensively engaging with the GT literature, and the debates therein, some clarification regarding the basic premises of Classic GT would appear to be wanting. A stronger emphasis from advocates of Classic GT that Classic GT exposes only one of the many potential latent patterns in the data and that as a methodology it provides procedures which attempt to prioritise the concerns of participants, might reduce the misrepresentation of Classic GT. Classic GT has been inaccurately understood as a methodology which can render data objective. These clarifications may alleviate some of the "rhetorical wrestle" occurring between divergent schools of GT (Glaser, 1998, p. 35).

13.3 CONTRIBUTIONS TO THE ADVANCEMENT OF THEORY IN THE AREAS OF CLINICAL PRAGMATICS AND CLINICAL UNCERTAINTY IN RELATION TO SLT PRACTICE

The theory of *Reshaping Remit* is substantive because its focus was on a specific area of inquiry that concerned one discipline's main concern with regards to a particular area of its work. As such its main contributions revolve around the provision of suggestions for further research directions in the area of uncertainty management in relation to SLT practice in the context of clinical pragmatics.

13.3.1 SPECIFIC CONTRIBUTIONS TO THE THEORY OF SLT PRACTICE.

13.3.1.1 CONCEPTUAL EXPLICATION OF PATTERNS IN SLT PRACTICE.

The study has shed light on a relatively novel research area in focusing on *Uncertainty* in relation to SLT practice and clinical pragmatics. As noted in Chapters 2 and 3, previous literature had cited a variety of issues as being problematic in the area of clinical pragmatics. Much of the literature appears to identify problematic issues in the realm of clinical pragmatics and SLT practice via the analysis of, and reflections on, personal experiences or published accounts of intervention in the area of clinical pragmatics, rather than specifically exploring the SLT community's concerns in relation to clinical pragmatics.

This study is relatively unique in how it has looked to members of the SLT community to explore their concerns, rather than approaching participants with extant concerns and theory. This study hopes to add to the growing body of literature that has begun to explore the patterns

that underpin and characterise SLT practice (Anderson & van der Gaag, 2005; Bunning, 2004). To date, reflections on SLT practice have drawn on a variety of methodologies and analytical lenses, including case studies (Bunning, 2005), complexity theory (Mowles, van der Gaag & Fox 2010) Ethnography (van der Gaag & Davies, 1994), Frame Analysis (Duchan, 2004), grounded theory (Hersh, 2003, 2009) and the broad field of related methodologies known as discourse analysis (Duchan 1998; Kovarsky, Kimbarrow & Kastner, 1998; Walsh, 2007, 2008)–which also includes a pocket of studies which explicitly draw on critical discourse theory (Ferguson, 2009; Penn, 2004). The current study contributes to this body of work by explicating the complex nature of speech and language therapy practice and by exposing latent patterns of action which occur in relation to the multifaceted and intricate challenges, conceptualised as *Uncertainty*, faced by those in everyday clinical practice.

While the literature on clinical pragmatics has identified SLT practice in the area to be problematic,[120] few attempts have been made to explore how the SLT community has been coping with and resolving problematic issues in this area of practice. This research exposes how members of the SLT community have been attempting to resolve significant challenges. As explicated in Chapters 6-9, the development of *Reshaping Remit* provides an initial, conceptual account of *Uncertainty* and its resolution in the area of clinical pragmatics and SLT practice which has not been provided elsewhere, to the best of the author's knowledge. By exploring clinical uncertainty in the context of SLT practice, this study adds to the limited research which has been carried out to explore the conceptual patterns and frameworks which inform SLT practice in general.

There is a distinct rhetoric in the SLT related literature concerning a need to change practice patterns in light of the broader, evolving, socio-political climate (as noted by Graves, 2007). This shifting socio-political context in which health care services are situated is due in no small part to the emergence of alternative models for conceptualising the nature of disability (such as the social model of disability, as discussed in Chapter 10) which have urged practitioners to look beyond individualised interventions in order to realign the asymmetries in society at large that maintain disability. The data here has exposed the great opportunity provided by *Uncertainty* for realigning the asymmetries within the clinician-client relationship.

[120] Problems in the area of SLT practice and clinical pragmatics which have been raised in the literature include: a lack of consensus regarding effective clinical practice (Adams, 2008); divergent terminology use (Body & Perkins, 2006); misappropriation of terminology from the area of mainstream pragmatics (Cummings, 2007a; Perkins, 2010) and a need to reassess the theoretical basis of practice in the area of clinical pragmatics (Cummings, 2009; Duchan 2000b).

13.3.2 SPECIFIC CONTRIBUTIONS TO THE THEORY OF UNCERTAINTY MANAGEMENT IN RELATION TO SLT PRACTICE

13.3.2.1 CONCEPTUAL EXPLICATION OF THE NATURE OF CLINICAL UNCERTAINTY

This study adds support to and extends previous research which has exposed clinical pragmatics as a problematic area in relation to SLT practice, by theorising about the nature of *Uncertainty* in this substantive area. Correspondingly, a conceptual insight into the distributed and multifaceted nature of *Uncertainty* in the area of clinical pragmatics and SLT practice has been provided in this study. The insight generated into the nature of *Uncertainty* tentatively suggests it may be an inevitable part of clinical practice in this area.

It has been suggested without full empirical validation, that uncertainty is an issue across clinical practice of SLT community in general. For example, Bernstein Ratner (2011, p. 77) noted the presence of obvious forms of uncertainty as a reflection of the unformulated knowledge base of SLT (with regards to which SLT interventions work and for whom) in that, "nothing we do is certain, and that there is tension among competing approaches to a disorder as well as the competing characteristics of the people we see (age, concomitant problems, etc.)".

Additionally, the work of Kovarsky, as discussed in Chapter 10, has lent support to the notion that inherent uncertainty may be integral to the nature of communication health and disorder and as such may be an inescapable facet of SLT clinical practice.

This current study has attempted to explicate and specify, albeit at a conceptual and preliminary level, the nature of *Uncertainty* and how it has been managed via *Reshaping Remit*. This study uncovered the distributed and multifaceted nature of *Uncertainty* (i.e., *Uncertainty* as simultaneously an obvious knowledge-based and wider more inherent issue in clinical practice). As such, this study has made a particular contribution to understanding the nature of *Uncertainty*, in the context of SLT practice and clinical pragmatics, and has both supported and extended previous accounts of clinical uncertainty. The insight into the nature of *Uncertainty* generated here has thus contributed towards a better understanding of clinical uncertainty which has been called for:

> In sum, a firm understanding of the variety of meanings of uncertainty would in all likelihood yield substantially improved scholarship as well as enhancements in medical policies, in practitioners' and patients' communicative competence, and in patients' illness experiences and outcomes.
>
> (Babrow et al., 1998, pp. 3-4)

13.3.2.2 CONSIDERATIONS OF ROLE MAY INFLUENCE RESPONSES TO UNCERTAINTY

Typologies of responses to *Uncertainty* in the data, vis-à-vis the theory of *Reshaping Remit*, portrayed varying enactments of the SLT role. Thus, this study points to the use of role as a platform for exploring uncertainty management. Sites in which clinical role formation occurs may provide settings where divergent responses to uncertainty could potentially be acculturated. Chapter 11 explored some suggestions about how divergent reactions to uncertainty (other than the current socialisation of certainty, as suggested by Kamhi, 2011a) might be incubated during clinical training.

If *Uncertainty* is inherent to clinical pragmatics and SLT practice, then facilitating clinicians better understand *Uncertainty* by providing them with language and concepts to untangle and acceptable forms of clinical uncertainty from less acceptable forms of the same may be beneficial, Additionally, this may enable clinicians to embrace *Uncertainty* as part of the SLT role, rather than disregard its presence. This study also has suggested that the responses to *Uncertainty* captured by *Stretching Remit* may be the most thorough and complete form of uncertainty management, in light of the nature of *Uncertainty* evident in the data. The normalisation of *Uncertainty* as an inevitable element of SLT practice facilitated the response of *Stretching Remit* to be enacted. However, how the role of the Speech and Language Therapist can best integrate and accommodate *Uncertainty* requires much more verification in further research. This study is not representative and, as such cannot make claims to have represented the profession of SLT or the area of clinical pragmatics entirely.

13.3.2.3 NON-CLINICAL KNOWLEDGE AS A LEGITIMATE SOURCE OF CERTAINTY IN CLINICAL PRACTICE.

Recognition of *Stretching Remit* as the most thorough response to *Uncertainty*, in acknowledgement of the nature of *Uncertainty* that emerged in this data, can be taken to imply that the inclusion of subjective and non-clinical knowledge may be necessary in the clinical process. Although conceptual, *Stretching Remit* posited some initial suggestions for how subjective and non-clinical perspectives might be drawn on for informing SLT practice in relation to clinical pragmatics.

13.3.3 SPECIFIC CONTRIBUTIONS TO THE THEORY OF CLINICAL PRAGMATICS IN RELATION TO SLT PRACTICE

13.3.3.1 FUNCTIONALIST-INSPIRED DEFINITIONS OF PRAGMATICS MAY COMPLEMENT UNCERTAINTY

The fact that *Uncertainty* emerged in a study of clinical pragmatics is perhaps unsurprising, given the definitional confusion evident in the area of mainstream and clinical pragmatics, discussed earlier in Chapters 2 and 3, as well as the hybrid emergence of the SLT profession noted in the Chapter 1. However, specifically in light of the nature of *Uncertainty* emergent in this study, the theory of clinical pragmatics may be better supported by drawing on contextualised approaches to pragmatics, following on from the tradition of Ordinary Language Philosophy and functional linguistics, for future theorising about clinical pragmatics.

Chapters 2 illustrated the divergent ways in which formal and functional linguistic traditions specify and conceptualise pragmatics and, as such, point to functionalist-inspired and Ordinary Language Philosophy definitions of pragmatics as the most complementary to both the obvious and inherent nature of *Uncertainty*. This study highlights the need for further theory development in the area of clinical pragmatics and has suggested that explorations into clinical applications of pragmatic theory, even at a conceptual level, have the potential to inform the theory of clinical pragmatics.

13.4 FINAL THOUGHTS

Clearly, this is a preliminary piece of research which has generated more questions than it has answered. However, the take-home message from this study is that we cannot assume to be certain about SLT practice in the area of clinical pragmatics. *Uncertainty* emerged for a number of intricate and interacting reasons which touched on some of most profound issues regarding the nature of communication health and communication disorder and a clinician's shared understanding of these with the client. As noted in the conclusions, and as advised in the data, the normalisation of *Uncertainty* is one way of dealing with clinical uncertainty that appreciates its complex obvious and inherent nature and consequently, the totality of what *Uncertainty* might bring to clinical practice. Normalising clinical uncertainty involves acknowledging that it may well be a pervasive and inevitable issue in clinical practice:

EXTRACT 13. 1

"maybe we're certain about the uncertainty and we're certain about the reality of that uncertainty that's getting a bit philosophical but maybe it's never going to be that certain"

Interview No. 4:
Page 30: lines 1503-1509

Indeed, from a philosophical stance, Russell mirrors the sentiments expressed by the participant above, noting how in order to prevent stagnation as a response to uncertainty, in general, we must learn to tolerate uncertainty:

> Uncertainty in the presence of vivid hopes and fears, is painful, but must be endured if we wish to live without the support of comforting fairy tales...To teach how to live without certainty, and yet without being paralyzed with hesitation, is perhaps the chief thing that philosophy in our age can still do for those who study it.
>
> (Russell, 2005, p. 2)

Fairy tales are hallmarked by the fact that they are not real. Following the data, and expanding on Russell's point, the author would like to suggest that certainty is a "fairly tale" in the context of SLT practice and clinical pragmatics. The data here provided impetus for conceptualising multiple ways of working in the context of *Uncertainty*, and modifying the role of the client and clinician accordingly. In denying uncertainty, we may be in danger of falling prey to the "support of comforting fairy tales", as Russell noted above. This tendency towards the fairy tale of certainty in clinical practice is a well established criticism of the underpinnings of much modern clinical work and education (Atkinson, 1984, 1995). From a SLT perspective, the challenge of operationalising a role which is less focused on technique and certainty and more concerned with reflective practice and professional artistry has been recognised. However, it has been suggested that embracing uncertainty is not an easy or straightforward task:

> Professional practice is therefore more than its surface features and skills. This is a more uncomfortable place to work in the absence of certainties and the necessity of continually re-evaluating practice. Quality in this approach is about making appropriate moral judgements, which comes through examining our own interactions, attitudes and beliefs.
>
> (van der Gaag & Anderson, 2005, p.4)

The conundrum which clinical pragmatics has placed the SLT community in has exposed the resilience of clinicians for managing *Uncertainty* and the creative and innovative ways in which participants got things done in the context of *Uncertainty*. Additionally, this thesis has suggested that standardisation may not provide the most appropriate way for dealing with *Uncertainty*, for the SLT community in the area of clinical pragmatics. It may be that the way in which the SLT community deals with *Uncertainty* will shape how the role of the Speech and Language Therapist evolves in the future. As such, the question remains with the profession of SLT, in light of *Uncertainty*, do SLTs want to be seen as "**fairy godmother[s]**[121]" promising and promoting

[121] Letters in brackets have been added to this phrase taken from extract 13.2.

certainty, or clinicians who "**empower other people**" by acknowledging *Uncertainty* and sharing responsibility, authority and expertise during the clinical process.

EXTRACT 13.2

"well I see kids twice a week so you know we spend a lot of time together ((laugh)) twice a week you know for sometimes over a year so it's a lot of intervention but sometimes with the you know I would try with the language kids to gradually reduce that and eventually fade out em because you don't want to be seen as the fairy godmother whose going to fix it that's my worst fear ((laugh)) cos then when you've stopped you know when you withdraw it's just like you know you're pulling the rug from under them and it's they're totally on their own so I suppose trying to trying all the all the way along to kinda keep them involved to keep the school involved just empower other people you know"

Interview No. 4:
Page 13: lines 633-656

To borrow Russell's (2005, p. 2) terminology, striking a balance between becoming overwhelmed by "hesitation" and "paralysis" on one hand, and allured by "fairy tales" on the other, is the challenge to be faced in light of clinical uncertainty. The analysis here has provided a number of ways for thinking about how the SLT community might strike this balance.

Finally, going through the research process under supervision has significantly contributed to the author's development as a researcher and as a clinician. In addition to the development of technical research skills, the luxury of spending a considerable amount of time reflecting on clinical practice has fostered the development of insight into SLT practice which will profoundly impact on how the author's own clinical practice will be approached in the future.

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Appendices

Appendix 1: Sequence of data generation and analysis, in relation to seeking ethics approval

Appendix 2: Blank questionnaire as used during data collection

Appendix 3: Cover letter inviting SLTs to participate in focus groups and to complete questionnaires

Appendix 4: Reminder letter used to encourage return of questionnaires and to invite participation in focus groups

Appendix 5: Face sheet/biographical information about the practising SLTs who participated in focus groups.

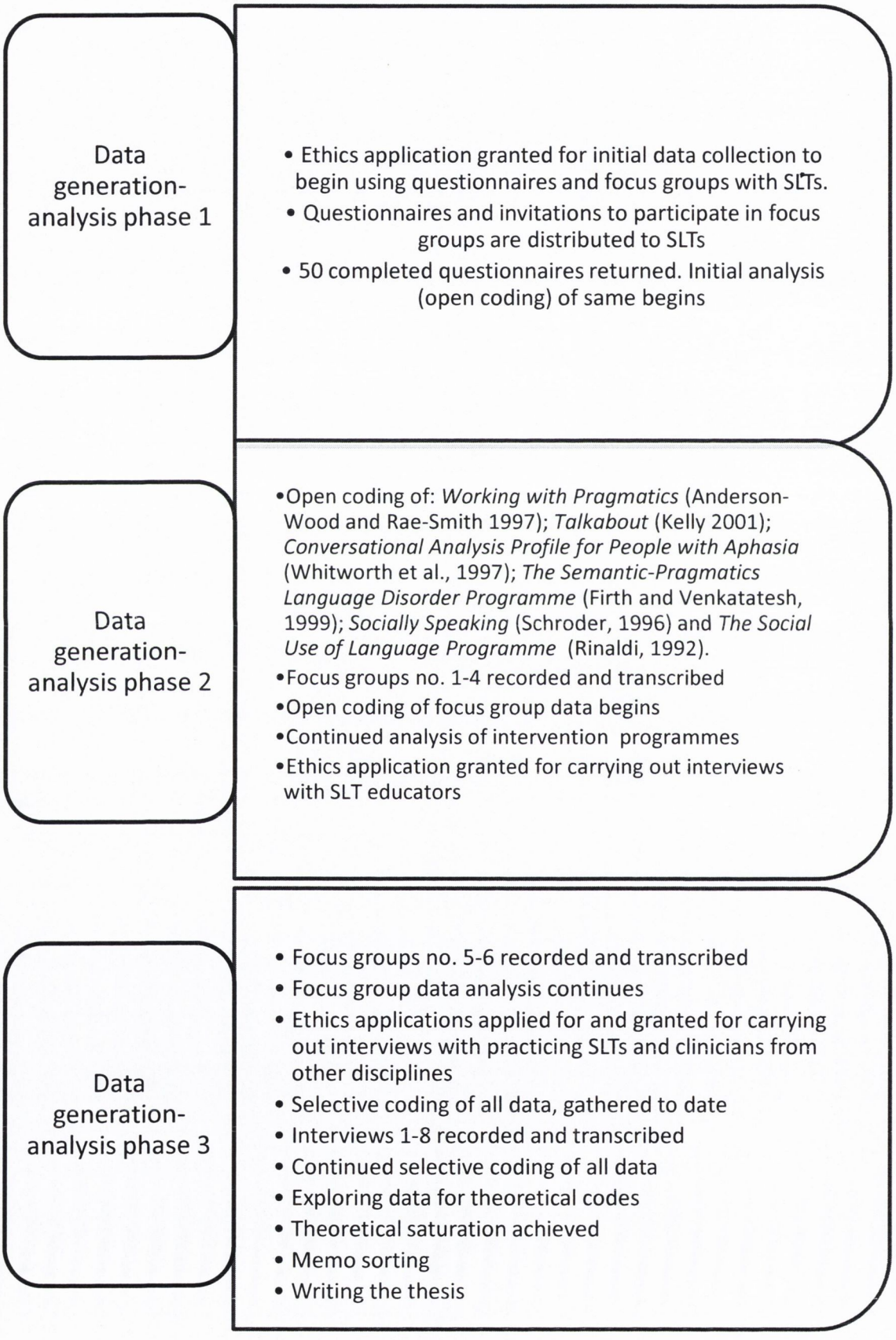
Appendix 6: Template of letter used for securing informed consent from participants

Appendix 7: Frequency with which commercially available intervention resources were cited in questionnaire responses from practicing SLTs.

Appendix 8: Table illustrating the data used in the creation of Figure 8: *"Phenomena used in participants' definitions of 'Pragmatics/Pragmatic language".*

Appendix 9: Two tables illustrating the data used in the creation of Figure 12: "Features leading participants to "suspect" and "diagnose" Pragmatic language difficulties"

Appendix 1: Sequence of data generation and analysis, in relation to seeking ethics approval



Appendix 2: Blank questionnaire as used during data collection

Data Collection: Questionnaire

Pragmatics & SLT

19/03/2008

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Please complete this questionnaire by answering all questions, 1-21. This questionnaire can be returned via post. Answer spaces are provided otherwise, tick as many boxes as necessary. All information obtained in this questionnaire will be treated confidentially and anonymously. Your participation in this questionnaire is greatly appreciated.

Q 1. In your clinical experience, by virtue of presenting with Speech and language difficulties, clients also present with Pragmatic language difficulties, to some extent.

- ☐ True
- ☐ False
- ☐ Unsure
- ☐ Don't know

Q 2. If you had to describe 'Pragmatics/Pragmatic Language' to a parent/carer/spouse what would you say?

_____
_____
_____
_____
_____
_____

Q 3. If you had to describe 'Pragmatics/Pragmatic Language' to another professional e.g. psychologist/psychiatrist, what would you say to them?

_____
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Q 4. Do you believe that Pragmatic language difficulties can exist independent of social skills difficulties?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Don't know

Q 5. A final year Speech and Language Therapy student is on clinical placement with you. She/he asks you what 'Pragmatic Language Difficulties/Impairment' means, how would you explain this to the student?

Q 6. In your opinion, a SLT can independently diagnose Pragmatic language difficulties?

- ☐ Yes, please explain:
- ☐ No, please explain:
- ☐ Unsure
- ☐ Don't know

Q 7. What features lead you to ***suspect*** Pragmatic language difficulties in an adult or child?

Q 8. What features lead you to ***diagnose*** Pragmatic language difficulties in an adult or child?

Q 9. A client presents with language and communication difficulties despite the fact that their standardised scores from formal assessment (e.g. The Test of Pragmatic Language 2, Western Aphasia Battery, or the Clinical Evaluation of Language Fundamentals) are all falling within the average range. What further assessments or forms of assessment might you carry out?

_____

_____

_____

_____

_____

Q 10. In one of your SLT sessions focusing on Pragmatics, what might 3 typical objectives/goals/areas of focus be?

_____

_____

_____

_____

_____

_____

Q 11. In your clinical experience, intervention focusing on Pragmatics is carried out in which of the following settings:

- ☐ In a clinical setting
- ☐ In a non-clinical setting:
  Please
  specify_____
- ☐ Both of the above
  Please specify non clinical setting _____
- ☐ Don't know

Q 12. In your clinical experience, who else is best placed to be involved in SLT intervention with clients who have Pragmatic language difficulties?

_____

_____

_____

_____

Q13. When working with clients with Pragmatic language difficulties please specify which published materials and resources you use (e.g. assessments, therapy programs, books etc). Please rate each one on a scale of 1 to 5, with 1 being not very useful, and 5 being very useful.

_____

_____

_____

_____

_____

_____

Q 14. In your experience, SLT Intervention for clients with Pragmatic language difficulties generally occurs in which of the following settings:

- ☐ 1:1 setting
- ☐ 2/3:1 setting (small group)
- ☐ 4+:1 setting (larger group)
- ☐ 1:2 setting (joint setting with other professional)
- ☐ Other, please specify

_____

Q 15. In your daily clinical practice, are differences or changes in Pragmatic language measured pre and post therapy?

- ☐ Yes

  Please specify method(s) used:

  _____

  _____

  _____
- ☐ No
- ☐ Sometimes
- ☐ Don't know

Q 16. In your clinical practice, are the same assessment methods used for pre and post therapy measurement?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ Don't know

Q 17. Discharge criteria for clients with 'Pragmatic Language Difficulties/Impairment' are set using:

- ☐ Assessment results from standardised assessments
- ☐ Assessment results from non-standardised assessments
- ☐ Client satisfaction levels
- ☐ Other, please specify

_____

Q18. Over the passing years, how has your clinical practice informed your:

A) Understanding of Pragmatics

_____

_____

_____

B) Understanding of Pragmatic language difficulties

_____

_____

_____

Q 19. Roughly speaking what percentage of your therapy is pragmatically orientated, i.e. focuses on the area of pragmatics?

- ☐ 0-10%
- ☐ 10-30%
- ☐ 30-50%
- ☐ 50% or more
- ☐ Other, please specify: _____%

The next short section asks for some biographical information:

Q 20. How long are you practising as a SLT:

- ☐ 0-5 years
- ☐ 5-10 years
- ☐ 10-15 years
- ☐ 15+ years

Q 21. What clinical population do you work with (please tick as many as appropriate):

- ☐ Children
  - ☐ Developmental Speech and Language
  - ☐ Physical Disability
  - ☐ Learning Disability
  - ☐ Voice
  - ☐ Language Unit/Class
  - ☐ Child Psychiatry
  - ☐ Fluency
  - ☐ Dysphagia
  - ☐ Traumatic Brain Injury
  - ☐ Other, please specify below:
- ☐ Adults
  - ☐ Traumatic Brain Injury
  - ☐ Physical Disability
  - ☐ Learning Disability
  - ☐ Voice
  - ☐ Acquired Neurological Disorders
  - ☐ Mental Health
  - ☐ Fluency
  - ☐ Dysphagia
  - ☐ Other, please specify below:

_____

_____

_____

If there is anything on a related note, which you wish to share/include, please do so here:

_____

_____

_____

_____

_____

THANK YOU FOR YOUR VALUABLE INPUT AND TIME

Appendix 3: Cover letter inviting SLTs to participate in focus groups and to complete questionnaires

UNIVERSITY OF DUBLIN

SCHOOL OF LINGUISTIC, SPEECH AND COMMUNICATION SCIENCES

Department of Clinical Speech and Language Studies

Tel: (++ 353 1) 896 1496
Fax: (++ 353 1) 6712152
e-mail : cslssec@tcd.ie

184 PEARSE STREET
TRINITY COLLEGE
DUBLIN 2, IRELAND

Dear SLT Manager,

I am writing to ask you for some support in data collection for my PhD research study which is in the subject area of Pragmatics. I am specifically interested in how we as a profession have come to operationalise and use pragmatic principles in our practice.

My research question will address issues such as how the SLT literature environment (e.g. textbooks on pragmatics and published materials dealing with pragmatic assessment and intervention) influences our practice. My research question also seeks to discover the perception of pragmatics from other members of the SLT world, including service users (and parents, partners), SLT educators and SLTs themselves. I would appreciate your help in gaining access to the later group, hence this letter.

To really get a grasp of what SLTs think about pragmatics, I need to hear their professional "voice." In the first instance, I am distributing **questionnaires** (as enclosed and as forwarded to you by e mail). I would greatly appreciate if you could distribute or forward these to your team as you deem appropriate. Questionnaires can then be returned via e mail or by post. I would be most grateful if these questionnaires could be returned **on or before Wednesday 30th April, 2008.**

Secondly, as an extension to this initial stage of data collection, I intend running some **focus group meetings** to discuss issues relevant to pragmatic assessment and intervention by SLTs. As such then, may I ask you to nominate a member of your team or others who may be interested and willing to join me in a short focus group discussion at a time and place of convenience to the participants. I have enclosed (attached) a form for interested parties requesting contact details so that I may be able to contact them directly once you are happy that they participate. Again, these forms may be returned via e mail or by post. Also attached is further information on the focus groups. I would also appreciate if these could be returned by the above-mentioned deadline of **Wednesday 30th April, 2008**. I do not see the focus group taking up any more than 2 hours of their time.

Given our professional expertise and experience, we as Speech and Language Therapists are uniquely placed to comment on, critically evaluate, and intervene clinically in the area of Pragmatics. As you know, service providers and users, are continually calling for us to provide and practice within an intervention framework that is evidence-based. By taking part in this research you are contributing to that process, and adding to the SLT research pool. My data analysis and research aims to inform the area of clinical and non-clinical Pragmatics, and to acknowledge our unique, professional contribution to the subject area of Pragmatics. I will be happy to present my findings to your team on completion of my research.

My supervisor and I would be delighted to discuss any questions or queries you might have on this project. Our contact details are outlined below*:*

Sinéad Kellaghan at 087-1366631 or via email skellagh@tcd.ie

Dr. Irene Walsh at 01 6233190 or via e mail: ipwalsh@tcd.ie

Thanking you in anticipation,
Kind regards,

Sinead Kellaghan
Speech & Language Therapist

Dr Irene Walsh (PhD Supervisor)
Director of Undergraduate Teaching& Learning

Appendix 4: Reminder letter used to encourage return of questionnaires and to invite participation in focus groups

UNIVERSITY OF DUBLIN

SCHOOL OF LINGUISTIC, SPEECH AND COMMUNICATION SCIENCES

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Fax: (++ 353 1) 6712152

e-mail : cslssec@tcd.ie

184 PEARSE STREET

TRINITY COLLEGE

DUBLIN 2,
IRELAND

Please disregard this letter if you have returned all relevant documentation

Dear SLT Manager,

I am writing to thank you and your staff, for your support to date, in contributing to data collection for my PhD research study. My research interest is in the subject area of Pragmatics, and is focused on exploring Pragmatics in the context of Speech and Language Therapy practice. There has been a very encouraging response from the SLT community so far.

I had distributed questionnaires and focus group participation forms as an invitation to take part in this piece of research. The deadline for the return of completed questionnaires and focus group participation forms has recently passed. In light of this, I am now writing to call for any outstanding questionnaires and in particular, focus group participation forms to be returned. I would be very grateful if you could bring this to the attention of your staff, as a reminder to return any outstanding completed questionnaires and focus group participation forms. Forms can be returned to me at the above address or via email at skellagh@tcd.ie , additional forms can also be obtained from me at these points of contact.

Given our professional expertise and experience, we as Speech and Language Therapists are uniquely placed to comment on, critically evaluate and intervene clinically in the area of Pragmatics. As you know, service providers and users, are continually calling for us to provide and practice within an intervention framework that is evidence-based. By taking part in this research you are contributing to that process, and adding to the SLT research pool. My data analysis and research aims to inform the area of clinical and non-clinical Pragmatics, and to acknowledge our unique, professional contribution to the subject area of Pragmatics. I will be happy to present my findings to your team on completion of my research.

I would be delighted to discuss any questions or queries you might have on this project. My contact details are outlined below:

Sinéad Kellaghan at 087-1366631 or via email skellagh@tcd.ie

With sincerest thanks

Sinead Kellaghan
Speech & Language Therapist

Appendix 5 : Face sheet/biographical information about the practising SLTs who participated in focus groups.

Participant No.	*What clinical population do you work with?*	*How long are you practising as a SLT?*
Focus Group 1		
Participant 1	Children→ Developmental Speech and Language	**15 + years**
Participant 2	Children→ Developmental Speech and Language Children→ Fluency	**5-10 years**
Participant 3	Children→ Developmental Speech and Language	**0-5 years**
Participant 4	Children→ Developmental Speech and Language Children→ Language Unit/Class	**10-15 years**
Participant 5	Children→ Developmental Speech and Language Children→ Language Unit/Class	**5-10 years**
Participant 6	Children→ Learning Disability	**0-5 years**
Participant 7	Children→ Developmental Speech and Language	**15+years**
Participant 8	Children→ Developmental Speech and Language Children→ Language Unit/Class Children→ Voice	**0-5 years**
Participant 9	Children→ Language Unit/Class	**5-10 years**
Focus Group 2		
Participant 1	Children→ Physical Disability Children→ Learning Disability Children→ Voice Children→ Fluency Children→ Dysphagia Children→ Traumatic Brain Injury	**5-10 years**
Participant 2	Children→ Physical Disability Children→ Learning Disability Children→ Traumatic Brain Injury Adult→ Traumatic Brain Injury Adult→ Physical Disability Adult→ Learning Disability Adult→ Acquired Neurological Dis.	**0-5 years**
Participant 3	Children→ Developmental Speech and Language Children→ Physical Disability Children→ Dysphagia Children→ Traumatic Brain Injury	**0-5 years**
Participant 4	Children→ Developmental Speech and Language Children → Physical Disability Children→ Learning Disability Children→ Dysphagia	**0-5 years**
Participant 5	Children→ Physical Disability	**10-15 years**
Participant 6	Children→ Physical Disability Children→ Learning Disability Children→ Dysphagia Children→ Traumatic Brain Injury	**0-5 years**

Focus Group 3		
Participant 1	Children→ Autism	**10-15 years**
Participant 2	Children→ ASD	**5-10 years**
Participant 3	Children→ Developmental Speech and Language Children→ Learning Disability Children→ Language Unit Class Children→ Autism	**5-10 years**
Focus Group 4		
Participant 1	Children→ Developmental Speech and Language Children→ Physical Disability Children→ Learning Disability Children→ Autism	**0-5 years**
Participant 2	Children→ Developmental Speech and Language Children→ Physical Disability Children→ Learning Disability Children→ Voice Children→ Fluency	**0-5 years**
Participant 3	Children→ Developmental Speech and Language Children→ Physical Disability Children→ Learning Disability Children→ Language Unit/Class	**0-5 years**
Focus Group 5		
Participant 1	Adult→ Learning Disability Adult→ Mental health Adult→ Fluency	**0-5 years**
Participant 2	Adult→ Learning Disability Adult→ Mental health Adult→ Fluency Adult→ Dysphagia	**15+ years**
Participant 3	Adult→ Learning Disability	**5-10 years**
Focus Group 6		
Participant 1	Adult→ Traumatic Brain Injury Adult→ Acquired Neurological Dis. Adult→ Dysphagia	**5-10 years**
Participant 2	Adult→ Traumatic Brain Injury Adult→ Acquired Neurological Dis. Adult→ Dysphagia	**5-10 years**
Participant 3	Adult→ Voice Adult→ Acquired Neurological Dis. Adult→ Dysphagia	**15+ years**

Appendix 6 : Template of letter used for securing informed consent from participants

UNIVERSITY OF DUBLIN

SCHOOL OF LINGUISTIC, SPEECH AND COMMUNICATION SCIENCES

Department of Clinical Speech and Language Studies

Tel: (++ 353 1) 896 1496
Fax: (++ 353 1) 6712152
e-mail : cslssec@tcd.ie

184 PEARSE STREET
TRINITY COLLEGE
DUBLIN 2,
IRELAND

Working Title of Project: Pragmatics in the Speech & Language Therapy Community

Researcher Sinead Kellaghan (PhD. candidate)

Supervisor: Dr. Irene Walsh, School of Clinical Speech and Language Studies,

You are invited to participate in this research project which is being carried out by the above, in conjunction with The School of Clinical Speech & Language Studies, Trinity College Dublin. Your participation is voluntary. Even if you agree to participate now, you can withdraw at any time from the interview/focus group without any consequences of any kind.

This Research Project is designed to explore the subject area of Pragmatics in the context of speech and Language Therapy practice. If you agree to participate you will be involved in taking part in a once off focus group or interview.

All data gathered will be treated anonymously. Any identifying elements will be omitted from transcription of the data and thus will not appear in any part of the research project. The original audio recordings will be stored in a secure location and will be used only by the principal researcher. Audio recordings will be stored for a period of 5 years post research completion date, after this time they will be destroyed. You are free to contact the project supervisor or researcher for further clarification or information as required.

Thank you for your valuable time and input

I have read the above and I am giving informed consent to participate in the above research, and I consent with audio-recording specifications

Signature of participant: _____ Date: _____

I believe the participant is giving informed consent to participate in this study,

Signature of researcher: _____ Date: _____

Appendix 7: Frequency with which commercially available intervention resources were cited in questionnaire responses from practicing SLTs.

Key:

Names of resources below are verbatim from the responses of SLTs in the questionnaire

X= Number of times cited across all 50 questionnaires

"ACE (narrative section)" X1
"Assessment of High Level language" X1
"Auditory/Language Processing assessment" X1
"Australian screening test for Aspergers" X1
"Autism checklists" X1
"Autism in the early years observational profile" X1

"Blacksheep materials" X1
"Blacksheep Press Pragmatics" X1
"Blacksheep press pragmatics/emotions" X1
"Blacksheep press" X1
"Blacksheep Press-figurative language" X1
"Blacksheep speech bubbles" X2
"Blacksheep (section which has visual prompts for telling stories)" X1
"Bus Story" X1

"CAPPA" X1
"CASL subtest (Pragmatic Judgement" X1
"CASL-Pragmatic language section of" X1
"CAT" X1
"CELF-4 Pragmatics checklist" X6
"CELF-4 UK pragmatic profile/subtest" X4
"CELF-4 UK" X1
"Children's communication checklist" X 5
"Children's communication checklist-2" X 9
"Clip Pragmatics Book" X5
"Colour cards what's wrong?" X1
"Comic Strip Conversations" X1
"Conversations Connections: A whole language approach. Preschool Programme" X1
"Conversations: A framework for intervention (B. Hoskins)"X1

"Daily Communication therapy" X1
"Don't take it so literally Programme" X1

"Everyday communication profile" X1
"Expression, Reception &Recall of Narrative Instrument" X2
"(ERRNI)(Pete and the cat)" X1

"Functional Communication checklist" X1

"Hanen-More than words" X1
"HELP social language workbook" X1

"I say workbook" X 2
"ICD10-Aspergers? Gillberg/Australian Scales" X1

"Language for thinking workbook" 1
"Language Processing test revised" X1
"Listening Test" X4

"Maxwell's Manner board games" X1
"Measure of Cognitive-Linguistic Abilities" X1 (is this a pub material?)
"Mount Wilga" X1

"NEALE"X1

"PACE"X1
"PALPA" X1
"PDD questionnaire" X1
"PEC" X1
"Practical language Activities" X1
"Pragmatic Activities from Blacksheep Press" X1
"Pragmatic Checklist" X1
"Pragmatic language program" X1
"Pragmatic profile of Everyday Communication Skills in Children" X2
"Pragmatics pack of picture cards" X1
"Pragmatics Profile (adults)"X1
"Pragmatics Profile (CELF-4)" X1
"Pragmatics Profile (children)" X1
"Pragmatics Profile (not specified)" X 18
"Pragmatics Profile (self/other version)" X1
"Pragmatics profiles" X2
"Question the Direction" X1
"Rating scales e.g. Talkabout" X1
"RCBA" X1
"REEL-2" X1
"Right Hemisphere Battery"X1
"Right hemi-sphere language Battery" X1
"Room 14" X1

"Sandbox stories" X1
"Semantic Pragmatic Checklist" X1
"Semantic –Pragmatic Language Disorder: speechmark practical resource pack" X3
"Social competence, skills and worries questionnaire" X1
"Social Skills Checklist from McTear & Conti Ramsden" X2
"Social Skills for Schizophrenia (A. Bellack)" X1
"Social Skills handbook" X1
"Social Skills Strategies" X1
"Social skills training for children and adolescents with Asperger Syndrome" X1
"Social skills training questionnaires" X1
"Social Skills Training" X1
"Social Star (Gajewski)" X1
"Social Stories(Carol Gray)" X5
"Social use of language program" X 17
"Social use of language program-adapted" X 1
"Social use of language questionnaires (Wendy Rinaldi)" X1
"Social use of language" X 1
"Socially Speaking Profiles" X1
"Socially Speaking" X5

"Sourcebook of Pragmatic activities, Weinrich, B & Johnston, Elizabeth Booth" X2
"Speaking of speech.com" X1
"SPPARC" X2
"Strengths and Difficulties questionnaire SPQ" X2
"Super Duper pragmatics fun deck" X1

"Talkability" X1
"Talkabout activities" X1
"Talkabout Ax (Alex Kelly)" X1
"Talkabout DVD (A.Kelly)" X1
"Talkabout relationships (A. Kelly)" X1
"Talkabout" X 14
"Talking it out" X1
"Test of Ambiguity" X1
"Test of Pragmatic Language" X 8
"Test of Problem Solving" X1
"Test of Word Finding" X2
"The Coping Skills Workbook" X1
"The language of Perspective Taking" x1
"The sourcebook of Practical Communication" X1
"The Word Book" X1
"The Word Kit" X1
"The WORD Test" X 1
"Think it say it" X3
"Time to Talk LDA" X1
"TOMs" X3
"Tony Attwoods" Book X1
"TOPL " X 4
"TOWK (Test of Word Knowledge) Multiple meaning subtests" X1

"Understanding Ambiguity" X1

"What would you do cards" X1
"What's wrong pictures/cards" X2
"Working Things out program John Sharing" X1
"Working with Pragmatic difficulties" X1
"Working with Pragmatics" X4
"Working with students with Asperger Syndrome" X1

Appendix 8: Table illustrating the data used in the creation of Figure 8: *"Phenomena used in participants' definitions of 'Pragmatics/Pragmatic language".*

Table of categories of phenomena used in participants responses to Q2 and Q 3 from the questionnaire in which they defined Pragmatics

Descriptive Categories	Frequency	Percentage of these features in all responses to questions No. 2 and 3	Examples of features from each descriptive category *[Words in italics have been added]*
Linguistic Phenomena	147	41.6%	'turn taking, initiating and terminating' (QA No.4) 'Child's ability to take conversational turns...Also ability to initiate conversation' (QA No. 11) 'how well we get our message across to people using words..' (QA. No 46)
Extralingiustic phenomena	53	15.0%	'reading signals from others eg body language and facial expression' (QA No. 6) 'eye contact...tone of voice' (QA No. 4) 'intonation, proximity' (QA No. 16)
Social phenomena	129	36.6%	'linked c [*with*] Social skill' (QA No. 11) 'Our knowledge of social rules' (QA No. 3) 'impacts our ability to socialise and form relationships with others' (QA No. 17) 'child having difficulty relating to their peers' (QA No. 43)
Cognitive phenomena	18	5.1%	'taking the listener's perspective' (QA No. 7) 'taking into account your listeners knowledge about what you are talking about' (QA No. 12)
Behavioural phenomena	4	1.1%	'Inappropriate social skills masked sometimes as an unusual eccentric personality' (QA No. 29) 'odd c [*with*] reg [*regard to*] beh [*behaviour*]' (QA. No. 24)
Other phenomena	2	0.6%	'perhaps give an example of a right hemi-sphere presentation' (QA No. 24)

Appendix 9: Two tables illustrating the data used in the creation of Figure 12: "Features leading participants to "suspect" and "diagnose" Pragmatic language difficulties"

Table of responses to Q7 in the questionnaire in which participants were asked to detail the factors which would lead clinicians to "suspect Pragmatic language difficulties in an adult or child"

Descriptive Categories	Frequency	Percentage of indicators of these categories in all responses to Q.7	Examples of features from each descriptive category *[Words in italics have been added]*
Linguistic	99	38.5%	'Poor topic management-ie flitting from one topic to another or alternatively speaking at ++length about 1 topics' (Questionnaire No. 2) Difficulties with higher end language: idiom/sarcasm (Questionnaire No. 3) 'disorganised narrative, rambling' (Questionnaire No. 9)
Extralingiustic	33	12.8%	'Poor eye contact' (Questionnaire No. 6) 'Inappropriate paralinguistic features' (Questionnaire No. 34)
Cognitive	32	12.4%	'Difficulty with inferred information' (Questionnaire No. 3)5 'In young children concerns would most likely relate to attn' [*attention*] (Questionnaire No. 6) 'Lack of awareness of listeners' perspective, (Questionnaire No. 2)
Social	50	19.5%	'over friendly...difficulty c [*with*] friendships ' (Questionnaire No. 27) 'poor peer relationship' (Questionnaire No. 32) 'difficulty developing a rapport c [*with*] T [*with therapist*]/peers' (Questionnaire No. 6)

Behavioural	16	6.2%	'Reports of a child/adult getting into trouble in the classroom/school yard/workplace for making ''smart'' or ''off'' comments' (Questionnaire No. 36) 'If there is hx [*history*] of isolation/loner' (Questionnaire No. 33)
Emotional	10	3.9%	'withdrawn' (Questionnaire No. 26) 'lack of emotion' (Questionnaire No. 28)
Reports from other professionals	1	0.4%	'People report that they cannot follow what their child is saying/teacher reports same' (Questionnaire No. 23)
Reports from significant others	1	0.4%	'and reports from parents' (Questionnaire No. 26)
Prior diagnoses	4	1.6%	'Diagnosis of ASD/SLI' (Questionnaire No. 11) 'Has the child been diagnosed as on the autistic spectrum' (Questionnaire No. 13)
Formal Ax	6	2.3%	''Average scores on language but difficulty functioning reported/observed'' (Questionnaire No. 19) 'Poor conversation skills in the presence of within average language ability on formal assessment...formal Ax [*assessment*] scores on Test of Pragmatic Language' [*words in italics added*]....Above features evidenced on Pragmatics Profile of everyday Commn. [*communication*] skills in Children' [*words in italics added*] (Questionnaire No. 21)
Persistence and pervasiveness of behaviour	1	0.4%	'constantly observed) difficulties with appropriate interaction with SLT' (Questionnaire No. 48)
Other	4	1.6%	'difficulties listening to others' (Questionnaire No.10)

Table of Responses to Q8 in the questionnaire in which participants were asked to detail the factors which would lead clinicians to "diagnose" Pragmatic language difficulties in an adult or child"

Descriptive Category	Frequency	Percentage of indicators of these categories in all responses to Q.8	Examples of features from each descriptive category *[Words in italics have been added]*
Linguistic	38	30.2%	'Poor topic initiation/maintenance/termination' 'decreased communicative intent eg. use of speech acts such as requesting, protesting, complaining, greeting' (Questionnaire No. 7) 'inability to take turns in a conversation & contestant interruption... to maintain a conversation...inappropriate responses to questions,' (Questionnaire No. 44)
Extralingiustic features	18	14.3%	'Poor proxemics awareness of self in relation to others distance between people body posture/eye contact etc.' (Questionnaire No. 3) 'atypical prosody' (Questionnaire No. 43)
Cognitive	12	9.5%	'client self awareness' (Questionnaire No. 26) 'listener awareness' (Questionnaire No. 32)
Social	11	8.7%	'-Difficulty with peer interaction - Reducing social circle/peer group - Frequent problems in school /centre' (Questionnaire No. 21) 'Significant difficulty in relating to peers' (Questionnaire No. 43) 'Difficulties in social situations in relating with other children/adults' (Questionnaire No. 5)
Formal Ax	14	11.1%	'Mostly features in the Pragmatics Profile' (Questionnaire No. 1) 'Results in a standardised assessment of Pragmatics' (Questionnaire No. 5)

			'Would carry out comprehensive speech and language assessments to rule in/out any other diagnosis (eg. SLI)' (Questionnaire No. 47) 'Assessment findings eg pragmatics profile, CELF 4 UK' (Questionnaire No. 26)
Informal assessment findings	3	2.4%	'informal assessment and observation.' (Questionnaire No. 14) 'Informal assessment is required' (Questionnaire No. 18)
Behavioural	2	1.6%	'always in trouble' (Questionnaire No. 26)
Emotional	1	0.8%	'happiness levels'(Questionnaire No. 26)
Reports from other professionals	7	5.6%	'feedback/input from other family members, teachers, psychologist' (Questionnaire No. 4) 'Above points plus opinions of other professionals' (Questionnaire No. 45)
Reports from significant others	3	2.4%	'reports from parents' (Questionnaire No. 26) 'Carer/parent/spouse reports ' (Questionnaires No. 7)
Prior diagnoses	0	0	NA
Perseverance and pervasiveness of features	5	3.9%	'Persistence c [*with*]the above ...failure to improve following intervention'' (Questionnaire No. 24) 'Difficulties identified above noted over time + in various settings + different people' (Questionnaire No.29) 'If a number of the above are present, are not transient' (Questionnaire No. 9)

Other	5	3.9%	'Difficulties described above that are present to a degree not expected from their age & that cannot be attributed to a different difficulty- although can be present as part of another difficulty such as learning disability etc.' (Questionnaire No. 42)
Unsure/do not diagnose PLD	7	5.6%	'I would be unsure as to how to defiantly diagnose this' (Questionnaire No. 34) 'Unknown' (Questionnaire No. 25) 'would not diagnose PLD's or give this label' (Questionnaire No. 23)