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Clinical Pragmatics

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Abstract

Clinical pragmatics is a sub-field of clinical linguistics. It studies the different situations in which communication can be impaired or funpctions inefficiently. It also focuses on the various reasons that might cause this communication impairment. The present paper is a theoretical survey that tries to shed some light on what exactly clinical pragmatics is and what is its scope. It presents the current status of the field within clinical linguistics in general. More specifically, the present paper tries to answer the following question: What are the basic tenets of clinical pragmatic ؟

In this regard and in order to achieve the aim of the present paper, a theoretical survey has been made to clearly illustrate the basic concepts of the field under scrutiny. The paper has concluded that the field of clinical pragmatic is a troubled one because of the lack of accordance between pragmaticians and clinicians on which pragmatic concepts ought to be considered .

Keywords: clinical pragmatics, pragmatic disability, primary pragmatic disability, secondary disability, complex problems, origin, key concepts, social cognition .

المستخلص

ان التداوليـة السـريرية هـي فـرع مـن فـروع اللغويات السريرية و تتناول المواقف المختلفة الـتي يمكـن للتواصـل الـذي مـن الممكـن ان يصـاب بخلـل مـا أو ان يعمـل بـدون كفـاءة كافية. كما و يركز على الأسباب المختلفة التي قـد تسـبب ضـعف في التواصـل. يعـد البحـث الحـالي عبـارة عـن مسـح نظـري يحـاول إلقـاء بعـض الضـوء علـى ماهيـة التداوليـة السـريرية وما هو نطاقها. و كـذلك يتنـاول هـذا المجال في اللغويات السريرية بشكل عـام. وبشـكل أكثـر تحديداً ، تحاول الدراسة الحالية الإجابة على السـؤال التـالي: مـا هـي المبـادئ الأساسـية للتداوليات السريرية ؟

في هذا الصدد، ولتحقيق الهـدف مـن هـذه الدراسـة، تم إجـراء مسـح نظـري لتوضـيح المفـاهيم الأساسـية للموضـوع قيـد التـدقيق و بشـكل واضـح. وقـد خلصـت الورقـة إلى أن مجال التداولية السريرية مجال مضـطرب بسـبب عدم التوافق بين التداوليين.

الكلمـات المفتاحيـة: البراغماتيـة السـريرية ، الإعاقـة البراغماتيـة ، الإعاقـة البراغماتيـة الأوليـة ، الإعاقـة الثانويـة ، المشـاكل المعقـدة ، الأصـــل ، المفـــاهيم الأساســـية ، الإدراك الاجتماعي.

1. Introduction

Those who are specialized in clinical sciences are often conscious of the distinction between sorts of language impairments on one side and communicative abilities on the other. It is well known that aphasic people can be considered as successful communicators despite their linguistic difficulties, other people such as those with right brain damage or advanced level of autism are poor communicators despite having approximately intact linguistic system. However, terminological words like pragmatic disability and pragmatic ability have recently come to be used (Smith and Leinonen, 1992: 32).

The pragmatic terms such as speech acts, implicature, maxims of conversation, relevance and the like seem to be common in the literature of language pathology disciplines. Besides the terminology, a great deal theoretical issues have been found in spite of the fact that these issues were developed out of the communication impairment in mind domain. Therefore, pragmatic theories and clinical domain have largely gone unquestioned (Gallagher, 1991:9).

2. Clinical Pragmatics Defined

Cummings (2009: 6) states that "Clinical pragmatics is the study of the various ways in which an individual's use of language to achieve communicative purposes can be disrupted. The cerebral injury pathology or other anomaly that causes this disruption has its onset in the developmental period or during adolescence or adulthood. Developmental and acquired pragmatic disorders have diverse aetiologies and may be the consequence of, related to or perpetuated by a range of cognitive and linguistic factors."

Cummings (2009) adds that his definition comprises a set of points that needs some clarification. He elaborated, "communicative purposes" which he considered as an open-ended notion. On the other hand, the definition says that the communication can be achieved by the "use of language", and on a third, he states that this definition purposely avoids linking "developmental and acquired pragmatic disorders to specific chronological periods". Plus, it emphasizes "the role of cognitive and linguistic factors in pragmatic disorders".

In another definition clinical pragmatics is explained as a "sub-discipline of clinical linguistics, which in turn is a branch of applied linguistics concerned with the ways in which communication may be impaired. The term clinical pragmatics refers to the study of pragmatic ability in individuals with communication disorders. It covers the

description and classification of pragmatic impairments, their elucidation in terms of various pragmatic, linguistic, psychological and neurological theories, and their assessment and treatment." (*Handbook of Pragmatics Online*).

3. Approaches to Clinical Pragmatics

Means for delineating a programme for clinical pragmatics is problematic because the term "pragmatics" itself lacks unity in its scope. Horn (1988: 113) describes it as "a large, loose, and disorganized collection of research efforts", and descriptions of pragmatic disability turn out to be similarly diverse and inconsistent. For example, there is considerable overlap between the terms "pragmatics" and "discourse" and similar types of disability may be described almost arbitrarily under either heading. Much work on "acquired disorders in adults" uses the term "discourse disability" (Bloom, et al., 1994: 43) While, the developmental literature prefers the term "pragmatic disability" (Craig, 1995: 623). Some researchers have opted for a particular theoretical framework such as "speech act theory" (McDonald, 1992: 295), "Gricean implicature" (Ahlsén, 1993: 57), "conversation analysis" (Ferguson, 1996: 55), "relevance theory" (Happé, 1993: 101) or "cohesion analysis" (Armstrong, 1991: 39), though in many cases the phenomena described could have been accounted for equally well using alternate frames.

4. The Scope of Clinical Pragmatic

Penn (1985: 23) in her Profile of Communicative Appropriateness slices the cake somewhat differently. Her six superordinate categories are:

"a. *response to interlocutor*, b. *control of semantic content*, c. *cohesion*, d. *fluency*, e. *sociolinguistic sensitivity* f. *non-verbal communication*".

These are divided into a further fifty one subcategories. In spite of the fact that the checklists have been utilized effectively to describe and recognize distinctive impaired populaces, it is clear that the principles for what can be considered as "pragmatic disability" are to some degree subjective and do exclude hypothetical consistency or soundness (Prutting and Kirchner, 1987: 105)

Not all communication problems can show an implication that can be useful for pragmatics, since problems like these are not due to deficit in "pragmatic competence". People who suffer from pragmatic disorders have problems in achieving different communicative purposes compared

with people who suffer from a disorder in voice or those who stutter for instance (Cummings, 2009: 4).

The communicative purposes are variant, Cummings (2009: 4) refers to some of them, and they may include "relating a story to a friend, ordering a meal in a restaurant, asking for times at a train station or making a promise to be home early". According to Cummings (2009), communicative activities like those will require a many different linguistics as well as cognitive skills. Cummings (2009) adds that "the disruption of one or more of these processes and abilities will lead to communicative failure in that the speaker will not be able to relate, or at least will not relate particularly effectively, a story to a friend. The particular cognitive and linguistic processes that are the cause of this failure are the concern of practitioners and researchers in the field of clinical pragmatics".

5. The Origins Clinical Pragmatics

The origins of clinical pragmatics as a discipline shares interesting similarities with the origin of linguistic pragmatics itself. The origins of both, standardly, dwell in the work of notable philosophers, "H.P. Grice, J.L. Austin and John Searle". Their effort is considered as a reaction to the view of language that was dominant in the early 20th century. As it is well known, Austin defied the idea that sentence, a declarative one, is often used to give a description of some state of affairs which is either true or false. He also states that many declarative sentences are not used to describe or report something and the dichotomy of true/false is not applicable to them. The mere act of uttering these sentences constitutes performing of an action. He called them performative and they, according to him, are used in ceremonial and archetypal situations (Cummings, 2009: 9).

A new branch of linguistic enquiry appeared which was based on the view (How to do things with language). At the center of pragmatics, the new linguistic branch, was the language user whose communicative intentions involving describing state of affairs as well as making promises and requests. Moreover, some problematic linguistic phenomena that could not be explained by semanticists have been explained by the field of pragmatic. A new evolutionary analysis of language is made by Grice when he made a distinction between what a sentence (says) and what does it really (implicate). Grice states that sentences may carry implications beyond what they say then; he expands his conversational maxims (Cooperative Principle) and types of

implicature. Shortly after presenting these advances in language philosophy and research, clinical researchers started to realize that it is not possible to make an assessment or treatment for people with language disorders without taking the pragmatic concepts in their consideration and this was the inception of clinical pragmatics (ibid, 9-10).

One of the first clinical manifestations interest in pragmatics is reflected in the developmental language disorders classification. The philosophical ideas of Austin and Grice have an impact not only on the linguistics but also on clinical studies. This is evident in the practice of clinicians when they started to realize that communicative impairment in children is not only is not only related to deficit in structural language. "Children who are not obviously autistic yet share some of the communicative patterns of autism led clinicians and researchers to revise classifications of developmental language disorders. This poor use of language by children is reflected in Rapin and Allen (1983) in the US, and later Bishop and Rosenbloom (1987) in the UK", they prefer to use the term "semantic-pragmatic disorder". Despite the fact that the use and the application of this term varies between researchers, it emergence in clinical studies and literature constitutes a very important turning point in the transition of pragmatics for a completely neglected discipline in clinical literature into an aspect of markedly diagnostic importance. Pragmatics, today, is strongly present in the nosology of developmental language disorder. Another reflection of the clinical emphasis on pragmatics is reflected in the techniques that are related to language assessment among adults. Clinicians found that pragmatics is a great assistant in the examination of how people use language to communicate with others (Cummings, 2009: 11).

The situation of pragmatics in "clinical practice and research" is presently verified. Pragmatics is a standard part of "the evaluation and treatment convention of language disorders". Its job in communication problems keeps on being broadly examined by clinical specialists (ibid, 12).

6. Clinical Pragmatics and Cognition

Pragmatic theorists focus mostly on language use in linguistic, sociological or philosophical terms; in other words, they focus on the characteristics of language in use, and the sociolinguistic and logical principles which govern it. An alternative way of approaching pragmatics is to consider "what determines language use in psychological terms?" More specifically, "what are the various cognitive systems and processes

which underlie and contribute to language behaviour?" (Morris and Franklin, 1995: 245). Wilson and Sperber (1991) "*Relevance Theory*" is a serious shot to place pragmatics in cognition. They argue that pragmatics is not a primary cognitive module at all, but rather "the domain in which grammar, logic and memory interact". In other words, theories such as "speech acts" and "conversational maxims" are not main cognitive themselves but are instead the secondary results of connections between more essential cognitive systems (Perkins, 1998: 291).

Figure (1) which is adopted from Perkins (1998) summarizes the cognitive basis of pragmatics:

PRAGMATIC ABILITY		
Linguistic systems	Nonlinguistic systems	
Cognitive systems		*Sensory and motor input & output systems*
prosody phonology morphology syntax lexis	inferential ability social cognition theory of mind executive function memory affect world knowledge	vocal-auditory visual tactile

Figure (1) *Schematic summary of the cognitive and sensorimotor bases of pragmatics*

7. Key Concepts in Clinical Pragmatics

As stated earlier, clinical pragmatics focuses on the ways in which an individual's pragmatic abilities are impaired due to a variety of factors and which causes pragmatic disability. So, the filed has divided its focus on those factors depending on their severity, i.e. the degree to which the pragmatic performance is affected by a particular factor(s). Accordingly, the following sections outline these key concepts.

7.1 Primary Pragmatic Disability

"Primary Pragmatic Disability (PPD) refers to a condition in which the linguistic system (i.e. phonology, morphology, syntax, and semantics) is essentially intact, but where communicative performance is impaired as a result of dysfunction somewhere within the central cognitive

system". Therefore, this type of dysfunction can be referred to as "central pragmatic disability" (Smith and Tsimpli, 1995: 65).

More familiar examples to speech and language therapists can be found in cases of aphasia and other language disorders where relatively effective communication can still be achieved, in spite of deficiency in the language system, through compensatory use of nonlinguistic cognitive abilities (Penn 1984, 6).

A list of the major cognitive systems which underlie primary pragmatic ability is given in Figure 1 and repeated as follows:

"*a. inferential ability , b. social cognition, c. theory of mind, d. executive function. e. memory, f. affect, g. world knowledge*"

This list makes no claims about the modular status of each system, and indeed is a considerable overlap between them for example between "theory of mind and social cognition" on one hand and "theory of mind and executive function" on the other. It is offered simply as a checklist of cognitive abilities which, if impaired, are likely to result in the type of communicative impairment which can be labeled broadly as PPD (Hughes et al., 1994: 477).

7.1.1 Inferential Ability

Some theorists have argued that "inferential reasoning is verbally mediated, but neuropsychological evidence suggests that it may well be an independent cognitive process" (Johnson-Laird, 1995: 999). Bishop and Adams (1992: 119) state that "children with specific language impairment (SLI) are impaired in constructing an integrated representation from a sequence of propositions even when these were presented nonverbally". Similar difficulties with inference are also found in children with semantic-pragmatic disorder. In example (1) (from Perkins 1998), a child with a diagnosis of semantic-pragmatic disorder is unable to carry out a particularly obvious inference until relevant information is presented visually.

1)

"T (therapist) and P (child) are playing a picture guessing game
T this one is an animal
P oh
T and it barks - it goes woof woof
P oh dear
T what kind of animal is that?
P it’s gonna run and run
T it’s an animal - and it can run

P yes
T and it goes woof woof woof woof woof
P yes
T what kind of animal is it?
P a lion?
T a lion? it might be or it might be …
P the lion - the lion
T *(shows picture)*
P a dog"

7.1.2 Social Cognition and Theory of Mind

Social cognition is defined by McTear and Conti-Ramsden (1992: 159) as "the ability to make social inferences about the actions, beliefs, and intentions of other persons in order to understand the behaviour of others and to be able to adapt messages to their needs". A "theory of mind" is defined by Carruthers and Smith (1996: 1-2) as "the ability to explain and predict the actions, both of oneself, and of other intelligent agents".

Problems in social cognition may appear in states which range from an inability to predict precisely how much information to encode in one's utterances to satisfy an interlocutor's needs (as in the exchange in example (2) between a therapist and a child with semantic-pragmatic disorder), to an inability in full-blown autism to entertain the possibility that other people might have mental states such as beliefs, intentions and desires (Baron-Cohen, et al., 1985: 37).

2)
"Therapist what will happen if he doesn't get better?
Child he - - get some medicine - and make - and make - -
my brother was feeling sick on Monday
Therapist right
Child - and I took my trouser off
Therapist uhuh - why did you take your trousers off?
Child he was sick on my trouser"
(Bishop and Adams, 1989: 241).

7.1.3 Executive Function

Executive function is "an umbrella term for the mental operations which enable an individual to disengage from the immediate context in order to guide behaviour by reference to mental models or future goals" (Hughes *et al*. 1994: 477). It includes intentionality, planning, attention, flexibility and abstract reasoning. It therefore overlaps to some extent

with other nonlinguistic systems. Executive dysfunction typically occurs as a result of damage to the frontal lobes and is seen as a key contributory factor to repetitiveness, poor topic maintenance and poor conversational performance generally in disorders such as schizophrenia, autism and closed head injury (Gazzaniga, 1995: 1). The following extract is an example of poor topic maintenance in a man with closed head injury:

3)

"and did you know then what's happened to Colin now
fallen off a `roof and fractured his ´skull you know that
I look on life as a bonus
and just enjoy every day as it comes
but . I would say . a bad fault of mine
and I would say s it's happening over t last - couple of month
I call a spade a spade a trump a trump
and - I just said to Sarah
because I do go to church a lot
and I said she says what people do I love
and I says I only love ´four"
(Perkins *et al.,* 1995: 296–7)

7.1.4 Memory

Shimamura (1995: 803) mentions that memory is linked to the frontal lobes and overlap to a considerable extent with executive function. As an example of how memory impairment may contribute to PPD, Perkins, et al. (1996: 89) suggest that excessive repetitiveness and topic bias in one particular case of closed head injury may be seen as a compensatory conversational strategy used to conceal the fact that the person has forgotten what has been, and is being, talked about by either switching to a favorite default topic or by providing a general statement of opinion.

7.1.5 Affect

Emotion or what is referred to as affect has an essential role in communication and is strongly related to social cognition and theory of mind. The linguistic system expresses one's affective state is prosody, and it is important to make a distinction between "dysprosody" and "prosodic disability" (Crystal, 1981: 393) where one lacks either the physical or linguistic means of prosodically expressing one's affective state, and on the other hand cases where "the prosodic system itself is intact and atypical prosodic patterns are simply a reflection of an affective impairment and therefore an instance of PPD". Autistic children, for instance, have problems identifying the affective states of others and although there is little evidence of a primary dysprosody or prosodic disability, the range of emotions they express is often communicatively inappropriate (ibid).

7.1.6 World Knowledge

Levelt (1989: 9–10) distinguishes between two different types of preverbal knowledge which must exist before the encoding of messages for communication may take place. The first is procedural knowledge, for example, "IF the intention is to commit oneself to the truth of *p*, THEN asserts *p* where *p* is some proposition the speaker wishes to express". The content of *p* is part of a store of declarative or encyclopedic knowledge built up over the speaker's lifetime and available in long-term memory.

World knowledge thus depends on other cognitive systems such as memory and social cognition for its storage and acquisition, and in addition is closely linked to the lexicon in which each lexical item is represented in terms of both its linguistic and conceptual characteristics.

7.2 Secondary Pragmatic Disability

McTear and Conti-Ramsden (1992: 87) show clearly that "pragmatic disability is not a unitary phenomenon" and illustrate a range of contributory factors such as linguistic, cognitive and social deficits. Thus, "Secondary Pragmatic Disability" (SPD) which is applied to instances of communicative impairment not due to nonlinguistic cognitive impairment. SPD can be a consequence of either "linguistic dysfunction or sensorimotor dysfunction" (ibid).

7.2.1 Linguistic Dysfunction

"Any speech or language disorder inevitably reduces communicative effectiveness, and there is therefore a sense in which a phonological, grammatical or semantic limitation can also be described as incurring a concomitant pragmatic disorder" (i.e. SPD). In particular, a speaker impaired in this way is restricted in the range of choices available for encoding what they wish to say. SPD can result from impairment at any language level. The example in (4) is spoken by a 51 year old man and it shows the dysfunction on the syntactic and morphological level.

4)

"oh it's alright aye . mate . mate . Jack comes and all but . . er . oh dear . Jack . . er . old er . . seventy . no . sixty eight . Jack . . but swim . me . me like this . . swimming . . er . . I can't say it . . but Jack . . er . . swimming on front . er . . back" (Perkins and Varley, 1996: 137).

Moreover, they listed examples on other linguistic levels such as lexis, segmental phonology, and prosody.

7.3 Complex Pragmatic Disability

There are different degrees of Complex Pragmatic Disability (CPD). A possible example of this is "specific language impairment" (SLI), in that there is recent evidence to suggest that "the linguistic deficits found in children with SLI are linked both to problems with sequential verbal memory" (Kushnir and Blake 1996: 21) and auditory perception

(Fletcher and Ingham 1995: 603). A type of CPD can arise as a result of compensatory communicative strategies. People with aphasia often employ a range of such strategies to enhance their communicative effectiveness (Penn 1984), but sometimes there can be unintended negative consequences. For example, receptive aphasics will often try to hold on to their conversational turn in order to reduce the number of occasions where they might misunderstand what their interlocutors say to them. Sometimes this might be perceived as an instance of PPD (e.g. sociocognitive deficit) rather than SPD (i.e. linguistic deficit). Finally, there are cases where both a linguistic and a nonlinguistic deficit exist simultaneously but unconnectedly. It might be more accurate to describe these in terms of "compound" rather than "complex" pragmatic disability. Ultimately, the ability to distinguish between CPD on the one hand, and PPD and/or SPD on the other, will depend on understanding of the disorders in question, and the effectiveness of the assessment tools available (ibid).
Figure (2) shows the scope of clinical pragmatics in all its branches:

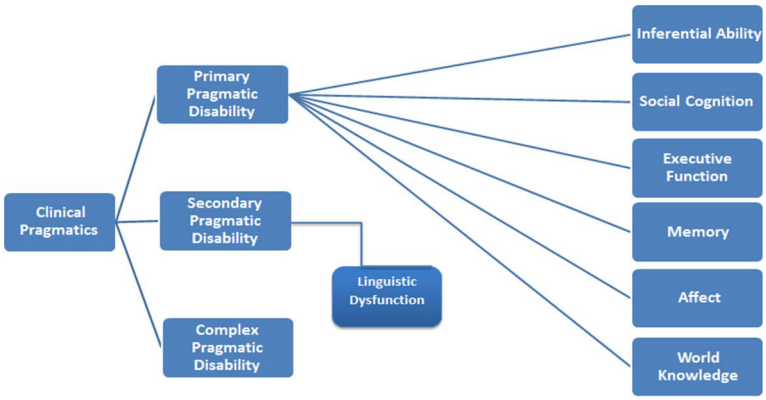

Figure (2) *The basic tenets of clinical pragmatics.*

8. Conclusion

The paper has sketched out the current status of "clinical pragmatics". The field is portrayed as one which was troubled. Numerous clinical researches have ignored fundamental pragmatic ideas. There is little accordance among scholars and clinicians on which pragmatic highlights ought to be considered. Then, the term "pragmatic disability" is presented and it is clear that this term is too broad and vague to be of much use in the diagnosis and remediation of communicative impairments.

A strong implication of clinical practice is that instead of focusing exclusively on the linguistic behaviors identified by pragmatic theory, therapy should be directed at the underlying causes. For example, rather than simply noting whether a patient may be described as having problems with Grice's maxim of quantity or with indirect speech acts, there must be an attempt to ascertain whether this is a result of a sociocognitive deficit (PPD), a problem with sentence formulation or visuo-spatial perception (SPD) or some combination of both (CPD).

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