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Reflections on speech–language therapists' talk: implications for clinical practice and education

Alison Ferguson† and Elizabeth Armstrong‡

† University of Newcastle, Callaghan Newcastle, Australia
‡ Macquarie University, Sydney, Australia

Abstract

Background: Research into the practices of speech–language therapists in clinical sessions is beginning to identify the way communication in clinical interactions both facilitates and potentially impedes the achievement of therapy goals.
Aims: This target article aims to raise the issues that arise from critical reflections on the communication of speech–language therapists for both clinical practice and clinical education of future speech–language therapists.
Methods & Procedures: The paper reviews the past and current literature into the communication of speech–language therapists with their clients and provide examples drawn from the authors' own empirical research.
Outcomes & Results: It is argued that one cannot assume that the current rhetoric regarding collaborative practice matches what is currently done in clinical work.
Conclusions: This paper calls attention to the need to evaluate critically the processes and nature of acculturation that occurs during the first stages of professional development as a student speech–language therapist through to the ongoing development of professional practice.

Introduction

Speech–language therapists share the challenges faced by other health professionals in seeking to enhance communication in the delivery of care (Sarangi and Roberts 1999, Candlin 2000). The key feature they have in common with other health professionals is in the institutionally derived asymmetrical power relationship between professional and client. Early research into clinical interactions in speech–language therapy tended to focus more on the interaction behaviours of clinician and client rather than on the socio-cultural or socio-political implications of the relationships evidenced by these behaviours. For example, this early research made

Address correspondence to: Alison Ferguson, Speech Pathology Discipline Convenor & Program Co-ordinator, School of Language & Media, Faculty of Education & Arts (General Purpose Building GP1.18), University of Newcastle, University Drive, Callaghan Newcastle NSW 2308, Australia; e-mail: Alison.Ferguson@newcastle.edu.au

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use of interaction coding systems to develop 'content and sequence' analyses that could be use actively to reflect on the therapeutic processes (Boone and Prescott 1972), and to code behaviours considered facilitative for the achievement of therapy goals (Brookshire 1976). However, empirical studies of applications of these systems have not been identified by the authors, and for the most part they remain with the profession as suggestions of expert clinicians. In the medical profession, on the other hand, empirical research has been relatively plentiful, as doctor–patient communication has been identified as problematic (Coulthard and Ashby 1975, Aronsson and Satterlund-Larsson 1987, Hein and Wodak 1987, Frankel 2001, McNeilis 2001). The source of this problematic medical communication has been recognized as being related to the power differences between clinician and patient due to both asymmetry of knowledge (doctor as 'expert') and the cultural values that accord high social status to the medical profession. Problematic communication for medical practitioners is seen as significant in that it relates to reduced health effectiveness and efficiency outcomes (e.g. through lack of compliance and misunderstandings resulting in re-admissions).

In the speech–language therapy profession, communication difficulties are seen to rest with the client, and the speech–language therapists' communication is assumed to be an idealized model of effective communication. Perhaps this explains the paucity of reflection on speech–language therapists' communication, but certainly there have been speech–language therapists who have attempted to draw attention to the need for greater professional reflection on these matters. Research into child language treatment sessions, for example, has found that 'The clinicians' communicative role within the interaction rendered few opportunities for clients to become competent in communicative roles other than that of respondent' (Lewis and Hand 1998, p. 30). These researchers argue that this pattern of interaction is at odds with current theoretical paradigms of child language intervention in which language learning is facilitated by more natural interaction (Camarata and Nelson 1992, Camarata 1993). Camarata (2000) then draws attention to the need for explicit analysis and selection of communication environments to facilitate specific language therapy goals. Such calls for socially based language learning go back at least 20 years (Snow *et al.* 1984). However, critical and empirical analysis indicates that what one thinks one might be achieving communicatively in sessions may conflict with one's actual communication (Pillay 2001).

This conflict is also seen between what one wants to achieve and how one goes about trying to achieve it in the way one works with other professionals. One of the most complex linguistic interactions for the profession is when one needs to work through an interpreter to assess the language difficulties of a child or adult client. As for any other health professional, the possibilities for miscommunication are manifold—with linguistic, social and pragmatic sources of misunderstanding common to any encounter (Coupland *et al.* 1991) multiplied between the speech–language therapist, interpreter and client (Thomas 1984, Pauwels 1990, 1995). However, what is distinct about speech–language therapist and interpreter interactions is that the work being undertaken involves finding out about the speech and language of the client (apart from the actual content of what is being communicated). This aspect of the work means that it is more important for the interpreter to be an equal partner in a collaborative approach to the work with the client rather than acting as an on-line translator. Recent research suggests that while

speech–language therapists generally believe they work with interpreters collaboratively, linguistic analysis of exchanges between speech–language therapists and interpreters suggest that speech–language therapists take the role of 'primary knower' rather than using the interpreters as a cultural or linguistic informant (Isaac 2002). Recent theoretical and empirical work by Hand (2001a, b, 2003a, b) considers these complex interactions within the context of critical discourse studies. While current theoretical paradigms challenge us to move to an understanding of language use and development as a co-constructed, situated achievement, the therapeutic methods remain rooted in an expert, medical model.

While such critical research is being undertaken across the profession, the present paper focuses on the work of speech–language therapists with people who have aphasia since this is the area of the present authors' own empirical research.

Communicating in intervention

Over 10 years ago, Silvast (1991) clearly identified the need to reflect more closely on the social interactional features of clinical sessions with aphasia, since she identified the clear asymmetry between speech–language therapists when trying to have 'natural' conversations with people with aphasia. However, since then most theoretical work in the area has related to task variables and components (Horner *et al.* 1994, Byng and Black 1995), with empirical research exploring the stimulus–response–feedback loop (Horton and Byng 2000) while drawing heavily on work in applied linguistics in classroom discourse (Sinclair and Coulthard 1975). The level of interest in aphasia therapy remains heavily skewed to those parts of therapy sessions in which specific behaviours are being trained, or in which specific psycholinguistic targets are being stimulated or facilitated. The therapeutic work of counselling and support, planning and problem solving for life adjustments remains obscure, despite this being a major focus of much of aphasia therapy (Boles and Lewis 2000, 2002).

Recent research (Ferguson and Elliot 2001) has undertaken preliminary investigation into other elements within a session through the development of a Generic Structure Potential for clinical sessions. In comparing the sessions of novice clinicians with an experienced clinician, it was possible to see how a greater proportion of 'moves' (units of meaning within conversational turns) were devoted to interactive rapport-building and to planning for the future by the experienced clinician. Such elements did not occur in the beginning student's session, and only minimally in the final-year student's session.

Of particular importance in the field of speech–language pathology is an understanding of how the ways speech–language therapists interact with their clients are shaped by the intrinsic asymmetry in the access to language itself, since the clients have communication disabilities. For example, a case study (Simmons-Mackie and Damico 1999) highlighted the difficulties faced by an adult with communication disability following brain damage when attempting to negotiate conflict with a clinician. These individuals are disempowered by their role as 'patient', and unlike other patients, do not have access to communication as a means by which they could redress this disempowerment. Such powerlessness in the relationship has been demonstrated to result in significant restrictions on the

clients' ability to negotiate both the conduct of therapy and its continuation or termination (Hersh 2001, 2002).

Data from recent research (Madonna *et al.* 2002) provide a preliminary look at the contrasts between clinicians' and clients' perceptions of the therapy process. The evidence provides further support for the dislocation of the discourses of practice and clinical discourse, particularly with regard to collaborative approaches to therapy. In this descriptive study based on interviews with five individuals with aphasia and five speech–language therapists, it was found that although some clinicians commented on their attempts to employ a collaborative approach to therapy and to involve the client as an equal partner in both assessment and therapy sessions, the aphasic individuals often appeared to display a limited understanding of the assessment and therapy processes and rarely conveyed a feeling of being an active participant in the interactions.

Part of developing a collaborative model of rehabilitation involves valuing the insiders' perspective and experiences. While there has been a steady stream of published accounts over the years from people who have experienced aphasia, there has been a movement recently to investigate aphasia through the narratives of those affected by it (Parr *et al.* 1997, 2001). Working collaboratively with people with aphasia and their relatives has become a major part of service provision within the recently emerging social participation approach to treatment (Byng *et al.* Parr 2000, Chapey *et al.* 2001) with a number of approaches offering conversational training (Kagan 1998, Kagan *et al.* 2001). The sorts of communicative strategies taught are often drawn from one's own clinical experience in therapeutic interactions (Flowers and Peizer 1984, Green 1984, Linebaugh *et al.* 1984, Kagan 1999), e.g. repeating instructions, using gestures, using high-frequency words, allowing the patient time to respond and requesting clarification. However, the skills that speech–language therapists develop that serve to promote therapeutic ends might not necessarily achieve the communicative goals of people with aphasia and their communication partners in everyday interactions. For example, while it may be beneficial within a clinical session for the client to self-repair to assist learning, it might be more important within a natural conversation to maintain the flow of conversation (Goffman 1971, 1981), and so frequent self and other repair may be inappropriate and disruptive to the interpersonal harmony between people with aphasia and their conversational partners (Ferguson 1994a, b). The skills of the speech–language therapist facilitate the clinician's agendas in the context of the session, but may prevent understandings of the client's communicative competence in natural, non-clinical contexts (Ferguson and Armstrong 2003). Clinicians in both assessment and intervention hold implicit medical models in which the individual is seen as a 'container' for more or less competence (Kovarsky *et al.* 1999). These implicit models mitigate against the recognition of interactional, situated communicative competence able to be achieved by people with communication disability. The very skills one develops to facilitate one's own communication agendas might actively work against one's ability to provide support for other communication partners with other agendas.

Professional communication

As well as carers and families, other communication partners include health professionals who deal with clients with communication disorders. Speech–language therapists work with these professionals by providing guidance and support on how to facilitate communication with these clients (Holland and Halper

1996). Previous research (Gravel and LaPointe 1982, 1983) indicates that health professionals do not slow down their rate of speech when talking with a person with auditory comprehension difficulties (with physicians speaking at a faster rate than physiotherapists, nurses, occupational therapists and speech–language therapists). However, all health professionals were observed to reduce their length of utterance, and speech–language therapists were observed to repeat and revise more often than other professionals. Adjustment requiring more conscious adaptations might be made less often than would be supposed. For example, while recognition of the need for use of sign language with the deaf community was found in a study of doctors, there was little evidence of sign interpreters being used (Ebert and Heckerling 1995). This is an area in which speech–language therapists see that they have a role in educating other health professionals about effective communication strategies. However, there is some evidence that the sorts of communication strategies that speech–language therapists in hospitals encourage nurses to use with patients with aphasia are different from those communication strategies that nursing staff report finding useful in their interactions with patients with aphasia (Winkworth *et al.* 2002). For example, these researchers found that while speech–language therapists most frequently suggested the increased use of gesture to assist nurses in getting their message across, nurses most frequently reported using the strategy of 'speaking slowly and clearly' to achieve this goal. Again, rather than accepting the 'expert' (i.e. the speech–language therapist) as knowing the ultimate correct strategies suitable to all individuals, further investigation of such findings may lead to more collaborative and very possibly more productive approaches to a variety of clients and situations.

The process of acculturation to the discourse of clinical practice is an integral part of the clinical education process for speech pathologists, just as it is in other health professions (Royston 1997). Discourse analysis has been suggested as in important tool in the past to aid reflection on supervisor–student talk (Culatta and Seltzer 1976), but such analyses tend to be behavioural descriptions rather than reflections on the significance of the power asymmetries and the wider socio-political implications. Example 1 presents some data from current research being undertaken by Ferguson into supervisory conferences between speech pathology students and their clinical educators across the period of the students' clinical placement. This particular example shows how the clinical educator seeks to inculcate the professional jargon used amongst speech–language therapists, in this case with regard to a client with a voice disorder.

While technical jargon serves valid purposes of description and explanation of particular disorders, the teaching of jargon highlights the way in which student speech–language therapists are acculturated into the professional 'language'. The use of profession-specific terminology is perhaps the most superficial evidence of professional acculturation, but is very much reflective of the way in which professionals acquire their 'expertise'. Such expertise with the professional terminology is valued as an objective and specific view of disorder, leading to specific intervention strategies. However, the aim of the professional is often to convey this view successfully to the client to reach a desired goal, and so the student speech–language therapist, paradoxically, then has to learn to 'use lay terms' and 'avoid jargon'.

Discourse analysis provides a valuable tool for the development of the reflective practitioner, but also raises important issues regarding gate-keeping and professional socialization (Sarangi 2001). Speech–language therapists internationally have a very homogeneous social demographic profile (White, middle class, female), and

Example 1. Speech pathology student and clinical educator (K and B) (Ferguson, work in progress)

Student: Um yeah all her voice stuff like I thought was pretty good except for sort of the high-pitched things she had trouble and the singing was a bit—um difficult for her I thought. Um—yeah

Clinical educator: [overlap] That, that was actually one of the questions I had written down, um, was how would you compare her speaking voice with her singing voice, and the difference in quality.

Student: Yeah, oh, the singing voice was terrible, the quality there was no [laughs] um—yeah, oh—she had a lot of tension I thought when she was singing, so—and her voice—wasn't even [intonation rises as if awaiting confirmation]—uh, I don't know what the correct XXX

CE: [overlap] So how, how would you describe them—that—I s'pose that's what I'm after, trying to get a—

Student: [overlap] Yes—

CE: [overlap]—get more of a clinical description of her singing voice.

Student: [overlap] Yeah, um [pause for three beats] I'm just trying to think of the right words to use. [pause for three beats] Well it wasn't singing, like it was—I didn't think she was really singing, um [pause for four beats]—I don't really know

CE: [overlap] Yes.

Student: How to describe it

CE: [overlap] I think when she was—singing, she had a lot more constriction.

Student: Yeah, oh, definitely.

yet people with communication disability cross the full social spectrum. Gender in particular may be a particularly important consideration in critical reflections on speech–language therapists' talk, given the predominance of females in the profession. For example, research in the medical field has shown substantial differences in the identification of key communication issues between male and female doctors (Roter *et al.* 2002). In a profession that requires the clinician's communication skills as both the medium and the content of therapy, it becomes difficult to disentangle linguistic and socio-linguistic competence from clinical competence, and all too easy to conflate lack of clinical competence with perceived language variation (McAllister and Whiteford 2002). The issue of the communication skills of speech–language therapists strikes at the 'persona' of speech–language pathology, in which there is fundamental split, between being a community that identifies its raison-d'être as treating disorder, not difference or variation, on the one hand, and yet at the same time being a community which characterizes itself by equating high communication skills with standard communication. How does such a community work through the issues, for example, of therapists of different gender, with different accents, different first languages and, indeed, different 'Englishes' (Clark and Quaglio 2002)?

To conclude, discourse analysis provides speech–language therapists the opportunity to challenge their ways of thinking and their ways of doing speech therapy (Hand 2001a). As Fairclough (1997) puts it, to enter such transdisciplinary collaboration 'is to put one's own disciplinary theories and practices at risk'. The present paper has sketched out just some of the territory that a critical approach to speech–language therapy could cover, confining its enquiry to verbal interactions in clinical sessions only, and much more remains to be done. In engaging in critical analysis of speech pathology practice, one seeks to identify where explicit debate and investigation might offer the profession future directions for development of services, without obscuring one's vision of the contribution of current and emerging theories and practices to improved quality of life for people with communication disability.

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Commentaries

Reflections on speech–language therapists' talk: implications for clinical practice and education

Martin Cortazzi† and Lixian Jin‡

† Brunel University, UK
‡ De Montfort University, Leicester, UK

In this paper, Ferguson and Armstrong invite critical reflection by professionals on a crucial paradox of speech clinicians' work—that the clinical interaction with

Address correspondence to: Lixian Jin, Psychology and Speech & Language Therapy, Faculty of Health and Life Sciences, De Montfort University, 0.19b Hawthorn Building, Gateway, Leicester LE1 9BH, UK; e-mail: jin@dmu.ac.uk

clients, in which the focus of assessment and therapy is the client's language and communication, is itself mediated by discourse processes that are institutionalized yet co-constructed with the client (and sometimes with others, such as language assistants/interpreters and relatives).

These discourse processes are embedded in several asymmetries and reflections on these point out the need for speech therapists to think further about a number of functions of their professional talk. The present comments consider three kinds of asymmetries and four functions of therapists' talk.

A first asymmetry is inherent in the therapist–client situation: the client has communication difficulties that the therapist does not have and, as indicated by Ferguson and Armstrong, this difference is exaggerated if the therapist has an idealized model of her/his own talk in clinical sessions. This asymmetry is somewhat parallel to that faced by foreign-language teachers who have long since learned to cut down teacher-talking time and maximize learners' participation and meaningful practice in pair and group work or through task-based and problem-solving approaches so that learners remain cognitively or emotionally engaged. Such pedagogic approaches might be useful for speech and language therapists who seek to complement a predominantly medical model with more socially oriented ones.

A second asymmetry is that of the differences in power derived from the therapist's technical knowledge and social status as a professional. This is evident in the frequent three-part exchanges of talk where an Initiation (such as question or instruction) from the therapist is followed by a client Response and then the therapist's Follow-up (giving feedback, comment or evaluation). There are therapeutic reasons for the structure of such 'IRF' exchanges, of course, but the client's communication is effectively sandwiched into a respondent role controlled by the therapist; the client is put in a disempowered position which excludes initiating or offering follow-ups. Note that novice therapists often need to feel this sense of control in exchanges to feel like therapists—an important early stage of professional identity. One solution, again well developed by language teachers, is to give clients other roles through tasks, games and role plays in which initiations and follow-ups by clients have a natural place.

A third asymmetry is one we see in terms of discourse identities. 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. However, each therapist inevitably has a personal communication style that is bound up with personal identity. This includes elements of discourse influenced by accent and dialect, gender, and socio-cultural and ethnic background. As Ferguson and Armstrong point out, the professional discourse has an expectation of the use of Standard English and aspects of personal discourse are likely to permeate at least parts of therapists' talk in sessions. The extent and effect of any such permeation will remain an unknown constraint, uncharted unless therapists self-monitor and reflect on their talk. This reflection will be greatly informed by those therapists who have developed sound awareness of socio-linguistic features of speech situations and have an appreciation of principles of discourse. This would be an important argument for the inclusion of specific elements of socio-linguistics and discourse studies in training programmes. The dilemmas related to this asymmetry can be seen in the light of Ferguson and Armstrong's point about the homogeneity of the speech of language therapists as a

professional group (predominantly middle class, female, White). This homogeneity constrains the personal discourse of therapists as a group and it contrasts markedly with more socially and ethnically diverse professional groups such as nurses, teachers or interpreters with whom speech and language therapists often need to collaborate. Obviously, it also contrasts with many client groups. A glimpse of the increasing extent of the linguistic/ethnic diversity can be seen from recent figures concerning children as one significant potential client group. Children in London schools between them speak over 300 languages (Baker and Eversley 2000), while in New York and Melbourne schools, children speak over 200 languages. Twenty years ago, surveys indicated 'only' 100–150 languages. In England and Wales, 8% of primary children are identified as having specific needs to develop their English as an additional language (EAL or ESL), but in cities like London, over 20% of the children are bilingual. Of course, in some schools over 90% of the children are bilingual and perhaps 40 or 50% may need EAL support. Among the current adult and child population in Canada, over 15% were born outside that country. There are similar figures for migrant populations elsewhere: Australia, 23%; France, 10%; the UK, around 9%; the USA, 8%; and an astonishing 90% in the United Arab Emirates (Swerdlow 1998). One implication of these indications of diversity is that the asymmetry of a relatively homogenous personal discourse of speech therapists, as a group, will be increasingly out of line with the enormous diversity of personal discourses of clients, so therapists will need to make increasing efforts to understand and tackle appropriately this discourse range in therapy.

In the context of these asymmetries that affect their talk, therapists would be recommended to focus on developing at least four functions of their talk. The first is an educative function, which goes beyond the pedagogic aspect mentioned above. Part of the process of realigning client talk—or empowering clients—is to involve clients more in the therapy processes of supporting and planning goals, solving problems and evaluating progress. This suggestion of Ferguson and Armstrong depends on clients' knowledge and awareness of their own communicative situation and needs, so therapists need to develop the educative function of their talk, which is to help clients learn about and understand their communication difficulties and develops strategies for improvement. This is a challenge with some client groups such as children since it depends on the dynamics of their general language development and particular language awareness.

Related to this is the professional development function, where through talk a tutor, mentor or expert works with a novice or co-professional in another discipline to help them develop understanding of and/or skills in therapy practices. In this function, the talk of the skilled practitioner not only models relevant professional–technical language, but also implicitly models ways of learning it, together with related skills.

A third function is the collaborative one in which the therapist uses talk to construct collaboration with—in Ferguson and Armstrong's examples—interpreters, clients' relatives or co-professionals. It is worth stressing the importance of social talk in rapport building for collaboration. Our own research with speech and language therapy students (Cortazzi *et al.* 2001a, b) shows that these newcomers to the profession learn a surprising amount in their clinical experience from an elaborate network of the clients themselves and co-professionals (including teachers, occupational therapists, physiotherapists, nurses, doctors, midwives and dieticians). Students identified this as one of their most effective ways of clinical

learning. However, this learning, like the students' interaction with mentors and tutors, is mediated by the degree of rapport. With good rapport, there is a reciprocal sharing of information and mutually reinforced effort to help a client. Poor rapport filters out some of this learning and information sharing. The rapport is, of course, negotiated through both social and professional talk. In working with an interpreter, time spent in getting to know something about the client's first language and in orienting the interpreter towards broad therapy goals is worthwhile. However, such information exchanges and getting to know the other takes time—and using an interpreter already puts pressure on time because of the alternating use of two languages, so therapists need to retain the sense of this reciprocal collaborative function and not feel pressured into a retreat to more unidirectional talk.

A fourth function that needs development is an intercultural one. The importance of this should be self-evident in increasingly multicultural and multilingual contexts of both clients and co-professionals, but developing a reflective awareness of intercultural variation and commonality in communication is a particularly useful way of reflecting on general features of therapists' talk. Cross-cultural variation of the meanings of gestures and signs, the different social evaluations given to repetition across cultures, or contrasting ways of being direct or indirect in instructions, requests, complements or apologies are examples of features to notice. Note, for instance, that British and American professionals give praise far more frequently than their East Asian counterparts; an East Asian client working with a British therapist might hear an apparent over-use of praise, in their perspective, which devalues its use and may lead the client to believe that if anything and everything is praised, then no special effort is needed. Worse, the client may conclude that the therapist does not have high expectations or standards and is therefore not very competent. This example may show that developing appropriate intercultural talk is a lot more challenging than it might appear. The goal of intercultural communication is to interact not only efficiently and effectively, but also satisfyingly—for all participants. Examples of practice that have led to client dissatisfaction include using items of fruit for language activities with Muslim clients during the fast in the month of Ramadan, using pictures of pigs or pork products with Muslims, and putting members of rival Somali clans together for group sessions. Here, some knowledge of religious and cultural practices or socio-cultural background is part of intercultural awareness if conflict is to be avoided and productive rapport is to be established through talk.

The complexity of these asymmetries that have been commented upon here is that they are at work on several levels simultaneously. Similarly, the development of these four functions of therapists' talk (and possibly other functions) needs to be carried forward so that they work together, reinforcing each other on all these levels.

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SLT talk and practice knowledge: a response to Ferguson and Armstrong

Margaret Freeman

University of Sheffield, Sheffield, UK

This thought-provoking paper from Ferguson and Armstrong reflects the growing recognition among many speech and language therapists (SLTs) of the need for more detailed consideration of the knowledge, skills, attitudes and values that are brought to our interactions with people with communication disabilities. This has been stimulated by two key changes. The first is the general movement away from the medical model and towards more socially motivated concepts of client-centred care, collaborative decision-making and acceptance of the social model of disability, which is occurring throughout the health and social care services (Roter and Hall 1993, Lupton 1997, Cox 1999, Trede and Higgs 2003). The second is the increasing recognition within SLT of the complexity of the processes of communication, with the resulting need to consider how our therapy relates to the functional communication needs and expectations of our clients (Parr *et al.* 1997, Worrall 2000, Togher 2001, Kagan and LeBlanc 2002, Damico and Simmons-Mackie 2003).

As Ferguson and Armstrong have observed, both these factors have caused the profession to reflect on its 'ways of thinking and … ways of doing speech therapy' (Ferguson and Armstrong, present issue) and, in particular, has raised awareness of the need for more focus on the interactions between clinicians and clients. As they point out, comparatively little attention has been given to the ways that SLTs interact with people who have communication disabilities, despite the obvious fact that this is central to everybody's work. Like others, Ferguson and Armstrong suggest that this reflects the influence of the medical model in SLT, which gave greater emphasis to the development of scientific knowledge and diagnosis and treatment of impairment (Enderby and Emerson 1995) than to the development of therapy approaches which aimed to optimize the clients' strengths (Byng *et al.* 2000, Worrall 2000) or consideration of the social consequences of communication disability (Van der Gaag and Dormandy 1993, Hartley and Wirz 2002).

Although an increasing number of SLTs have recognized the limitations of the medical model and are moving towards a more collaborative or social/participation approach to therapy, the evidence from a number of sources indicates that many SLTs are still grappling with questions about how to translate the principles of collaborative decision-making into their interactions with clients meaningfully and effectively (Jordan and Bryan 2001, Hartley and Wirz 2002, Ferguson and Armstrong, present issue). This, as Byng *et al.* (2002: 95) have noted, has led some SLTs to feel they are being 'pushed out of their professional comfort zone'.

Address correspondence to: Margaret Freeman, Department of Human Communication Sciences, University of Sheffield, Sheffield S10 2TA, UK; e-mail: m.freeman@sheffield.ac.uk

It seems that Ferguson and Armstrong have sketched out a picture of a transitional phase in which the profession has recognized some of the limitations of the previously accepted ways of doing therapy, but have not yet integrated the theory of the social model into practice. This is, of course, not an issue that is unique to speech and language therapy, as the large number of studies reported in the literature of medical education (Greco *et al.* 2002, Willis *et al.* 2003), medical practice (Hall and Roter 2002) and other healthcare professions (Trede and Higgs 2003) tend to indicate. There are, however, some obvious issues that are more specific to SLTs and their clients. The first, as Ferguson and Armstrong pointed out, is that a better understanding needs to be gained of the ways that interactions are 'shaped by the intrinsic asymmetry to language itself', when one of the communication partners has a communication disability. Although Ferguson and Armstrong refer specifically to the SLT's interactions, their discussion indicates that more naturalistic data are also needed from a wide range of different types of discourse, including examples of effective and less-effective discourse between clients and their partners, to inform our understanding of different types of discourse (Togher 2001, Damico and Simmons-Mackie 2003).

A second, related issue is that although an increasing number of studies of the interactions between SLTs and clients with different types of impairment have been published (Gardner 1998, Comrie *et al.* 2001), they still tend to be few in number and dispersed across a wide range of publications, a fact that limits dissemination of the findings to many of our profession, despite the fact that these detailed analyses provide useful insights into the therapist–client interaction.

In the present authors' view, however, the key issue raised by Ferguson and Armstrong is their discussion of the influence of socialization and implicit learning on the way that SLTs learn, develop, and use their knowledge and skills of interaction with people with communication disabilities. This, it is suggested here, is not only a key concern for everyone involved in professional education, but also might be an influencing factor for experienced SLTs who are finding it difficult to change their approach to therapy.

Implicit learning, tacit knowledge and professional practice knowledge

There is now quite a major body of research that has provided insights into the practice, knowledge and skills used in a wide range of professions including medicine, nursing, teaching, occupational therapy and physiotherapy (Eraut 1994, Higgs and Titchen 2001). One of the key themes to emerge from these studies is the recognition that professional practice is 'rich and complex in nature' (Williamson 2001). This research has included new uses of the terms 'expert' and 'expertise' (Higgs and Bithell 2001). In contrast to the somewhat negative connotations assigned to these terms in relation to the traditional medical model, the researchers into professional practice have reclaimed the concept of expertise as a way of emphasizing that experienced practitioners demonstrate a broad range of skills and competencies based on several different forms of knowledge (Higgs *et al.* 2001), which can be defined as follows:

- Formal, propositional or scientific knowledge, which is typically taught in lectures or obtained from textbooks, journals or conferences.

- Professional craft knowledge or 'knowing how' to do the tasks and procedures required for practice, which is often implicit and gained from experience.
- Personal knowledge, which includes attitudes and values about oneself as a person and in relation to others, which is typically partly implicit and partly explicit.

According to (Eraut 2000), formal or propositional learning is, by definition, explicit, whereas the knowledge one develops and uses in practice is more likely to be gained through a combination of formal teaching, which is guided more by experienced practitioners and implicit learning, which is typically acquired without an apparent 'intention to learn and no awareness of learning at the time it takes place' (Eraut 2000: 115). This type of implicit learning is often gained by inference, via the processes of observation, increasing participation and socialization. Typical examples of implicit learning are the norms of the organizational and occupational culture, which tend to be acquired over time, or learning how experienced practitioners 'do' their routine practice. As Eraut has observed, 'implicit knowledge can be very powerful indeed' and, in fact, can be more powerful than formal knowledge 'even when explicit knowledge is available by the bucketful' (p. 115).

The issue here is that implicit knowledge is not only powerful, but also is absorbed without conscious mediation and strengthened by repeated experiences, so that the learner does not really know what s/he has learned or how s/he learned it, unless someone or something causes the individual to explain their thinking or justify their actions. Although this kind of 'know how' is a useful resource that experienced practitioners draw upon in day-to-day practice, it is both difficult to define and, because it is gained without conscious mediation, difficult to access or modify, unless it is converted into formal knowledge through processes such as reflection, peer mentoring or critical event analysis (Titchen and Ersser 2001a). By extension, tacit knowledge is knowledge gained from implicit learning, but it is often shared by a group or an organization. Eraut (2000: 119) cites Spender's (1995) definition of tacit knowledge as 'that which has not yet been extracted from practice'.

Is SLT talk an example of tacit knowledge?

It seems that what Ferguson and Armstrong describe as 'SLT talk' can be viewed as one of the practice skills or clinical 'know how' of SLT (Higgs and Titchen 1995), because it is mainly learned by example and experience of practice and, as such, has been 'taken for granted' and, therefore, under-researched (Titchen and Ersser 2001b). It is also, like many of the skills of 'knowing how' described in the literature, the most difficult element of practice to define. However, Williamson (2001) has suggested a model of competency that breaks down the activity of practice into three layers. The outer and most readily described layer is identified as the task (or '*what* we do'), while the middle (the process or '*how* the tasks are carried out') and the inner layer (the judgement and decision-making that underlie the observable activity) are both less easy to define or articulate. Note that the middle layer, which Williamson (2001: 5) identifies as the process or 'how to', is identified as the 'part of practice [which] frequently passes un-remarked unless done badly'.

Like Ferguson and Armstrong, researchers in a number of disciplines have

adopted approaches such as discourse analysis as a means of both obtaining more detailed descriptions of the processes of practice and accessing the levels of know how or practice expertise that lie below the surface (Titchen and Ersser 2001a). In these studies, however, the researchers have used an ethnographic approach in which the practitioners' discourse or commentary on their actions is analysed to gain more explicit understanding of the underlying reasoning and clinical decision-making (Patel and Arocha 2000).

The ethnographic approach to discourse has also been a feature of research into clinical education and clinical competencies in SLT (Stengelhofen 1984, 1993, Van der Gaag and Davies 1994). These studies indicated that experienced SLTs can identify the knowledge and skills they use in practice, especially when the discussion is based on concrete examples such as transcripts and audio- or video-recordings of their therapy sessions. At the same time, there were indications that practitioners did not draw on their knowledge equally, or at the same level of consciousness. Even formal knowledge that is 'secure and well-integrated appears to become embedded at a deep level and is used tacitly' (Stengelhofen 1993: 12), while other aspects of practice knowledge may be classed as common sense and, thus, not worth mentioning (Van der Gaag and Davies 1994, Titchen and Ersser 2001b). It seems significant that specific reference to the SLT's communication skills was found in only one (Van der Gaag and Davies 1994) of the studies of SLT competencies reviewed for this commentary (Stengelhofen 1993, Williamson 2001, Stansfield 2004).

Clearly, the challenge for SLTs, as for researchers, practitioners and clinical educators in other disciplines, is to access and identify the tacit and implicit knowledge used in practice, so that the factors that lead to effective interaction in the discipline can be articulated, used to define our professional competencies (Williamson 2001) and made more accessible to ourselves, students, patients and others with whom our patients want or need to communicate. It is apparent that the analysis of SLT discourse, as described by Ferguson and Armstrong, adds another layer of detail into the analysis of the SLT process and, thus, should enable the monitoring and developing of the interactive skills used in therapy more appropriately. It seems that if this approach was to be used as part of the reflective process, it would also provide a clearer understanding of the way that students acquire their skills, while enabling the students to translate their implicit learning into explicit knowledge for practice.

Conclusion

There can be little doubt that Ferguson and Armstrong have presented much food for thought about the knowledge, skills, values and attitudes that SLTs bring to many different aspects of their professional practice. Although I suspect that some of the interpretations from their critical appraisal may also provoke a few cases of mental indigestion, it is evident they have raised a number of important issues about the way SLTs interact with clients, as well as identifying many aspects of practice that need to be explored in more detail by the profession. One of the clearest messages is the need for closer examination of the processes of therapy, which, they suggest, can be accomplished through the use of discourse analysis. In this response, the present aim has been to suggest that this can be a valuable tool, as long as the analysis enables SLTs to articulate their tacit knowledge and transform it into explicit understanding of the expertise of their profession.

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Critical reflection in speech and language therapy: research and practice

Simon Horton

School of Allied Health Professions, University of East Anglia, UK

Ferguson and Armstrong raise important questions about current practices in speech and language therapy (SLT) and the education of future therapists. The debate is timely in that, at least in the UK, it coincides with widespread concerns about the involvement of service users in their healthcare, with principles of good practice now embodied in government policy (e.g. The National Health Service Modernization Agency 2002 and the National Service Framework for Older People 2001). Good communication with service users is considered crucial to successful rehabilitation in key areas such as stroke, but, as Ferguson and Armstrong rightly point out, it cannot be assumed that the rhetoric matches current practice.

The authors not only raise many questions, but also cover a wide range of topics: the nature of the relationship between professionals and clients, research into the clinician–client interaction, a review of studies of 'communication in intervention', including comparisons of research into health communication in other professions. They also touch on cultural and gender issues, research into student education practices and the role of discourse analysis as a tool for

Address correspondence to: Simon Horton, School of Allied Health Professions, University of East Anglia, Norwich NR4 7TJ, UK; e-mail: s.horton@uea.ac.uk

developing critical reflective practice. The scope is ambitious and this commentary will limit itself to two main areas.

Developing tools for critical reflection

As Eraut (1994) points out, self-knowledge of performance is very difficult to acquire, and the professional mindset tends to be justificatory rather than self-critical. Here the authors highlight what might be considered to be one of the key issues confronting a profession striving for strategies to enable critical reflection on therapy process and practice. The fact that clinicians' communication skills are both the medium for and content of therapy means that a good deal of conceptual effort needs to be devoted, at least in the first instance, to understanding the relationship between therapist as social actor and therapist as 'technician' in work with people with communication impairments. This applies not only to psycholinguistic therapy, but also to 'business' that less directly concerns language and communication issues, such as counselling or planning for life adjustments. The authors quite rightly point out that early research into SLT clinical interactions tended to focus on technical aspects of the interaction in language-oriented therapy, developing and, in limited ways, applying various coding systems to clinician behaviours (e.g. Brookshire *et al.* 1978).

However, recent work has begun to examine therapy more broadly in terms of social action. Empirical work by Ferguson and Elliott (2001) is briefly mentioned, where 'other elements within a session' were investigated. A more explicit description of these elements and the analytic tools (Generic Structure Potential) referred to by the authors would have been welcomed. Research in the conversation analysis (CA) tradition has begun to make important contributions to the understanding of the impact of clients' communication impairments on the asymmetry of power relations in therapy (Simmons-Mackie and Damico 1999). Ethnographic and CA methods have been crucial in developing insights into how various therapy techniques, so long taken for granted and implicit in practice (Byng 1995), function in ways that contribute to therapy interaction both at the technical and social levels (Simmons Mackie *et al.* 1999).

Recent work by Horton (2003) has applied ethnographic and CA methods in the description and analysis of aphasia language therapy sessions. One of the motivations for the research was to develop more explicit definitions of therapy techniques (e.g. 'cueing', 'scaffolding', 'facilitation'). However, there was also a key concern to describe the characteristic features of the interaction between therapist and aphasic person during the course of the session as a whole, to examine the relationship between the 'main business' (various types of psycholinguistic therapy) and other aspects of sessions, and to take account of the contributions of the aphasic person to the discourse. A 'phase structure'—a conceptual rather than a categorical framework—was developed to give a general feel for what is being observed, alerting the observer to anomalies and links between different parts of the session. In addition, various features typical of the application of CA to 'institutional talk' (Drew and Heritage 1992) were taken into account, e.g. turn taking organization, turn design and topic management.

This framework and associated techniques have the potential to enable therapists to develop a greater understanding of their practice in the enactment of therapy. The aim is that therapists would be enabled to develop their awareness of how they are enacting tasks both in terms of the skilful application of technique,

and also in terms of their relationship with the person with aphasia as a collaborator in the enterprise, e.g. how their values as therapists find expression in the actual manner of enacting therapy, which includes therapy techniques, and how the functions of those techniques can be made explicit and shared with clients and other people involved.

Findings from the study show how therapists control the proceedings in various ways, e.g. choosing to topicalize the aphasic person's contribution only if it appears relevant to the clinician's agenda, or 'testing' the aphasic person in phases of the session that otherwise have an ostensibly conversational or quasi-conversational flavour. Intriguingly, however, the aphasic person does exercise noticeable control over the ways in which therapists conduct therapy tasks. For example, therapists were observed to deviate from their intended follow-up routines (i.e. feedback) due to the actions of the aphasic person, quite often resulting in inconsistent application of therapy activities.

Findings from this study, based on therapy work with people with aphasia, show similarities with findings from research in associated fields of healthcare communication (e.g. Ten Have 1991). Ferguson and Armstrong quite rightly draw attention to how empirical studies of professional–client communication in other fields, in some cases representing extensive bodies of work, may be helpful in guiding our own endeavours.

Learning from work across the SLT practice domains and in related healthcare fields

The authors discuss how research into child language teaching sessions has demonstrated how patterns of therapist–child interactions are at odds with theoretically motivated initiatives to facilitate language learning through more naturalistic approaches. While there is much to be gained by SLTs as a whole from such insights, caution should be exercised when applying them to different domains of SLT provision. For example, child language therapy potentially benefits from a number of different theories of language acquisition that may usefully guide the ways in which therapy is enacted (Vigil and Van Kleek 1996), while therapy for people with aphasia is still in its theoretical infancy. However, notwithstanding this note of caution, research into the practices of therapists in diverse fields may transcend the boundaries of impairment-specific theory. For example, writing about therapy for phonological impairments, Gardner (1997) argues that it should not be assumed that children know what their therapy is about, and that therapists need to be explicit about their expectations. Pillay (2001), referred to by Ferguson and Armstrong, argues that our discourse as practitioners should help us move from a pathology focus to one that enables us to consider the ways in which we are implicated in maintaining existing knowledge and power relationships.

Researchers in other therapy disciplines are also beginning to attend to apparent discrepancies between the ideals of service user involvement, active participation and the realities of day-to-day practice. Harrison and Williams (2000) used in-depth, semistructured interviews with five physiotherapists and five patients to explore the nature of the power relationship in physiotherapy treatment. They found a complex interplay of patient, therapist and environmental variables in relation to the manifestation of power in the therapeutic interaction. Their key finding was a mismatch of perception between professionals and their clients, therapists perceiving a

slight power imbalance in their favour, while patients considered the imbalance to be overwhelming, with their own position being one of relative powerlessness.

Talvitie and Reunanen (2002) applied discourse analysis to video recordings of nine physiotherapy sessions. Their aim—perhaps similar those of Horton (2003) or Simmons Mackie *et al.* (1999)—was to study how social reality was produced in different conditions in day-to-day practice. They found that therapists and patients demonstrated powerful role behaviours, with professional control rather than open communication serving to establish authoritative power and perpetuate the power imbalance.

Mention by Ferguson and Armstrong of the socio-cultural or socio-political implications evidenced by therapists' interactional behaviours serves well to sound a note of methodological caution in interpreting 'institutional data'. While there has now been much work in applying CA methods to the study of interactions in a wide range of institutional settings, the words of caution expressed by Schegloff (1987) in relation to the problematic nature of the relationship between macro-relevant attributes of the participants—e.g. 'powerful doctors'—and microlevel processes surely still hold true. It is after all to the actual behaviours of the participants that one must look in the first instance. A not dissimilar note of caution about the use of interview data—'the temptation … to treat respondents' formulations as reflections of some pre-existing social or psychological world'—is sounded by Silverman (2000: 7, 97), who raises the important methodological issue of whether responses in interviews should be treated as giving direct access to experience or as actively constructed narratives, demanding analysis in their own right.

Conclusion

Ferguson and Armstrong have raised many important issues, all of which demand attention, not least how current research findings can be developed and applied in continuing professional development and to the education of SLT students. It is clear from their paper that the effort to make the process of healthcare practice more explicit can no longer be considered to be a research and development luxury. Therapists who engage in critical reflection facilitated by an understanding of the communicative processes at work in the therapeutic relationship are potentially in a position to change their own practice, and to work with clients as equal partners in the therapy process. As Atwell *et al.* (2001) pointed out, this type of awareness may allow therapists to facilitate client choice and involvement in therapy decisions, and at the same time facilitate their ability to retain their own professional identity.

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'Festina lente': a case for making haste slowly in reflective practice. A response to Ferguson and Armstrong

Claire Penn

School of Human and Community Development, University of the Witwatersrand, Witwatersrand, South Africa

Critical Speech–Language Pathology is a developing branch of our discipline that has great potential to advance the methods and scope of practice. This branch

Address correspondence to: Claire Penn, Speech Pathology and Audiology, School of Human and Community Development, University of the Witwatersrand, Witwatersrand PO WITS 2050, South Africa; e-mail: pennc@umthombo.wits.ac.za

comprises the art of reflective practice and an approach to diagnosis and therapy that reflects a sensitivity to social, cultural and linguistic influences and their interface with communication disorders. The goal of any clinical encounter in the field is to maximize the flow of information and to optimize clinical effectiveness. Critical Speech–Language Pathology examines what facilitates such exchange and what inhibits it. Clearly these issues relate not only just to language issues, but also to an understanding of how a range of cultural and contextual indices such as family, gender, artefact, history, geography, religion, education, myths and attitudes interface. The term 'Critical Speech–Language Pathology' hence implies a detailed examination of biopsycho social influences on the discipline where analysis and explanations extend beyond the therapeutic dyad (Penn 2000).

Ferguson and Armstrong's paper is an example of this relatively new perspective that to date has been taken on board by only a few. Two possible reasons might exist for this apparent tardiness.

The first explanation may link to the fact that up to now there have not been the tools to engage in some of the issues of clinical discourse. The second reason for our reluctance to examine our own communication might be simply for fear of what shall be found. Because the profession has been constantly taken to task about its efficacy, especially in aphasia, we have searched for methods such as randomized controlled trials and well-designed single case studies to defend its role. There tends to have been a preoccupation with measuring an outcome that demonstrates language change in the client, with relatively little emphasis on process variables and client perceptions.

Yet as Ferguson and Armstrong amply demonstrate, the profession is probably better equipped than most to tackle these issues. Their thought-provoking analysis of aphasia therapy highlights new vocabulary and methods and their import for clinical practice. They provide a powerful argument that the context of the therapist and client is ultimately the most important influence on the therapy process.

Traditionally, the stereotyped 'Suzie speech pathologist' has at best been perceived as harmless in an institutional setting and often, unfortunately, as ineffective, optional or unduly expensive. Leary (1997, p. 1680), for example, describes the role of therapists in neurorehabilitation 'as motivators, facilitators and informal counsellors', further suggesting that 'it is the therapist's personality and approach to her patients rather than what she does which is to their advantage'.

This kind of attitude might stem from the fact that a lot of what therapists know and do remains unpublished and therefore not open to the scrutiny of the cynical eye.

Alarmingly, as the present paper demonstrates, when efforts are made to analyse the power relationships within therapy and assess our own language, patterns are seen to be emerging which are not necessarily benign. The extent to which our own behaviours perpetuate dimensions of helplessness and incompetence in others with communication disability are a rather unexpected cause for concern.

Simmons-Mackie and Damico (1999), for instance, have shown how aphasia therapists have a powerful role in the reconstruction of social roles after the onset of aphasia and that these social roles can be disabling as well as enabling. Some of what is said in a session reinforces assumptions of incompetence, enforces dependency and comprises what they term 'gate-keeping, pulling rank and playing the expert'.

Similarly, in some important early work on non-verbal communication, Chester and Egolf (1974) found that there was marked incongruence between what the clinician conveys non-verbally and the verbal message. Given that up to 90% of the message conveyed is non-verbally and that often non-verbal competence is preserved in aphasia when verbal competence is compromised, they point to the need for a closer examination of the messages conveyed and revealed some really embarrassing home truths about what is really being conveyed during therapy.

Ferguson and Armstrong take up this challenge in a careful and mostly convincing way.

My response to Ferguson and Armstrong's paper will comprise a consideration of methodological variables and some caveats for the profession in general as it expands its scope of practice.

Methodological variables and sources of evidence

Ferguson and Armstrong demonstrate how critical practice draws from several sources. These are primarily qualitative and incorporate a range of methods that enable the description and analysis of the process of therapy and its subjective impact on the client. Though the profession has not always been trained in these methods, they are proving fruitful, especially for clinical education (Damico and Simmons-Mackie 2003).

It is not a coincidence that researchers in the field of aphasia in particular have been pleasingly proactive in adopting these methods. As Ferguson and Armstrong demonstrate, in many respects the dynamics and complexities of such interactions in aphasia therapy have demanded this shift.

This is reflected for instance in the two 1999 volumes of *Aphasiology* dedicated to qualitative research methods and conversation analysis and in the cited series of studies examining the detailed dynamics of the aphasia therapy process and the collaborative model (Byng and Black 1995, Ferguson and Eliot 2001, Hersh 2002, Horton and Byng 2003). With very few exceptions, the proponents of these methods have been careful and explicit in justifying the adoption of such paradigms and demonstrating their clinical application.

Critical discourse analysis, as discussed in the present paper, similarly provides a wealth of texture. Some of the properties of language including vocabulary and grammatical features provide profoundly powerful insight into the knowledge and beliefs of those producing the texts, their social identities and social relationships. Narrative evidence also has a powerful influence, as Ferguson and Armstrong suggest.

Aphasia is a diagnosis, but like other chronic conditions, it is also a socially constructed event or label. The difference between the disease and the illness becomes clear in the narrative of the patient who has the function of expressing life identity and provides the clinician with an opportunity to 'receive' (rather than take) a case history and to harness the healing power of self-expression. Stories can bridge cultures and inform clinical decision-making and service development.

Ferguson and Armstrong also suggest that the field of interpreting is a source of powerful evidence. This can be endorsed by the findings of a series of studies undertaken in multiple health settings in South Africa. The research has as its goal the description and documentation of the communicative and interpersonal

interactions in the triad, highlighting in separate studies the effect of interpreter training on content and process aspects of the medical interview, the impact of the type of interview on the accuracy of interpretation, the perceptions of the participants about the process, and the influence of different sites of service delivery on the process.

A range of content and process variables have been examined in these interviews.

To date the data from 39 such triadic interviews were analysed using different qualitative methods, different languages, different clinical interactions and focusing on different levels of interpreter training.

The data were collected in several different contexts—including a children's hospital and a community-based day-care clinic. Participants have included interpreters and clinicians (speech–language pathologists and doctors) and Xhosa-speaking caregivers of children with a suspected severe hearing loss. The different genres studied included case history sessions, feedback sessions (about the child's diagnosis) and counselling sessions about the management of the hearing loss following the diagnosis.

Preliminary finding suggest that there are fewer instances of miscommunication in the sessions using trained (as opposed to 'ad hoc') interpreters and that participant perceptions about the success of the encounters vary according to the type of interaction (Penn *et al.* 2004). The counselling session, for example, yields many more opportunities for communication breakdown than the standard case history interview. conversation analysis as a technique has proven particularly useful in highlighting a list of inhibitors and facilitators in the interview process (Friedland and Penn 2003). Further, the cultural narrative has proven often more effective an index for gaining relevant content units than traditional structured interviews.

Unexpectedly, but probably most importantly, has been the finding about the influence of context on the therapeutic triad. In contexts where there is less hierarchy and more trust between doctors and therapists and the institution, there are tangible benefits to be seen for the patient emerging in the triadic transcripts. Thus, interestingly, indices of client satisfaction seem linked not only to participant variables (including the training of the interpreter), but also to the power relationships and institutional dynamics that seem to play out clearly in the individual sessions with clients.

Ferguson and Armstrong urge us to use the data derived from such research as evidence and remind us that specifically in aphasia, there are methods and philosophies that are very useful adjuncts to the traditional approach. What must remain a challenge to everyone as these methods are used is methodological rigor. Principles of triangulation or 'plausibilization' with its many facets must pervade all such research (Flick 2002: 218–237) and should be seen as the *sine qua non* of scientific method. Changing the role of the therapist from that of 'expert' to 'participant–observer' demands this.

Kovarsky and Crago (1991), for example, have shown how ethnographic methodology allows access to a realm of meaning but urge us to observe the various cornerstones to methodology within this framework including ways to collect data and establish authenticity (Tetnowski and Franklin 2003).

There are some vivid examples in the field (and, of course, in other applied disciplines such as education) of these methods being used without due regard to this important criterion. Pillay's (2001) use of discourse analysis, for example, while

clearly driven from a context in which social and political inequalities are rife, is relatively opaque and difficult to replicate or even engage with, without further knowledge and background into some of its critical constructs.

It is the obligation of people working within this paradigm to make absolutely explicit their frame of reference and to describe in detail the assumptions underlying their methods. This is an especial obligation given the historical obsession with accountability (sadly often justified).

If these methods are to be taken on board, then it must be done holistically with rigor and integrity. It would be a mistake to be too selective or superficial in the choice of these methods, as a consequence of this would be to lose the very ground we have struggled so far to reach in the broader struggle for recognition of our professional relevance. This time, we will not just have to account to our employers and the medical profession, but to the social sciences in which many of these new methods are grounded.

We have a responsibility to root ourselves in the conceptual theory and backgrounds of the primary disciplines from which these methods emanate and be willing to defend the choice of framework in relation to other options. Such disciplines may include sociology, anthropology and linguistics, for example.

For reasons of credibility, the evidence must remain the most important grounding aspect. The single extract provided in the paper provides rich reinforcement of the points made by the authors, but one wishes that there were more examples to substantiate the often fairly strong and inclusive claims being made.

A final point for consideration is linked to the ethical implications of research in this area. What exactly should informed consent comprise when the agenda of the researcher is to unpack power, language and gender imbalances in a particular setting? There is no question that an apparently harmless and routine clinical interaction may, through methods such as discourse analysis, reveal profound disparities and imbalances, open to public scrutiny. Self-reflection is one thing. Exposure is another. Standard consent forms and procedures will undoubtedly have to be revisited in the light of these new methods.

Focus on therapy

The main assumption behind Ferguson and Armstrong's paper is that the therapeutic relationship carries with it an 'institutionally derived power relationship' between professional and client. The whole argument of the paper appears to be predicated on equating the power asymmetry in the culture of medical contexts with that observed in the speech–language therapy session.

I do not believe that the case is as simple as that. Though our profession is derived largely from a medical basis, and from the well-established inequities of the medical model, I believe that the profession is more sensitive than most to such institutional dynamics and the heritage of the system. It would be wrong to equate the role of the speech–language therapist entirely with that of the doctor. Indeed, this profession has actively sought ways for a very long time to reduce or minimize such obstacles. The training in humanities, the counselling skills, the careful clinical education that students are put through, acknowledges both the importance of relationship aspects and the understanding of potential barriers to communication that exist in any institutional setting.

While indeed the identification of barriers and facilitators may not yet be complete or as accurate as one would wish, I believe there is a tangible difference between the interaction dynamic of the profession and that of the medical profession with its consumers. Evidence from this comes not the least from the very narratives of the clients being treated.

Moreover, I agree that one should certainly not discount the substantial gains being made in the medical profession in the field of reflective practice. As we begin to explore more systematically a range of methods, the evidence accumulating in the fields of Health Communication and its relation, Medical Education (Sarangi 2001), should not be excluded. Both are internationally well-recognized developing disciplines that bring together scholars from different disciplinary backgrounds involving a range of medical specialties and the human and social sciences. Well established centres exist and several scientific publications reflect research in these disciplines. Ironically, the profession of speech–language pathology, whose bread and butter has for decades been the prevention, diagnosis and treatment of communication disorders in healthcare settings, is a relative newcomer to the methods of these disciplines and there is a lot to learn.

Research has demonstrated that the communication behaviours of lay persons and health personnel can be modified effectively and demonstrably after appropriate context-specific training (Rollnick *et al.* 2002).

We are slowly understanding what it takes to be a good or bad communicator (Maguire and Pitceathly 2002, Roberts *et al.* 2003) and can as clinical educators recognize almost from the beginning which students will develop into competent clinicians. Furthermore, one can usually predict with accuracy whether they will be good aphasia clinicians or whether they should deal primarily with other types of communication disorders.

What it takes to identify and modify specific skills of relevance is another story. Checklists and prescriptive advice seem not to help. Ferguson and Armstrong provide, for example, paradoxical evidence (albeit frustratingly limited) that what is taught is not what we find and that what we think is successful, on closer analysis is ineffective.

It is often something in the nature of the session and in the interface of two (or more) individuals within the session that determines its outcome. Ultimately, this may boil down to attitude and issues of contextual rather than technical competence. For example, an understanding of the personal influences on the clinician (parents, press, public, priests, politics) might be a prerequisite to understanding other's opinions. Sjardin's (1996) three powerful questions perhaps hold the key:

- Where are you coming from?
- What do you need?
- How can I best help you?

Good outcomes for effective communication can be measured in tangible benefits for the patients, doctors and therapists, and the institution. While the tangible indices of effective communication at the sessional level have yet to be fully delineated, this paper reminds us that process variables are critical. Frattali (1998: 219) sums this up by saying:

> in the enterprise of measuring outcomes, even the most sensitive and psychometrically sound outcome measures will fail to detect that uncovered only by a clinician's keen observations or sharpened sixth sense of behavioural

> change. In the realm of human connectedness with all its nuances, secrets and beauties, the best outcome measures will always fall short of expectations.

Instead of decontextualizing and rarefying outcome issues, we need to begin to understand that relevant practice embraces contextual influences. Various methodologies are available and we would do well to remember that 'Far from obviating the need for subjectivity in the clinical encounter, the valid application of clinical evidence requires a solid grounding in the narrative based world' (Greenhalgh 1999).

Conclusion

The speech–language pathologist is a potentially powerful agent of change in the healthcare setting, not only just for individuals with aphasia and other communication impairments, but also for all those communication challenges brought about (or perhaps magnified) by certain contextual variables.

However, to do this effectively, the profession will have to retool and absorb more content matter. We will need to expand our vocabulary, our methods and world view and become more informed about the filters of gender, language, ethnicity and chronic illness. Such changes need to appear in the syllabus of the students being taught (Penn 2000), as well as in the focus of our therapy sessions and in our research.

As Swartz (1998) has pointed out, no debate on these issues can really be empirical or neutral. There are relationships of power, historical influences and a long history of labelling within the profession which we need to acknowledge and redress.

Ultimately, one enormous advantage of extending beyond traditional boundaries is that it helps us to see what the real and critical issues are within our own professional culture. Increasing diversity of caseload, the growing need for adopting a transdisciplinary role and an expanded improved armament of qualitative methods in our toolbox are all the domain of Critical Speech–Language Pathology. Daily practice demands rigorous self-examination, but the search for relevance must proceed carefully and must always be grounded in the evidence.

I commend the authors of this paper that promotes an expansion of perspective which will absorb the reality of therapeutic practice and the participants' world.

In this era of globalization, the future of our profession probably does not lie in the development of further checklists for assessment and therapy, but in the adoption of contextually relevant methodologies. As this paper implies, there are great benefits to be derived from moving in this direction. This journey should not, however, be by default, but with a systematic plan and a proven efficiency.

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Reflecting on talk in speech and language therapy: some contributions using conversation analysis

Ray Wilkinson

Department of Human Communication Science, University College London, UK

With their thought-provoking and wide-ranging paper, Ferguson and Armstrong have performed a valuable service both in drawing attention to 'the paucity of reflection on speech–language therapists' communication' and in making a case for why more reflection and research would be useful for clinical practice and education. I would agree with them that more focused reflection on speech and

Address correspondence to: Ray Wilkinson, Department of Human Communication Science, University College London, Chandler House, 2 Wakefield Street, London WC1N 1PF, UK; e-mail: ray.wilkinson@ucl.ac.uk

language therapy talk is justified since it seems that this issue has important practical implications.

While there is not the space to respond to all or even most of Ferguson and Armstrong's points, I will comment on what I feel are the key issues they raise in relation to clinical practice and education. To do this, I will be drawing predominantly on work in conversation analysis (Hutchby and Wooffitt 1998). There are, of course, a number of other approaches (e.g. discourse analysis, pragmatics and socio-linguistics), which could provide, and as Ferguson and Armstrong show, in some cases already have provided, useful insights into the issues being discussed. I believe, however, that as a method for reflecting on talk conversation analysis has something distinctive to contribute both as an analytic tool for investigation into, for example, the nature of talk between professionals and clients (Drew and Heritage 1992), and also in terms of its recent clinical application within speech and language therapy as a practical intervention tool to assist speakers in reflecting on their own talk (through, for example, video feedback and discussion) and changing it (Lock *et al.* 2001, Wilkinson and Llewellyn 2002).

The paper is in two parts. The first examines some of the main findings that work using a conversation-analytic approach has uncovered about the nature of talk-in-interaction between speech and language therapists and clients with aphasia. Based on these findings, the second part questions what the implications of such findings might be for some of the issues raised by Ferguson and Armstrong. While the paper will focus on talk in relation to aphasia since this is where most clinical conversation analysis work has taken place thus far, I would hope that many of the issues would be of relevance for speech and language therapy clinical practice and research more generally.

Talk-in-interaction of speech and language therapists and clients with aphasia

One of the major issues that Ferguson and Armstrong focus on is that of asymmetry in clinical interactions. I would agree that asymmetry exists in the talk between therapists and their clients and that this is an important issue for clinical practice and education. I will examine this phenomenon in the light of what is known about 'professional–client' talk in general and examine some more of the evidence concerning the nature of the talk between speech and language therapists and clients with aphasia.

It has long been argued within conversation-analytic work (e.g. Sacks *et al.* 1974) that ordinary conversation between peers can be viewed as the basic form of talk-in-interaction in the everyday social world and that other forms of talk such as 'institutional interaction' between professionals and clients (Drew and Heritage 1992) or interactive verbal activities such as testing or teaching differ from conversation in systematic ways. Thus, one typical feature of talk between professionals and clients (e.g. teachers and pupils, doctors and patients or counsellors and clients) is that question–answer sequences can be common, with an asymmetrical distribution such that questions tend to be produced by the professional and answers by the client (Drew and Sorjonen 1997). As well as asking the questions, the professional might also typically be the one who initiates topics and thus controls the 'agenda' of the interaction, how it progresses through its course, and how and when it starts and finishes (Drew and Heritage 1992).

The ways in which each type of institutional talk differs from everyday conversation and from other types of institutional talk provides what Drew and Heritage (1992: 26) call 'a unique "fingerprint" for each institutional form of interaction'. While there has not yet been enough research into speech and language therapists' talk to uncover what is its unique fingerprint (or how it might differ when, for example, the client is a child as opposed to an adult), there have been some studies that have shed light on this issue. One such study, as Ferguson and Armstrong note, is that of Silvast (1991). While Silvast does not provide any data samples or extended analysis of particular examples, the reported findings appear to be in line with some of the broad patterns one might expect based on research into other types of professional–client talk. Using categories derived from the behaviours of the six speech and language therapist–aphasic speaker dyads in her data, Silvast argued that these interactions were characterized by common patterns such as a request for information by the therapist followed by an answer (often an extended turn) from the speaker with aphasia, which was itself responded to with short turns from the therapist in order to encourage further talk. In general, the speakers with aphasia performed very few actions that could be seen as initiating, such as requesting information. Thus, Silvast notes that while the speakers with aphasia tended to talk more than the therapists, it was the therapists who tended to direct and regulate the interactions.

While Silvast's study limits itself to analysing the talk of the person with aphasia with a speech and language therapist, other studies have been important in highlighting how the talk involving a client with aphasia can differ systematically depending on whether that client is engaging in institutional interaction with a speech and language therapist or in peer conversation with a significant other, such as a spouse or relative. Perkins (1995), for example, studied each of three people with aphasia recorded in interaction with a speech and language therapist/researcher and separately with a significant other. Having classified each turn at talk as either a major or minor turn, Perkins found that each person with aphasia produced a greater percentage of major turns in interaction with the therapist/researcher than with the significant other. Lindsay and Wilkinson (1999) also noted differences between client–therapist and client–significant other interactions, in this case in relation to repair behaviour in talk. For example, in both client–significant other conversations, linguistic errors by the speakers with aphasia were regularly the start of extended attempts to say the mis-produced word correctly, with the spouses often active in initiating and/or maintaining the aphasic speaker's attempt at correct production. Such sequences did not occur when the same speakers with aphasia were each talking with a speech and language therapist since the therapists did not respond to the aphasic speakers' errors by initiating or encouraging such sequences.

While the 'general chat' between speech and language therapists and clients with aphasia thus differs in systematic ways from the type of talk the client is likely to have with significant others, the form of talk-in-interaction displayed when therapists and clients engage in assessment and therapy tasks regularly displays an even greater asymmetry and deviation from peer conversation. As with the forms of testing and teaching used with other populations such as children (Mehan 1979, Marlaire and Maynard 1990, Lerner 1995), aphasia assessment and therapy tasks are often based around a three-part structure of a question/prompt by the therapist (e.g. 'what's this called?'), a response by the client (e.g. 'a comb') and some type of reaction to the response by the therapist in the third turn (such as 'good')

(Simmons-Mackie *et al.* 1999, Wilkinson and Llewellyn 2002). In such sequences, the talk of the client is thus typically constrained both in terms of its function (an answer in response to a question or prompt) and form (often a single word or subject–verb–object sentence form).

Asymmetry and deviation from peer conversation are also present, although perhaps less immediately obvious, in the case of assessments using story recall or procedural narrative methods which are designed to encourage the speaker to produce 'connected speech' in a monologue consisting of more than one sentence. While such assessments are sometimes described as eliciting 'spontaneous speech', they are different from conversation. The fact that in these tasks the speaker can construct her/his talk without the same time constraints as in conversation (Jefferson 1989) or the same possibility of another speaker coming in to take over the conversational floor at the end of each utterance (Sacks *et al.* 1974) is likely to affect how that talk is constructed. Such differences may well be part of the explanation for the finding that clients' performance on naming, picture description or monologues can differ from their performance in conversation (Beeke *et al.* 2003, Heeschen and Schegloff 2003, Wilkinson 1995). Similarly, methods such as role play and semi-structured interviewing or questionnaires, while useful for many purposes within speech and language therapy, are less useful as the main methods of finding out about what a client's conversation is like since they do not provide access to the intricate ways in which speakers construct conversations collaboratively in real-time, real-life contexts (Heritage 1984, 1989).

Some possible implications for assessment, intervention, training of other professionals and self-reflection/clinical education

This section discusses what some of the clinical and educational implications of the above findings might be in relation to some of the main areas discussed by Ferguson and Armstrong.

Implications for clients' assessment and intervention

The aim of speech and language therapy intervention is to make a difference to the client not just in the clinic with the therapist, but in spontaneous everyday interactions in real life outside the clinic. In the case of intervention aimed at changing spoken language or pragmatic skills, this therefore means being able to show a change in the way the client performs in everyday conversation. In terms of assessment, the fact that, as highlighted above, the client's performance in talking with the therapist and in clinical tasks cannot be assumed to predict her/his performance in everyday conversation backs up Ferguson and Armstrong's notion of 'situated communicative competence' and their statement that '[t]he skills of the speech–language therapist facilitate the clinicians' agendas in the context of the session but may prevent understandings of the client's communicative competence in natural, non-clinical contexts'. As such, it suggests that recordings of client–significant other everyday conversation should be part of the battery of assessment data that therapists collect as the basis for planning intervention and assessing the efficacy of that intervention.

Similarly, Ferguson and Armstrong would seem justified in arguing that in trying to

facilitate communication it may not be most beneficial for therapists to rely only on general communication strategies (such as 'use gesture' or 'request clarification') since, as they say, 'the skills which we, as speech–language therapists, develop which serve to promote therapeutic ends, may not necessarily achieve the communicative goals of people with aphasia and their communication partners in everyday interactions'. Assessment of the everyday interactions of people with aphasia and their significant others has shown that regularly both speakers may develop methods of talking which are, for example, specific to that particular couple, spontaneously acquired rather than taught and, in various ways, context sensitive (Simmons-Mackie and Damico 1997, Wilkinson *et al.* 2003). Problems may arise when speakers have not developed new ways of talking which assist them in getting round their problems or when the methods they have developed do not work well for them. Rather than suggesting general strategies based on performance in the clinic, much of the therapy using a conversation analysis approach has been based on home recordings of client–significant other conversation with therapy starting from how the speakers are actually talking and using language in their own particular styles in their everyday life. The therapist can then facilitate one or both speakers to reflect on their own conversation (using, for example, video feedback and discussion), decide what, if anything, they wish to change, then discuss together what their interactional options are at any particular point in the conversation and support them in trying out one or more of these options (Booth and Perkins 1999, Lock *et al.* 2001).

The above suggests one way of considering the potential dilemma highlighted by Ferguson and Armstrong between the therapist as 'expert' and her/his wish to move more towards 'a collaborative model of rehabilitation'. Therapists *are* experts and it is their expertise in, for example, communication disorders, models of therapy, and normal language and communication processes that puts them in a position to change and empower the client and her/his significant others. At the same time perhaps we need a greater recognition in terms of everyday clinical practice that the client and her/his significant others are also experts; only they know what their interactional style was like before their illness, how well any information we gather about them reflects the reality of their everyday life, and what their aims are for the future. Ethnography, conversation analysis and discourse analysis are some of the methods that can provide us as therapists with some access to the 'life world' of the client and her/his significant others and thus allow us to acknowledge that expertise and incorporate it more centrally within our intervention.

Implications for training communication skills in other professionals

Other professionals will have their own goals in interacting with clients and their own type of institutional interaction which they use in pursuit of those goals. As Ferguson and Armstrong suggest, if therapists wish to facilitate interactions between other professionals and clients with communication difficulties, then, as with the work with clients outlined above, any a priori assumption that we have 'the ultimate correct strategies suitable to all individuals' might miss the interactional issues and difficulties in that particular type of interaction for those particular participants. Again, one solution might be for speech and language therapists to record such interactions, discuss the recording with those concerned

and, if appropriate, practise in consultation with them other possible options they have for talking with clients.

Implications for speech and language therapists' self-reflection and clinical education

Speech and language therapy activities such as building relationships with clients, providing support, counselling or advice and doing assessment and treatment are primarily constituted through talk-in-interaction. The more pertinent information there is about how we use talk to do these activities, the more able we will be to change aspects of them and to be explicit in our teaching of them to others such as student therapists (Wilkinson and Llewellyn 2002). While concepts discussed by Ferguson and Armstrong such as power, gender or class can be complex and controversial issues in relation to the analysis of talk (Schegloff 1997, Hutchby and Wooffitt 1998), these and related issues such as asymmetry are, it seems, primarily empirical issues to be dealt with through analysis of interactional data, and, as Ferguson and Armstrong suggest, much of that analysis is yet to be done.

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Reply

Reflections: a shared view

Alison Ferguson and Elizabeth Armstrong

The responses to our target paper in this Clinical Forum have shown remarkable consensus on a number of key issues, and in themselves provide exemplars of the reflective 'discourse on discourse' that we would like to see developing in the profession. The lead article attempted to draw out two main points: first, that critical reflection on practice is both necessary and useful in understanding and improving our work, and second, that a range of methodologies within what might be loosely described as discourse analysis provide a means to provide an empirical basis for reflective practice. By way of concluding this forum, we now turn to engage with some of the many interesting points raised by the respondents.

The notion that the kinds of analyses/approaches proposed in our paper (aptly termed 'Critical Speech–Language Pathology' by Penn) might be potentially professionally challenging to SLTs was an interesting and important point raised by several of the commentators. Freeman cites Byng *et al.* (2002), who suggest that SLTs are being 'pushed out of their professional comfort zone' by recent advocacy for social/participation or collaborative approaches to therapy. Hence, research investigating therapeutic interactions along these lines could well be problematic for those clinicians. Freeman suggests that clinicians often find it difficult in translating such models into clinical interactions, when traditional practice has relied more on the medical expert model. Penn suggests that little critical research has been undertaken into the therapy process itself because of 'fear of what we shall find' and that the stereotyped nice, helpful, positive 'Suzie speech pathologist' may well be revealed to have less than benign effects on her clients with aphasia after all. Horton suggests, along with Penn, that since SLTs have had to defend their practice, particularly in the area of aphasia rehabilitation, for many years their approach to research and their primary mind-sets have been 'justificatory rather than self-critical'. Such comments provide potential explanations for the relative lack of self-examination of professional practice within speech pathology and potential difficulty clinicians may have in changing practice as a result of such examination.

Certainly there could be a sentiment that critical analysis of any sort might have negative consequences if results of the analysis are used at the 'coal face' (i.e. clinical situations) by managers or colleagues to evaluate a clinical service by reflecting on what could be perceived as documented 'weaknesses' of that service by the naive reader. And certainly, some individuals might not feel comfortable with any critique of their practice whatsoever. However, critical analysis is not about identifying 'weaknesses'. Critical analysis attempts to understand and 'unpack' underlying assumptions arising from the immediate culture of the profession and the wider institutional culture in which it operates. Its purpose is 'deconstruction' not destruction (Skrtic 1995a, b).

As Horton notes, the ability to self-reflect and have a critical awareness of one's own practice may presumably not undermine a professional's role, but should in fact 'facilitate their ability to retain their own professional identity'. It would seem that in finding out more about what SLTs do, the profession will become even more clearly defined and may ultimately assume a more well-rounded and specific identity through its examination of its basic underpinnings and premises.

The notion of professional identity was also raised by Cortazzi and Jin, who noted that novice SLTs tend to engage in more controlled and asymmetric interactions with their clients than more experienced clinicians in order to 'feel like therapists'—an interesting reflection of how the therapeutic role is seen by those possibly outside the profession as well as those very recently introduced to the profession. This then returns to the idea that there are notions of what are 'correct' or 'most effective' ways of communicating with clients as an SLT, and while the novice SLT's perception of this is a little different from the experienced clinician's, the latter often retains a notion of this as well, evidenced in the general advice given to relatives/communication partners about 'good' ways of interacting with the person with aphasia. Wilkinson discusses working with clients and partners on an individual basis, tailoring advice to suit the couple, and incorporating their own experiences as to what works and what does not. Certainly, this involves a change of focus for clinicians, in as much as they are not necessarily seen as 'the expert' in a traditional way. Instead, their 'expertise' lies in their ability to explicate the nature of the interaction, and work collaboratively with their clients in facilitating change. As such, this different perspective may present a challenge, but clinical research as a whole is ultimately about improving services, and involves the critical examination of both surface behaviours that constitute treatment, as well as the principles underlying how the treatment is enacted.

There was general agreement amongst the respondents that the area of professional discourse warranted further empirical research, and both Penn and Horton suggested that further examples would be a helpful inclusion in this present forum in order to provide further support for our argument that the rhetoric and realities of practice may not be as closely aligned as we may like to think. To do this, we take one aspect of SLT communication that was left underexplored in the lead paper: interprofessional communication. There is an emerging interest in how health professionals interact, as one particular type of workplace communication (Candlin and Candlin 2003), and empirical research is needed in this area for application in training and professional development (Schroeder *et al.* 1999). Isaac (2002a, b) conducted a study of speech–language therapists and interpreters who work with clients from a range of cultural and linguistic backgrounds. This research found that SLTs and interpreters were in strong agreement with regard to the

importance of the presession briefing in establishing effective collaboration. However, empirical data collection suggested a gap between the ideal of collaboration and the reality. The following example (see example 1) was chosen from those collected during the research for its higher than usual collaboration, and provides one explicit opportunity only for interpreter contribution during the presession briefing.

For an in-depth analysis of this interaction, see Isaac (2002a). For the purposes of this paper, we can see that there are a number of features in this interaction that are of interest. The SLT holds the floor, and there are a reduced number of explicit openings for the interpreter. When the explicit opening occurs, it is in the context of the need for haste (the client has been waiting) and the therapist has signalled that she is about to get the client. However, we might also consider the number of more subtle interactive signals given by the SLT that offer opportunities for the interpreter to contribute, for example, the repeated pauses. The interpreter is observed to contribute and affirm at specific points during the briefing, and provides a steady flow of backchannels indicating understanding. The cultural background of the interpreter (Vietnam-born, first language Vietnamese) and the SLT (Australian-born, first language Australian-English) need to be considered in this interaction—does the interpreter's acquiescence in this interaction reflect politeness strategies rather than understanding? Against this, we need to consider the professional culture in this community health setting (where the interpreter is employed by the same health institution, and has recognized training and qualifications as a health interpreter), i.e. this is an interaction of colleagues within the same institution, and the text suggests that they have worked together before, and so there may be considerable shared knowledge between them, to which we as outside observers do not have access. However, this sample does exemplify the many layers involved in this interprofessional interaction. Speech–language therapists are not the only profession working with interpreters of course, but more than any other profession, we rely heavily on interpreters in the role of linguistic informants. This role presents interpreters with significant challenges to their professional role and ethical training, and presents speech–language therapists with similarly significant challenges to their role as expert. Like the other aspects of professional discourse raised during the course of this forum, speech–language therapist and interpreter interaction needs further research so that we can build an empirical basis for professional development (Candlin *et al.* 2004). We see this direction for research as important, given the current situation where SLTs are primarily from one dominant culture while our clients come from many different cultures. Like Cortazzi and Jin, we query whether this situation might adversely affect the services we provide.

In concluding our remarks, we note Wilkinson's question about the extent to which SLT interaction (whether 'technical' or 'interpersonal') was generic or specifically tied to particular types of communication disorder. We do have some preliminary insights into this from some work by Ferguson, contrasting the generic structure of stuttering therapy sessions using a behavioural paradigm with aphasia therapy sessions using a neurofacilitation paradigm (Ferguson 1998). In this work, Ferguson found that the main elements and their sequence in the session were similar across disorders. However, this research did not 'drill down' into the microfeatures of the stimulus–response–feedback interactions, and this is where more important differences may emerge, particularly with the role and application

Example 1. Speech–language therapist and interpreter in presession briefing (from Isaac 2002a)
SLT: This little boy is 8 years and 3 months old, (Interpreter: yes) and his name is [deleted]. Is that how I say it?
I: [gives correct pronunciation]
SLT: I'm not sure who's going to be coming, but I'm assuming that mum will be bringing him.
I: They haven't arrived yet?
SLT: Yes, they're here already.
I: Aha. They're here already.
SLT: They've been here for a little while, so we'll just whiz through it, um,
I: Just quick,
SLT: What I'm going to do, he's obviously older than the little one we did just then, (I: Aha) so, I'm going to spend some time just chatting to mum, getting a bit of a history on how, ah, how his development's been going. Ah, um, I'm not sure of her English, (I: Mmhm) so, we'll see how we go, um, and probably do it through you anyway.
I: Yes, okay.
SLT: Um, then I'll spend some time with him, firstly assessing, like, his articulation … (I: Mmhm) because that was the main concern, but then I'll take a language sample (I: Mmhm) so, the language sample that I'm going to do is a storybook (I: Mmhm) and I'm going to tell the story (I: Mmhm) and I'm going to get him to retell it.
I: Yes, okay.
SLT: Okay?
I: Aha.
SLT: So, depending on, I'd like to do it in Vietnamese (I: Mmhm) um, so what we might do is I'll tell the story, and then I'll get you to translate it to him.
I: Yes, okay.
SLT: And then he can tell it back in Vietnamese.
I: Yes.
SLT: And then you translate that back to me.
I: [simultaneous] back to you.
SLT: And I'll scribe it down as quick as I possibly can.
I: Okay.
SLT: Um, there's one other little test that I'd like to do with him. It's an understanding of different words type test. It's called an auditory analysis (I: Mmhm) so, the questions will be like 'say cowboy, now say it again but don't say boy'. I'll be doing that in English … (I: Mmhm) because obviously that's hard to translate into Vietnamese, that's if his English is good enough to cope with that ….
I: Yes.
SLT: But, from the referral, I think it is. Um, so, I'll go out and get them. Is there anything you wanted to ask before?
I: No, I think that's it.
SLT: Yep, great.

of feedback. The issue of generic skills is important, since it ties directly to the questions that Freeman raises with regard to using discourse analysis as one methodology for examining the notion of 'competence' in clinical work. For example, if we can validly ascertain the key generic features that signify clinical interactive competence, then we will have more grounded ways of sign-posting students' development of these generic skills, and perhaps even be able to unpack what it is that (as Penn suggests) makes us more or less sure of predicting students' eventual potential as therapists.

To conclude, we thank the commentators for their thoughtful responses. The readings, insights and knowledge shared in this Clinical Forum provide an important framework for the conduct of research within this domain, as well as some key suggestions for immediate clinical application.

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