

1 Clinical pragmatics: theory and practice

1.1 Introduction

The emergence of clinical pragmatics as a field of study in its own right is confirmed by several developments. A number of books, which have either used the title ‘clinical pragmatics’ or have clinical pragmatics as their central theme, have been published in the last fifteen years.¹ In the same time, academic journals have dedicated special issues to the discussion of clinical pragmatics.² Entries on clinical pragmatics are now as likely to appear in encyclopaedias and other reference texts as are entries on phonetics and syntax.³ Symposia and conferences now routinely dedicate sessions to clinical pragmatics.⁴ A greater level of academic interest in clinical pragmatic issues is scarcely imaginable. The question I want to address in this book is whether this interest has advanced our understanding of pragmatic disorders to a significant extent and if the assessment and treatment of these disorders has been facilitated by research in clinical pragmatics. So my task is in part a critical one – a critical evaluation of our current state of knowledge in clinical pragmatics as well as of the application of this knowledge to the assessment and treatment of pragmatic disorders in children and adults. Yet, such a critical evaluation can only reasonably proceed in the context of a wider examination of the clinical studies that have been conducted in the field. One consequence of the intense research activity that has been undertaken in clinical pragmatics is that theorists and clinicians must assimilate the findings of a large and disparate group of studies. Some order must be imposed on these studies if we are to derive new insights from them for our understanding and management of pragmatic disorders. So another part of my task in this book is to reflect on the findings of clinical pragmatic studies that have been undertaken to date. To this end, I conduct a survey of what these studies have revealed about a range of developmental and acquired pragmatic disorders in Chapters 2 and 3.

Before I can embark upon a survey and critical evaluation of clinical pragmatics, it is incumbent on me to address a number of preliminary issues. Since its emergence as a distinct area of enquiry, the field of pragmatics has been bedevilled by discussions about its definition and scope. While these discussions

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have brought several theoretical issues into sharp focus,⁵ they have also had the unintended consequence of creating considerable uncertainty about exactly where the limits of the discipline should lie. In Chapter 7, I argue that this same uncertainty and confusion pervades the related discipline of clinical pragmatics. In the full knowledge that no definition of clinical pragmatics will be wholly adequate on all occasions, I provide a working definition of clinical pragmatics in the next section. This definition will at least have the merits of orientating the reader to the types of issues that are of concern to theorists and practitioners in the field. Pragmatics is still a relatively recent development in both the history of linguistics and the clinical communication sciences. Its 'late' emergence explains certain features of pragmatics itself and of the neighbouring discipline of clinical pragmatics. For example, while developmental stages in the acquisition of phonology and syntax are well documented, we lack comparable milestones in the acquisition of pragmatics. Also, while interventions for phonological disorder in children are theoretically motivated and clinically effective, pragmatic interventions in children consist of a rather ad hoc group of techniques which have no clear theoretical basis and can demonstrate few clinical outcomes. Some sense of the rather limited state of our knowledge in certain areas of clinical pragmatics can be gleaned by examining developments in the past. For this reason, a brief overview of the emergence and development of clinical pragmatics will be presented.

Discussions about the scope of pragmatics notwithstanding, a book of this type is only possible to the extent that we are prepared to accept certain phenomena as pragmatic in nature. Concepts such as speech act and implicature are part of the original Searlean and Gricean reflections that launched pragmatics and, by general consensus, are core pragmatic notions. Topic management, conversational turn-taking and coherence in narrative production are clearly drawing on many of the same competences that are needed to generate and recover implicatures, even though these notions did not receive the direct attention of early theorists such as Austin, Searle and Grice. In short, as the field of pragmatics has developed, an increasing number of linguistic and nonlinguistic behaviours have been described as pragmatic. I will argue in Chapter 7 that this multiplication of pragmatic behaviours has gone too far and that behaviours that are not in any sense pragmatic are now being included in clinical pragmatic studies. In the meantime, however, an account must be given of the nature of different pragmatic concepts, as it is these concepts that are the focus of investigation in the studies reviewed in Chapters 2 and 3. Few theories in pragmatics motivate the studies that have been undertaken of children and adults with pragmatic disorders. This lack of theoretical rationale is in large part responsible for the rather ad hoc nature with which many clinical pragmatic studies have been undertaken. As well as surveying the work that has been undertaken in clinical pragmatics, a further purpose of this book is to

highlight those areas in which improvements can be made. One of these areas – the most important one, in my opinion – is that clinical pragmatic investigators need to demonstrate a much stronger sense of theoretical rationale for the particular studies that they undertake. To this end, I will examine significant theoretical approaches within pragmatics in this chapter.

A large range of disciplines converge on the study of disordered pragmatics in children and adults. Speech-language pathologists, educationalists, cognitive and neuroscientists, linguists, psychologists and psychiatrists are just some of the investigators with a professional interest in how the pragmatics of language is disrupted by a brain injury or other problem that has its onset in the developmental period or during adolescence or adulthood. An equally extensive knowledge base is required in order to assimilate the findings of clinical pragmatic studies and to appreciate the implications of these findings for an individual's wider communicative functioning. For example, studies that are investigating the neurocognitive substrates of pragmatic phenomena will only have full significance for a reader who is versed in the neuroanatomical structures that subserve various cognitive and language functions (e.g. the connection between damage to the prefrontal cortex and executive dysfunction). In the same way, the implications of theory of mind deficits in autistic children for communicative functioning in those children will be largely lost on the reader who fails to appreciate that much pragmatic interpretation involves mental state attribution. In short, an extensive knowledge base that includes information about neuroanatomy and neuroimaging techniques, cognition, developmental psychology, language acquisition and processing, and brain injury, amongst many other things, is needed in order to do the work of clinical pragmatics. We will return to the issue of the different disciplines that inform clinical pragmatics in section 1.5 below.

Finally, it is important to be clear from the outset that theorists and clinicians recognise a distinction between primary and secondary pragmatic disorders. In a significant number of children and adults, pragmatic impairments may be related to structural language deficits. For example, the child with specific language impairment or the adult with agrammatic aphasia may be unable to produce indirect requests. However, this inability may not be related to any impairment of pragmatic competence as such – an individual may know that a particular conversational interaction demands the use of an indirect speech act – but may simply reflect the fact that the child or adult lacks the syntactic and semantic structures to formulate indirect requests. In such a case, clinicians and theorists use the term 'secondary' to describe an individual's pragmatic disorder – the disorder is secondary to an impairment of structural language. This type of pragmatic disorder is quite different from the child or adult who doesn't understand that conversational interaction with a teacher or an employer demands the use of polite language forms such as indirect requests.

The child or adult in this case exhibits a primary pragmatic disorder. A final point of note is that the emphasis in clinical studies of pragmatics has been on the deficits or impairments displayed by children or adults. Diagnostic categories such as pragmatic language impairment (formerly semantic-pragmatic disorder) also reflect the preoccupation of clinicians and theorists with the study of deficits and disorders. However, it is worth remarking that even in the most pragmatically impaired clients, some pragmatic skills often remain intact. The preservation of pragmatic skills is frequently overlooked by investigators in their rush to analyse deficits. This book will attempt to redress the balance by giving emphasis whenever possible to aspects of intact pragmatic functioning.

1.2 The scope of clinical pragmatics

In this section, I will endeavour to delineate the types of problems and clients that are studied by workers in clinical pragmatics. Some communication problems have few, if any, adverse implications for language pragmatics. For example, the client who stutters or the adult with a voice disorder will certainly experience problems with communication. However, these problems are not related to any deficit in pragmatic competence. The client with a pragmatic disorder is in a very different situation to the adult with a voice disorder. He or she will be unable to use language to achieve various communicative purposes. These purposes may include relating a story to a friend, ordering a meal in a restaurant, asking for times at a train station or making a promise to be home early. A wide range of cognitive and linguistic skills are needed to perform these seemingly mundane communicative activities. For example, in order to relate a story to a friend, a speaker must be able to secure the attention of a listener, recall the events in the story, link these events in a coherent manner and monitor a listener's state of understanding. These individual skills draw on cognitive processes such as memory and attention, a cognitive capacity to have a theory of other minds and linguistic abilities that are necessary for the construction of grammatical and meaningful utterances. The disruption of one or more of these processes and abilities will lead to communicative failure in that the speaker will not be able to relate, or at least will not relate particularly effectively, a story to a friend. The particular cognitive and linguistic processes that are the cause of this failure are the concern of practitioners and researchers in the field of clinical pragmatics.

Although the child who stutters or the adult with a voice disorder will not struggle with the cognitive and linguistic processes outlined above, there are a substantial number of children and adults for whom these processes are severely disordered. The development of language skills is markedly delayed in the Down's syndrome child with mental retardation. Such a child will lack some of the syntactic and semantic structures that are needed to formulate

speech acts. This same child will also exhibit problems with receptive language, so that he or she will be unable to decode the linguistic constructions in which speech acts and other pragmatic phenomena are couched. Similarly, it is now widely acknowledged that autistic children lack the theory of mind skills that are present in normally developing four-year-olds. The ability to attribute beliefs and other mental states to the minds of others is the same cognitive skill that is necessary for pragmatic interpretation – we cannot recover the intended implicature of a speaker's utterance, for example, if we cannot view our interlocutor as someone who entertains certain mental states (viz., communicative intentions). Owing to their underlying cognitive deficit in theory of mind, autistic children can be expected to struggle with language pragmatics. We will see in Chapter 4 that a substantial number of studies are demonstrating the presence of severe and persistent pragmatic deficits in this population of children. The Down's syndrome child and the autistic child both experience developmental pragmatic disorders even though the specific cause of these disorders differs in these cases (language impairment related to mental retardation in the child with Down's syndrome and theory of mind deficits related to cognitive dysfunction in the autistic child). In Chapter 2, we examine the pragmatic deficits that occur in mental retardation and autistic spectrum disorder as well as deficits in two other clinical populations – children with developmental language disorder and emotional and behavioural problems.

Even in the case where pragmatic language skills have developed along normal lines (see section 1.5), an individual may still present with disordered pragmatics. An adult may sustain a right-hemisphere stroke subsequent to which he or she may experience difficulties interpreting non-literal language. The fifteen-year-old boy who is involved in a road traffic accident may have significant cognitive and communication problems related to frontal lobe pathology as part of a traumatic brain injury. The twenty-five-year-old male may present for the first time with pragmatic breakdown during an acute psychotic episode that marks the onset of schizophrenia. In each of these cases, the onset of the brain injury or other event (e.g. cerebrovascular accident) that causes pragmatic disorder takes place during adolescence or adulthood, when the acquisition of most pragmatic skills is likely to be complete. Like developmental pragmatic disorders, acquired pragmatic disorders may be related to linguistic and cognitive problems. For example, the nonfluent aphasic speaker may have such restricted linguistic output that he or she may be unable to implicate anything at all. Also, the verbal output of the fluent aphasic speaker may contain so much jargon that there are few, if any, grammatical and meaningful utterances that a listener can use to recover implicatures. Cognitive deficits in schizophrenic adults are increasingly being linked to the discourse and pragmatic problems of this clinical population. For example, discourse coherence deficits such as non sequiturs, tangential responses and derailment have

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been significantly correlated with working memory deficits in schizophrenic clients (Melinder and Barch 2003). In Chapter 3, pragmatic deficits in schizophrenia, traumatic brain injury and right-hemisphere damage will be examined at length. We will also discuss two other clinical populations in that chapter – adults with left-hemisphere damage and neurodegenerative disorders, principally Alzheimer's disease.

Thus far, a brief overview has been given of the types of problems and clients that are studied by workers in clinical pragmatics. On the basis of this overview, I want to introduce the following working definition of the field of clinical pragmatics:

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

This definition contains a number of features that require some elaboration. First, the notion of a 'communicative purpose' is necessarily open-ended. An individual's purpose in communicating may be to inform a friend of a forthcoming event, to warn residents to leave a burning building or to protest against the actions of a colleague. But, equally, a speaker may choose to communicate in order to maintain or develop a social relationship with an interlocutor, to distract a listener from his or her current preoccupations or to advise a friend that a particular course of action is ill-advised. In short, the purposes for which we communicate are indefinably large and are no more amenable to circumscription than are the grammatical or meaningful sentences in a language. Second, this definition states that communicative purposes are achieved through the 'use of language'. This emphasis on language is intended to counteract a widespread tendency in clinical pragmatic studies to label a whole range of behaviours, including nonlinguistic behaviours, as pragmatic. Certainly, non-linguistic behaviours such as gesture and eye contact can facilitate a listener's interpretation of a speaker's utterance. The speaker who maintains eye contact with his or her listener, for example, is more likely to be viewed by that listener as a cooperative communicator who will contribute only those utterances that will facilitate an exchange. This assumption of cooperation is the basis of the rational framework by means of which, Grice contends, speakers generate and listeners recover implicatures during conversation with each other. However, a behaviour that contributes to the successful interpretation of a speaker's utterance is not thereby pragmatic in nature (syntactic and cognitive processes also play a significant role in the interpretation of utterances, yet we wouldn't think of labelling these processes 'pragmatic'). The notion of pragmatics that I want

to employ in this book is one that is more deeply rooted in language use than many practitioners and researchers in clinical pragmatics have tended to adopt. This point is sufficiently important to warrant further discussion.

Even a brief survey of studies that have been conducted in the area of clinical pragmatics reveals a tendency amongst investigators that is at once puzzling and revealing. This is the tendency to construe pragmatics in such broad terms that it is not clear what this term is intended to exclude. In fact, the term ‘pragmatics’ has now become coextensive in many (if not most) clinical studies with the notion of communication itself (these studies, and the same pernicious tendency at work in techniques of pragmatic assessment and treatment, are critically evaluated in Chapter 7). I argue in Chapter 7 that this tendency on the part of clinical pragmatic investigators to identify pragmatics with communication has its origin in the Chomskyan distinction between competence and performance, a distinction which served to force pragmatics into the domain of performance. Only knowledge that enabled us to produce grammatical and meaningful sentences warranted, according to Chomsky, the title of ‘linguistic competence’. In this book, I want to reverse the tendency set in motion by Chomsky’s famous competence/performance distinction by arguing for the integration of pragmatics within our linguistic competence. Specifically, I want to argue that the knowledge that permits communicators to issue threats and warnings, establish the presuppositions of an utterance, produce coherent narratives and recover the implicatures of an utterance is part of our linguistic competence in the same way that the knowledge that enables us to form grammatical, meaningful sentences is part of our linguistic competence. Under this conception, pragmatics is about the knowledge that allows a speaker to employ a linguistic utterance to achieve a certain communicative effect. The fact that other behaviours may attend the employment of this utterance should not detract from the centrality of the linguistic utterance to pragmatics.

This conception of pragmatics has an important precedent in the philosophical views of John Searle. Searle identifies in Chomsky the same conception of the distinction between competence and performance that, I am arguing, is responsible for an unfortunate tendency in clinical pragmatic studies – the tendency to reject any role for pragmatics within a theory of competence by confining pragmatics to an account of language performance. In his essay ‘Chomsky’s revolution in linguistics’, Searle (1974) describes Chomsky’s reluctance to countenance a role for a theory of speech acts within his grammar. Chomsky’s reluctance, Searle argues, can be explained by several reasons, the first of which he captures as follows:

He (Chomsky) has a mistaken conception of the distinction between performance and competence. He seems to think that a theory of speech acts must be a theory of performance rather than of competence, because he fails to see that competence is ultimately the

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competence to perform, and that for this reason a study of the linguistic aspects of the ability to perform speech acts is a study of linguistic competence. (1974: 31)

Searle believes that Chomsky's characterisation of a speaker's linguistic competence as 'his ability to produce and understand sentences' is at best misleading, because 'a person's knowledge of the meaning of sentences consists in large part in his knowledge of how to use sentences to make statements, ask questions, give orders, make requests, make promises, warnings, etc., and to understand other people when they use sentences for such purposes' (1974: 28). Any account of our knowledge of how to use sentences for these various purposes, Searle argues, necessarily involves a notion of competence that extends beyond the rather limited conception that Chomsky is prepared to countenance to include a theory of speech acts. By the same token, the reader should be aware that in describing pragmatic language skills and, equally importantly, pragmatic disorders, I am making statements about a speaker's linguistic competence and not merely describing features of language performance. Our knowledge of how to use language to perform a range of speech acts (and do much else besides) is a core component of our linguistic competence that is on a par with our knowledge of how to form grammatical, meaningful sentences. I believe that it is only when we locate pragmatics fully within a speaker's linguistic competence that the various errors that have occurred in the identification of pragmatic phenomena can begin to be corrected. I will return to this issue in Chapter 7.

Third, the above definition deliberately avoids linking developmental and acquired pragmatic disorders to specific chronological periods (i.e. the developmental period, adolescence and adulthood). This linkage has been avoided for an important reason. Pragmatic aspects of language are still being acquired long after syntactic and semantic structures are established in a child's language system. It is now known that pragmatic development can extend well into adolescence (see section 1.5). This creates something of a classification problem for investigators, as it is not always clear in a particular case if a pragmatic disorder is developmental or acquired in nature. For example, a fifteen-year-old who develops a pragmatic disorder following traumatic brain injury is likely to have both developmental and acquired components to his or her disorder. Compared to stages in pragmatic development, chronological periods denoted by terms such as 'adolescence' and 'adulthood' are of secondary importance in determining whether an individual has a developmental or acquired pragmatic disorder. This is why a clear understanding of stages in pragmatic development is important in the study of pragmatic disorder and why the lack of extensive research in this area has adverse implications for clinical pragmatics. Fourth, I have acknowledged through the use of 'other anomaly' in the above definition that not all pragmatic disorders can be linked

to the presence of cerebral injuries and pathologies. Indeed, in a disorder such as specific language impairment (SLI) in children, there is a distinct absence of neurological aetiology (in fact, a neurological aetiology must be excluded in order for a diagnosis of SLI to be made). The reader should therefore be aware that while a neurological aetiology is implicated in many of the pragmatic disorders that will be examined in this book, other aetiologies or indeed no clear aetiology at all may underlie these disorders.

Fifth, the above definition emphasises the role of cognitive and linguistic factors in pragmatic disorders. We described earlier how a pragmatic disorder may be secondary to structural language problems. The child with Down's syndrome, for example, who does not have inversion of subject pronouns and auxiliary verbs as part of his or her syntactic repertoire, will not have the syntactic structures required to form indirect requests such as 'Can you open the window?' The same indirect request is likely to be problematic for the agrammatic aphasic adult who has considerably reduced expressive syntax. However, such an adult will be aware of the politeness constraints that operate in conversation and that an indirect request of this type is more appropriate in a formal setting than the direct, but less polite form 'Open the window!' The dependence of pragmatics on other language subsystems is to be expected – after all, we can only produce and comprehend speech acts, generate and recover implicatures and frame coherent narratives if we have access to certain syntactic and semantic structures. The link between pragmatic disorders and cognitive deficits is now well established. An increasing number of pragmatic impairments in both children and adults are being linked to theory of mind deficits. Working memory and executive function deficits have also been found to be associated with pragmatic disorders. The ability to attribute mental states to others, to engage in flexible thinking, to reason deductively and non-deductively and to retrieve information from memory are key cognitive skills that underpin pragmatic interpretation. Given the dependence of pragmatic phenomena on cognition, I will return to the topic of cognition time and again in the chapters of this book. In the meantime, the reader should be aware that in order to understand disordered pragmatics, one must understand how pragmatics is related to other linguistic and cognitive domains.

1.3 The emergence of clinical pragmatics

The impetus for a new discipline of clinical pragmatics shares certain interesting similarities with the origins of pragmatics itself. These origins are standardly taken to reside in the language philosophies of H.P. Grice, J.L. Austin and John Searle.⁶ The work of each of these theorists can be seen as a critical reaction to the view of language that was dominant amongst philosophers in the early part of the twentieth century. For his part, Austin challenged the idea

that a declarative sentence is always used to describe, either truly or falsely, some state of affairs (what he called the descriptive fallacy). Many declarative sentences, Austin argued, do not describe or report anything. Nor can we sensibly ask if they are true or false. Rather, the act of uttering these sentences constitutes the performance of an action. These so-called performatives include examples like 'I baptise this child Fred Brown' and 'I pronounce you man and wife', in which the mere utterance of these statements constitutes an act of baptism and marriage, respectively. In *How to do things with words*, Austin (1962) states that performative utterances:

- A. do not 'describe' or 'report' or constatae anything at all, are not 'true or false'; and
- B. the uttering of the sentence is, or is a part of, the doing of an action, which again would not *normally* be described as saying something. (1962: 5; italics in original)

The view that language could be used to do things ushered in a new branch of linguistic enquiry. At the centre of this new field of pragmatics was the language user whose linguistic goals in everyday communicative situations were as likely to involve making requests and expressing promises as they were to involve describing events and other states of affairs. Linguistic phenomena that were proving problematic for the logical frameworks employed by semanticists could be more readily explained by this new field of study. In his William James lectures in 1967, Grice proposed a new and revolutionary analysis of sentences such as *Some students pass their exams*. Grice proposed a distinction between what a sentence *says* and what it may be taken to conventionally *implicate*. While a logician and a natural language user may both *say* the same thing, it is a convention of natural language not shared by logic that sentences may also carry implications beyond what they say. In the above sentence, for example, a speaker may be taken to implicate that not all students pass their exams. This is the case even though there is no inconsistency in logic between the sentences *Some students pass their exams* and *All students pass their exams*. As well as conventional implicature, Grice introduced a further category of implicature which has had a profound influence on the development of pragmatic theory. Known as conversational implicature, we will see subsequently that this type of implicature has been one of the most extensively investigated pragmatic phenomena in the clinical literature.

It was not long before practitioners and clinical researchers began to realise that the assessment and treatment of language disorders in children and adults required something of a pragmatic turn. In the same way that theorists such as Austin and Grice had revealed the inadequacy of semantic and logical frameworks in analysing how speakers actually use language, clinicians and researchers set about dismantling some rather unhelpful assumptions about