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Contents

PREFACE vii
ACKNOWLEDGMENTS x

1 A Critical Discourse Perspective on Speech-Language Pathology: *Discourse as a Reflection of Culture* 1

2 The Focus of Assessment: *Layers of Discourse, Layers of Thinking* 19

3 The Process of Assessment: *Discourse Is Dynamic* 45

4 Service Provision: *Discourse and Power* 61

5 Working Collaboratively: *Discourse Involves Multiple Parties* 77

6 Speech-Language Pathology Genres: *Discourse Is Systematic* 95

7 Intraprofessional Discourse: *Discourse Is Learned* 115

8 Curriculum Development: *Discourse Is Institutionally Based* 139

9 Future Directions from a Critical Discourse Perspective: *Discourse Perpetuates and Creates Culture* 165

INDEX 189

00_Ferguson_i-xiiFM 10/3/07 9:31 PM Page vii

Preface

This book integrates three notions that are important to practicing speech-language pathologists: the notion of *expert*, the notion of a *critical* perspective, and the approach of *critical discourse analysis*.

Expert practice is distinguished from that of the novice through the seamless integration of past learning (both theoretical and experiential) with fast, flexible, and ethical problem-solving in response to individual cases and situations. For example, experts have been found to recognize and analyze problems through holistic pattern recognition, in contrast with the more atomistic and stepwise problem-solving of novices. This book presents the argument that the achievement of expertise brings with it an intrinsic paradox in that expert practice also demands critical reflection on practice in order to develop further—that is, the more automatic and patterned practice becomes, the more crucial it becomes to deconstruct these patterned practices in order to allow for objective examination. Without critical reflection, expert practitioners run the risk of fossilization of the very patterns that defined their expertise.

The notion of a critical perspective is part of a wider theoretical paradigm that emerged during the latter half of the twentieth century, in which a range of disciplines have drawn on the philosophical works of such scholars as Habermas and Foucault. Different disciplines and researchers who use this approach have very different agendas and methodologies, but broadly speaking, the common threads are, first, an explicit stance in which truths or facts within a discipline are seen in relation to the social and cultural context in which they emerge and operate; second, a theoretical presumption of the pivotal role of social power and its distribution in defining accepted truths; and third, an explicit agenda that the outcome of such research aims for sociopolitical change. In the more concrete world of everyday clinical practice, the adoption of a critical perspective means that expert speech-language pathologists seek to critique and evaluate their practice in light of evidence, while at the same time reflecting on the nature of that evidence and its social context and its contribution to the betterment of the services provided to children and adults with communication and swallowing problems.

Critical discourse analysis is one of the approaches to research that has emerged from the critical paradigm. Speech-language pathologists are familiar with discourse analysis as a tool for the assessment of children and adults with language disorders, and many

00_Ferguson_i-xiiFM 10/3/07 9:31 PM Page viii

practitioners make use of a discourse framework as the context for intervention. Thus, speech-language pathologists are accustomed to engaging with texts (instances of language produced in natural and meaningful exchanges) through using a range of linguistic analytic methodologies, such as identifying grammatical forms available for the speaker or listener, or identifying macrostructural elements used by the speaker to organize different types of discourse (e.g., narrative or procedural texts). A critical discourse analysis approach integrates such text-based analyses within a framework that incorporates the three critical aspects just outlined—through the analysis of the relationship between texts and sociocultural contexts, through the analysis of how texts reflect and instantiate power relationships, and with the assumption that with greater understanding comes the identification of ways for change to occur. In critical discourse analysis, the detailed text-based analysis is integrated within an analysis of the wider social and cultural discourses in which these texts emerge (and which these texts also serve to produce or maintain). One of the leading linguistic analytic approaches used in critical discourse analysis has been systemic functional linguistics, developed through the work of Halliday and Hasan, and this approach is used in the illustrations of practice—presented in the book. In common with other critical theories, critical discourse analysis also places the examination of power relationships (interpersonal, sociocultural) at the center of explanation and interpretation and explicitly adopts a sociopolitical agenda for change. For example, researchers from a critical discourse perspective have challenged current orthodoxies with regard to the identification and intervention approaches used for differences in literacy development in light of the influence of socioeconomic factors, and have argued for the importance of explicit teaching of different genres (types of discourse) as a means of empowerment.

This book examines a series of key issues for the expert speech-language pathologist through the lens of critical discourse analysis, in order to offer the opportunity for critical reflection with a view to change. Looking first at practice, the book reconsiders a central and long-standing area for debate among expert practitioners: the validity of assessments. This issue is approached through considering the social context in which speech-language pathology exists and the social roles and functions that speech-language pathologists serve. Subsequently, the book critically examines student learning and curriculum development, taking the view that a primary role for the expert practitioner is that of educator of future speech-language pathologists. A critical perspective is argued to be essential for the educator if we are to avoid "cloning" ourselves and our practices. In every chapter, in order to provide concrete illustration and practical direction for the reader in considering the issues, a number of situations in the area of practice for both children and adults with communication disorders are presented.

Although other works have applied the methodology of discourse analysis to the assessment of clients, and individual contributions appear in chapters in more disorder-focused works that have begun to engage with this

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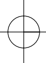
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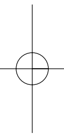
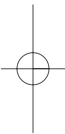
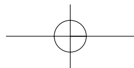
paradigm, there has been little recognition of the relevance of the critical approach to professional practice as a whole. This book attempts to address this gap.

The book has been designed to provide advanced-level speech-language pathology theory and practice debate, while introducing the reader to a critical perspective.

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A Critical Discourse Perspective on Speech-Language Pathology

Discourse as a Reflection of Culture

Expertise typically is seen as a strictly personal attribute of an individual, and much of the research on expert practice has focused on the particular ways in which experts differ from novices with regard to cognition, affect, and psychomotor skills (Higgs & Bithell, 2001). The notion of expertise that emerges throughout this book, however, is that it is socially constructed, created, and reproduced. A critical discourse perspective provides the lens through which expert practice can be viewed as a social construct. Accordingly, no attempt is made here to define expertise at the outset; rather, this different view of expertise unfolds as various aspects and applications of critical discourse analysis are explored throughout the book.

This chapter presents a critical discourse perspective on speech-language pathology, moving beyond those aspects of discourse analysis that are well recognized in the profession to the recognition of the potential contribution of critical discourse analysis as an approach that enables expert practitioners to reflect on their practice. The main conceptual foundations of a critical discourse perspective are outlined first. Examination of expert practice then commences through an analysis of the domain of expertise to which the profession lays claim in documents that set out the scope of practice. It is suggested that notions of appropriateness in communication are fundamental to the identification of the profession's expertise, and yet at the same time, judgments of appropriateness arguably are the most problematic for a critical conception of speech-language pathology practice.

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Toward a Definition of a Critical Discourse Perspective

Critical discourse is described in the literature variously as a theory, a method, a perspective, and an approach. The term *critical linguistics* usually is applied as an umbrella concept to cover the many diverse linguistic perspectives that embody a critical point of view, whereas *critical discourse* generally covers sociolinguistic perspectives used critically. Use of the term *critical discourse analysis* signals that the methodology for the investigation is based on textual analysis, although such work also may include analysis of broader sociological factors from a range of frameworks. Many introductory reference works are available, designed generally for applied linguists as well as for professionals working in the field of education, and throughout this book, these interdisciplinary insights form a useful counterpoint to the issues that can be identified in speech-language pathology (Locke, 2004; Pennycook, 2001; Rogers, 2004; Young & Harrison, 2004).

This opening section of the chapter outlines the main concepts involved in a critical discourse perspective and examines the relevance of this perspective to speech-language pathology.

"Critical"

The *critical* aspect of a critical discourse perspective encompasses the notion that the explicit goal of the perspective is to reflect on the everyday, taken-for-granted assumptions of social practices involving discourse in order to provide the opportunity for change. One of the dangers of this perspective is that it can be viewed as unnecessarily negative, and certainly the process of such an approach can be very challenging, because it will investigate ideas and practices in which both the researchers and the subjects being studied have considerable personal, professional, and potentially emotional investment. A generally held assumption within critical discourse perspectives, however, is that the spirit of inquiry is essentially positive, aiming to prompt or support some kind of social action for the betterment of those whose lives are affected by whatever it is being studied. This explicit idealistic investment is consistent with the aims of speech-language pathologists, who seek to improve the quality of life for people with communication and swallowing disorders. At the same time, the investment in change clearly biases critical discourse investigations in a particular direction, typically toward problems in which culturally embedded power imbalances can be seen as the central issue.

So, if not "criticism," then, what is meant by *critical*? As an entry point into the diverse approaches within critical theories, it is useful to consider the three main ways of understanding phenomena delineated by Habermas (1972): "The approach of the empirical-analytic sciences incorporates a *technical* cognitive interest; that of the historical-hermeneutic sciences incorporates a *practical* one; and the approach of critically oriented sciences incorporates the *emancipatory* cognitive interest . . . " (p. 308). In line with current terminology, this book uses the following terms

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to describe these three main ways of understanding the world: *empirical-logical*, as applied in analysis; *interpretive* (integrative), as applied in synthesis; and *reflective* (emancipatory), as applied in critical thinking. *Analysis* provides logical ways of segmenting, categorizing, and deducing information and is associated with modern (or *positivist*) thought. The scientific basis of speech-language pathology is founded on this way of understanding communication phenomena. *Synthesis* provides ways of bringing pieces of information together inductively, to interpret, to theorize as to what the whole might mean, and forms the basis of practical problem-solving. Clinical reasoning in speech-language pathology depends crucially on this way of transforming understanding into action plans. *Critical thinking* provides one further layer, wherein reflection can occur on both analyses and syntheses, from outside the boundaries within which these ways of thinking were framed, with the goal of emancipating people and societies from constraints of knowledge, thinking, and action. Critical approaches have in common a shared view of the relativity of different perspectives on phenomena and generally are seen as *postmodern* or *postpositivist* (although many of the major critical theorists, including Habermas, explicitly reject such labeling).

For example, in a speech-language pathology approach to understanding the sounds of speech, a phonetic and phonemic analysis will provide much information, and from these findings, particular phonological theories are applied and generated to explain how the sounds of speech are made, both in general and in the particular case of a child or adult who is producing sounds differently. In reflecting critically on findings and theories, a speech-language pathologist may ask questions about whether the analysis and theory will hold for the sounds of speech in dialects or other cultures. Furthermore, the speech-language pathologist may question the social and political consequences of applying normative tests of sound production milestones for both an individual child and for the child's cultural peers within the institutional framework of school education. Thus, the "critical" in a critical discourse perspective is all about asking questions, reflecting, and reframing and ideally drives lines of inquiry back through other ways of thinking.

An inherent attention to culture lies within these critical reflections, as both a point of departure (does the phenomenon being studied reflect aspects of culture?) and as a driving force (does the phenomenon being studied create aspects of culture?). Culture within a critical discourse perspective is considered in the broadest sense, in that although it may apply to a particular ethnic culture, it can apply equally to a subculture (for example, teenage gangs or bowling club members). Essentially, culture within a critical discourse perspective refers to groups that share some sense of collective membership within a particular society. Unlike in a line of sociological inquiry, however, it is not general aspects of culture that attract a critical discourse inquiry but particularly those aspects of culture in which issues of power are central to the problems being examined. In one sense, professionals who work within critical discourse perspectives see power as central to all cultural concerns, but

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this generality arguably is too broad to be helpful for a research focus, so it is the more narrow sense of power relations that focuses critical discourse inquiries. In view of the concerns of the critical discourse perspective with social change, issues of power imbalance and resultant social inequity drive the research focus. These concerns again are consistent with the concerns of speech-language pathology in maximizing social participation for people who experience communication disorders and swallowing disorders, and who face societal barriers and inequities in achieving such participation.

For critical discourse perspectives, one of the major ways in which the operation of power can be seen within cultures is through the examination of the discourses of that culture. One of the axiomatic assumptions within a critical discourse perspective is that specific cultural groups share particular discourses, and that these discourses define, identify, and create the group membership, as discussed next.

"Discourse"

Discourse in a critical discourse perspective is defined broadly in the sense of referring to all of those *types* of talk and writing that are used by members of a culture or society. Although discourse analysts examine particular instances of talk and writing, they are examining them with reference to the type of talk, or the type of writing, of which the instance is an example. Discourse perspectives fall somewhere in between the two extreme views within linguistics, that of language as an abstract conception of the rules for language reception and formulation (that is, a top-down perspective) and that of "language-in-use," wherein each instance of use is to be examined in its own right (that is, a bottom-up perspective). From the perspective of "language-as-abstract," the proliferation of variation within language-in-use is seen as essentially noise in the system, while from the perspective of language-in-use, the theoretical abstractions do not explain adequately what are seen to be systematic patterns in variation. Perhaps the closest to a true bottom-up perspective is *conversation analysis*, in which instances of language use are seen and analyzed from the participants' perspectives (in the sense of the observable communicative accounts of the participants) for the moment of conversation being examined. Even conversation analysis, however, builds generalizable theories regarding, for example, the general applicability of the turn-taking structures and resources for negotiating understanding and misunderstanding, so it certainly incorporates concerns beyond the instance of language-in-use. Discourse analysis falls somewhere along this continuum, in the sense that it is a sociolinguistic endeavor and therefore remains close to the data of language-in-use and at the same time often is theory-driven.

What constitutes different types of discourse? A diverse array of approaches to this question have been developed, with more or less rigor, within discourse analysis. For example, what one researcher may refer to as a narrative, another may delineate further to describe as a personal recounting, as opposed to a story narrative; or a procedure may be described equally

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well as just one type of explanation. The terms used to describe types of discourse also are numerous, with *genre* and *text type* among the most common. Each of these terms comes with its own theoretical underpinnings and assumptions. The term *genre* in this book is applied in the sense used in the approach of *systemic functional linguistics*, which allows characterization of the type of discourse in very particular linguistic ways, resulting in a unique configuration of the words and grammar used in association with what is being talked about (for example, the technicality of the vocabulary), with how the language reflects and creates the interpersonal relationship between speaker and listener or writer and reader (for example, the politeness forms used), and with the role of language (for example, whether it is verbal or nonverbal, or whether it constitutes or is ancillary to the interaction) (Halliday & Hasan, 1985). For example, the narrative genre tends to have low-level technical vocabulary, demonstrates considerable use of politeness forms of language to engage the listener or reader, and is verbal or graphic, and wholly constitutes the interaction. By contrast, the exposition genre tends toward higher-level technical vocabulary, uses language to disengage or objectify, may include diagrammatic communication as well as verbal or graphic communication, and may either constitute or partially accompany an interaction.

The term *text type*, on the other hand, generally is associated with theories that relate the generation and understanding of texts to mental models or cognitive schema (Van Dijk, 2006; Van Dijk & Kintsch, 1983), so macrostructural elements within texts are the important defining features distinguishing different types of texts. For example, although narrative text types may consist of establishing the setting (location, participants, and so on), describing the complicating action, providing a resolution, and optionally a coda, expository text types may consist of establishing the domain, setting out a logical train of points, and providing a conclusion, and optionally a recommendation. In diverse approaches within discourse analysis, however, the terms *genre* and *text type* often are used fairly loosely, and certainly both the lexicogrammatical features and the macrostructural elements are common concerns across many approaches to discourse analysis.

The study of both genre and text types requires data commonly referred to as *texts*, in the practical sense of instances of speaking or writing. A feature of texts is their unity, with their selection guided by observation of moments of talk or writing that "hang together" or form some sort of coherent instance. Any particular text could in fact contain a number of different genres or text types; for example, conversation during a coffee-break may contain examples of narrative discourse (what happened over the weekend), expository discourse (an explanation of a political point of view), and casual chat (such as gossip) (Eggins & Slade, 2004/1997).

Critical discourse inquiries have at their center the study of textual data, and the study of the types of discourse associated with particular cultural contexts. *Context* as used here is another term variously defined by different approaches. Throughout this book, the

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term is used to allow movement from the general construct of culture to the particular instantiation of culture in a particular situation. So, for example, in considering the culture of hospitals, a particular inquiry may focus more narrowly on particular contexts (for practical purposes, even if for no other reason)—the inquiry may look more closely at case conferences in order to examine professional interactions within the hospital culture. The *context of situation* is another construct very much associated with systemic functional linguistics, which is very specifically described with reference to the *field* of discourse (what is being talked about), the *tenor* of discourse (the role relationship between interactants), and the *mode* of discourse (the role of language within that context) (Halliday & Hasan, 1985). This dialectic, between the cultural context and the discourses associated with it, is another key assumption within a critical discourse perspective. The term *dialectic* implies a two-way interaction between cultural contexts and types of discourse such that the cultural context shapes (dictates or constrains) the types of discourse considered to be allowable or appropriate within that context, while at the same time, the types of discourse shape or change the cultural context (the notion of appropriateness is revisited later in the chapter). For example, an argument with a client is an unexpected type of discourse within a typical therapy session, so such nonstandard discourse in this context will have consequences for the interaction, generating a shift in the role relationship between therapist and client and challenging cultural assumptions (Simmons-Mackie & Damico, 1999).

"Analysis"

If a critical discourse perspective involves studying and reflecting on the types of discourse used within cultural contexts, then the final aspect to be considered is that of *analysis*. Diverse methodologies are used to conduct such analyses, with some inquiries using broad sociological and sociolinguistic constructs, others using ethnography and ethnomethodologically inspired qualitative analyses (including conversation analysis), and still others making use of linguistic methods of discourse analysis (Kress, 1990). Although a range of linguistic analyses have been applied, one of the most useful and widely applied within critical discourse perspectives is that of systemic functional linguistics (Halliday & Matthiessen, 2004). This linguistic model is a top-down approach to language-in-use that seeks to describe and explain the dialectical relationship between context and text—that is, between culture as encapsulated within contexts of situation and the levels of language used in texts (phonological and gestural expression, lexicogrammar, discourse-semantic levels of language). The application of systemic functional linguistics to empirical studies of discourse has provided critical discourse inquiries with systematic and replicable methodological tools. Of the examples presented in this book, many make use of systemic functional linguistics, although both broader qualitative analyses as well as conversation analysis also are used. Chapter 9 returns to these diverse methodologies and considers their relative contributions for a critical discourse perspective on speech-language pathology.

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To summarize, a critical discourse perspective is concerned with shedding light on power relations in cultures, as revealed and instantiated through discourse, and in promoting change to alleviate social inequities associated with power imbalances. This perspective is critical in the sense of considering and reflecting on ideas and practice embedded within cultural contexts and uses the study of types of discourse as the relevant artifacts for this consideration, making use of a range of methodologies including sociolinguistic approaches to analyze the discourse.

A Critical Discourse Perspective on Scope of Practice

The most fundamental question that can be asked regarding speech-language pathology is "What is the domain of expertise within the field?" It is possible, for example, to consider the expertise of speech-language pathologists from the point of view of the "person-in-the-street" (and such research is discussed in Chapter 9). For the moment, however, by way of an entry point to thinking within a critical discourse perspective, this discussion focuses on the profession's ideas regarding its domain of expertise. Statements about scope of practice in speech-language pathology are a source of textual data that encapsulate the profession's view of itself. Such statements usually contain some explicit declaration of their purpose, generally aiming to provide information to the general public, potential employers, and clients and their caregivers regarding what they can expect a speech-language pathologist to do. These statements are put together through the work of members and employees of the associations that represent the profession and are available to the general public in a number of countries. In view of the time and effort that go into producing these documents, it is possible to be confident that the wording has been given close attention by the writers and that these writers are experts in the field; hence, these artifacts are of particular interest from a critical discourse perspective as a way of unpacking the sociocultural meanings conveyed in these texts. The following discussion is based on the examination of statements of scope of practice available on the websites for the American Speech-Language-Hearing Association (ASHA) (www.asha.org), the Canadian Association of Speech-Language Pathologists and Audiologists (CASLPA) (www.caslpa.ca), and the Speech Pathology Association of Australia (SPAA) (www.speechpathologyaustralia.org.au). Each of these associations provides a particular document identified as the profession's statement with regard to scope of practice.

The first point of interest from a critical discourse perspective is in the description of the nature of the problems with which speech-language pathologists are concerned. Both ASHA and SPAA statements explicitly draw on the World Health Organization (WHO) framework (WHO, 2001) in order to describe communication and swallowing with reference to impairment of bodily functions, limitations on communication and swallowing activity, and restrictions of social participation in relation to communication

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and swallowing. The ASHA statement provides the more detailed description of scope of practice in this regard:

> The scope of practice in speech-language pathology encompasses all components and factors identified in the WHO framework. That is, speech-language pathologists work to improve quality of life by reducing impairments of body functions and structures, activity limitations, participation restrictions, and environmental barriers of the individuals they serve. They serve individuals with known disease processes (e.g., aphasia, cleft palate) as well as those with activity limitations or participation restrictions (e.g., individuals needing classroom support services or special educational placement), including when such limitations or restrictions occur in the absence of known disease processes or impairments (e.g. individuals with differences in dialect). The role of speech-language pathologists includes prevention of communication, swallowing, or other upper aerodigestive disorders as well as diagnosis, habilitation, rehabilitation, and enhancement of these functions. (ASHA, 2001, p. 1–28)

The WHO framework used here attempts to circumvent terminology and taxonomic classifications that have become stigmatized over the years—for example, the replacement of the concept of handicap, which was an important step forward in the 1980s in the recognition of social restrictions that could occur independently of impairment, with the concept of restrictions on social participation. Accordingly, the current terminology could be seen as "politically correct" terminology. Of interest, in more recent years, the term *politically correct* has come to be used pejoratively, with some backlash against the use of terms seen to be used euphemistically. Such debates regarding the social acceptability of terms, however, represent just the surface of a critical discourse inquiry. Of greater interest here is the clear identification that speech-language pathologists are concerned with difficulties that arise as a result of speech and language difference or variation. This point opens the issues surrounding how judgments can be made and when the determination of difference and variation is appropriate or not. This issue of appropriateness is central to practice in speech-language pathology and is taken up later in this chapter.

The statements of scope of practice identify the speech-language pathologist as the active agent, with relative "backgrounding" of the person with a communication or swallowing disorder or difficulty. In these documents, speech-language pathologists *do* things—for example, "assess," "treat," and so on—whereas people with communication and swallowing disorders are passive recipients of actions instigated by speech-language pathologists. Person-first description of people with communication disorder is increasingly in use in line with current debates and concerns with regard to how to describe the populations involved. This person-first terminology provides greater potential for agentive forms than if just disorder types were listed. For example, such terminology means that it would be possible to state: "Individuals with communication disorders can contact speech-language pathologists

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directly for services"—but in fact no instances exist in any of these documents in which persons with communication or swallowing disorders or difficulties are agentive. The relative invisibility of such persons in relation to the professional in these documents becomes more apparent when it is noted that speech-language pathologists either "provide services for" or "serve" people in these populations. A striking finding is that in these documents, "collaboration" occurs only between speech-language pathologists and other professionals who similarly "provide services." The closest characterization of working partnerships with persons with communication and swallowing disorders or difficulties comes with the identification of "family-centered approaches" and the description of "working with" people in these populations in the SPAA document (SPAA, 2002). From a critical discourse perspective, these observations point to a fundamental imbalance in the power relationship between professionals and people with communication and swallowing disorders.

A more detailed examination of the wording in these documents is possible through a taxonomic analysis (Martin & Rose, 2003, p. 103), which reveals that, as might be expected, a large proportion (32%) of terms used in these documents are highly specialized and technical. For example, concrete specialized terms such as "cleft palate" or "augmentative and alternative communication devices," as well as abstract technical terms such as "phonology," "morphology," "semantics," and "syntax," are used. Additionally, the relationship between speech-language pathology and the social institutions in which it is embedded is revealed through the incorporation of abstract institutional terms such as "service delivery models," "local, state, and national levels," and "outcomes measurement activities."

Another feature of interest in these scope of practice documents is the tension between a very plain-English use of active verbs to describe what speech-language pathologists do ("identify, define, and diagnose," "educate, supervise, and mentor," and so on, which is most notable in the ASHA document) and the adoption of a writing style commonly associated with scientific writing, involving heavy use of *nominalization* (Halliday, 1985/1989). Nominalization is described within systemic functional linguistics as an ideational metaphor wherein one type of language is used for another; in this case, a process becomes a thing (Martin & Rose, 2003, pp. 103–107). Nominalization essentially renders active verbs into static nouns—for example, *prevent* becomes *prevention*, and so on. These metaphorical entities make up 50% of all of the different kinds of entities referred to in the scope of practice documents. All three documents use the following terms to describe the processes involved in speech-language pathology: *identify*, *treat*, *educate*, *counsel*, *prevent*, *manage*, *assess*, *refer*, and *rehabilitate*. In all three documents, these terms are nominalized. Two other terms are used to describe processes in the three documents: *enhance* and *research*; these are nominalized in two of the three documents. None of the documents use the terms 'counsel', 'prevent', and 'rehabilitate' as verbs;

01_Ferguson_1-18 10/3/07 9:32 PM Page 10

that is, these terms always appear in nominalized form (*counseling*, *prevention*, *rehabilitation*).

Nominalization is a stylistic device that can be seen as serving social purposes—for example, to raise the status of the writing. This aspect of scientific writing style not only is seen in published documents but infiltrates spoken scientific presentations, again with associations of higher status within the social community of such events (Rowley-Jolivet & Carter-Thomas, 2005). On looking at the scope of practice documents from a critical discourse perspective, then, it can be asked what are the social messages sent (and received by target audiences) by the use of such stylistic devices. A possible result of use of such devices (and only one possibility) is the shift of focus from what is done as a process to the provision of a product—for example, speech-language pathologists provide a product called "screening," and so on. Such language choices are rarely conscious, but the product focus may be seen as reflecting important current social movements of corporatization of health and education services, involving, among other things, a consumer or customer focus (rather than a focus on patients, clients, or people) and a delineation of particular markets for these services. In other words, through this product focus, the profession identifies what others can purchase or use. Within this wider social movement of corporatization (Fairclough, 2004), such a linguistic convention may be considered to be strategic for the profession. Possibly, however, the strategy also may be seen to contribute to the relative invisibility of the person with a communication or swallowing difficulty or disorder.

Of course, the social purpose in relation to the aspect of scope in these documents is not just to state what it is that speech-language pathologists do, or with whom they work, but to delineate the boundaries of practice. The statement of the territory within the boundaries is very broad, with no explicit statements as to what is done by speech-language pathologists rather than by others. Through such wide-ranging claims for territory, these documents attempt to provide a resource for speech-language pathologists to use in particular instances. As insiders, members of the profession can recognize perhaps where these territorial justifications are implicit in the documents, such as in statements regarding speech-language pathologists' role in case management and financial administration, and in statements regarding use of instrumentation, such as videoendoscopy, in which requirements for specialized training are noted. On the other hand, the statement of what lies outside the boundaries is more explicit, particularly with regard to hearing, probably because of the historically close association between audiology and speech-language pathology training and practice—for example, "This does not include sensory devices used by individuals with hearing loss or other auditory perceptual devices" (ASHA, 2001, section 6, p. 1–29). Other statements regarding what lies outside the boundaries are more implicit and possibly require an insider to notice the fine distinctions being made—for example, "Counselling on aspects of communication, swallowing disorders and therapy" (SPAA, 2002, p. 2) and "Screening of hearing and other factors for the purpose of speech-language

01_Ferguson_1-18 10/3/07 9:32 PM Page 11

evaluation" (CASLPA, 1998, p. 1). An alternative way to identify the boundaries that speech-language pathologists are not to cross is through statements of when referral to other professionals is required, although these professionals are relatively underspecified—for example, " . . . evaluation of esophageal function is for the purpose of referral to medical professionals" (ASHA, 2001, section 1, p. 1–28).

All three documents stress that scope of practice can be expected to change over the course of time and thereby implicitly acknowledge the role of historical sociocultural context in shaping practice, while at the same time providing a gap in the fence, as it were, for territorial expansion. The way in which boundaries shift raises important questions that warrant further attention in the field. The scope of practice documents themselves provide textual artifacts that signal the points at which these boundary shifts may be occurring. As Wenger and colleagues have discussed in relation to communities of practice, well-accepted practices require no special justification or debate, because these practices constitute assumed knowledge within and outside the particular community, but boundary disputes and justifications are required when practices are changing (Wenger, 1998; Wenger, McDermott, & Snyder, 2002). In the scope of practice documents, it can be seen that expert practice drives change, as, for example, when specialized training in particular techniques becomes, first, a possibility for some practitioners and then, over time, a fundamental requirement of professional preparation (a sociohistorical account of the rise of dysphagia practice would provide such an illustrative case example). On the other hand, what might be seen as non-expert practice also drives change. For example, the Royal College of Speech and Language Therapists (www.rcslt.org) embeds much of its statements with regard to scope of practice within a range of pivotal documents, but the most explicit delineation of scope of practice is found within its documents outlining the work of support personnel, in order to attempt to clearly delineate the limitations of the role of such personnel in relation to that of a qualified speech-language pathologist (*RCSLT competencies project support practitioner framework*, 2002).

In summary, then, thus far it has been suggested that speech-language pathology practice reflects its sociocultural and sociohistorical context, and a critical analysis of the discourses produced by the profession in relation to scope of practice has shed some light on past, present, and future practices. As previously mentioned, however, scope of practice involves tackling the notion of appropriateness of communication, and this notion has a major role in identifying the specific expertise of the profession.

A Critical Perspective on the Notion of Appropriateness

The term *appropriateness of communication* came into prominence in the field of speech-language pathology during the 1980s, associated with a significant theoretical paradigm shift influenced by linguistic perspectives on pragmatics. Pragmatics in linguistics refers to a

5

Working Collaboratively: Discourse Involves Multiple Parties

In an ideal world, interdisciplinary teams work together smoothly to provide intervention, but in reality, communication processes present major challenges to the provision of health care. Multiple terms have proliferated to describe the many ways in which professionals work together: interdisciplinary, multidisciplinary, transdisciplinary, interprofessional. In this chapter, the term *multidisciplinary* is reserved for situations in which professionals from specific disciplines retain their professional identities, contributing discipline-specific knowledge or skills to a situation. The term *transdisciplinary* is used to refer to situations in which professions adopt and integrate the knowledge and skills of other disciplines within shared practice. The terms *interdisciplinary* and *interprofessional* are used somewhat interchangeably to refer generically to situations in which professionals from different disciplines work together, although the term *interprofessional* is favored when the discussion is about aspects of professional practice, rather than aspects related to the theoretical or empirical frameworks informing the discipline. Also, the terms *collaboration* and *partnership*, used widely in the literature, are used synonymously in this chapter.

Many aspects of working collaboratively have been recognized, but collaborative work is mediated primarily through discourse. Roberts and Sarangi identify three main discourses in which professionals are involved: personal discourse (describing their own experiences), professional discourse (the discourse needed to carry out their professional roles), and institutional discourse (the discourse that describes and accounts for professional discourse) (Roberts & Sarangi, 2003). Chapter 1 of this book explored some of the aspects of institutional discourse (through examination of documents describing scope of practice), and Chapter 4 looked at some of the published material on discourse describing

05_Ferguson_77-94 10/3/07 9:33 PM Page 78

the personal experiences of professionals. This chapter focuses on professional discourse and, in particular, on the discourse required by professionals when working together.

Speaking the Same Language

One of the most apparent areas of difficulty that arises in the discourse between members of different professional groups is the difficulty with terminology (Walsh, 2005). Even the terms used to describe the profession itself are not unproblematic. For example, Ukrainetz and Fresquez (2003) found that speech-language pathologists working in schools described themselves as "speech teachers" with their school students, and as either "speech therapists" or "speech pathologists" when talking with teachers. Of interest, one participant described her reluctance to use the term "speech-language pathologist" with reference to the sociocultural implications of increasing the perceived status gap between herself and teachers (Ukrainetz & Fresquez, p. 288). Within the profession of speech-language pathology itself, considerable debate around terminology remains, extending beyond the trivial. For example, debates surrounding the use of such terms as *specific language impairment*, *developmental verbal dyspraxia*, and *cluttering* are not reducible to debates about lists of symptoms that are to be considered fundamental to the application of the labels. Instead, these debates center on the extent of shared understanding of the fundamental nature of the difficulties captured by these terms. For example, how "specific" is *specific language impairment*? Does the presence of other cognitive difficulties mean that the nature of the type of language problem observed is any different (Plante, 1998)? As another example, is there a qualitative difference in the types of difficulties seen in children with severe phonological disorder compared with those seen in developmental verbal dyspraxia, and if (as some researchers argue) the differences observed point to the presence of neurological impairment, then is the presence of neurological symptoms sufficient to clearly differentiate the two? This debate has resulted in the proposal to use *childhood apraxia of speech* instead of the now muddied term *developmental verbal dyspraxia of speech* (Forrest, 2003). If experienced clinicians are able to "know cluttering when they hear it," does it matter that checklists of diagnostic symptoms for stuttering, prosodic and articulatory disorders, and cluttering fail to clearly delineate the category of "cluttering"? (St. Louis, Raphael, Myers, & Bakker, 2003). Such terminological debates are important to the profession and are likely to continue, despite repeated calls for consistency of use of terms, because terms and meanings undergo change over time, as is the way of all language use, reflecting shifts in the culture of speech-language pathology. The debates themselves, however, are important to the profession, because such debates reflect the sharing and growth of understandings of communication disorders among members of the professional community. Despite inconsistencies and differences in use of terms, shared understandings are likely to be sufficient to prevent serious misunderstandings between

05_Ferguson_77-94 10/3/07 9:33 PM Page 79

people. For example, the historical term "developmental aphasia" is no longer used but is still available in the shared consciousness of the profession, allowing access to historical understandings of child language disorders (Eadie, 2005; Kamhi, 1998).

More difficulties with terminology arise in interprofessional contexts for which shared understandings have not emerged. In general, such interprofessional misunderstandings are described in terms of the uses and abuses of jargon that is specific to the particular profession. For example, if a speech-language pathologist uses a profession-specific term such as *phonological input lexicon*, or a linguistic term such as *left embedding*, then it is only reasonable that a doctor, nurse, or teacher would not understand what is meant. In such situations, however, it is clear to listeners or readers that they have not understood, and this awareness provides the potential trigger for seeking clarification.

More fundamental misunderstandings can arise when each person is assuming that the other is using terms in the same way, without either party being aware of the difficulty. Such problems arise when everyday words are used by one profession in very specific ways. For example, the term *comprehension* is used very narrowly in speech-language pathology to relate to comprehension of written or spoken language that is separable from other cognitive skills such as memory or executive judgment and decision-making, whereas in the general community, *comprehension* typically embraces all such meanings. Both the adoption of novel jargon and the narrowing of meaning of everyday terms to convey specific profession-related meanings are common to every social grouping within a community. The idiosyncratic sets of terms and meanings in different health and education disciplines, for example, differ not only from each other but also from the discourse of the administrative organization, so that words such as "report to" may imply "keep informed" to a clinician but "be directly supervised" to an administrator (Schroeder et al., 1999). Such misunderstandings can be expected in all types of interprofessional discourse.

A good example of problems with terminology was highlighted in the findings of research on teachers' awareness of language impairment (Webb, 2007). Webb used a questionnaire to find out more about the understanding of 215 teachers with regard to a number of aspects of matters related to speech-language pathology (for the 6- to 12-year-old age group). In their responses to the questionnaire, teachers used "speech" and "language" interchangeably (pp.157–158). Similar terminology issues were reported by Ukrainetz and Fresquez (2003) in their qualitative study of such usages by 5 speech-language pathologists and 15 teachers. The term *language* appeared to be a general umbrella term for teachers in their study, in comparison with the very specific aspects of language (such as syntax and semantics) that fell within the use of this term for the speech-language pathologists. Such terminology issues present a significant barrier to collaborative approaches widely held to be of value in this area, as discussed by Tollerfield (2003), who similarly found that speech-language pathologists working with teachers needed to explain such terms as "receptive" and "expressive." From an analysis of 50 in-depth

05_Ferguson_77-94 10/3/07 9:33 PM Page 80

interviews with early childhood teachers, Mroz (2006) reports that the identification of children with communication disorders was a major concern to teachers, and the suggested need for training in this area would rely heavily on clear description and definition.

Although use of terminology points toward the important role of understanding discourse in interprofessional interaction, in one sense terminology issues are relatively straightforward to address—through awareness, and with an attitude of responsiveness and mutual respect in seeking clarification. Terminology, however, is just one small part of the wider complexities in interprofessional discourse.

Working Together

Working together in collaborative partnerships can involve many different ways of relating, which fall somewhere along a continuum of independence to interdependence. For example, referral from one professional to another leaves both professionals working very separately, yet each relies on the other for some aspect of service delivery. Somewhere toward the middle of this continuum would fall the type of collaboration in which the speech-language pathologist works alongside another professional, for example, in a multidisciplinary team. Toward closer interdependence falls the type of partnership in which the professionals are involved in simultaneous service provision to the client.

One of the most tightly interdependent working relationships between a speech-language pathologist and another professional occurs in work with an interpreter in either the assessment or the treatment of a client, in that the speech-language pathologist is unable to assess the client without the mediation of the interpreter—for example, when the client speaks another spoken or signed language (Isaac, 2001; Seal, 2000). The complexity of the discourse in interpreter-mediated sessions is illustrated in Examples 5–1 and 5–2.

Example 5–1 is drawn from the research of Roger (2003) into interpreter-mediated assessment of people with aphasia. In this example, the speech-language pathologist is trying to assess a patient with a tentative diagnosis of aphasia following stroke, and the interpreter is attempting to interpret (into Tagalog) as the speech-language pathologist administers the repetition task from the Western Aphasia Battery (Kertesz, 1982, 2006). On coming to the item "The pastry cook was elated," the interpreter has been uncertain as to how to interpret "elated." Perhaps deciding that an online discussion regarding items of similar co-articulatory complexity was not possible at that moment, the speech-language pathologist instead asks the interpreter to find a word of roughly equivalent meaning. This moment involves a shift in what Goffman (1974) describes as a "frame," in that the culturally framed role of "interpreter" has shifted—now the interpreter is deciding on and providing stimuli, rather than straightforward interpreting. A second frame shift occurs at utterance 4, when the speech-language pathologist inquires about the clarity of the patient's repetition attempt—here again, the interpreter's role shifts again from interpreting to evaluating. This type of frame shift

05_Ferguson_77-94 10/3/07 9:33 PM Page 81

Example 5–1
Interpreter-Mediated Assessment

(*Key:* I, interpreter; P, patient; S, speech-language pathologist; =, simultaneous talk.)

1	S:	Just say "happy" . . . "happy"'s fine . . . instead of "elated," just say "happy."
2	I:	*Ang tagapagluto ay masaya.*
3	P:	*Ang tag-pagluto masaya.*
4	S:	Clear?
5	I:	Ah . . . no . . . a bit . . . not clear . . . *tagapagluto* . . . [slowly to P] *ang tagapagluto ay masaya*.
6	P:	*Ang tagipagluto masaya*.
7	S:	Better that time . . . or not?
8	I:	No . . . no . . . I mean . . . um . . . like . . . It's a bit . . . not . . . ah . . . there is like a . . .
9	S:	Okay, this . . . how does it sound different?
10	I:	No, it's not different but ah . . . you know it's just like . . . ah . . . like stuttering . . . something like that.

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is extremely common in interpreter-mediated speech pathology sessions and causes considerable tension and concern for interpreters, because it challenges their professional precepts regarding the importance of *not* judging (Ferguson, Candlin, Armstrong, Isaac, & Roger, 2005; Isaac, Roger, Candlin, Ferguson, & Armstrong, 2004). This moment in the interaction also represents what Goffman describes as a shift in "footing" (Goffman, 1981, p. 124) within the frame, in that here the speech-language pathologist and the interpreter align, aside from the patient, to consult regarding the clarity of the patient's attempt. This footing shift recurs at utterance 7, and in utterance 8, the interpreter can be seen to be displaying a high degree of uncertainty in her response, through discourse markers of hesitancy, and considerable modulation (for example, "it's *a bit* like," "*just* like"). This display of uncertainty signals (whether consciously or unconsciously) that the interpreter is being asked to step outside what Goffman (1974) describes as the "frame space"—that is, the interpreter is being asked to step outside the usual role of an interpreter. The speech-language pathologist in utterance 9 seeks what amounts to a metatextual analysis ("how does it sound different?") as she tries to identify what it is that was different in the patient's repetition

05_Ferguson_77-94 10/3/07 9:33 PM Page 82

(phonology or grammar); this relates to the speech-language pathologist's main agenda, that is, the textual analysis of the patient's utterances. Such metatextual analysis, however, is well beyond the cultural frame for the interpreter's role. Of note, this interaction is taking place in front of the patient; thus, in line with Goffman's (1974) notions of the "participation framework," the patient is the "audience" as well as the "object" under discussion, so in analyzing this discourse, it needs to be considered whether the choice of words and wordings reflect some adjustment for this audience. For example, noticeably absent are evaluative words such as *wrong* or *error*, with words such as "clear," "not clear," "better," "different," and "not different" being used instead.

From the perspective of the speech-language pathologist, the frame shifts and shifts of footing within the frames in such interactions may be invisible. For the speech-language pathologist, all interactions with the client would involve a "meta-frame," in that the speech-language pathologist is engaging with the client in conversational or testing interactions while simultaneously evaluating the content and form of the language and the interaction itself. The speech-language pathologist's role involves continual adjustments to his or her own contributions to the interaction specifically designed to elicit types of language use that will further enable this meta-analysis. Interpreters also engage in a "meta-frame" as they conduct their professional work, constantly recasting meaning within the other language. Both interpreters and speech-language pathologists, however, can fail to recognize each other's frames, and this can account for much of the "getting off on the wrong foot" that can arise during interpreter-mediated interactions. Whereas speech-language pathologists seek to use interpreters' insights and judgments as a set of data (along with, for example, the judgments of patients, family members, and nursing staff), interpreters can feel as if they are being asked to step outside their role by providing such judgments. In the example provided, the matter being interpreted was concrete and related to the linguistic code, yet interpreters frequently are asked to comment on far more abstract and culturally laden matters. Friedland and Penn (2003), for example, discuss the complexities involved in an interpreter-mediated session involving what they describe as "cultural brokerage."

Isaac (2002a, 2002b) has stressed the important role of presession briefing in trying to set up a framework to negotiate such role alignments and shifts. Her work also demonstrates, however, the existence of a considerable power differential in the partnership, as revealed very tellingly in Example 5–2, drawn from her work. In this example of presession briefing, the speech-language pathologist dominates the interaction, explaining what will happen.

In this briefing, the speech-language pathologist provides only one explicit opportunity in turn-taking for the interpreter to seek clarification or to initiate a comment (turn 17: "Okay?"). Three points can be identified at which turn transitions might have occurred (turns 10, 12, 16), but in this session, the interpreter does not make use of these opportunities. In this situation, the two professionals have just completed another session, so perhaps prior negotiation has occurred. Another possibility is lack of experience: Less experienced interpreters may not know what

05_Ferguson_77-94 10/3/07 9:33 PM Page 83

Example 5–2
Interpreter Presession Briefing

(*Key:* BC, backchannel; I, interpreter; P, patient; S, speech-language pathologist.)

1	S:	This little boy is eight years and three months old . . .
BC	I:	Yes.
	S:	. . . and his name is . . . Ch . . . ? Is that how I say it?
2	I:	[*gives correct pronunciation*]
3	S:	I'm not sure who's going to be coming, but I'm assuming that mum [*unintelligible*] will be bringing him.
4	I:	They haven't arrived yet?
5	S:	Yeah, they're here already.
6	I:	Aha. They're here already.
7	S:	They've been here for a little while, so we'll just whiz through it. Um . . .
8	I:	Just quick.
9	S:	What I'm going to do . . . he's obviously older than the little one we did just then.
10	I:	Aha.
11	S:	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 . . .
BC	I:	Mmhm.
	S:	. . . so, we'll see how we go . . . um . . . and probably do it through you anyway.
12	I:	Yes, okay.
13	S:	Um . . . then I'll spend some time with him, firstly assessing, like, his articulation . . .
BC	I:	Mmhm.
	S:	. . . because that was the main concern, but then I'll take a language sample.
14	I:	Mmhm.
15	S:	So, the language sample that I'm going to do is a storybook . . .
BC	I:	Mmhm.
	S:	. . . and I'm going to tell the story . . .
	I:	Mmhm.
	S:	. . . and I'm going to get him to retell it.
16	I:	Yes, okay.
17	S:	Okay?
18	I:	Aha.

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05_Ferguson_77-94 10/3/07 9:33 PM Page 84

challenges lie ahead, or what needs to be negotiated. Certainly, from the example of the discourse that takes place during the session itself (i.e.,Example 5–1), it can be seen that perhaps the most important thing to be negotiated in the presession preparation between the two professionals is how online realignments, changes in footing, and shifts in frames or roles will be signaled and managed between the professionals.

Modeling Interprofessional Discourse

The issues highlighted in the interaction between interpreters and speech-language pathologists in the previous section apply equally to other interprofessional collaborations. Whenever different professionals work together, it is possible to see what Burger and Fillettaz (2002) call "an intersection of multiple social practices." The social practices of each professional grouping arise from the cultural discourse of that profession and shape what members from each grouping consider to be the appropriate contribution to the interaction, and also their "reading" of the activities of the other professional. Figure 5–1 provides a model of the multiple social practices involved in interprofessional discourse involving speech-language pathology, which involve the framing of the interprofessional interaction, and the relative footing in the interpersonal relationship between the interactants, and the assessment practices from which the findings in relation to the client/patient emerge.

The most common intersection between professions involves consultation, and such consultation may take place with or without the presence of the person with the communication or swallowing disorder. The main issue affecting the discourse in such consultation is the cultural frame of reference that informs the understandings of each profession. Naturally, as discussed earlier, terminological confusions can arise here, but misunderstandings also can arise when cultural frames of reference differ. For example, as a speech-language pathologist seeks to consult with a teacher regarding the return to schooling of a child who has suffered traumatic brain injury, it is likely that the medical model, which attributes lack of attention and impulsivity to organic causes, is going to be discordant with the educational model, in which these difficulties are attributed to emotional or environmental causes (Chapman, Nasits, Challas, & Billinger, 1999). Beyond these more immediate sources of misunderstanding, it is important to consider the relative power and status for each of the professional frames involved. For example, the relative weight given to evidence-based paradigms is allied closely with differing levels of social status.

In addition to identifying each individual discipline and its contribution to the interaction, another important factor in interprofessional collaboration is the recognition of the consultation process as a unified discourse in itself. For example, the type of patient-related case conference common in rehabilitation settings creates what Maseide (2003) describes as a "socially distributed cognitive process" (pp. 372–373), as instantiated in the discourse of the group discussion. At the end of such a case conference, decisions about diag-

05_Ferguson_77-94 10/3/07 9:33 PM Page 85

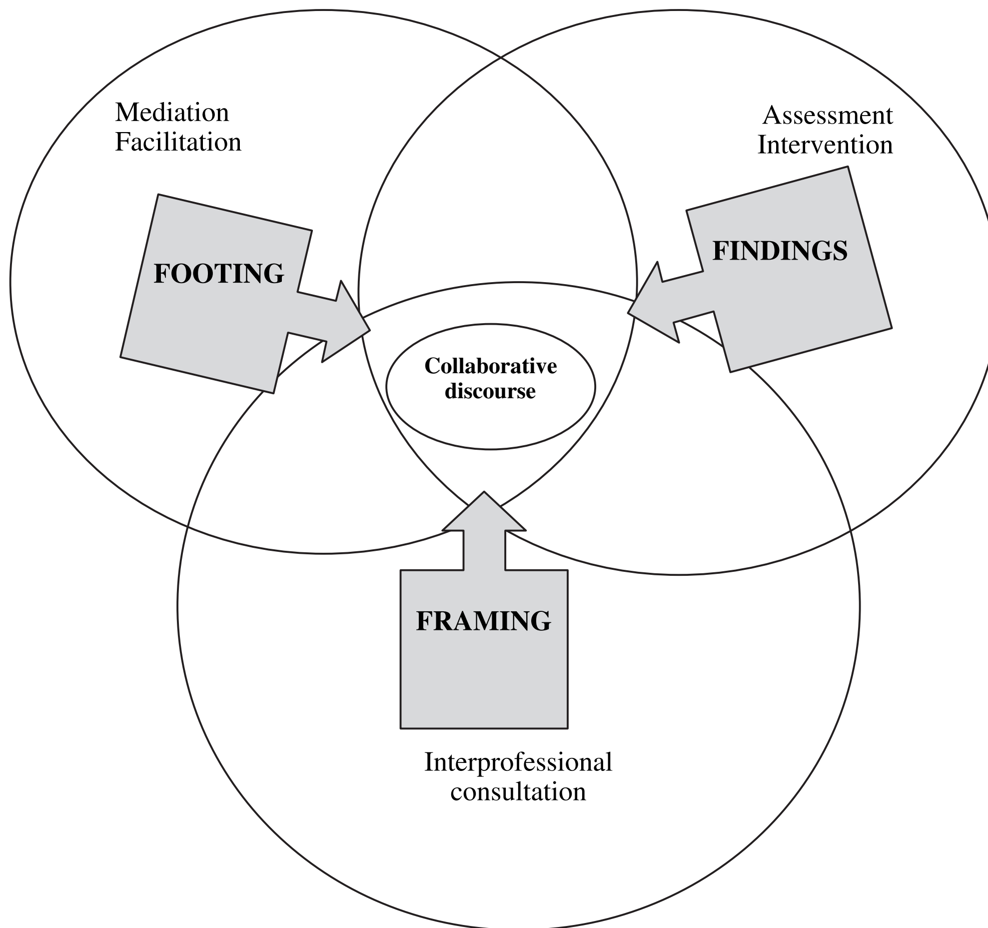

Figure 5–1. Multiple social practices.

nosis, prognosis, treatment goals, likely discharge destination, and so on have been made, but no one professional may be attributed with each decision or judgment. Maseide describes medical case conferences on patients with cancer and describes the interplay of explicit medical decision-making with the implicit interpersonal alignments required as moral problem-solving is negotiated in the team. Drawing on Goffman's work, Maseide draws attention to the way the medical frame creates the institutionalized footings of the members of the medical team (for example, hierarchies) but also how, in the moment-by-moment unfolding of the discourse, identities and alignments (footings) are created. As Maseide notes, "For this team to function a delicate balance is required between collegiality, equity, and recognition of special competence" (p. 399). In a study of interprofessional case conferences, Engestrom and colleagues identified three main ways in which such teams managed these tensions between professional and team goals and decision-making: articulation,

05_Ferguson_77-94 10/3/07 9:33 PM Page 86

cross-appropriation, and reconfiguration (Engestrom, Engestrom, & Keruso, 2003, p. 294). Articulation involved the explicit communication of professional knowledge or information to other professionals. Cross-appropriation occurred when professionals took up perspectives of other professionals. Reconfiguration was seen as emergent from the group discussions when new ways of thinking and decision-making arose from the interprofessional group discussion. The institutional discourse of the setting thus provides the broader frame for such locally negotiated decisions (Cook-Gumperz & Messerman, 1999), so that, in the rehabilitation setting example, "discharge" probably is the most important part of the case conference from the moment of admission, because the institutional imperative is reduced length of stay. Thus, for inpatient rehabilitation case conferences, the cultural ideology is primarily that of the medical model paradigm, in which discharge is the taken-for-granted assumed end point. The institutional imperatives preclude or marginalize other perspectives, with the issues of chronicity deferred to community settings. Therapy goals are reported by individual disciplines, but the shared goal in the discourse is that of discharge. The patient is absent from such case conferences and is represented through the discourse of the professionals. This representation, as in the matter of competence, for example, will have a major impact on the decisions that are made (Hall, Sarangi, & Slembrouck, 1999a, 1999b).

Figure 5–1 also illustrates the intersection of the issues surrounding the relative footing or alignment of the professionals working together to mediate or facilitate a client-clinician interaction. Although the most obvious example of this is the use of interpreters by speech-language pathologists in working with clients who speak another language, speech-language pathologists may find themselves mediating an interaction between the client and another professional, for example, when assisting a patient with aphasia to give instructions to a legal professional (Critchley, 1970; Enderby, 1994; Ferguson et al., 2004). Such discourse involves at least three interactants, so the alignment of participants shifts throughout the unfolding interaction—for example, as the clinician and other professional negotiate, as the clinician engages with the client, and as the other professional engages with the client. The relative power of each interactant will shape who gets the floor, when, and for how long.

The actual business of the session and the findings or outcomes of the session also are portrayed in Figure 5–1. This core business is the assessment or intervention processes and products of the main professional group involved and chiefly revolves around the clinician-client relationship. Although some of this core business continues in a unidisciplinary fashion, even when the other professional is absent, professionals may integrate interdisciplinary goals within their own sessions and interactions. For example, Lewis (2002) describes how generalization of a naming strategy for a person with aphasia was programmed into the occupational therapy sessions for the client.

At the central point of the interprofessional collaboration is an intersection of the purposes or agenda for the interaction of each participant (field)

05_Ferguson_77-94 10/3/07 9:33 PM Page 87

and the power and role relationships of the interactants (tenor); these factors will shape the way language is used in the interaction (mode). Figure 5–2 summarizes this intersection of purposes.

This intersection of collaborative practice can be viewed from the perspective of each participant. For the professionals involved, the purpose of the session probably will be the key factor deciding which professional takes the lead role in the interaction. This lead role is powerful, incorporating responsibility for involving establishing and maintaining rapport and directing the activities of the patient and the other professional(s). Within speech-language pathology sessions, the process is likely to be largely a metalinguistic endeavor (e.g., meta-textual, meta-pragmatic). For the other professional in any particular collaboration, the interpersonal roles are likely to proliferate and shift during the course of the interaction as the other professional mediates or facilitates or takes the opportunity to carry out his or her own professional agenda. For the patient, some goals are essentially passive (to be assessed, treated), but goals also may be actively pursued, such as seeking to understand the problem or seeking to ensure that the professionals understand the degree of difficulties being experienced. The power of the patient in relation to the professionals is not straightforward, in that although the power to initiate and direct rests with the professionals, the patient holds considerable power to withhold, and in the three-way interaction, multiple opportunities emerge for the patient to align differentially with either of the professionals.

Expertise: Border Protection or Visa Application?

Such a model of interprofessional discourse provides the opportunity to look at some of the problems commonly

Contextual Configuration → **Metafunctions** (from perspective of systemic functional linguistics)	**Interprofessional Collaborative Discourse in Speech-Language Pathology**
Field → **Ideational**	• Content interpretation related to discourse goals • Multiple agenda • Multiple frames
Tenor → **Interpersonal**	• Negotiated roles • Shifts in "footing" (alignments)
Mode → **Textual**	• Language as both the medium of expression and the object of study • Reflected in, and realized by, frame shifts

Figure 5–2. Interdisciplinary collaborative discourse.