Can Walsh’s conceptual model improve the appropriateness and consistency of terminology in speech pathology?

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The topic of the lead article by Regina Walsh is obviously one that I have been very interested in (Walsh, 2005). In 1998, I wrote about the problems our field has had in coming up with a consistent term for children with language disorders. A few years later in 2004, I used the notion of “memes” to explain why language-based terms have had difficulty permeating the community at large. In her excellent article, Walsh argues that the terminology problems are not limited to child speech and language disorders, but are problematic in speech pathology in general. My colleagues here in the Department of Communicative Disorders at Northern Illinois University would certainly agree.

At a recent all day beginning of the semester retreat, one of the agenda items was how to increase the visibility of our undergraduate major in communication disorders. Several participants made the comment that the name of the department was one of the biggest obstacles in attracting new undergraduate students. Our department is unique because in addition to speech pathology and audiology, we also have a program in rehabilitative counseling with a special focus in the hearing impaired. Several faculty thought that “Communication and Disability” would be a much better name for the department because the term “disability” is a more familiar term and is more inclusive than the term “disorder”. It was quickly pointed out, however, that the Department of Special Education would never allow us to use the term “disability”. Another faculty member reminded us how difficult it is to change the name of a department. The name-change option thwarted, the discussion turned to other ways to increase our undergraduate enrollment.

The name of our academic departments is no less problematic than the terms we use to describe individuals with communication disorders. In my 30 year professional career, I got my degree from a Department of Speech and Hearing Sciences and worked in Departments of Communication Sciences and Disorders, Communication Disorders and Sciences, Communicative Disorders, and a School of Audiology and Speech-Language Pathology. These departments have been housed in Colleges of Education, Arts and Sciences, and Health Sciences. In Memphis, the department was not affiliated with any college until it became a separate School. The lack of consistency in what we call our academic departments and in which colleges these departments are housed is one more example of the terminology problems in our profession. Without consistent terminology, not only will our clients will be poorly represented in service planning and political decision making, as Walsh notes, but our academic programs will also lack visibility and have difficulty attracting students.

The frustration Walsh has experienced in 20 years of clinical practice led her to plea urgently for the development of more appropriate and consistent terminology in our profession. In the first part of her article, Walsh provided an excellent discussion of the various factors that contribute to the inconsistent terminology in the field. I particularly enjoyed the section on the use of descriptive diagnostic terminology. Walsh made the point that it is common for professionals who deal with behavioral disorders to describe a number of behavioral symptoms and give this grouping a label as a disorder. The “disorder” label implies that there is a common etiology for the behaviors though none has been established. More importantly, descriptive labels are often interpreted as explanatory ones.

After reviewing all of the reasons for the inconsistent terminology in the field, Walsh concluded as I have (Kamhi, 1998, p. 13) that “it is doubtful that a single, functional, universal list of terminology with...
agreed definitions could be formulated”. Acknowledging my appeal for some “logic to the inconsistency”, Walsh suggests that the purpose a label serves can provide this logic and devotes the remainder of her paper to describing a conceptual model for differentiating these purposes. The model she proposes makes a basic distinction between professional and public uses of terminology. The purposes of professional terminology include diagnosis, description, and research, whereas the purposes of public terminology include service delivery, advocacy, and legislative. Walsh suggests that a fully developed conceptual model would include definitions, parameters, and examples of terminology for each purpose. She does not provide suggestions for possible terms in the model, however, because she feels that the model “will only have power for the profession if it is developed by the profession, as broadly and inclusively as possible”.

Can the model succeed?

This is the ultimate question on which Walsh’s article will be judged. I don’t think Walsh will be satisfied with anything less than a concerted, profession-wide initiative to improve the consistency of terminology in speech pathology. Her conceptual framework provides a starting point for discussion, but I wish she would have provided some possible terms for us to consider. I understand her reasons for not doing this, but I think completing her Table IV with suggested terms would help to facilitate the inclusive, collaborative discussions that Walsh envisions. She argues forcefully that there “needs to be a wide ranging debate at conferences, in literature and in work settings” (p. 74) and feels that this will require an international collaboration of professional associations as well as clients and families affected by communication disorders.

I must admit that I have difficulty envisioning a group as diverse and inclusive as the one proposed by Walsh being able to agree on specific terms for disorder types. As I read her plea for international collaboration, I was reminded of many class discussions I have had about terminology issues in our field. In these discussions, I point out, as Walsh has, that clinicians are often the ones most affected by the inconsistent use of terms. When students express their frustration and confusion about the inconsistent terminology, I ask them to imagine how confusing and frustrating it must be for parents and non-professionals. There is usually at least one student, who in a pique of frustration, cries out, “Why can’t you just agree on what to call these disorders?” I respond by asking who the “you” should be? Should it be researchers, teachers, clinicians, educators, administrators, professional associations, parents, or whatever other group has a vested interest in speech and language disorders? Unlike Walsh, I cannot envision a group this diverse being able to reach any agreement on speech pathology terminology.

My goal in class as well as in my articles (Kamhi, 1998, 2004) has been to explain the reasons for the inconsistencies in terminology in our profession and the difficulty language-based disorders have had in gaining widespread acceptance. The particular appeal of the notion of memes for me was that it provided an explanation for these troubling issues that made a lot of sense. The key notion of memes is that like genes, they care only about their own self-replication. A meme’s survival or perverseness does not depend on whether they are useful, accurate, or that they represent a consensus. A successful meme is one that gets copied accurately, has many copies, and lasts a long time. It follows that successful memes are those that are easy to understand, remember, and communicate to others. Language has not been a very successful meme because our professional definition of language is not easy to understand or communicate to others (Kamhi, 2004). Although language is a word that is familiar to everyone—a language is what one speaks, like English or Spanish—our professional definition of language is very different. Walsh feels that our professional definition of language is problematic because it encompasses a large number of concepts and that the way to solve this problem is for the profession to define its key words better.

Memetic theory provides another explanation: There is nothing wrong with our professional definition of language; language does in fact encompass a large number of concepts and it is this complexity of language that makes language a poor meme. I just spent almost three full class periods (3 hours) deconstructing a simple definition of language in my course on language development. The definition I used was from Owens (2005, p. 7): “Language is a socially shared code or conventional system for representing concepts through the use of arbitrary symbols and rule-governed combinations of those symbols”. Almost every term in the definition needs some explanation. I spend considerable time getting students to appreciate the symbolic aspect of language and the nature of the concepts that these symbols refer to. I also spend a lot of time having students give examples of the syntactic, morphologic, semantic, phonologic, and pragmatic rules that govern language use. I don’t think it is possible to consider how language is acquired or develops without an understanding of all that it encompasses.

So what does all this talk about language have to do with terminology in speech pathology? If our professional construct of language is not a good meme, then any term with language in it will have difficulty gaining acceptance. Stated another way, terms with language will often lose meme competitions to non-language-based terms. This is why 30 years after Norma Rees (1973) convincingly exposed the problem with an Auditory Processing Disorder
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Why do APD, sensory integration disorder (SID), dyslexia, Asperger's, and articulation disorder have more widespread appeal than language-based disorders or a phonological disorder? It all comes back to what makes a successful meme. These terms are easy to understand, replicate, and communicate to others. APD and SID reflect exactly what causes the learning problem – difficulty processing auditory information or integrating sensory information. What could be clearer? Contrast the explanatory clarity of these terms with language-based or phonological disorders. What non-professional would have any idea what a phonological problem was? Professionals have different definitions of a phonological disorder and many would not be able to readily explain the difference between phonological processes and phonological processing (Kamhi, 2004).

Memetic theory also shows us that even if the international, collaborative group Walsh envisions could reach agreement on terminology, there is no guarantee that the profession or the public would readily use the terms proposed. Australians might not be aware that “speech language pathologist” has been the official professional term for the clinicians in the United States for the past 30 years. Despite the use of this term in every official publication of the American Speech-Language-Hearing Association (ASHA) during these 30 years, most American clinicians continue to refer to themselves as speech therapists or speech pathologists. ASHA could prescribe how professionals had to refer to themselves when communicating in ASHA-sponsored activities or publications, but could not influence how professionals would refer to themselves in their day-to-day jobs and lives. The problem that ASHA did not anticipate was that any term with language in it has difficulty gaining acceptance, even one that accurately describes our scope of practice. It is failures such as these that make me doubtful that much can be done to improve the appropriateness and consistent of terminology in our profession.

Concluding thoughts

It should be clear from my previous articles (Kamhi, 1998, 2004) that I share Walsh’s frustration with the inconsistent use of terminology in our field. Like Walsh, I have tried to understand the factors that contribute to this inconsistency. I think her article provides an excellent conceptual framework for understanding the nature of these factors. Yet, as I noted above, I am not optimistic that this framework or any other one will lead to more appropriate or consistent terminology in our profession. With the wisdom of hindsight and memetic theory, our successes and failures are rather predictable. Language-based terms have had an uphill battle in achieving widespread usage in the profession, whereas constructs such as APD and SID have thrived because they are easily understood and communicated to others. In Australia and other English speaking countries, “language” is apparently still not a consistent part of the professional terminology. Walsh’s article provides a conceptual model for “speech pathology” that will appear in a journal of “speech-language pathology”.

I wish I could be more optimistic that Walsh’s conceptual model could improve the appropriateness and consistency of terminology in our profession. I also wish that my beliefs mattered more. If they did, then Walsh’s model would generate a concerted international collaborative effort to improve terminology, language-based terms would be widely used, and no one would be diagnosing clients as APD or SID. The situation is not hopeless, however. As I said at the end of my article (Kamhi, 2004), one should not use the notion of memes as an excuse to sit back and accept the status quo. Knowing why APD and SID persist as meaningful constructs should not prevent us from continuing to spread our language-based memes, nor should it prevent Walsh and others from trying to implement her conceptual framework and do whatever else is necessary to address the terminology problems in our profession. Knowledge of the factors that affect how readily terms spread should aid our attempts to improve how terms are used in our profession. Despite my less than optimistic outlook, I would welcome the opportunity to work with Walsh and anyone else toward this goal.

References
