

A Tradition of Discussion and Debate

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As chairperson of the Twelfth Clinical Aphasiology Conference, I would like to welcome you to this beautiful setting and to, what has been for me, one of the genuine highlights of the year for the past seven years. I love the Clinical Aphasiology Conference. It is the only conference I know of that will begin with a panel discussion devoted to figuring out what the conference is all about.

One of the things that makes this experience unique is that equal time is given to carefully planned formal presentations and to spontaneous unrehearsed contributions from the mind and heart. For every calculated paper, there is 15 minutes of time for uncalculated questions, discussion, and sometimes a little debate. One of the reasons for requiring a proposal for invitation to CAC is to populate this group with people who have demonstrated an inclination to expose their ideas and work to a group of colleagues, people who will be inclined to participate in the discussions and share their ideas within the informality and relative compactness of the CAC setting.

Sometimes sparks fly during these 15 minute interludes, charging the conference air with excitement. It has seemed to me that this excitement has increased steadily from year to year at CAC. These contributions have been vitally important as a source of constructive feedback for our work, as a source of encouragement for our work, and as a means of solving problems. The discussion periods contribute as much as anything else to our common pursuit of improving our clinical services to the aphasic individual.

So what will be some sources of discussion and occasional debate at CAC? One of the main needs we might have will be clarification. We have come to look upon the problem of aphasia from different backgrounds, and we have been weaned in the disciplines of language pathology at different periods in the development of knowledge about aphasia, language, and the brain. Some of us grew up on behaviorism and learning theory; others became fascinated with linguistics; others have been awed by the mysteries of hidden mental processes studied in cognitive psychology; and still others have become sensitive to issues raised by the pragmatics of communication. Some of us see ourselves as Schuelleans, PICA-people, or Boston-people. Sometimes these different orientations become sacred territories to be defended, instead of simply being different orientations which might someday be neatly pieced together and perhaps even blended. At CAC, we come together in an effort to understand each other and to learn from our different perspectives.

Another reason for the fact that we will learn from each other this week is that we represent a variety of roles and settings for dealing with clinical aphasiology. We are a mixture of clinicians, teachers, researchers, and scholars. Some of us think we are a little of each. Others of us may think especially that we are clinicians with little patience for the academician when it comes to solving clinical problems. It is out of this perception that I would like to offer my advice for the future of this conference and for clinical aphasiology in general.

You see, there is this notion of clinical relevance which is used for sorting through information pertaining to aphasia and which is used as a

criterion for selecting papers to be presented at CAC. Also, we tend to listen to presentations for information that we can take home and actually use on our patients next week. Some information is more clearly or immediately applicable for diagnosis, assessment, treatment, prognosis, and counseling than other types of information. It is at this end of a continuum on which we try to select contributions to be presented at this conference. However, the perspective I would like to bring to this opening of CAC is that there is really nothing designed to improve our understanding of aphasia which in truth is clinically irrelevant. Theory, research, and scholarship are all relevant to the achievement of clinical goals.

Many clinicians are acutely aware of this interdependence. We want to know what is in the literature, and because there is so much of it, we look to the scholars to keep track of it, sort through it, and interpret its implications for clinical decision-making and procedures. Some new books on aphasia are helpful to this end and someday the scholars will be sifting through these. There are many journals including Cortex and Brain and Language with insights on the deficits we are to be looking for and treating, and with investigative procedures which might be molded into clinical procedures. And just the other day, on my doorstep next to the morning paper, milk bottles, and my neighbor's cat, I found the first issue of Brain and Cognition. And by the end of the year the proceedings of the next few days also will become part of "the literature."

What do we find in some of the literature that is clinically relevant? We find theories which define and explain deficits and research attempting to verify these theories. It's stuff that tells us what to look for in our patients and gives us ideas for identifying and treating these deficits. If there truly is a receptive agrammatism in some of our patients, then our diagnostic procedures will be modified to help us find it. If some aphasic persons truly have an impaired semantic organization, then we will develop procedures that minimize this problem. Goodglass and Gleason's Story Completion Test was used to study agrammatism in Broca's aphasia, but later it became part of a treatment program developed by Nancy Helm-Estabrooks. This process has been reflected in the proceedings of CAC, which have included reviews and analyses and basic research with obvious clinical implications.

Yet, I continue to run into clinicians who complain about a lecturer who talked only about theory and, "therefore," said nothing about therapy. However, if the theory is a good one, there should be very little difference between theory and treatment goals, between theory and therapy. This has been recognized at CAC--Luria's inter and intrasystemic reorganization, being one example. In effect, his theory of the brain's response to focal damage is a description of one of his approaches to treatment. Yet sometimes we have a problem relating to theory, and I think there are a few reasons for this.

One is not that theory itself is irrelevant to clinical practice but rather that the particular theory we are reading about is simply a bad theory. It can be too vague or too broad for us to discern anything that we can relate to the real problems of our patients. Sometimes what is presented as an explanatory model actually is description and not explanation at all. Or we may be dealing with theory that has not been useful in generating answerable research questions or in generating an approach to treatment. Rather than turning off to theory, we should perhaps be a little more demanding of the theories that have been proposed.

Also, we should be demanding of our theorists. Often when we hear an aphasiologist discussing a theory, he or she has simply not communicated clearly how the theory has some logical consequences for diagnosis and treatment. The burden for exchange of this message sometimes rests a little too heavily on the reader or listener.

And so, if I am to give you something to discuss and debate while you're here, I think it might be this. Don't get too involved in defining us as a clinical conference as opposed to some other conference over there as being a theory conference. Let someone else have just a theory conference, but we clinicians need it all. To be clinical aphasiology, we need theory as well as procedures. It is all one, and I want us to keep it going that way.

I think our profession will become stronger as we become more appreciative and analytical regarding the theory and basic research which attempts to explain the nature of aphasia and the recovery process. This analytical process takes place once a year through our discussion and debate at CAC. All of us gets our minds jogged here. The new clinicians want to hear from those of us with much experience. However, those of us with much experience want to hear from the fresh perspectives of those who are relatively new to clinical aphasiology. If you want us to hear what you think, you have plenty of opportunity here. Go for it.