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Terminology – Much More Than a Definition

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In the past, there have been numerous attempts to define the terminology of the speech pathology profession. However, defining words is only a small part of improving the appropriateness and consistency of our terminology. Identifying and addressing some fundamental problems with our terms is also required. A first step would be to identify the purposes of our terminology. A wide range of purposes exist, but we lack a clear framework for how we use terms for these purposes. Without this, it is unfortunately easy to mix up these purposes, resulting in confusion in professional debate. Developing a framework for the purposes of terminology is a key aim of the Terminology Project.

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Inconsistent terminology within the speech pathology profession presents a major hurdle to successful communication in many areas – with the public, in professional debate, and in advocating for services to clients. The Terminology Project was initiated in 2005 in response to members' concerns. The aim of the project is to improve the accessibility, appropriateness and consistency of the terminology used by our profession.

Improving terminology is no small task. The project will focus on a range of issues in the different arenas of terminology. These include the public arena, the workplace arena, and the profession-specific arena. This article looks at the use of terminology in the profession-specific arena, that is, among speech pathologists.

In the past, there have been numerous attempts to define the terminology of our profession, and several reputable dictionaries exist. However, defining words is only a small part of improving the appropriateness and consistency of our terminology. Bain (2005) makes a strong argument that the natural impulse to create lists of defined words in response to inconsistency is unlikely to succeed. He reminds us that no decree can force people to use words in a certain way. Defining words does not take into account the much larger challenges of ensuring that the words used are appropriate for the needs of the profession, that terms are used for purposes that are in line with their definition, and that approved terms are a valid part of the professional schema.

So while we do need definitions, they form only a small aspect of improving the appropriateness and consistency of the terminology of our profession. This is the reason Speech Pathology Australia's Terminology Project is *not* about creating a list of words. Instead, the project seeks first to explore and clarify the issues in terminology use.

This article explores some of the issues in the profession-specific arena including:

- treating words as equivalent in nature when they are not;
- treating descriptive terms as clinical entities in the absence of evidence;
- choice of professional terms – Latin and Greek based words;
- words that change meaning with context.

Treating words as equivalent in nature when they are not

Our profession-specific terms vary in nature, in that some terms have an aetiological reference, some label a diagnosis, some describe behaviour, and so on. Terms have emerged over the development of the profession based on a variety of underlying theories and paradigms. This provides us with a rich professional vocabulary which need not be a problem in itself.

Treating different types of words as if they were equivalent in nature provides scope for overlap and confusion. Two terms that we might use to make a contrast – a feature of professional debate – may in fact actually overlap. For example, can one usefully contrast semantic-pragmatic disorder (a descriptive label) with autism (a diagnostic label)? One term is descriptive in nature and describes the areas of concern, while the second term is a label for a diagnosis. Due to their different nature based on the different purposes these terms serve, a professional debate about the difference between these two terms does not start with a clear distinction – there will be overlap due to the different nature of the terms.

The nature of a word is also critical in determining whether it is suitable for a particular purpose. For example, Oates (2004) highlighted the difficulty of establishing the prevalence of voice disorders through analysis of the literature when researchers used terms of different natures, some of which referred to aetiology and others to clinical features. Simeonsson (2003) pointed out that previous work attempting to classify children's language problems used terms that are a mixture of diagnostic, aetiological and clinical. It is not possible to contrast terms referring to different aspects of a "condition" without creating overlap and mismatch within any classification system.

What would help is a distinction between the types of terminology, and being clearer when words refer to phenomena of a different nature. Identifying the purposes for our profession-specific terminology would be a good starting point. We use our profession-specific terminology for many purposes, including:

- labelling aetiology
- labelling causal/underlying factors
- labelling the identified risk factors
- labelling a condition/disorder – diagnosis, differential diagnosis, taxonomy, classification, prevalence
- describing linguistic skills and subskills
- describing linguistic behaviour and measuring change in behaviour
- describing linguistic dysfunction and measuring change in dysfunction – models of disability, functioning and dysfunction

- labelling mechanisms for change or indicators for intervention
- grouping people for research purposes.

This rich diversity of purposes is not a problem in itself. It is the tendency to mix up these purposes that causes problems, for example, using terms that are suitable to describe linguistic behaviour, for the purpose of labelling a diagnosis. The confusion resulting from inconsistent use of terms can hinder professional debate and development.

Treating descriptive terms as clinical entities in the absence of evidence

The list of purposes above contrasts terms which are designed to describe linguistic behaviour with those that label conditions or disorders. Gagnon, Mottron and Joanette (1997) cautioned that it is very simple to create a "condition" (a supposed clinical entity). They bemoan the current predilection for creating names for "conditions" based on describing a group of language behaviours, which may overlap with another "condition" which is also a name for a group of language behaviours. Once there is a term for a "condition", it implies an aetiology that has not been demonstrated, and an "entity" which may not even exist. Gagnon et al. (1997) point out that explicit and distinctive diagnostic criteria are required to identify a clinical entity – even a good theory is insufficient to claim that a "condition" exists. Examples of terms for "conditions" for which there is no clear empirical evidence nor a consensus about diagnostic criteria include *auditory processing disorder* and *developmental verbal dyspraxia*.

The use of descriptive or theoretical terms as a label for a diagnosis can hinder professional thinking and debate. In the box I have traced the creation of a descriptive term which is wrongly interpreted to imply the existence of a "condition" and the debate that ensues. The example is a joke, but the cost to the profession in the energy expended in research and practice is a serious issue.

The intriguing case of blue-eyed vagueness!

This illustration shows what can happen with a descriptive, poorly conceived term with no clear reference to valid empirical data.

I have a fondly held theory that people with lower levels of pigment in the vascular body for the ear will have poorer ability to handle high pitch sounds, and will not hear all the high frequency consonants, thus affecting their ability to understand spoken communication. This results in a person not fully understanding what they hear, and my main criteria is if a person appears to be listening, but then is a bit vague in their response. I call this my theory of auditory vagueness and I publish a short paper about my research on this topic. In my research I have to impute some finding because I cannot do direct observation of the amount of pigment in the ear. I also only look at this aspect of my subjects' functioning. Because there are a lot of vague people around, I have to exclude some other causes of vagueness, such as fatigue, and lack of interest if the topic is steam engines, and, of course, deafness. Intriguingly I notice that this effect happens more in blue eyed people, so I start referring to it as blue-eyed vagueness! This is an easy term for people to understand, so the term really catches on. Soon the theory that having blue eyes causes vagueness is being debated in the literature. Some people are aghast, and write hard-to-follow diatribes about my lack of proper scientific protocol. Others accept its existence, but debate the best kind of intervention for blue-eyed vagueness. Consumers feel relieved to know that their vagueness has a clearly identified cause. However, soon more papers appear debating the clinical validity of blue-eyed vagueness. A paper that disputes my finding, and has data that would quash the theory, is not published due to publication preference for positive results. Some people question if auditory vagueness causes blue eyes or whether the relationship is the other way around. Someone questions the causal relationship between the two features of blue eyes and low levels of pigment in the vascular body for the ear, and suggests that they are just co-occurring due to the fact that low levels of pigment is generally a consistent pattern all over the body. Finally, after 20 years, and much research, the professional debate is rocked by the old news that the level of pigment is actually irrelevant to hearing specific frequencies. The clinical condition of blue-eyed vagueness is thoroughly discredited, but by this time the public has caught on and the term persists regardless. There is even a Blue-Eyed Vagueness lobby group, and special resources developed for a remediation program for people who need this sort of help. Over two decades extensive professional energy is expended into a "condition" that I never demonstrated to actually exist.

The choice of professional terms

As a project of the International Association of Logopedics and Phoniatrics (IALP), Sonnenin and Damsté (1971) undertook a large-scale comparison of terminology across a number of countries. Their report proposed a framework for using the existing Greek and Latin terms, but they ultimately questioned the actual words:

> Like the style of a suit or a uniform reveals the class or rank of the wearer, a professional jargon clothes the user in the frock of the learned. No wonder then that many of us feel safe inside solid walls, armoured with exclusive words. … The words help us to cover up our weak spots in our knowledge with appropriate impressive words. (Sonnenin & Damsté, 1971, p. 28)

They concluded by suggesting that the terms we used were more of a hindrance than a help: "Professional terms may become more an obstacle than an expedient for communication. … By translating professional jargon into plain language, whenever possible, we promote cooperation between different disciplines, we facilitate coordinated endeavours" (Sonnenin & Damsté, 1971, pp. 29–30).

Rockey (1969) wrote an extensive critique of the profession's terminology, which included the inaccurate use of Latin and Greek words. For example, she pointed out the use of prefixes that changed the meaning rather than acted as qualifiers, including the then current definition of *alalia* referring to language and/or articulation but *dyslalia* referring only to articulation. Contemporary use of the prefixes a and dys no longer indicates a clear meaning, for example resulting in *aphasia* and *dysphasia* used interchangeably in some contexts.

We do need terminology that is specific enough for our needs, and that can make fine distinctions that the ordinary person does not need to make. Hence there may be an argument to retain some terminology based on Latin and Greek as long as they are used correctly. Such words may also assist in aiming for international consistency.

On the other hand, these terms may be creating many problems as well; it may be time to consider if the profession's needs can be better met with plain language. Eadie (2005) points out that after speech pathology students learn specific professional terminology during their

university education, they then go to workplaces where much of this terminology is not appropriate for use with clients, family members or co-workers, and they need to learn how to adapt their use of terminology to these contexts.

The key question remains: do the terms that we use really meet all our needs or do they actually create problems? Rather than defining words, should we be creating and disposing of words?

Words that change meaning with context

Issues also exist in our use of "everyday" vocabulary. Speech pathologists are familiar with the problems of using the words *speech, language, voice*, and *communication*. We have our specific meaning for these words, while the general population has another. To compound the confusion, other professionals also often have different meanings to us. We reluctantly accept that the definitions of our core vocabulary – the words that define our scope of practice – are complex and hard to explain to others.

However, another confounding issue may be that the meanings we give these core words also depends on how we use them. Words that change meaning with the context may actually be a much greater stumbling block to communicating both inside and outside the profession than complex definitions.

For example, *language* does not have the same meaning when used across a range of contexts and for a range of purposes. To illustrate, we can take a definition such as "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" (Owens, 2005, p. 7). This is a complex but meaningful (to us!) definition of *language*. But does this definition permeate our practice and our everyday use of the word language? When we say that someone has a *language impairment* do we mean they have *an impairment of the socially shared code or conventional system for representing concepts through the use of arbitrary symbols and rule-governed combinations of those symbols?* Consider the terms *language test, language functioning, language problems, and age-appropriate language ability*. We cannot apply the Owen (2005) definition (or any other comprehensive definition) directly to these terms. The meaning of *language* will differ depending on the context.

We can use this one word *language* to mean the overall linguistic system, and each of the subsystems within it, as well as the social application within human communication, and the neurological basis of it. Apel (1999) says that using the same term to refer to completely different phenomena can lead to scientific communication breakdown.

Summary

This article has addressed a number of key issues in terminology which are compounded by history and differing theories about communication itself. There are no quick and easy answers. We already know from experience that defining words is insufficient to get us out of our communicative quagmire. Exploring the issues further would help to bring clarity to the situation.

A first step would be greater exploration of our terminology, but at the meta-terminology level. Can we clarify just what we want our terminology to do for us? Can we articulate the profession-specific purposes that we require? Can we create a shared framework for the purposes of our terminology that would facilitate professional debate?

A second step would be to become more critical of our own behaviour as professionals. Can we acknowledge where we simply do not have the answers yet, and be brave enough to leave these gaps for further exploration? Can we tame the tendency to endlessly create descriptive labels and treat them as though they were diagnostic labels?

A third area would be to build on existing work. Can we revisit earlier critiques and advance the work done by Sonnenin and Damsté (1971) and Rockey (1969) over 30 years ago? Can we revisit our core terminology and improve it to serve our many needs and improve professional communication? Can we create useful and consistent core terminology that delineates our scope of practice to allow others to understand our role better?

The purpose of a term is as important as the definition of it. We currently have a wide range of purposes, even in the profession-specific arena, but we lack a clear framework for these purposes. Without this, it is unfortunately easy to mix up these purposes, resulting in confusion in profession debate. Developing such a framework is the aim of the Terminology Project. Participation by members in the project would be warmly welcomed.

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