LETTERS TO THE EDITOR

Terminology in Augmentative Communication

In the October 1985 issue of *LSHSS*, Shrewsbury, Lass, and Joseph wrote an article entitled, "A Survey of Special Educators' Awareness of, Experience With, and Attitudes Toward Nonverbal Communication Aids in the Schools," which successfully pointed out that effective carryover of communication treatment for multiple-handicapped students must involve all individuals in the students' environments. The authors referred to multiple-handicapped clients as nonverbal students and the treatment techniques as nonverbal communication aids. Unfortunately, Shrewsbury et al. (1985) failed to describe the "nonverbal student" or explain what is meant by a "nonverbal communication aid." Since specialists in the field of augmentative communication are wrestling with terminology and the standardization of descriptors for communication techniques, devices, and nonspeech behavior, it is important that reports about augmentative communication include clear definitions or descriptors of all concepts, techniques, and equipment presented. It is time for professionals in the field of communication disorders to start agreeing on and using terminology that makes a distinction between nonverbal communication and nonspeech communication.

Lloyd (1985) defines communication as "the transmission of meaning from one individual to another whatever the means used." Communication can be verbal, with and without the use of speech, or nonverbal, with and without the use of speech. Unfortunately, confusion over the terms "verbal/nonverbal" and "speech/nonspeech" appears to have emerged because "verbal" and "speaking" became synonymous. *Verbal Communication* refers to the use of words in either written, spoken, and/or signed modes. *Verbal* is used synonymously with *linguistic* to indicate a system that has convention-governed rules, productivity and semanticity (Shane, 1980). Verbal communication can be expressed vocally or nonvocally, that is, with or without the use of voice and oral speech. *Vocal Verbal Behavior* or *Speech* implies the communication of information expressed with functional oral speech using the vocal tract and heard by a listener/observer. *Nonvocal Verbal Behavior* implies the communication of information through some physical structure other than the vocal tract and oral musculature which will be seen by the listener/observer (Shane, 1980). Written language, sign systems, and the use of rule-governed graphic symbol systems such as Blissymbols are examples of nonvocal, verbal communication.

Nonverbal Communication, as defined by Vanderheiden and Yoder (1986) in a working draft on terminology in augmentative communication, refers to communication that does not involve the use of words (spoken, written, or signed). According to Higgenbotham and Yoder (1982), nonverbal behavior refers to kinesics (posturing and bodily movements that occur during communication); paralinguistics (pitch height and range, stress, intonation, vocal intensity, articulation control, etc); proxemics (interpersonal distance); and chronemics (the timing of interpersonal communication). Vicker (1974) described nonverbal expression as body language (an approving smile, hugging a child) and metalanguage (intonational patterns, rate of speech, etc.) which signal messages. Lloyd (1985) admits that use of the term *nonverbal* is confusing because some professionals use it to mean symbolic, linguistic communication other than speech, and others limit its use to nonlinguistic forms of communication. Yoder and Kraat (1983) point out that nonverbal behavior can be as conventional as verbal behavior. The shake of a head, or closing your eyes and drooping your head convey the same meaning as "no" and "I'm tired" without the use of words or combinatory rules.

Nonverbal communication can be both vocal and nonvocal. Shane (1980) described *Vocal Nonverbal Communication* as audible information that conveys meaning by itself (i.e., "shh," a sigh or moan), or conveys meaning in conjunction with other forms of communication (a grunt produced while simultaneously looking at an unappetizing plate of food). *Nonvocal Nonverbal Communication* includes the expression of information through aided and unaided techniques where no oral output or rule-governed words are used. Gestures, facial postures,

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mime, line drawings, pictures, and symbol sets that are not designed with rule-governed conventions are all examples of nonvocal nonverbal communication.

These operational definitions are the result of one attempt to amalgamate terminology in this field. In addition to defining various communication behaviors consistently, efforts should be made to use standard descriptors for augmentative communication techniques and to delineate client populations. Beukelman, Yorkston, and Dowden (1985) refer to communication augmentation as "any approach designed to support, enhance, or augment the communication of individuals who are not independent verbal communicators in all situations."

The ASHA position statement on nonspeech communication (ASHA, 1981) attempted to provide consistency with regard to terminology by suggesting "generic definitions" for communication techniques and client populations. The position statement recommends using the following terminology:

Augmentative Communication System: The total functional communication system of an individual which includes: (a) a communication technique; (b) a symbol set or system; and (c) communication/interaction behavior.

Unaided Communication Techniques: All techniques, such as manual, gestural, manual/visual, sign, or facial communication, which do not require any physical aids.

Aided Communication Techniques: All techniques, like communication boards, charts, mechanical and electrical aids, where some type of physical object or device is used.

Nonspeaking Persons: The group of individuals for whom speech is temporarily or permanently inadequate to meet all of his or her communication needs, and whose inability to speak is not due primarily to a hearing impairment. Musselwhite and St. Louis (1982) list five categories of clients with basic impairments who benefit from augmentative communication. They are: cognitive (mental retardation); emotional (i.e., autism); sensory (i.e., deafness-blindness); neurological (i.e., dysarthria, cerebral palsy); and structural (glossectomy, laryngectomy) impairments.

It is unfortunate that Shrewsbury, Lass, and Joseph (1985) did not provide operational definitions for terms in their questionnaire or survey discussion. The authors generally refer to *nonverbal communication aids* in the results section, apparently confusing aided techniques (i.e., picture boards) with unaided techniques (i.e., gestures), and verbal communication (i.e., sign language or Blissymbols) with nonverbal communication (i.e., line drawings or gestures). There is mention of "appropriate means of communication," "techniques," "communication systems," and "nonverbal modes of communication," but again these terms are not defined. How could an educator be asked to respond to questions about the prerequisites for successful aid use or the efficacy of nonverbal communication aids when there were no clear operational descriptions of the various aids or techniques? The authors did not appear to delineate the characteristics of the student population either. This is indeed crucial when canvassing teachers about whether nonverbal communication aids meet the needs of the student in the classroom environment. Given the wide range of disabilities that require various augmentative communication systems, details about nonverbal students and treatment techniques were needed. Specific operational definitions used for terminology in the survey questions and results section would have increased the impact of this survey.

The problem of terminology in augmentative communication is not unique to this publication. As the subspecialty of augmentative communication defines itself further, terminology will become standardized and clearly understood. Until then, authors must carefully choose terms and provide operational definitions for concepts, techniques, communication behavior, and equipment so that the information presented will be uniformly understood by all readers.

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Response to Pindzola and White

I read with interest "A Protocol for Differentiating the Incipient Stutterer" (*LSHSS/January* 1986). Drs. Pindzola and White are to be complimented for attempting to "decrease the gap between theory and practice" in stuttering therapy. Too few of us engage in this necessary activity. The protocol certainly addresses the major factors associated with differentiating incipient stutterers from normally nonfluent children. It also was refreshing to note the word "probably" in the protocol; the word reflects accurately the state of the art in this diagnostic determination.

I, however, take issue with the statement "additional information collected from parental reports, while useful, is often subject to errors of memory and interpretation." Although the authors temper the statement with the qualifier of the usefulness of parental reports, the assertion that parents are inferior observers, amnesic when it comes to the behaviors of children and/or too subjective to face up to meaningful diagnostic determinations is without support. And unfortunately, too many practicing clinicians, professors, and researchers defend this unsupported assertion. Although Drs. Pindzola and White provide for systematic parental input into the diagnostic determination of stuttering, it reflects their belief of the inferior status of parents as observers and is relatively unstructured and superficial in its approach to utilizing their input. I believe parents should be the primary providers of information about stuttering, and clinical observations should be considered tentatively because of the variability of the disorder.

Once again, Drs. Pindzola and White have created an excellent direct observation instrument which should be a supplement to systematic parental input for each of the sections.

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