Sweet Sixteen or Middle Age?
Welcome and Opening Remarks

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As conference chairperson and on behalf of everyone working on this year's meeting, I welcome you to the 16th Clinical Aphasiology Conference. It seems we're ready to embark on another four days of professional learning, stimulation, and debate, this year interspersed with western barbecues and white water adventures, and, as always, a variety of other self-destructive behaviors.

The 16th annual occurrence of anything invites a host of bright images; "Sweet 16," the emergence of new abilities, the first experiences with the privileges and pleasures of adulthood. On the dark side, we see the emerging capacity of innocence to get into trouble, the struggle to develop meaningful bonds with others without a firm self-image, frightening suicide rates, and shaving. All of these could serve as metaphors for this conference, but they all require qualification because the meaning of our age as a discipline and a conference can only be understood in the context of the age in which we grow. Several years ago, LaPointe (1981) asked for patience from other disciplines regarding our coming of age because speech-language pathology has its roots in the time of Herbert Hoover and Al Capone. Examining CAC's lineage we find its roots firmly planted in the times of Richard Nixon and the Viet Nam war.

In spite of being 16, we can ask if we're passing through adolescence at all. Can the age of a discipline or a conference be cast in human terms? When the 25th CAC is held, will it be thought of as a young adult? Most likely it will be viewed as a rather old conference, firmly established and perhaps set in its ways and a bit crotchety, hopefully not reflecting some of the disabilities we come here to talk about. I think a look at ourselves requires us to put more candles on the cake, and I believe we can make a case that as clinical aphasiologists and as a conference we may just be moving from young adulthood to middle age.

I believe we're not adolescents anymore because we seem to accept that there's more to understanding a problem than meets the eye, that what we see and hear from our patients doesn't tell us everything about their problems or why they have them. We also seem to accept the notion that our theories of aphasia can have important implications for clinical practice. We look for and appreciate the contributions of others to its understnding. And, importantly, we don't seem to have abdicated our own crucial role in developing theoretical explanations for aphasic behavior and putting them to the test in the real world. Our first session tonight attests to our recognition of theories' importance to clinical aphasiology and it commands attention equal to that paid to diagnostic and management issues.

I believe we're not adolescents anymore because our accomplishments over the years extend beyond getting through our workdays without mussing our hair or hurting ourselves, our colleagues, or our patients. Nor are we so paranoid anymore about getting caught treating aphasia by some physician who says it doesn't work and that we shouldn't bother to do it. When confronted with such fixed-and-dilated attitudes we have an increasing data base to support our activities and less and less need to apologize for what we do, as if we were driving without a license. In fact, I sense that we feel fully capable of being the law in these matters and of policing our standards for clinical adequacy and excellence.

Even more important than our concern about what the world thinks about the value of what we do, we seem to have passed from cocksure ignorance to thoughtful uncertainty about our diagnosis and management of aphasia. We have this fairly well-grounded data-based sense that what we do makes a difference, but we're mature enough to insist and persist in finding out validly and reliably why and when it works. These beliefs, attitudes, and practices are just a few examples of where we seem to be in 1986, and I don't think they reflect what we usually think of as mid-pubescent traits.

In addition to the apparent evidence of maturity, confidence, sense of self, and recognition by others of our abilities, are there other, perhaps more thought-provoking, signs of middle age? This is a much more difficult question to answer, if only because of our proclivity for denying middle age in ourselves. But I think there are some midlife issues that we might do well to think about, debate, come to grips with, and make decisions about, without any implied obligation to change; a taking stock, an effort to establish what we're happy with and wish to preserve and enhance, an effort to recognize goals we have not yet achieved, and an effort to confront issues or establish goals that could not have been seen in the past but are crucial to our future clinical competence and practice. Let me review just two issues that are relevant to this conference and our discipline.

The first relates to the scope of our practice in neuropathologies of speech, language, and communication. If we were to construct a 1971 homunculus--the body of disorders attended to by us in 1971, with size relative to our apportioned time and interest--we'd find essentially three very large parts: aphasia, apraxia, and dysarthria (we'll ignore dysarthria because there's already another conference devoted to it). To perhaps oversimplify, those problems represented the huge bulk of our academic and clinical training back in 1971. We learned about the problems associated with diffuse, multifocal, or generalized brain injury mostly in the context of differential diagnosis, as problems to be recognized as different from aphasia and apraxia, and that primarily because we were really supposed to diagnose and manage aphasia and apraxia and not diagnose and manage the others. The dementias and closed head injury were barely heard of in our literature and only superficially became familiar to us in our clinics, and the right hemisphere was familiar mostly as an unimportant cortical appendage that did funny things in split-brain studies. For example, in the first five years of CAC, there were no papers that I know of on communication problems associated with closed head injury, dementia, or right hemisphere involvement. We've seen the world change since then and, in the past five years in our journals and more than two dozen times in this conference which is devoted to clinical aphasia, we have seen increased attention paid to the communication disorders associated with closed head injury, dementia, and right hemisphere involvement. Thursday's special session on competency issues in clinical practice is further evidence of the reality of these deficit areas in our professional lives. In spite of this, there seems to be some suspicion about the legitimacy of efforts in those areas. One reason is that, in too many instances, the rigor of clinical investigations and practice has not been equal to that that we demand for the investigation and management of aphasia. Another is that many are not sure if we should be involved in understanding or managing those problems--if it's not a speech problem and if it's not a specific language problem, should we be dealing with it even if it is a communication problem? As a discipline, this seems to be a critical question for us to answer. Are we going to continue to embrace an defend the distribution of the left middle cerebral artery as our clinical territory or should we have

an expansionist approach because of apparent need or, more important, because knowing more about how the whole brain functions and dysfunctions for speech, language and communication is a valuable pursuit for a host of reasons and, for the purist, may even contribute greatly to what we know about what language and aphasia are and are not? A much tougher question to answer, and one more relevant to us CAC'ers, is whether CAC should be strictly an aphasiology conference, should maintain its current laissez faire attitude about discussing nonaphasic disorders of communication, or if its scope should be officially broadened, without reducing requirements for rigor, to include other higher-level neurologically-based disorders of communication.

The second issue relates to clinical research in aphasiology. Part of our middle-aged paunch probably comes from deservedly partaking of the fruits of the labors that have produced satisfying strides in the development of clinical diagnostic tools and establishing the efficacy of aphasia treatment. But this pudgy contentedness has been earned for us by a relatively small number of investigations and investigators and we've simply reaped the dividends of their labor. Last year, Brookshire's (1985) review of the preceding five years of research published in the major journals dealing with aphasia indicated that clinical aphasiologists are not publishing much and that what is published is published by a small number of individuals. The reasons for this are complicated for sure, but I suspect the finding doesn't represent just a recent trend. This doesn't portend well for the future communication of our activities within our discipline, and it predicts continuing problems for our colleagues in other disciplines who need to know who we are and what we're about. It also runs strangely counter to the fact that 60-90 papers, mostly data-based, are submitted to this conference each year. Perhaps our self-examination deserves an appraisal of how to carry our work to completion and how best to communicate and share our completed work within and across disciplines, both in personal presentations and in print. Unless we do these things, we're probably destined to go on patting ourselves on the back without the rest of the world knowing that that's going on or ever finding out why.

In summary, I think there's every reason to believe we'll survive our journey to middle age and that self-examination will leave us satisfied that we're doing some things awfully well and confident that we have the drive and skill to set some new courses. The advantage of going through questioning or change as a discipline and as a conference, as opposed to as individuals, is that our members bring to the group qualities ranging from clinical, research, teaching, and political perseverence, experience, and wisdom to fresh blood (in the figurative sense) with the impulse to explore new ideas and insights and lots of energy unencumbered by bias. We need all of these traits. If CAC holds true to form we have all of them; we'll have another great conference; and we'll be able to look to the years ahead with a continuing sense of tradition and progress.

REFERENCES

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