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INTRODUCTION

Persevering with prosody

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In 1958, the British phonetician Alan Sharp memorably characterized intonation as "the Cinderella of the linguistic sciences". Fifty years on, Cinderella's job description has changed, but hardly her status. She has now been given more jobs to do—not only has she to look after rooms of linguistically contrastive pitch-movement, she is now responsible for a whole suite of prosodic apartments, including loudness, tempo, and rhythm. She has met her prince—or rather, princes—in the form of the various linguists and phoneticians who have carried out detailed analyses of these phenomena. But when it comes to the application of these analyses to the understanding of prosodic disability, she remains in the cellar, with few visitors.

Progress in prosodic research has been considerable since the 1950s. There are now several insightful descriptive frameworks, and the relevance of prosodic phenomena to grammar, discourse analysis, and pragmatics has been well explored, both in normal and disordered speech. There is no longer any question about the significance of prosody in relation to language processing. These days, nobody who claims to be linguistically informed can dismiss prosody as being merely "paralinguistic": on the edge of language, adding only minor attitudinal nuances, and thus essentially ignorable. On the contrary, prosody is central to the analysis of speech, and one ignores it at one's peril.

In the context of speech-language pathology, it is the patient who is in peril. Whether it is a child finding difficulty in mastering prosodic contrasts, or an adult no longer able to manage the organizational role of prosody in speech production, or a child or adult trying to cope with the confusion caused by prosodically uncontrolled input, the result is the same: inadequate diagnosis, assessment, and treatment. It is difficult to think of another medical area where a set of potentially relevant symptoms would be treated with such unconcern. Prosody provides speech with its rhythmical heartbeat, governs the temperature of an interaction, and makes manifest a language's grammatical skeleton. And it needs to be investigated with the same level of thoroughness as would be found in a medical enquiry into someone's anatomy, physiology, or neurology.

At present, we are still some way from this outcome. There remains a huge distance between theory and practice. The prosodic transcription of pathological speech samples is far from being routine. Observations about prosody in case notes are often sporadic and impressionistic. The role of input prosody in treatment sessions is often left to chance. The word "often" is important. Some practitioners are scrupulous about maintaining a prosodic perspective in their work. But, whether for reasons of training or constraints of time, many find working with prosody to be a problem.

I can understand the practical difficulties, but I have no sympathy for a system which does not try to overcome them. Personally, I cannot imagine working with patients where I do not have a reasonable prosodic transcription of the spoken interaction between them and their therapists. Note, I do not say "full". Sometimes a transcription of simply the main prosodic features will suffice—the pauses, tone-unit boundaries, and tonicity, for example. Sometimes, one needs more. And in some cases, it pays to incorporate as much phonetic detail as possible, such as when working with non-fluency problems. Developing a prosodic mindset is the aim. Monitoring prosody ought to be as routine as a doctor taking a pulse or a temperature.

Cinderella has not yet transmuted from pauper to princess. To enable this to happen, she will, it seems, need some fairy godmothers. It is good to see two appearing to compile this timely and informative special issue.

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