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The Social Organization of Echolalia in Clinical Encounters Involving a Child Diagnosed with Autism Spectrum Disorder

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Introduction

Children with developmental disabilities face stigma and stereotyping from others in their lives, associated with their perceived incompetence in or inability to interact with others (Gray, 2002). *Echolalia*, which refers to the automatic repetition of words or phrases, is a characteristic speech

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pattern of individuals who meet the diagnostic criteria of what is currently known as Autism Spectrum Disorder and are at risk for stigmatization and stereotyping (DSM 5th, 2013). Echolalia often presents in early childhood and is generally viewed as an indication of Autism Spectrum Disorder—particularly, as a symptom of the communication deficit—in clinical settings.

In this chapter, we examine whether echolalia as a speech pattern has different interactional functions depending on its sequential location in clinical conversations. We analyzed two videotaped clinical sessions between a child with Autism Spectrum Disorder and clinicians, which included several test batteries. We focused on how echolalia in the interaction between the child and professionals emerges within the standardized tasks that the child with Autism Spectrum Disorder had to perform.

The study concerns *immediate echolalia*, which refers to the child's repetition of a single phrase or sentence heard at that moment. This differs from *delayed echolalia*, or the repetition of past utterances, including those emitted in other settings than the current one. The analysis first examines how echolalia works conversationally within a turn-taking system. More specifically, it analyzes how echolalia operates within the instruction and testing sequences described by Marlaire and Maynard (1990) and Maynard and Marlaire (1992), which consist of three turns, as follows:

Teacher: What is this? Question (initiation)
Child: Apple. Answer (reaction)
Teacher: Good! Evaluation

The analysis is based on the perspective that echolalia relates to the completion of tasks in test batteries, in and through the "interactional substrate" (Marlaire & Maynard, 1990) of psychological testing, which is discussed later in this paper.

The second part of the analysis focuses on how echolalia contributes to a bodily action such as moving a piece in a puzzle, in that nonvocal activities are also considered to be an important aspect of the interactional

substrate (Maynard & Marlaire, 1992), which functions as an essential basis for the possibility of testing. In order to analyze whether or how a child performs tasks in a testing sequence in which the child needs to comply with instructions requiring bodily actions, we examine how a clinician's utterances are intended to invite bodily action and how the child handles such invitations. Finally, we discuss how the analysis of echolalia can contribute to or aid the completion of tasks in a testing situation by a child with Autism Spectrum Disorder. That manifestation of echolalia fits with what Maynard and Turowetz (2017: 472) define as the realm of "concrete competence"—"the basic know-how or set of skills and practices required to participate in social activities," including formal ones, such as test-taking.

Previous Research

Fay (1969) defined immediate echolalia as the meaningless repetition of a word just spoken by another speaker. Delayed echolalia, on the other hand, involves repeating a phrase or sentence heard in a conversation at some earlier point in time. This latter type has been drawing the attention of researchers because it can be seen as one of the ways by which researchers can understand how individuals with Autism Spectrum Disorder "process information, organize their experiences, conceive of language and in some cases, attempt to participate in social exchange" (Schuler & Prizant, 1985: 164). As well, delayed echolalia is considered to be related to cognitive, memory, and other neuropsychological deficits. Immediate echolalia is often treated as an indication of language incomprehension (Fay, 1969; Shapiro, 1977). However, since immediate echolalia involves the repetition of utterances heard at that moment, it can indicate that the child is engaged with the current social exchange and is oriented toward the interaction. This behavior suggests that the child is exhibiting concrete competence. Our question is how immediate echolalia as interactional resources contributes to diagnostic testing circumstances.

The literature on Autism Spectrum Disorder has shown that echolalia generally serves positive functions in communication, especially when a recipient shows that they have "interpreted" the echolalic utterance (Prizant, 1978; Prizant & Duchan, 1981; Sterponi & Shankey, 2014; Tarplee & Barrow, 2009). Some studies have explored evidence of the interactional function and comprehension within immediate echolalic behavior (Prizant, 1978; Prizant & Duchan, 1981) and were able to identify several types of immediate echolalia based on its use: non-focused, turn-taking, declarative, rehearsal, self-regulatory, yes-answer, and request. This research indicates that echolalia can provide hints as to the competence of the child with Autism Spectrum Disorder, depending on the features of the echolalia.

Tarplee and Barrow (2009) conducted a case study on delayed echolalia using conversation analysis, seeking to identify how echolalia serves as an interactional resource. Their findings indicate that delayed echolalia helps establish intersubjectivity between a child with Autism Spectrum Disorder and mother. During interactions, delayed echolalia can solicit particular responses that carry routine and specific meanings for the participants.

However, Wootton (1999) has pointed out that, when engaged in delayed echoing, a child with Autism Spectrum Disorder may be disengaged communicatively from other people, even though the child is exhibiting an orientation to their interactional presence. That is, the child may position his echoes relative to segments such as turn boundaries in talk, suggesting a kind of monitoring of another's speech, but his echoes are otherwise non-interactional.

Using a detailed conversational and prosodic analytical approach, Sterponi and Shankey (2014) analyzed video recordings of a 5-year-old child with delayed and immediate echolalia in the home. They found that the child used both immediate and delayed echolalia with various modifications to the prosody as well as reformulations in order to steer interactions in a desired direction. For example, in response to directives, the child utilized immediate echolalia with marked modification to the prosodic contour to show his resistance. Sterponi and Shankey (2014) concluded that the echolalia enabled the child to express more nuance in his stance in an ongoing interaction.

Our study shares the view that echolalia serves as an interactional resource; also in fulfilling/completing certain institutional testing tasks. However, examination of immediate echolalia in an institutional setting (e.g., diagnostic testing) has not been fully studied in previous research. Therefore, it is relevant to determine where in conversation immediate echolalia occurs and the specific function of its placement in the context of the systematic evaluation of a child's ability.

Marlaire and Maynard (1990) noted that the testing sequence of an educational exam depends upon an "interactional substrate," which is established through collaborative work among participants. "The substrate consists of such practical activities as prompting with test items, answering, initiating repair and correction of prompts and answers, doing the repair and correction, acknowledging, evaluating, and engaging in other vocal and nonvocal embodied practices so as to effect the test as an official and valid enterprise" (Maynard & Marlaire, 1992: 193). This interactional substrate is therefore constructed through subtle cues from each participant—e.g., smiling, tone of voice, the form of third-turn responses—and acknowledgments from the clinician (Maynard & Marlaire, 1992). Echolalia may be one such subtle cue by the child and constitute one of the practical activities or forms of "concrete competence" (Maynard & Turowetz, 2017)—that sustain the interactional basis of the testing environment for the clinician and child.

Data and Methods

The data comprise two clinical sessions between a 5-year-old child with Autism Spectrum Disorder and clinicians videotaped in the mid-1980s. It comes from a larger data set involving 13 cases of children being evaluated in a US clinic for developmental disabilities. As Maynard and Turowetz (2017: 471) note, diagnostic tests, standards, and criteria have changed over time, but there has been an interactional organization that has remained stable over time; see also Maynard and Turowetz (2019). Hence, the data are part of a larger data set, and our selections were

made because of the phenomena of echolalia they contain. Our analysis is something like the single episode analytic strategy that Schegloff (1987) espouses and illustrates, where past work in CA is utilized in the analytic explication of a singular fragment or singular aspects in a small fragment of talk. Each of our two sessions was approximately one hour in length. The first session was conducted by a special education clinician and comprised several test batteries employed to identify problems in the child's ability to learn. Each test battery included a series of sub-tests. For example, there was a puzzle completion task, which consisted of different kinds of puzzle with animals and people. The second session was a pediatrician's meeting with the same child and his parents and included physical exams and sensory tests.

We analyzed the data primarily using conversation analysis, as this allows for a detailed and precise description of the interactions among participants (Clayman & Gill, 2012; Heritage, 2005; Sidnell & Stivers, 2013). Conversation analysis ensures a rich description of the ongoing sequential organization manifested in social interaction. Using this methodology, we could focus precisely on which parts of the conversation are repeated by the child and how this repetition is handled by both parties during the testing situation. As such, a sequential examination of echolalia may help in characterizing how echolalia contributes to the testing setting.

Analysis

Within the data set, most of the conversation, as explained in Marlaire and Maynard (1990), takes the form of a testing sequence [initiating (question)—reply (answer)—evaluation], which is similar to the IRE sequence in educational settings (Mehan, 1985). The test results are determined by evaluating whether the child's reaction is what is expected in that particular sequence—a display of "abstract competence" or the ability to produce general answers to theoretical or empirical questions. Accordingly, when the child repeats the first turn of the testing sequence—that is, the question—it may be considered inappropriate or wrong as an answer, although it may incorporate other skills.

This study finds four main patterns of echolalia within the testing sequence. The first pattern of immediate echolalia involved the repetition of a prior question addressed to the person with echolalia. The second pattern involved the repetition of a question followed by the production of an answer to that question. The third pattern involved repeating questions a number of times. The last and fourth pattern has a similar structure to the third and involved repeating the assessment within assessment-agreement sequences. Across these patterns, there are a number of consistent features related to the turn-exchange system and embodied interaction.

Echolalia in Question–Answer Sequences

Below is an fragment from a conversation between the clinician and the child with Autism Spectrum Disorder. The child, whose pseudonym is Tony Smith, was 7 years and 9 months old when school personnel referred him to a diagnostic clinic in 1985—see Turowetz and Maynard (2017) for an investigation of the diagnostic proceedings for Tony. During one portion of the examination, the clinician ("C") and Tony ("T") sat obliquely at the same table. Each had a number of pieces of paper used to complete the "little boy puzzle." In the prior conversation, the clinician had suggested that the child put the pieces of paper together in the shape of a boy, as she proceeded to complete the puzzle on her own. Having finished putting these pieces into the shape of a boy, they began gluing them together on a base mat. In this fragment, Tony is trying to glue the boy's pants onto the mat.

Transcript Instruction

[()] = Bodily movement overlapping with utterance

(()) = Bodily movement without overlapping utterance

Fragment 1

```
 1      T: ((putting glue on the pants and giving the glue back to
 2         clinician))
 3      C: Thank you. Good for you.
 4      T: ((bringing the pants upside down on the paper and turning
 5         the pants around))
 6      C: Is that the way the pants go_
 7      T: (2.5)((putting the pants upside down on the paper))
 8  →   T: [Is sat the way pants go_ Ss. (0.8)
 9      T: [(Stopping the hand movement)]
10      C: N::o, You put it in the way they go.
11      T: (0.5)((starting to turn the pants around))
12      C: Yeah. I know you know that's good.
13      T: (1.5)((stops at the almost correct position, with slight smile))
14      C: That's good.
15      T: (2.0)((starts torqueing his body to look at clinician and smiles))
16      C: All ri[ght.  Just okay o:::h.]
17      C:       [(putting the hand around the pants piece)]
18      T: ((tracking the clinician's hand movement, still with slight smile))
19      C: Let's put him up here.
20      T: ((placing the pants))
21      C: ((pushing the pants piece on the paper with the child's hand))
```

In this interaction, the clinician formulated a question about how the pants should be oriented on the paper (line 6), when the child began to put the pants upside down (line 7). After turning the piece around again, in an echolalic way, the child repeated the clinician's question (line 8). Subsequently, on line 10, the clinician herself produced the answer to the question.

In this instance, the child repeated the clinician's initial question. Sacks, Schegloff, and Jefferson (1974) noted that questions, when positioned as the first part of an adjacency pair, set "a constraints on what should be done in the next turn" (i.e., answering; p. 719). That is, Tony is in the "second position" relative to the question as a "first position" utterance (Schegloff, 2007). He avoids the constraint to provide an answer by repeating the question, which in effect is a "counter" that changes the direction of the sequence.

Notice how, after answering the child with "no" (line 10), the clinician answered the question herself, which, in effect, encouraged Tony to produce the correct answer or move. When the question was initiated by the clinician (line 6), the child was holding the pants piece upside down

(line 7). While repeating the question (line 8), the child stopped moving the piece (line 9). As the clinician answered her own question and directed Tony to "put it in the way they go" (line 10), the child began to relocate the piece (line 11). With the elicited encouragement from the clinician (line 12), and the child eventually reached a nearly correct position (line 13). Subsequently, the clinician gave the child a positive assessment (line 14). At this point, the child looks at the clinician with a slight smile (line 15).

Three points are of note here. First, the echolalia enabled a path for the child to avoid the social force of the question within the testing sequence, but without being heard as evasive or (more extremely) as leaving the interaction field (cf. Sacks 1989). That is, independently of producing an answer that could be coded as either correct or incorrect, Tony shows concrete competence (Maynard & Turowetz, 2017) in the sheer ability to produce an utterance in the answer "slot" of a testing sequence. Second, the echolalia elicited an instructional sequence of interaction within the testing sequence. Maynard and Marlaire (1992) noted that the instructional sequence is a preparatory phase of the interactional substrate that interactants often produce before entering the actual testing sequence. However, the authors do note that instruction can occur in the middle of the testing, and this is clearly evident in this case—the child received instruction on how to carry out the required task.

Third, with regard to bodily movement, the fragment shows the multimodal way in which the clinician directed the child, both haptically (via touch, line 9) and gesturally by handling the pants. This directive movement was received by the child positively, as evidenced by his smiling facial expression and compliance with the directive action. The clinician's instructional utterances further encouraged the child's completion of the task, which was needed for the appropriate evaluation. Completion of the task was therefore clearly marked by the collaborative action between both parties.

Echolalia with the Production of an Answer

Verbal alignment: When echolalia is located within a testing question-answer-evaluation sequence, it can be accompanied by an answering utterance that fulfilled the original sequential constraint of a testing question. This was evidenced in Fragment 2, which occurred just after Tony assumed that he had finished gluing of pieces onto the base of the "little boy" puzzle task.

Fragment 2

```
 1     C: You finish al:l by yourself.  That's a nice job.
 2     T: (8.0)((gluing & putting the piece on the paper))
 3     C: Okay.
 4     T: (4.0)((gluing & putting the piece on the paper))
 5     C: Ni::ce job.
 6     C: (1.5) Okay. An- (3.5)
 7     T: shu:
 8     T: (20.0)((putting other pieces on the paper))
 9     T: ((putting his hands off the paper and to the side)
10        ((looking torward the camera with slight smile))
11     C: Are you all do::ne? (1.2) We for[got one thing.]=
12     T:                                  [(facing to the clinician)]
13     C: =Can you find what we forget?
14        (1.5)
15     C: Ton[y, you forgot the one thing. ]
16     T:    [(facing to the clinician and looking down at the paper)]
17     C: What did we fo[rget? (0.8)]
18     T:               [(start rocking and looking at the paper)]
19     C: Look. [what did we forget? (4.0)]
20              [(pushes the base paper close to Tony, picking
21                up ear piece and putting it on the paper.)]
22     T: ((rocking & gazing at the paper))
23     C: ((putting her hand on T's shoulder))
24     T: ((pushes her hand away while rocking))
25     C: Look. (0.5) What did w[e forget?]
26                            [(C points to ear piece on the paper)]
27  →  T: What did we: forge:t? The Nose. hh  ehn.
28        ((stops rocking, picks up the other piece and starts gluing))
29     C: okay.
30     T: (20.0)((notetaking))
31     T: ((puts the nose on the paper))
32        (2.0)
33     C: [Wha:::t else] is left.
34        [(faces toward T)]
35       (1.0)
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```
36      C: What's left?
37      T: ((starts rocking))
38      T: The ey::e.  An- h. (1.5)
39         [(stops rocking and picks up one of the ear pieces,
40         putting this on the paper)]
41   →  T: [What's so- so- a:lso you left.]
42         [(touching both ear pieces)]
43      T: [The Ear.]
44         [(picking up and start gluing and putting it on the table)]
45      C: Right.
46      T: (6.0)((continues gluing))
47      C: [Put them on.]
48      T: [(gluing)]
49      C: [That's enough.]
50      T: [(gluing and looking inattentively)]
51      C: ((putting her hand on T's shoulder without actually touching))
52      C: [Put it down. (2.0)You can stop now.]
53         [(tapping on the table rightly) ]
54         (10.0)
55      C: We:: are all done.
56         (2.0)
57      C: Nice job.
```

Initially, the clinician complimented the child as he glued the required pieces onto the base paper (lines 1–5). Tony put his hand down on line 9 and directs his gaze toward the camera with a slight smile which could be suggestive of his task completion. On line 11, the clinician asked a question—"Are you all done?"—and immediately followed the question by informing Tony that they (i.e., Tony & Clinician) had forgotten one piece. This announcement can also function as directive as its action (cf. Schegloff, 2007: 9). At line 13, the clinician reformulated the question to produce a modally prefaced directive, "Can you find what we forgot?" suggestive (with the use of "we") of inclusive fault, but then later proposed Tony as the main agent responsible for the missing piece by saying "You forgot one thing" (line 15).

At lines 17 and 19, the clinician once again shifted the subject to "we," adding a more inclusive tone in directing. During these utterances, at line 18, the Tony began to exhibit some signs of distress (i.e., rocking on his chair). Furthermore, the clinician assisted with the task by pushing the correct piece toward the child, physically suggesting that he use the piece in the puzzle (lines 20–21). At line 25, the clinician re-issued the question—"What did we forget?" She prefaced this question with the word "look," which Sidnell (2007) shows is a canonical device for relaunching a course of action (in this case directing Tony toward the completion of the puzzle).

After these physical attempts (lines 20–26) toward guiding Tony, which he partially rejected by pushing away the clinician's hand, the Tony repeated the same directive at line 27.

Here is one focal utterance for our analysis. At line 27, Tony issued an echolalic repetition of the clinician's question and directly followed this with the answer (or the second part of the question–answer pair) by saying "the nose." The clinician acknowledged this answer in line 29 by saying "okay," while also making a note. Then, the child picked up the nose piece and began to apply glue and put the nose on the base (line 31).

After gluing the nose, the clinician asked, "wha:::t else is left?" (line 33), and then repeated the question on line 36. Tony answered with "the eye" in line 38. In another focal part of this episode, Tony mumbled slightly, and then repeated the clinician's question from line 33 at line 41, and answered it himself on line 43, saying "the ear." The clinician acknowledged this response (line 45), encouraged Tony (lines 47, 49), and proposed concluding the subtest on lines 51–57. Finally, she ended the exchange by way of a compliment, "NICE JOB" (line 57).

This use of echolalia immediately followed by the correct answer indicates the emergence of both components of an adjacency pair (Sacks et al., 1974), which are ordinarily produced by different parties to an interaction. The child's self-completion of these pair components is usually treated as an indication of the "loneliness of the autistic child" (Frith, 1989)—that is, the child's sense of confinement within the self. If the present case of echolalia is examined independently from the stream of interaction, it would indeed appear as being a product of the child's self-involvement. However, when considering it in the context of the entire interaction, it may reflect other features. First, the echolalia (lines 27, 41) appears to be a way for the child to delay answering while still introducing a relevant component of the talk—possibly processing the question in a way that projects an answer. Second, it can indicate that the child is exhibiting co-orientation with the clinician—as an aspect of the interactional substrate—and is following what the clinician is directing him to do.

Marking Bodily Alignment with Echolalia

A major part of co-orientation during testing episodes is how both the clinician and child position their bodies relative to one another and the tasks in which they are engaged (Maynard & Marlaire, 1992). For example, children may display recipiency toward a testing task by sitting in such a way that indicates that they are clearly prepared to engage in that task. In contrast, a child's rocking back and forth on his or her chair, or momentarily leaving the chair, may indicate the lack of co-orientation and readiness for a test item. Echolalia may occur at a point when the child represses the bodily rocking and shows greater recipiency.

Fragment 2 provides evidence of how echolalia shows interactional attentiveness. Note that Tony appeared to be inattentive or unaligned with the task orientation (lines 8 to 18), as evidenced by his rocking and appearing disengaged, until the point that he produced echolalia and a verbal answer to the question "What did we forget?" (lines 19–30). During this, the clinician called for his attention by placing her hand on his shoulder (line 23), which he rebuffed by pushing her hand away and continuing to rock (line 24). When Tony issued the repeated question and an answer (line 27), he stopped rocking (line 28) and began gluing the missing nose piece (line 31). In short, the echolalia was situated at the point where the rocking stopped (line 28) and engagement in—indeed, control over—the task began. This relationship between the cessation of rocking and verbal alignment was evident in the second instance of echolalia as well (lines 39–42). We address the import of this relationship between rocking and vocalizing below.

Multiple Productions of Echolalia Across Question–Answer Sequences

When an echolalic statement is repeated a number of times as part of the question–answer testing sequence, each instance may have different functions within the series of turns. In this case, multiple productions of echolalia invite further instructions.

Fragment 3 shows an example of repeated echolalia. This fragment occurs when the child was about to finish the little boy puzzle by gluing all the pieces. Following the clinician's question about where the child should put his name (line 12), the arrowed lines in the fragment indicate three productions of echolalia. The first instance (line 18) is repeated (23) and then partially repeated later (29).

Fragment 3

```
 1    C: Okay, Hey, I've got. some questions for you. Are you all
 2       done?
 3    T: Yaah. ((looking at the puzzle paper))
 4    C: That's very nice. Can [you put your name on there? (2.0)
 5                             [(putting the pencil in front of T)]
 6    T:  ((picking up the pencil and playing with it))
 7    C:  You write your name on there for me.
 8         (1.0)
 9    C:  You know how to write your name?
10        (1.5)
11    T: ((slowly holding the pencil in a writing style and facing
12          toward the paper))
13    C: Where (0.2) should you. You- where can you write your na:me.
14    T: ((holding the pencil and shaking head tremblingly))

15    T: [Enh. Enh.]
16       [(looking at Clinician's face)]
17    C: Can you?
18 →  T: Where [ do you write your name?]
19             [(continues looking at Clinician's face)]
20    C: Where-? you, let's do it right he[re.
21                                        [(pointing at the
22       corner of the paper)]
23 →  T: =Enh. Enh. (let's) should-  [let's shu- write
24       your name?]
25                                   [(looking up & lifting up
26       shoulders)]
27    C: Write it right [here.
28                      [(pointing to the same place again)]
29 →  T: Let's should, let's you (whe-  what's)
30       your name?
31       ((starts putting the pencil down on paper, looking
32       at Clinician's face))
33    C: (uhnn?) ((notetaking))
34    T: ((starts writing)) ((rocking)) ((puts down the pencil))
35       ((rocking))
36    C:  Write the rest of it?
37    T: ((stop rockings, picks up the pencil and start writing))
38    C: Should we take it off so it doesn't break? ((paper sound)) Now,
39       try.
40       ((moving the board under the paper))
41    T: ((stops writing, moving backward))
42       ((starts writing))
43       ((writing))
44       ((puts the pencil down and picks up the
45       paper))
46       ((brings the paper to the Clinician))
47    C: Hey, what does it say?
```

The echolalic utterances transpired as follows. First, the clinician initiated this segment by announcing the forthcoming testing task with "I've got some questions for you." She inquired about the completion of the puzzle (lines 1–2), which the child answered in the affirmative ("Yeah" on line 3). This completed a question–answer adjacency pair. The clinician subsequently provided a positive evaluation (line 4), thus completing a three-part testing sequence. Within the same turn as the evaluation, the clinician initiated the next testing sequence by asking whether the child can write his name on the finished puzzle (4), which is a kind of "directive" to do the task that encodes a degree of entitlement (Curl & Drew, 2008). However, this question was met with silence (end of line 4). Then, the clinician produced a more entitled directive ("You write your name …," line 7), using imperative grammar. However, after another silence (line 8), the clinician asked whether Tony knew "how to write" his name, clearly orienting to the issue of his ability to do the task. Next, as Tony appeared ready to answer (lines 11–12), the clinician asked *where* Tony can write his name, suggesting her assessment that he could do it but needed to figure out the location for writing it.

As the clinician repeats her directive partially at line 17 by reverting to the "can you?" formulation, Tony responded to the statement with an echolalic repeating of the clinician's question using the *where* preface (line 18), rather than the "can you" uttered in the prior turn by the clinician. This suggests that Tony was claiming competence for writing his name (he "can") and, instead, that he might have been orienting to an issue of the location for his signature.

The first echolalia elicited an answer in the form of a clear instruction from the clinician of "Let's do it right there." Thus, the echolalia functioned here to obtain a concrete directional instruction utterance from the clinician. Similarly, the child's second repetition of the question (line 23) preserved an orientation to "where," and elicits a repetition of the location (line 26) using the imperative ("write it right here") rather than the inclusive ("let's do it …," line 20). These first and second echolalic utterances, therefore, appear similar to the first type of echolalia shown in Fragment 1, in that they elicit responses from the clinician that suggest an orientation to Tony's indications of what sort of direction he needs.

The third instance of echolalia (line 29) did not receive a response from the clinician except for a small token (line 30) indicating simple recognition. In this third instance, Tony began writing immediately, and the clinician might have withheld verbal recognition as the indicated task was already in the process of being completed.

Echolalia in Suggestion–Agreement Sequences

When echolalia repeats a directive within a directive-response sequence, it may subsequently invite an "agreement" preferred by the initial suggestion (Pomerantz, 1984). In Fragment 4, Tony and the clinician have shifted to a different testing battery, requiring them to clear the pieces of a puzzle on which they had previously been working. The puzzle, which is a picture of a cow, is not yet completed. Tony has put the square puzzle pieces together into a rectangle without correctly ordering them.

Fragment 4

```
 1    C: Did you make a co::w? (1.5) Or you need a help?
 2    T:  ((turning around))
 3    T: I don't [need a help.
 4               [((looking away from the puzzle))]
 5    C: You do:n't. [Oka:y. (0.5)
 6    T:             [((facing toward the puzzle))]
 7    C: Okay, here,[you  know what?]
 8    T:            [((looking at her))]
 9    C: We got another puzzle here to make.(0.5) We gonna- do our own
10       puzzle here.
11    T: (1.0) ((touches the puzzle without moving pieces and continues
12       touching the puzzle))
13    C: Let's- let's put the cow away. We're all done with the
14       cow.
15 →  T: We are all done with the co::w.
16    C: Yeah. Let's put the co:w away.
17    T: (0.5)((picking up the puzzle))]
18    C: ((placing hands on the table ))
19    T: (2.5)((placing the puzzle on the clinician's hands while picking
20       up more pieces))
21    C: Thank you.
22    T: (5.0)((changing the direction of pieces on the pile/putting them
23       on her hand))
24    C: Okay.
25       ((taking the puzzle away))
```

After Tony strongly resisted having the clinician help him continue piecing together the cow (line 3), the clinician suggested moving on to the next puzzle (lines 7, 9–10). Tony continued to touch the puzzle pieces, seemingly "smoothing" the edges to create a straight rectangle out of the puzzle (lines 11–12). This suggests that he was not in alignment with the clinician's suggestion of starting the new puzzle. The clinician further directed Tony to "put the cow away" (line 13), announcing that they are "all done" (lines 13–14). Tony then repeated this utterance (line 15), which is received with an affirmative by the clinician, and an utterance directing the child to put the cow puzzle away (line 16). Thus, the echolalia here aligned to the clinician's trajectory, which he also followed with embodied activities—helping to pick up the puzzle pieces and putting them in the clinician's hands (lines 17–23).

Note that there is a similarity between this instance of echolalia and that described above, in relation to Fragment 1 (i.e., repetition of the question). This similarity can be summarized as follows:

Fragment 1

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Clinician Question: Is that the way the pants go?
Tony Echo: Is that the way the pants go?
Clinician Confirm/Disconfirm: No.
Clinician Directive: You put them the way they go.
Tony Compliance: ((Turns the pants piece around))
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Fragment 5

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Clinician Directive: We're all done with the cow.
Tony Echo: We are ALL done with the cow.
Clinician Confirm/Disconfirm: Yeah.
Clinician Directive: Let's put the co:w away.
Tony Compliance: ((Picks up the cow pieces))
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Both the question type and suggestion type of echolalia appear to facilitate achievement of the task at hand. More specifically, the locally produced task is carried out through the force of echolalia within a test sequence.

Conclusion

Close examination of immediate echolalia in a clinic for developmental disabilities revealed some of the ways in which this phenomenon is socially organized. By expanding the standard testing sequence (i.e., question-answer-evaluation), echolalia, as a facet of the interactional substrate, is a form of "concrete competence" (Maynard & Turowetz, 2017) that can enhance a child's performance. Our fragments show how Tony was able to solicit help from the clinician or complete the tasks in a self-regulatory manner. In addition, echolalia can expand the ordinary testing sequence in a way that allows for the exchange of more situated interactional cues, such as instructional utterances and confirming responses. Finally, as shown in Fragment 2, echolalia appeared at the point where the child stopped rocking. If the rocking indicated a need for coherence that was not being achieved verbally (Grinker, 2007: 186), it ceases at the moment when Tony showed himself—through the echolalia—to achieve such coherence by both *asking* and then *answering* the testing question. In short, a device in speech that traditionally has been seen as a deficit does not actually hinder, but rather enhances, the capacity of the child to perform particular tasks during testing. Through echolalia, children with Autism Spectrum Disorder are capable of producing relevant parts of the interactional sequences and adjust to requirements of the institutional setting.

The child with Autism Spectrum Disorder showed clear competency in this study which might disrupt preconceptions of these children's interactional disability. Indeed, close examination of this speech form, traditionally considered as deficit, can help us recognize how competent these children are in deploying the form as an interactional practice within a highly structured institutionalized setting. Often, people with recognizable disabilities are regarded as deviant and treated "not quite as humans"; they may be reduced from a whole person to a tainted, discounted, or stigmatized one (Goffman, 1963). This similarly applies to children with mental challenges, since their speech forms be taken as obvious or transparent indications of their disability. However, this study suggests that a particular speech form does not actually hinder, but rather enhances, the interactional accomplishment of testing tasks in institutionalized interactions.

The echolalia observed in this study reveals the numerous skilful interactional cues that facilitate a child with Autism Spectrum Disorder to achieve institutional tasks. When it involves repetition of a question or suggestion, echolalia avoids the sequential constraints of the moment, effectively shifting the conversational constraints to the other party. It also marks a point where the child is bodily aligned with a directive utterance placing a social constraint on him or her. When co-orientation is established, both bodily and verbally, echolalia can be used to initiate a child-owned conversational sequence. Following the echolalia, instructional utterances are produced and an interactional space is made, which may include extra conversational items. This permits the child to formulate his or her own interaction in a manner to which he or she is accustomed. The more the child creates a comfortable environment within which he or she can communicate in a routine way (e.g., using echolalia), the better he or she is able to adapt to changes in the situation.

Professional Reflection

Tetsuya Abe

Abstract

The empirical chapter on "Echolalia in clinical interaction" provides fine examinations of immediate echolalia during testing environment between a child with autism and a clinician. Echolalia is one of the popular symptoms in autism and has been understood as a neurological problem in developmental stage. In this reflection, I introduce three contributions this paper can offer to the medical field. First, autism has more social and interactional importance even though it is considered to have biological dysfunction in medical literature. Second, echolalia's communicative function has been recognized through a coding system. This paper shows richer description of its interactional function because of the sequential analysis of interaction. Third, proper responses towards echolalic utterances are useful to improve their communicative patterns. Conversation

analysis can offer actual and practical examples of such interactionally appropriate responses.

This chapter provides fine-grained examinations of verbal and nonverbal aspects of immediate echolalia in a testing environment with a child with Autism Spectrum Disorder and a clinician. In this reflection, I would like to discuss three major contributions of this chapter for clinical practice.

First, this paper highlights the social and interactional importance in our conceptualization of Autism Spectrum Disorder. Autism Spectrum Disorder has been historically conceived as a behavioral disorder, characterized by lack of responsiveness toward others, noticeable developmental language disability, difficulties of building relationships with others, and a strong obsession toward repetitiveness. Recently, the DSM-5 (American Psychiatric Association, 2013) re-defines what is now known as Autism Spectrum Disorder, characterizing conditions along this spectrum as neurodevelopmental disorders that are manifested in communicational/social difficulties and local/repetitive behavioral patterns. This new category includes what has been previously defined as Autism Spectrum Disorder, Asperger's syndrome, and Pervasive Developmental Disorder.

Echolalia has been understood as a developmental neurological problem in the medical field. In typical development, children learn language through repetition. In the repetitive process, they usually learn to recognize the intention embedded within the repetitive utterances during an interaction. However, children with Autism Spectrum Disorder are believed to have a neurological disjuncture which presupposes the connection between automatic repetition and one's intention. Belmonte et al. (2004) explain this as abnormal neural connectivity, which can be found in their brain activity patterns. In the most of medical literature, echolalia has been considered to be solely a biological phenomenon. Thus, this paper can surely shed light on our understanding of echolalia by expanding our sociological and interactional understandings of this phenomenon.

Second, prior studies of echolalia have also recognized its communicative function (Prizant & Duchan, 1981). Prizant and Duchan (1981) developed a classical coding system of echolalia according to three aspects and displayed comprehension level, orientation toward interlocutors such as gaze and co-occurrence of physical behavior. Based on this coding

scheme, they found seven functions of echolalia: non-focused, turn-taking, declarative, rehearsal, self-regulatory, yes-answer, and request. Most of all, their workplaces emphasis on the communicative function of echolalia. In the field of developmental education, their work has been cited as a major resource to understand echolalia as being functional instead of merely an abnormal form of speech. Nevertheless, although this research examined both verbal and nonverbal aspects of echolalia, it was limited to categorizing echolalia into the three above-mentioned characteristics. In the work of Prizant and Duchan (1981), however, the method of analyzing nonverbal aspects has not been fully developed. This limitation also has to do with its primary focus on individual capacity instead of understanding echolalia as being a more social and interactional phenomenon.

In addition, another previous study has examined what happens *before* the echolalic utterance. Rydell and Mirenda (1994) have focused on the nature of previous utterances, which occur before the echolalic utterance. They categorize the previous utterance into two groups: high and low constraint utterances. The high constraint utterances forced children to change their responses and behaviors such as directives whereas the low constraint utterances do not require the children to make such changes. As a result, echolalic utterances occur more often after the high constraint utterances.

On the contrary, this paper has offered its analysis based on more sequential organization of verbal behaviors based on conversation analysis, which allows us to acknowledge systematic details of the interaction. In Fragment 1, during the utterance of echolalia, the child is turning the puzzle toward right direction following the clinician's question "Is that the way the pants go?" Thus, this utterance shows understanding of the previous utterance. However, since the child is not looking at the clinician during this utterance, this utterance sounds more like self-talk. Thus, it can be considered as the type of echolalia called "self-regulatory" according to Prizant and Duchan (1981).

Furthermore, this paper includes analysis of what happens *after* the echolalic utterance. Thus, the analysis clarifies more functions of echolalia. First, with the echolalic utterance, the child can avoid social force posed by the clinician's question. Second, after the echolalic utterance, the clinician ends up assisting the child to complete the task at hand. Third, the

child then accepts what the clinician did for him after the echolalic utterance. This paper has offered richer description of echolalia's interactional function because of its sequential analysis of interaction.

Third, this paper has the possibility of being applied to the interventions focused on the speech patterns of children with Autism Spectrum Disorder. There are many interventions that have been found to improve the particular speech patterns of children with Autism Spectrum Disorder (Hetzroni & Tannous, 2004; Lim & Draper, 2011; Matson, Sevin, Box, Francis, & Sevin, 1993). For example, Kurai (1997) reported on the importance of visual aids for instructing such children. When these children are asked questions along with visual aids such as pictures, it is easier for them to understand audio information of the question and to respond to the questions itself. These studies show the possibility of improving their communicational patterns by responding to echolalic utterances properly. However, it is quite difficult to determine what the "proper" responses can be toward echolalic utterances. Therefore, this kind of detailed analysis of interaction among children with Autism Spectrum Disorder and clinicians at institutional setting shown in this paper has its value because it can offer actual and practical examples of interactionally appropriate responses toward echolalic utterances.

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