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Spotlight on: Humanities in speech and language therapy

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Abstract. In this ‘*Spotlight on: Humanities in speech and language therapy*’, we argue the case for the arts and humanities to find its way into speech and language therapy (SLT) course curricula, clinical practicum, and other areas related to SLT professional practice. We have a long-held belief that the arts and humanities have much to offer the discipline of speech and language therapy. This review begins with a consideration of what is meant by health humanities, within the more traditionally termed ‘medical humanities’. Considerations for curricular inclusion are also presented. An example from a literary autobiographical work is used to illustrate the possibility and potential of integrating a humanities’ approach to a speech and language therapy curriculum in order to better understand and appreciate communication and communication breakdown. Finally, although the case is made in this review for the discipline of speech and language therapy to embrace the humanities, by implication, there is no reason why other healthcare programmes cannot consider the possibility, where better understanding of the human condition of health and illness is core to teaching and learning.

Keywords: Medical humanities, health humanities, speech and language therapy, healthcare education, arts and humanities

1. Introduction

“Well, the truth is, we cannot speak other than by our paintings”

(Vincent van Gogh, to his brother, Theo, July 1890)

It is well known that van Gogh experienced mental health problems during his life (van Meekeren, 2003) and his descriptions of his attempts to communicate coherently were a core part of this experience, as frequently referenced in his letters to his brother, Theo, and fellow artists (de Leeuw, 1996). It is quotes like that of van Gogh’s, however, that can prompt the real-

isation that there is more to the science of language and communication disorders than the academic and theoretical study of speech and language pathology. An awareness of the diverse range of other learning resources and opportunities afforded by engaging with the arts and humanities can be both liberating and exciting. It can open a world that complements the knowledge and skill of our sometimes restricted or constrained world of speech and language therapy (SLT).

2. Medical / health humanities

Medical humanities is a multi- and inter- disciplinary field of study which strives to integrate, with medicine, the disciplines of the arts (e.g., literature,

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music, and visual arts), the humanities (e.g., philosophy, history) and the social sciences (e.g., psychology, sociology, anthropology), (Batistatou et al., 2010). Core to this integration of disciplines of study, is understanding the human condition in both health and illness. Medical humanities attempts 'to emphasise the subjective experience of patients within the objective and scientific world of medicine' (Oyebode, 2010, p. 242). The focus then is on the truly humane aspects of health care. O'Neill et al. (2016) state:

'our vision of the medical humanities is that it constitutes a vital aspect of the epistemology of what it is to be human and the nature and experiences of health, illness and healthcare' (p.109).

The person and their experience are at the centre of focus of medical humanities. This centrality of the experience of the person, be they be the patient/client/family, or the professional, is what is of interest here and core to the contribution the humanities might make to healthcare.

The term 'health humanities' (Crawford et al., 2010) is favoured over 'medical humanities' in the context of allied healthcare disciplines. We concur with this more inclusive terminology. The term 'health humanities' encompasses all those professionals who are key to multidisciplinary care. In their call for a broadening of the term, Crawford et al. define 'health humanities' as:

a more inclusive, outward-facing and applied discipline . . . which both embrace interdisciplinarity and engage with the contributions of those marginalised from the medical humanities - for example, allied health professionals, nurses, patients and carers (p.4).

We welcome this inclusive definition which respects the contributions of not only allied healthcare practitioners, but also patients/clients and their carers. We understand health humanities as a lens through which we can embrace conceptualisations and portrayals of health and illness, disorder, and impairment, beyond the confines of medical interpretations only. Furthermore, invoking such an inclusive term allows us to broaden the remit of a health humanities' understanding, and include consideration of the whole clinical encounter, including experiences of clinical processes and practices along with depictions of the professional and the patient/ client and their relationship.

3. Curriculum considerations

The study of medical humanities has been represented in disproportionate and highly varied ways in the education of healthcare professionals. It is afforded significantly greater notability in medical education, that is, in the training and education of physicians where its curricular visibility has been increasing in recent times, across teaching and learning activities (e.g., see Peterkin, 2016). However, other healthcare disciplines are beginning to see the potential and promise of the arts and humanities. For example, a Masters' programme in medical humanities at the University of Rochester (New York) includes both healthcare and allied healthcare students, such as nursing, social work, occupational therapy and physical therapy (see: <https://www.urmc.rochester.edu/education/graduate/masters/medical-humanities.aspx>).

For existing programmes in graduate and undergraduate healthcare education however, educators are often concerned with 'overload' in curriculum content. Many healthcare programmes of study are brimful with core modules that are mandatory to competency development of healthcare practitioners. Herein lies the difficulty of suggesting an arts and humanities' focus as an addition. Yet there are creative ways of integrating health humanities into existing modular content so that it permeates aspects of teaching and learning and is not merely seen as 'additive' (Evans & Greaves, 1999). Self-directed learning along with tutor-guided activities can enrich the teaching and learning experience for all. Student learners often embrace a different way of doing things and welcome the opportunity to explore and reflect beyond the academic textbook or the strict, formal, didactic learning activity. Anecdotal evidence suggests that students and practitioners are beginning to see the value of alternative and complementary ways of teaching and learning, with humanities having a part to play.

Moreover, educators and professionals are increasingly motivated and concerned with the qualification of well-rounded, empathic, critical, and perceptive professionals. The goal is to qualify healthcare professionals who can look beyond themselves and the constraints of their own discipline to enhance their knowledge and understanding of professional practice. Exploration of the arts and humanities within healthcare education can contribute to the enhancement of targeted graduate attributes.

4. Potentials and possibilities: Speech and language therapy

Taking speech and language therapy as a case in point, health humanities can offer opportunities to explore many aspects of the speech and language therapy clinical encounter. For example, experiences of clinical conditions and their associated communication challenges (e.g., in conditions such as aphasia, dementia, stuttering, autism, etc.) can be explored as portrayed in biographies and autobiographies, fiction and non-fiction, film and visual arts, or poetry and prose, for example. There are many examples of such resources awaiting excavation by the critical educator and motivated learner. Likewise, the experience of the clinical encounter itself is one which is often referenced directly or indirectly in such resources. For example, Waxman et al., (2005, pp. 125–129) review films that can be educationally employed to stimulate learning about dimensions of the clinical interview (e.g., ‘active listening’, ‘dealing with awkward moments’ and ‘interruptions’). Moreover, reflecting on one’s own biases as a professional in the clinical encounter, be they conscious or unconscious, can also be aided by the critical evaluation of portrayals of health and illness, and the healthcare practitioner’s response to them. Reflections can then be discussed in the relative safety and freedom of a clinically relevant space (e.g., clinical tutorial in the classroom) as opposed to the ‘*in vivo*’ direct clinical context of the consulting room.

5. An illustrative example

Walsh (2020) explored the potential of a literary autobiography to better understand the nature of the language and communication challenges that can present as an element of, or central to, the experience of mental health disorder, such as schizophrenia. Given that speech and language therapy involvement with people with mental health disorders and language and communication difficulties remains a relatively recent development in many countries, Walsh was concerned with grasping a better understanding and appreciation of the many challenges those affected face.

The literary autobiographical work in question was that of the New Zealand novelist Janet Frame (*Janet Frame: The Complete Autobiography*, 1989). Such exploration allowed the true reciprocal nature of

communication to come to the fore and be appreciated in this context, that is, underpinning the belief that (i) communication (breakdown) is a dynamic between two (or more) people, and that (ii) the locus of the breakdown should not be seen to solely reside in the person who happens to have the diagnosis (in this case a person with schizophrenia) (e.g., see Jagoe, 2013, 2015; Walsh, 2008 for further discussions of this point).

Moreover, Janet Frame’s experiences of mental ill-health and struggles to communicate at times, significantly informed both her biographical and fictional works. Of note was Frame’s descriptions of her perceptions of her listeners in communication. In this first example, Frame tells us of her anticipated difficulty in communicating in the hospital interview:

“I cannot talk about myself. I cannot. Every month I go to the hospital and [see] one of the doctors from Seacliff...I have been able scarcely to say a word to them...I just go into a kind of dream probably to escape their questioning. And my voice won’t work. And if it did it would utter what they would think to be utter nonsense...I keep silent because physically, I cannot speak”. (Frame 1949 in King, 2000, p.103)

That others would think what Frame would have to say to be ‘utter nonsense’ is also referenced in the following quote, where her identity as a ‘mad person’ is salient to her:

“I wrote my poems, showing them to no one. A member of my family had found and read a story I wrote and voiced the strong opinion that I would never be a writer. Sometimes when I began to say what I really felt, using a simile or metaphor, an image, I saw the embarrassment in my listener’s eyes - here was the mad person speaking”. (Frame 1989; p. 215)

These two exemplars underpin the reciprocal nature of communication and its effect on identity and communicator well-being, explored further in Walsh (2020). It could also be said that Frame’s works were a form of illness narrative and as such had potential to inform and educate beyond the literary or prosaic composition. The illness narrative, as Cohen (2008, p. 38) explains:

tells us about how life problems are created, controlled, and made meaningful. They are shaped by our cultural values and social relations and

will affect our self-perception of illness and health as well as the way we monitor our body and act towards bodily symptoms and complaints.

Arthur Frank's work on illness narratives can inform such critical evaluation and reflection (Frank, 1995; 2010). Frank talks of letting 'stories breathe', meaning they 'animate human life; that is their work' (Frank, 2010; 3). What better way to attempt to access some understanding of human suffering and our response to that suffering? Illness narratives, such as that which can be found in literary texts, can also be found in works of visual art, film, photography, and music – they are there for the taking, if educators and learners are prepared to explore them with an open mind.

Hence, in the exploration of Janet Frame's vast body of work, the writer's autobiographical accounts delivered learning in unanticipated ways about the many nuances of communication and communication breakdown and the lived experience of mental health disorders and incarceration. This appreciation then is the beauty and gift of the arts and humanities.

6. Conclusion

We see the awareness and acknowledgement of a formalised introduction of health humanities into healthcare education, and in this case speech and language therapy, as a 'win-win' situation. Who among educators does not want to see their learners gain a richer, more in-depth understanding of their clients' or patients' experiences, curricular content, or clinical practicum by embracing the arts and humanities? Who among students would not enjoy different, yet complementary, routes to learning? Surely the goal of healthcare education is to 'gain from a deeper learning experience and creative environment where the human (illness) condition, with all its attendant care practices, can be critically and authentically discussed' (Walsh, 2020; 171).

There is no doubt that healthcare educators have a lot of work to do, if such a health humanities' approach is to be adopted, welcomed, and integrated into existing programmes of study and practice in healthcare contexts. However, if educators are truly committed to education in all its varied nuances and complexions, an education that is rich, diverse, and stimulating, surely health humanities might have some part to play in the teaching and learning journey of discovery.

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Conflict of interest

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