The role of the speech and language therapist in psychiatry

N. J. Muir

Speech and language therapy is a small profession. It only reached its golden jubilee year in 1995 and misleadingly, remains for many highly associated with the elocution training in which the profession had its genesis. In the last few years the greatest developments have been in the area of cognitive neuropsychological and functional (pragmatic) models for the assessment and management of language and communication. It is the premise of this article that speech and language therapists are likely to prove flexible and valuable members of the multidisciplinary team, with the ability to contribute a further dimension to care planning – that of specific clinical input to the wide range of language, speech and communication impairments associated with the major mental illnesses (Gravell & France, 1991).

It comes as a surprise to many to be apprised of the level and standard of the honours degree course undertaken by speech and language therapists. The profession was the first of the 'therapies allied to medicine' to introduce the degree course and in many universities it is now spread over four years, in order to satisfactorily encompass all that is required by the syllabus. Central to the course and running in parallel with core learning on speech and language pathology and therapeutics, are the studies, in some considerable depth, of psychology, neurology and linguistics. It could be argued that this combination creates an ideal platform for work in psychiatry.

Among other behaviours, judgements as to mental state are made on those behaviours of language, speech and functional communication. It could be said that language is the most significant of the cognitive skills, involving as it does aspects of thought, memory, planning, perception and sensation. Research into localisation theory has taken us in to the linguistic functions of the right hemisphere (Cutting, 1991). Differential diagnoses, based on the proven principles of cognitive neuropsychological models, are now possible between distinct types of disorder within the continuum of aphasia and given the research into these models with, for example, schizophrenia (Frith, 1992), expanded analysis and description of linguistic and communicative behaviours might contribute to a broader understanding of all mental illness states and differential diagnoses (Thomas & Fraser, 1994). Weight may also be added to the neurodevelopmental implications currently under discussion, which are supporting the theory that early behavioural disturbances, many of which could be seen to be linked to specific delay in language acquisition or in the pragmatic elements of communication (Done *et al*, 1994; Jones *et al* 1994), are of significance among the predisposing factors for psychotic and affective disorders in later life.

Speech and language therapists are trained listeners and learn to become adept at decoding and reconstructing degraded speech and disordered language. The findings of Faber *et al* (1983) in relation to the efficacy of speech and language therapists in reconstructing the language of schizophrenia, as well as in aphasia, would merit further research. Hoffman & Satel (1993) explored the value of direct language therapy with schizophrenic clients suffering auditory hallucinations and reported good results. Part of speech and language therapy training will, unsurprisingly, be focused at enabling therapists to learn the arts of good language therapy, those of reflecting back, judging correct level of input and eliciting and maximising output. These elements are central to the cognitive–behavioural models of management.

Background

In the UK, speech and language therapy in psychiatry has been developing over the past 15 years. Each of the special hospitals has a full time therapist and many of the past and present large psychiatric hospitals have a provision of speech and language therapy services, which continues into the community bases. In total there are about 40 speech and language therapists working in various branches of psychiatry and a significantly higher number with the elderly with mental health problems. The profession itself is small and has had to make significant changes to encompass the demands of our increased knowledge of the range and depth of speech and language pathology. The National Psychiatry Special Interest Group was set up 15 years ago

https://doi.org/10.1192/pb.20.9.524 Published online by Cambridge University Press

in order to foster peer group supervision and to provide specialist training and broader education to its members and to interested others.

There is great difficulty in being a small profession with a very wide remit and there is a need to look at flexible methods of service delivery which will make the best use of resources.

The role

All members of the multidisciplinary team will have a contribution to make when discussing a client's communication but, in all skills directly related to speech and language function, it is the speech and language therapist who will have significant grasp of the specific neuropathology and psychopathology which can raise the level of description of the disorder and be of value in differential diagnosis.

In terms of *communicative environment* it is important to evaluate the factors which may be impeding the client's opportunity to communicate and to offer the therapeutic opportunities for change (if so desired). There may be little need or wish on the client's side to take part in communication. This may be to do with illness state, premorbid personality or the effects of institutionalisation. Following on from this the next level of involvement would be in the initial screening of *hearing*, the impact of which cannot be under rated. While speech and language therapists, in general, would not have the expertise of audiologists, the study of hearing and the necessary skills to form an early diagnosis is part of the statutory training. Practical management tips can also be provided, both to client and carers.

In the assessment and management of *attention*, *association* and *perception*, the speech and language therapist will work as part of the team, but will specifically be extrapolating and using the clinical information gained as to the effects of deficits in these skills on language processing and competence of communicative interaction. A large part of the function of a speech and language therapist working with clients suffering a major mental illness will be to assess their *receptive language* abilities and to devise targeted plans of intervention. This will extend into the higher level linguistic functioning of deeper processing and involve exploration and remediation of abilities such as logical and inferential thinking, grasp of metaphor and humour and also semantic memory capability. A full assessment will involve both written and verbal pathways and will look not only at dominant hemisphere language functions, but at those of the right hemisphere, particularly in relation to pragmatic skills.

Across the range of diagnostic groups the speech and language therapist will assess *expressive language* functioning, looking at semantic, syntactic and lexical organisation and output, again across both hemispheres and in order to specify and to target the exact level of difficulty that the client is experiencing. The motor function of *speech* itself, as well as voice, fluency and articulation will all be considered, as observation of need dictates and managed as appropriate. In cases of severe speech impairment, as, for example, the dysarthria of Parkinson's disease or Huntington's chorea, the client may be assessed for their suitability for an augmentative or alternative communication system. Eating and *swallowing* problems may be a feature and will often coincide with the dysarthrias – particularly in the older client and those with superimposed neurological problems or with drug-induced side-effects. Speech and language therapists have (almost by default) had to acquire high levels of skill in the management of dysphagia. Finally, and probably most importantly, the speech and language therapist can make a significant contribution to describing, assessing and managing specific features of *functional communication*, given that linguistic training will enable the therapist to bring a measure of specificity to these highly complex patterns of behaviour.

Treatment

Many of the interventions undertaken will be based on traditional speech and language therapy techniques which use cognitive neuropsychological principles to remediate language function. These are of great value in work with young people with elements of developmental delay and with elderly clients with a dementia. They also provide structure to elements of work with people experiencing thought disorder – or is it linguistic disturbance? Exercise regimes for speech intelligibility, voice problems or stutter will also be akin to those of traditional practice. Vocal difficulty or disturbances of fluency are often experienced by those with a neurosis or an agitated depression. Priorities for input in all the client groups could be said to be the building of improved attention and self-monitoring skills, thus increasing insight and therapy sessions will need above all to be flexible, in duration, location and content. Direct work on the semantic pragmatic elements of communication is central to the role of the speech and language therapist working in psychiatry, particularly with people whose main diagnosis is one of psychosis or personality disorder. This is the contribution of major significance which the speech and language therapist can make to social and communication skills training, which will also be undertaken by other team members, in more general formats.

Support and counselling for clients and carers will be vital and speech and language therapists

https://doi.org/10.1192/pb.20.9.524 Published online by Cambridge University Press

have the listening and reflective skills required in counselling and need not be afraid to take that step. Training in counselling is a part of the speech and language therapy degree syllabus, and most speech and language therapists currently working in psychiatry have had further counselling training, enabling them to work in a more psychodynamic way. Some have recognised psychotherapy qualifications and most elect to work in an experiential and re-constructivist way.

The way forward

Given that the speech and language therapy service in mental health is very thinly spread, due to financial constraints and the slowness of a long established system to implement change and encompass other clinical aspects and competencies, those therapists already working in psychiatric settings are having to find flexible and more far reaching ways of delivering care and developing the speciality. Thus, information within the team and on a much wider scale is of paramount importance. The speech and language therapist will need to inform fellow professionals on role as well on specific management techniques. Written packages of key information can give other staff and carers the guidelines for implementing communication care strategies themselves. If the speech and language therapist is willing to advise and inform others this may offer valuable opportunities for re-cap and for growth in insight and the development of coping strategies. This kind of approach may assure a more holistic and 24 hour setting for the client and prove of more lasting value than once a week therapy. Advice will be needed regarding the place of linguistic and communicative needs in care planning. Consultation will be needed on the optimum level of input.

As an extension of this, formal education and training for staff can have enormous impacts. The speech and language therapist is most unlikely to be able to see all the clients who may benefit from input, but is perhaps in a position to offer formal training to staff in order to upskill them and demystify some of the complexities of linguistic and communicative function which can often lead to making erroneous judgements. For services without any access to speech and language therapists, this may be a way of acquiring some level of input. Most speech and language therapists working in the National Health Service are usually willing to undertake training sessions on the nature of speech, language and communication and members of the Psychiatry Special Interest Group offer specific training packages on all aspects of communication and mental health. This is seen by the group as having potential for developing the specialism and as an effective way for unprovided units to use limited resources. A further way of flexible working in the current financial climate might be for the instigation of short-term contracts, enabling speech and language therapists to be seconded to undertake needs surveys, prioritisation ratings and efficacy measures, which could lead to informed discussions as to providing a level of dedicated service.

The aim of this article is to raise the level of awareness regarding the potential role of speech and language therapists in psychiatry and the presence of a small, core specialist group who can train, support, supervise and develop others, then perhaps services may consider making requests for further information, for some sessions of training or for specific clinical or research input. If it were not bordering on the realms of fantasy to speculate on how one would wish to see a service, one might suggest that at least one full-time post would be the minimum required cover for a sectorised mental health unit! The therapist would then be in a position to offer a rotational service between the various localities determined on the unique profile of priorities that the unit yields, both in regard to client and staff need. However, fantasy and reality at the present time are distinctly polarised and it may be that occasional input along some of the lines suggested is currently the only way forward.

References

CUTTING, J. (1991) *The Right Cerebral Hemisphere and Psychiatric Diagnosis*. Oxford: University Press.

DONE, D. J., CROW, T. J., JOHNSTONE, E. C., *et al* (1994) Childhood antecedents of schizophrenia and affective illness: social adjustments at ages 7 and 11. *British Medical Journal*, **309**, 699–703.

FABER, R., ABRAMS, R. & TAYLOR, M. (1983) Comparison of schizophrenic patients with formal thought disorder and neurologically impaired patients with Aphasia. *American Journal of Psychiatry*, **139**, 1348–1351.

FRITH, C. D. (1992) *The Cognitive Neuropsychology of Schizophrenia*. Hove: Lawrence Erlbaum Associates.

GRAVELL, R. & FRANCE, J. (1991) *Speech and Communication Disorders in Psychiatry*. London: Chapman & Hall.

HOFFMAN, R. E. & SATEL, S. (1993) Language Therapy for schizophrenic patients with persistent "voices". *British Journal of Psychiatry*, **162**, 755–758.

JONES, P. RODGERS, B., MURRAY, R., *et al* (1994) Child developmental risk factors for adult schizophrenia in the British 1946 Cohort. *Lancet*, **344**, 1398–1402.

THOMAS, P. & FRASER, W. (1994) Linguistics, human communication and psychiatry. *British Journal of Psychiatry*, **165**, 585–592.

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https://doi.org/10.1192/pb.20.9.524 Published online by Cambridge University Press