The Relation Between Speech Therapy and Psychotherapy

By JOAN PHILIPS, B.A., M.Sc.

Any therapist dealing with human beings must establish a good relationship with the patient, and must know how to use this relationship skilfully in order to achieve success. To that extent it is true that in a sense every speech therapist must be her own psychotherapist. The problem is: how far can and should she consciously attempt to act as such, and where should the dividing line be drawn? It is important to try and arrive at an answer to this question because in my experience some speech therapists tend to step right outside their province and to deal with psychological aspects of the problem for which they have neither sufficient training nor the kind of relationship with their patient which will enable them to adopt successfully the role of psychotherapist.

We can, to begin with, distinguish between two main types of speech defects:—

(1) Mechanical defects, e.g., those due to organic conditions such as cleft palate, failure to enunciate clearly, inability to pronounce certain consonants, faulty accent, etc.

(2) Defects involving, or related to personality difficulties, i.e., symptoms of disturbance within the personality which take the form of speech defects, e.g., stammering or refusal to speak. Into this class will also fall certain cases of lisping, lalling and mispronunciation, which may, for example, be part of a general tendency on the part of the individual to remain infantile.

In dealing with the first type of defect the task of the speech therapist is more or less straightforward. Primarily, her job is education or re-education in the technique of good speech. Nevertheless, she enters at once into a therapeutic relationship with the patient, and to some extent, if the patient be a child, with his parents. For one thing, the existence of the defect will in all probability already have produced secondary psychological difficulties, e.g., shyness, feeling of inferiority, reluctance to enter new situations. The therapist has to deal—though indirectly—with these aspects of the patient's personality as well as with his speech. It is also important that she understand a good deal about his background and past history, because the way in which she teaches will obviously be adapted and modified according to the sort of response she can elicit from her patient. When dealing with a child, it is also clearly important that she should be able to establish good rapport with the parents.

To this end the speech therapist must have a good understanding of behaviour and its meaning, and of the technique of handling individuals in need of help. But she should use it as the good teacher does—not obviously and self-consciously, but as part of her general approach. She is teaching the patient, not analysing him, and her psychotherapy must at all times be subordinate to her pedagogy. True, removal of the speech defect will probably have psychological effects on the patient—in many cases there will be growth and change, a better adaptation to life—but these should come as a result of the speech therapy as such, not as a result of attempts on the part of the speech therapist to use a determinedly psychological approach.

Let us turn now to the second type of defect—that involving or relating to the personality as a whole. It is here that there is most confusion about the role of the speech therapist, and where, with the best intentions in the world, real harm may be done to the patient by an overenthusiastic speech therapist trying to take over the functions of psychotherapy proper.

In the first place, it seems that there is a failure to appreciate that these defects are neurotic symptoms. Now a neurotic symptom is a compromise solution of a conflict intolerable to the personality. An unconscious wish or impulse-seeking realisation is opposed by other forces within the personality, such as conscience, fear of loss of love, fear of social disapproval. By producing a symptom the individual succeeds in keeping the conflict within bounds and giving expression to the warring elements. For instance, among the many factors contributing towards the development of a stammer are on the one hand, the unconscious wish to be extremely aggressive verbally and on the other, the fear of this aggression and the need to repress it. The stammer represents the compromise.

Speech is crippled (i.e., aggression is controlled), but at the same time the listener is irritated (i.e., aggression is expressed). The stammerer is punished by the disability (as demanded by his sense of guilt) but there is also some secondary gain (he draws attention to himself).

This oversimplified description of a neurotic symptom should serve to show what a very economical and convenient device it is for the neurotic individual. Small wonder, then, that he clings so tightly to his disability. Every speech therapist must know from her own experience how deep can be this reluctance to be cured, despite the strongest conscious wish to return to normality.

It must be emphasised that while a physical defect may be surgically removed with very little effect on the body as a whole, a neurotic symptom cannot be dealt with except in relation to the whole personality. To try and "cure" it by removing it may well mean that you are simply blocking up one channel of discharge for the personality without providing an alternative outlet. Here is an example of what I mean: a boy of fifteen came to me for treatment for continuous diarrhoea, which had been diagnosed by physicians as psychogenic. Two years previously he had started treatment by speech therapy for a severe stammer. The stammer had disappeared, and he had been discharged as "cured," but shortly afterwards the speech symptom had been replaced by this new symptom of diarrhoea.

Now it should have been clear from the history of this boy, as told by his mother, and from the very first interview with him that he was a deeply disturbed individual, and that the mere removal of the symptom of stammering would do little towards relieving his severe psychological problems. In these cases the onus is on the speech therapist to decide whether the speech defect is a comparatively simple, superficial symptom which is likely to respond to speech therapy as such, illumined with psychological understanding, or whether it is a symptom of really deep psychological disturbance. If the latter, the patient should be advised to seek psychological treatment in the first place. After improvement of his psychological condition it may still be necessary for him to seek treatment for the speech defect. This would be a far safer course to adopt, and probably more profitable, too, because the adjusted individual can absorb instruction far more easily than the maladjusted.

It may be argued that, in the light of these considerations, what the speech therapist needs is not less, but more psychology in her dealings with her patients. If more attention were paid to her psychological training and if she were taught more of the theory and technique of psychotherapy, would she not be better equipped to deal with all types of speech difficulties, including those which have deep psychological roots?

In order to answer this we must examine more closely what the practice of psychotherapy implies and where it differs from speech therapy. We have seen that, in dealing with a conflict within himself, one of the devices adopted by the individual is to repress—i.e., banish into the unconscious—the undesirable thoughts, wishes and impulses. An unequal conflict then rages within the personality—unequal, because one of the combatants is hidden, unknown. One of the objects of psychotherapy is to bring the repressed feelings and thoughts back again into consciousness. One way in which this is done is by re-living the original conflict within the therapy, only this time, feelings, wishes and thoughts which were originally directed towards the patient's parents, teachers, siblings, etc., are now directed towards the therapist, who represents now one, now another of these people at different stages of the treatment. When the patient discovers that he can bring out all the forbidden ideas and emotions with totally different results from those which he anticipated and dreaded, a change takes place in his attitude. Once he is aware of both sets of conflicting feelings, he can make a conscious choice between them, instead of producing a neurotic symptom. He can accept some of his feelings and critically reject others, instead of having to repress them under pressure of fear, guilt and shame.

This is again an oversimplification, but at least it may help to clarify what part the therapist must play in this struggle. He must be prepared to accept all types of feeling from the patient, both positive and negative. His task is not to judge, nor to criticise nor to teach. The speech therapist, on the other hand, must definitely have an educative approach, and like all educators can only achieve good results if she is able to establish a clear positive transference. She needs the conscious co-operation of the patient. She cannot afford to work directly with the unconscious or to encourage free play of aggression, hatred, guilt, suspicion, etc. Therefore, she cannot be both educator and therapist,

any more than the psychotherapist can set out to cure a neurosis and at the same time teach good speech. The two functions must remain separate. Attempts to combine them can only result in poor therapy and confusion for both patient and therapist.

The speech therapist may here interject that she attempts nothing so deep in the way of psychological treatment, but limits herself to fairly superficial interpretations of the patient's behaviour and difficulties. In some cases, it is true, this may be harmless, since the interpretations have no effect at all. In that case, why make them in the first place? In other cases they may touch upon and stir up anxieties which are far deeper than the therapist anticipates and which she then finds herself unable to deal with. Or, as in the case of the fifteen year old boy, the attempt to probe into deep psychological causes is felt by the patient as an attack, from which he tries to escape by giving up the speech symptom and choosing some other form of symptom.

It is not my intention to decry speech therapy as demanding less knowledge or less skill than psychotheraphy. The two professions, although closely allied, are completely separate. They rely on different bodies of knowledge and different techniques of practice, and this must be borne in mind by clinicians of both professions if they are to achieve the best results in their respective spheres of work.