Working the 'wise' in speech and language therapy: evidence-based practice, biopolitics and 'pastoral labour'

Abstract

This paper examines how power and knowledge are involved in the workings of speech and language therapy and in the work of speech and language therapists (SLTs). The paper draws on Foucault for its conceptual frame, with reference to his exposition of governmentality, biopolitics and pastoral power. Based on interviews with thirty-three SLTs in the UK, the findings show that evidence-based practice (EBP) is ever-present in speech and language therapy, despite its apparent absence; and that its power circulates in a multitude of ways. EBP as a process, and not an outcome, was workable. When competent practice was at risk, however, the SLTs challenged the dominance of EBP by saying it needed to 'get real' but then were troubled when it did. Working the 'wise' - those people involved with the client, including the SLTs themselves - was key to speech and language therapy; as was the making of subjects into biopolitical objects. At its most rewarding, but also most personally challenging, the work of SLTs involves mediating between different ways of being in the world and reimagining life, personhood and citizenship; to capture this complex labour process, the paper introduces the term 'pastoral labour'.

Keywords

UK; Biopolitics; Evidence-based practice; Foucault; Governmentality; Pastoral power; Reflective practice; Speech and language therapy

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1. Introduction

Over the past 60 years, there has been something of a therapy explosion (Madsen, 2014), with increasing numbers of people seeking the knowledge of experts to inform their response to a plethora of issues: whether for mental or physical health, relationships or career development, there will be a therapist. Yet, publicly funded therapists are a finite resource and the cost of private therapy restricts access to those who can afford it; so, the explosion is contained. That said, it is a mystery that anyone would choose to attend therapy, let alone pay for it. Historically, what might now be called talking therapies were regarded as painful - akin to a form of punishment (Foucault, 1978; 1988; Pilgrim, 2007). Their raison d'être was the exposure of an individual's feelings, experiences, abilities or behaviours that served to emphasise his or her lack, which alongside airing modes of retribution and prescriptive governing of behaviours, stressed the limitations of both the individual and therapy (Arney and Bergen, 1983; Goffman, 1961; Moore, 2011; Ruari-Santiago, 2017).

In current discourse, however, this pained voice is drowned out and replaced with a more gratifying, positive, even pleasurable, one (Pilgrim and Rogers, 2009): the journey through therapy is promoted as one with a few bumps in the road, but ultimately worthwhile because it will 'work' and you/I/we will be 'fixed' (Madsen, 2014). This talk is pervasive and persuasive (Pickersgill, 2011); creating challenges for therapists, clients and others (e.g. friends, family or carers) who are both part of and party to therapy (Sadler et al., 2018). These challenges are likely to arise from people's varying opinions on the aims and claims of therapy, the extent of their knowledge and experience, and their disparate roles within the therapeutic exchange. Drawing on a qualitative study of thirty-three speech and language therapists (SLTs) based in the UK, this paper explores these tensions. It asks, how do SLTs conceptualise therapy, their role and the role of others within therapy? How does power reveal itself in speech and language

therapy? And, how do SLTs regard and use different knowledges in their practice? By examining these issues, the paper addresses its aim, which is to: further our understanding of the workings of speech and language therapy and the work of SLTs.

To support this aim, the paper looks to the work of Michel Foucault whose exposition of the relationship between power and knowledge in the governing of behaviour offers notable analytical value. Of particular interest is Foucault's (1978; 1979; 1982; 1991; 2004; 2007) examination of how power is associated with certain forms of knowledge through discourse, reflection and/or confession; and its effects on the practices and lives of individuals and communities of people. The paper starts with a discussion of speech and language therapy. It then considers the education and work of SLTs, including a review of the drive for evidence-based practice in the profession. Next, Foucault's theories are introduced and put to work; highlighting their ability to frame and critique relations within healthcare. The rest of the paper is devoted to the empirical study, which explores SLTs' work and how they undertake their role. Based on the study's findings, the paper a) highlights systemic discrimination; b) calls for reflective practice to be further reflected upon; and c) argues that SLTs' work be regarded as 'pastoral labour', defined as a form of labour that mediates understandings, knowledges and relations between parties, individually and collectively, with reference to the range of ways that life, personhood and citizenship might be conceptualised.

2. Speech and Language Therapy

Members of the speech and language therapy profession support people who experience difficulties with communication, swallowing, eating and drinking (RCSLT, 2006). SLTs' clients may be adults or children; and their impairments could be developmental or acquired through traumatic injury or illness. In response to client need, SLTs often work as part of multi-disciplinary teams and in medical, educational, correctional or social care settings (Baeza et

al., 2016). In the UK, speech and language therapy is regulated in two main ways. First, through its professional body, the Royal College of Speech and Language Therapists (RCSLT), which provides leadership for the profession and supports the standing of its members. Second, via the Health and Care Professions Council: a statutory body that oversees the work of several allied health professions. Both bodies influence the way that SLTs are trained and work.

Qualifying to practise as an SLT typically involves studying a four-year undergraduate degree. The degree seeks to draw together the two foundational (and somewhat differing) schools-of-thought around the aims of therapy: the educational/elocution school, which focused on improving oratory and communication; and the medical school, with its emphasis on correcting and treating problems of speech (Armstrong and Stansfield, 1996; Robertson et al., 1995). Thus, the syllabus includes anatomy, brain and behaviour, and speech and language pathology; alongside, linguistics, phonetics and child language development (RCSLT, 2006).

Yet despite this drawing together, the syllabus contains bodies of knowledge that are afforded a different status - ontologically, philosophically and professionally (Benoit, 1989; Dunnet et al., 1995; Sataloff, 2017). The privileging of knowledge, and of one knowledge over another, assigns power (Berg, 1995), is the nature of professions and the battleground for many professional groups (Abbott, 1988). For speech and language therapy, this battle of knowledges is fought within and without (Baeza et al., 2016; Justice, 2010; McCurtin and Roddam, 2012); and is heightened in a context of neoliberal concerns, with its foregrounding of markets, competition, measurement and rankings (Brosnan, 2017; Greenhalgh et al., 2008).

In neoliberal healthcare, power is afforded to a certain kind of knowledge, i.e. measurable and evidence-able, which then feeds into a privileged evidence-based practice (EBP) (Baeza et al., 2016; Broom et al., 2009; Martin, 2008). EBP interventions are ranked according to the scientific legitimacy of their originating evidence base, outcomes and viability (Greenhalgh et

al., 2014; Timmermans and Berg, 2003). Knowledges and practices that are outside or challenge this frame are supposed less legitimate (Isaacs and Fitzgerald, 1999): often attracting lower research funding; limiting publications that establishes evidence; and, as a result, are excluded from case teaching with some practices ending up being regarded as quackery (Brosnan, 2017; Justice, 2010; Wahlberg, 2007).

Against this backdrop, EBP is of central importance to the profession and RCSLT. Fittingly, the efficacy of speech and language therapy has been evidenced in a plethora of studies, including a) treatment versus no treatment randomised control trials in children with primary speech impairment (Broomfield and Dodd, 2011); b) direct, indirect and no treatment trials with children experiencing receptive and expressive language difficulties (Gallagher and Chiat, 2009); and c) adults with acquired disorders (Fourie, 2009). Still, speech and language therapy is said to have a low evidence base (Justice, 2010). However, this claim is argued to be the result of faulty categorisation (Roulstone, 2011); a limited framing of 'evidence' (Garrett and Thomas, 2006); and a complete disregard for the craft of therapy (Justice, 2010). That said, there are barriers for EBP in speech and language therapy. The most commonly cited barrier is the difficulty of translating research into practice (Foster et al., 2015; O'Connor and Pettigrew, 2009) as a result of the 'problematic' nature of the client group. The 'problem' is us (you/me) and our individuality e.g. the individualised impact of a stroke or head injury on our functioning, and the differing ways in which we each acquire or lose speech and language.

Nonetheless, the profession is pushing for and promoting EBP (McCurtin and Roddam, 2012). As such, SLTs are increasingly required to a) draw on and refer to the evidence base in their everyday practice; b) build and enhance the profession's evidence base, via research and publications; and c) document their use of EBP within their employing organisation's performance management system (McCurtin and Roddam, 2012). Beyond the 'scientific'

evidence and SLT-related needs, there are other personal and social issues that therapists must consider in treating their clients (Roulstone, 2011), including further health conditions, familial or alternative support networks (Sadler et al., 2018); and, in light of limited resources, other clients who might benefit from support (Northcott et al., 2018). This raises the question as to how SLTs negotiate within and between these matters (Pring et al., 2012). The paper's aim is to directly address this knowledge gap; furthering our understanding of the workings of speech and language therapy and the work of SLTs. In the next section, Foucault is looked to for a conceptualising framework.

3. Approach: Foucault

3.1 Power, knowledge and the practices of governing

A key theme that runs through Foucault's (1982; 2004; 2007) work is the relationship between power, knowledge and government. Foucault (1979) rejects the notion that power is a possession belonging to a particular person, group or institution; rather, he conceptualises power as enactment and examines how power relates to preferred knowledge in the practices of governing. These practices he considers on three levels, the first is the apparatuses of knowledge: the institutions and the science that underpins what is known, and thinkable. The second level considers how what is known is knowable and who owns the knowledge. Professions, for example, are thought to have the right to jurisdictional government as a result of owning the right kind of knowledge (Abbott, 1988). The third level is individual, governing through knowledge of ourselves as individuals and/or in relation to others. Here, Foucault (1988:16) uses the term 'technologies of the self', whereby self-knowledge allows us to regulate our own behaviour via a) the internalisation of surveillance (as if being watched by others) and/or b) a quest for personal development or self-improvement (self-monitoring against an idealised and, as yet, unrealised self).

In governing behaviour, Foucault (2004) notes that knowledges are ascribed with different levels of power. Subjugated knowledges are marginalised knowledges 'that have been disqualified as nonconceptual knowledges, as insufficiently elaborated knowledges: naive knowledges, hierarchically inferior knowledges, knowledges that are below the required level of erudition or scientificity' (Foucault, 2004:7). In healthcare and for SLTs, at face value, the subjugation of experiential knowledge would always privilege EBP. This all-powerful view is all-too-common, but it fails to resonate with Foucault's (1979) argument that power is not possessed or fixed; and it does not reflect the more nuanced, political apparatuses examined in his later work (Foucault, 2004; 2007; 2008). He argues that subjugation can be resisted and challenged through processes of power, such as acting on localised knowing. As Foucault (2004:9) remarks, resistance is 'not so much against the contents, methods, or concepts of a science' but 'an insurrection against the centralizing power-effects that are bound up with the institutionalization and workings of any scientific discourse.'

The working of discourse is thus key to challenging subjugation and to another of Foucault's concepts: governmentality. Foucault's (1982:790) governmentality draws attention to the processes, tactics and techniques of government that characterise and direct the 'conduct of individuals or of groups.' Defined by Rose and Miller (2008:9) as a form of power 'that [is] productive of meanings, of interventions, of entities, of processes, of objects, of written traces and of lives'; key to the concept (and effectiveness) of governmentality is the entwining of discourse, knowledge and power as they feed into the apparatuses of government. These apparatuses make things known - through representation, listing, tabulating, quantifying, naming and/or framing - in order that these things can be governed via roles, programmes or regulations (Foucault, 1991). In healthcare, governmentality studies have exposed the language of skills training, which seeks to shift family members or partners into 'carer' roles (Sadler et

al., 2018); and policy documents that aim to shape clinicians into 'productive' professionals who consider individual patients, the wider public *and* limited resources (Moffatt et al., 2014).

3.2 Biopower, biopolitics and pastoral power

The wider public are considered in Foucault's biopower and biopolitics. For Foucault (1978) biopower describes numerous and varied techniques for achieving the control of populations. Unlike sovereign power, Foucault (2004) stresses that biopower does not give life or take life; rather, it looks to which lives are to be optimised and which left to die. Hence, biopower privileges a certain type of life; one that conforms, is of value (or at least is not of disvalue). In Goffman's (1963) terms, biopower values most those that are not spoiled. Biopower is, therefore, political and a 'power of regularization' (Foucault, 2004:247), which in neoliberalism is set in a context of quantification, averaging and calculating deviations from the norm (Moffatt et al., 2014).

Key to biopower and its biopolitical potency is that whoever governs needs to know its subjects in great detail; as Foucault (1982:783) observes 'this form of power cannot be exercised without knowing the inside of people's minds, without exploring their souls, without making them reveal their innermost secrets.' The exercising of this form of power is akin to that shown by pastors in the early Christian church (Foucault, 1982): hence, pastoral power.

For Foucault (1982), there are a number of interweaving features of pastoral governing including, first, its orientation toward salvation (in the next world) or wellbeing (in this one); on which, pastoral power calls for a degree of self-sacrifice. Second, pastoral power involves in-depth discussion, akin to confession, whereby it seeks to capture our deepest thoughts. Third, is the requirement for self-examination, checking and improvement. This might involve reflecting on progress against goals, and often draws on external knowledge via elders or experts. Together pastoral governing seeks the 'right' sort of citizenship, which is at once

individualising and collectivising. It aims for everyone to know and acknowledge themselves as an independent person (a citizen), but also through discussion and reflection to ensure they fully understand their role/place/impact within and on the group (per crew member on a ship).

Hence, pastoral power is participative, relational and productive: aiming toward producing people who are both proactive subjects (individually responsible and agentic) and responsive objects (drawing on the guidance of external sources to assess and shape their behaviour). Two studies exemplify biopower, biopolitics and pastoring in healthcare, of interest is how they traverse individual and collective responsibility. Crawshaw (2012) highlighted social marketing campaigns, which encourage men to take responsibility for their own health, for the good of themselves and their families. In the work of health visitors, Cowley et al., (2004) showed how the role has shifted in recent years: from a focus on individual health and the management of support, to a focus on public health and the management of risk.

The lens of pastoral power illuminates the active part that we each play in the exercise of power; it blurs the distinction between our roles as object and subject in power relations (Foucault, 1982). Yet, despite the circulating nature of power that is central to much of Foucault's work (Munro, 2012), the limited studies that have looked to pastoral power have, until recently, discussed a pastor, in the singular, as if power is possessed by one individual, role or institution (Waring et al., 2016). However, this is changing: recent studies have found Foucault and his concept of pastoral power useful to critique the increasingly complex roles in healthcare; for example, new knowledge and expert patients (Martin and Waring, 2018), self-care (Jones, 2018), HIV prevention (Shih et al., 2017) and community pharmacy, where general practitioners and pharmacists take on something of the pastoring (Waring et al., 2016). Given the nature and complexity of speech and language therapy and the relevance of his work, this paper draws on Foucault's study of power, knowledge and governing, along with extant

research, to meet its aim, which is to further our understanding of the workings of speech and language therapy and the work of SLTs.

4. Method

The research project titled 'The work of speech and language therapists' took place in 2014 and was funded by the Dominic Barker Trust. Following an initial email to SLT contacts made during an unrelated project, and subsequent snowball sampling, thirty-three SLTs throughout the UK took part in this research project. The sample were self-selecting, not known to the researcher and were all women; not purposively, but this is representative of the dominance of women in the profession (Litosseliti and Leadbeater, 2013). The participants had worked as SLTs for between six months and 39 years. As is common for SLTs, most participants started their careers in a generalist post and then moved to a specialism, such as paediatrics, adult, learning disabilities, voice, cleft lip and palate, autism or dysphagia. Their roles took them to a variety of work settings including schools, GP surgeries, health clinics, hospitals and between sectors delivering training, lecturing or private voice work. Looking across their clinical careers, participants' working lives were predominantly devoted to the client groups and work settings, as Table 1 below:

Table 1 Participant clinical careers: client groups and work settings

Client groups			Work settings		
Mixed - generalist	Adult - specialist	Children - specialist	Health	Education	Social care, training, private
9	7	17	19	10	4

Data were gathered via semi-structured, qualitative interviews. The interviews lasted an average of 70 minutes were wide ranging and conversational but guided by a wish to understand why participants became an SLT, how they think and feel about their work and about their interactions with others. They were also asked to discuss any changes in the role and other issues that I needed to know to understand the work. Interviews took place in a range of locations in order to fit each participant's work schedule and home life, this included worksites, quiet cafés and libraries. The study received University ethical approval [BH137910]; informed consent was obtained from all participants, and participation was voluntary. The interviews were audio recorded, transcribed and fully anonymised. As agreed with participants, pseudonyms and years as an SLT are used as identifiers. Along with the formal interviews, pre- and post-interview discussions with participants, and sometimes colleagues, also provided data. With permission, notes of the informal discussions were taken and, together with personal field notes, represented a supplementary data set.

The transcripts, notes and practice guidelines, specifically *Communicating Quality 3* (RCSLT, 2006), were compiled and represented the whole data set. The data were analysed thematically (Green and Thorogood, 2014) and coded to thematic nodes in NVivo 10. The nodes were created, revised or combined in a way that responded to the data and helped to make sense of them (Miles and Huberman, 1994). In practice, this meant that the initial coding identified broad themes, such as aims of therapy, training, knowledge and practice. Next, there was a closer reading of the data, looking across and within data sets. This analytical immersion included re-reading written texts and re-listening to audio; to promote greater involvement and prevent data loss (Butler, 2015). This process deepened the analysis and led to the emergence of points of emphasis, agreement, inconsistencies, changes and tensions. This analytical work culminated in three main themes, which address the research aim and will be used to structure the discussion: a) discriminating evidence, b) reflective rituals and c) pastoral labour.

5. Findings and Discussion

5.1 Discriminating evidence

All participants said EBP was vital to their work; yet, the word most often used about EBP was ‘difficult’:

> The biggest problem for EBP in the profession is there isn’t any evidence. Well, there’s hardly any - it’s lacking - because each and every client is different. So, we can’t do EBP, not really, and it’s difficult (SLT1-18 years)

The difficulty of EBP was attributed to the privileging of scientific knowledge (Lancaster et al., 2017), diminishing resources and increasingly exacting performance management regimes, which results in pressure to practise in a way that is proven (Moffatt et al., 2014). That said, participants were well aware of the wider context of EBP: its importance for the standing of the profession and issues with the alternatives, such as eminence-based and confidence-based practice (Isaacs and Fitzgerald, 1999). Nevertheless, as one SLT said, ‘ultimately, we have to deal with the impact of the current system’ (SLT14-12 years). The impact, and their dealings, were discussed across two fronts: a) the profession and b) clients.

For the profession, the SLTs spoke about the potential loss of legitimacy and authority without a robust evidence base (Abbott, 1988). Interestingly, there were particular concerns about de-legitimisation in the eyes of fellow healthcare professionals because of the ‘treating and fixing mentality’ (SLT12-11 years). In addressing this pressure, like the therapists in Baeza et al., (2016), they argued for the uniqueness of their role: highlighting that, unlike many other clinical specialties, the idiosyncratic and messiness of speech and language development (and loss), made their work ‘unevidenceable’:

> Language development does not follow a linear path, neither does its loss following a traumatic injury or stroke. Our work involves being directly responsive to the client, now, in the here and now, plus how they were and how they change over time. All individual. Each person is a varying, unique case study (SLT28-16 years)

On the surface, many of the SLTs appeared to be replaying the two-schools debate around the differing aims and claims of therapy, but further analysis shows that the majority of SLTs drew on the notion of competent practice (RCSLT, 2006) - practice that takes into account the clinician and client, along with evidence - to reframe and subjugate EBP:

> We're not scientists, dealing with cold hard facts. We're clinicians who use whatever resources we have available, including the evidence, to support, develop the person in front of us, and their families. I would say we're realists, pragmatists, and EBP needs to get real, it really needs to get real (SLT16-21 years)

Here, the SLTs were dealing with the apparent lack of legitimacy by challenging the dominant discourse - saying, EBP is not real. Just like in Lancaster et al., (2017) and Randall and Munro (2010:1502) they were clinicians using a local discourse to create new subject positions: competent pragmatists, who are less focused on the 'science of healing', and 'more concerned with the day-to-day practice of living'.

Yet, despite dismissing the 'science of healing' (Randall and Munro, 2010:1502) and not believing that the evidence for EBP could be found, nearly two-thirds of the SLTs were trying to find it by conducting research or seeking funding to conduct research. Indeed, they spoke with some animation of enjoying this seemingly futile activity. In responding to my apparent puzzlement, one asked 'are you wondering why we undertake [gesturing inverted commas] pointless research?' I was, and the reply was linked to its contribution to a valuable life:

> EBP. It’s not just a matter of competent practice, it's a matter of life or death for our clients. At least, life as you’d want to live it (SLT20-13 years)

Throughout the research, the SLTs highlighted that clients whose conditions either lack an evidence base and/or are unlikely to make demonstrable (quantifiable) progress, receive lessor support or are excluded from their lists. Undertaking ‘pointless research’ allowed them to enrol these clients in studies and, to some extent, redress the ‘discriminatory exclusion of people who need support’ (SLT22-16 years). In biopolitical terms, this moves people from those who are disregarded (lives not worth investing in) to those who are valued and worthy of optimising.

Here, a different form of knowledge governed their work: knowledge of ‘the system’, which presented ‘a great opportunity to do something good, despite the system, working the system for good’ (SLT27-17 years). The aim of their conduct was client care. The conductor was EBP, but as a governmental apparatus, a process to be enrolled in (and worked) and not an outcome to aim for (Lancaster et al., 2017). For the SLTs, it could be argued that EBP is indeed vital: as an energiser, offering an opportunity to reorganise work (Randall and Munro, 2010) and engage clients (Lancaster et al., 2017). As a result of re-presentation, these clients are no longer categorised as cost subjects (of disvalue, requiring treatment), but instead (re-named and reframed) as crucial objects: co-investigators in the search for evidence.

5.2 Reflective rituals

Notwithstanding the system sometimes being worked for good, the systems within which the SLTs work risk limiting the profession. Reflective practice is fundamental for developing competency as an SLT (RCSLT, 2006). Participants described how a key part of their degree was learning to become reflective. As students, they spoke of being observed by lecturers and peers as they conducted therapy with clients. Following each of these sessions, there was a

group meeting between the lecturer and students (typically 3-4 students). These clinical review meetings focused on planned activities, responses (client and own) and learning points:

> The post-therapy sessions we did at uni[versity] were so important. Still now, we all do it. It's what speechies do. We meet, we talk things through. They are a significant part of what we do (SLT17-10 years)

In a conversation while on-site: SLTa said 'the meetings, they're everything, it's how you learn, isn't it?' SLTb '… you learn how to do the job and how to cope, you know with tough cases...' SLTa '…and pass on what you've learnt. They're invaluable, invaluable'. Yet, despite the SLTs recounting the meetings as invaluable, related remarks highlighted several issues.

The meetings were spoken of as key to becoming an SLT; and, in Foucauldian terms, as confessional in nature. During training, the SLTs spoke of one pastor - the lecturer or clinical supervisor - and it was clear that they were being pastored: encouraged to air experiences and weaknesses and being supported toward improved knowledge and preferential practice. The aim was also clear: developing competent practice for the good of the client. As they progressed in their careers, the meetings involved collaborative pastoring and this peer-support was highly valued. However, many SLTs described how the meetings have changed in recent years:

> They used to be supportive discussions. Now, the meetings are performance, reporting sessions, but also they're training sessions. And, as a profession, we need to show we are using the evidence (SLT6-12 years)

For all, the increased performativity of the meetings was linked with power, knowledge and the governmentality of EBP, but the way in which their performance was governed seemingly differed depending on the SLTs' level of experience. For those who had worked as SLTs for 10 years or more, they spoke of themselves as if governing on behalf of 'the profession', rather than on behalf of clients. More specifically, they described how the pressure for EBP

(McCurtin and Roddam, 2012) meant that they were uncomfortable in discussing their non-EBP, especially to their less experienced colleagues: ‘when we sit and talk through cases - that’s when it becomes difficult and I start to question myself on what to say’ (SLT1-18 years). As a result, they spoke of ‘failing to pass on knowledge, my clinical practice knowledge’ (SLT18-19 years).

The less experienced SLTs were equally positive about the review meetings, but again the word ‘difficult’ was used. Specifically, they spoke of the difficulty of hearing that their practice was ‘wrong’ - that is, did not align with what their more experienced colleagues were saying:

> I look to the evidence base in everything I do. It informs my practice. It’s difficult, but it’s so important that we reflect on what we do and using the evidence helps that (SLT2-5 years)

> The evidence is our knowledge base. Sometimes what I’m hearing doesn’t fit with the evidence, but then that’s what being reflective is all about, isn’t it? Looking to the evidence to inform your practice (SLT7-3 years)

Considered alongside the comments of the more experienced SLTs, the above remarks highlight that in these settings non-EBP is being subjugated. It may be that ‘being reflective’ is what being an SLT is ‘all about’, but the drive for EBP has seemingly altered what is reflected on; and subjugated the therapists’ gaze - where gaze is a certain way of sensing, looking or hearing, based on valued knowing and experience (Foucault, 1976). That clinicians are guided toward privileging scientific evidence over the evidence of their own eyes (or ears) is, arguably, not news (Health and Care Professions Council, 2013). However, it is suggested that the nature of the SLTs’ clinical review meetings - the need to reflect, to confess - strengthens, realises and internalises the ‘difficult’ effects: leading to questioning and doubt, which limits the sharing of clinical practice, potentially limiting the profession.

5.3 Pastoral labour

All participants said they became an SLT 'to help people'. Coming from healthcare professionals, this statement is no surprise. Yet, what emerged from the data were the complexities of what the SLTs believe help is and, unexpectedly, the work that surrounds their conceptualisation of people. When they expanded on the notion of helping people, what the SLTs were describing was making and remaking people; and, in the process, rethinking what it means to be human. First, the majority of SLTs loved their work:

> Honestly, it's the best job in the world. Being able to communicate, it's what makes people human, isn't it? So, we give people their humanity, making them human, if you like (SLT15-19 years)

The SLTs spoke of their work as furthering people's ability to engage as full citizens; to be valued members of society. However, despite the positivity, the process that surrounds this 'making' work was described as the most challenging of the job. The tensions centred on renegotiating citizenship and personhood (considered as being an individual citizen who has the capacity to perceive self and relate to others). The SLTs spoke of the individuality of each client's personal needs. Alongside, they also described mediating between a multitude of different meanings of being human and, often, the changing role that the client may have in the family:

> He was a head-of-the-household type, barking out orders. Then, after his stroke he couldn't do that. It was devastating for him and the family. They loved his gruff ways. It was him. I remember his wife saying he'd been a miserable young sod, let alone an old one. We got them back some way to where they'd been. Took time, mostly with the family, not him actually, getting them to re-think Bill [pseudonym], but not to let him go or let him let himself go, if that makes sense (SLT9-26 years)

The work involved was different for every client, family and circumstance. Participants spoke of needing to understand where the client fits in the family; his or her situated, familial citizenship. To do this, they had to encourage the client and the family to talk, to confess - their past, present and future, wants and hopes. That is, the confessions that they were working to invoke were necessarily in-depth, personal, individual, collective and temporal. As above, the therapist had to consider the 'old' Bill as well as the current and future Bill, but while working to ensure the therapeutic talk was contained - 'fixing is rare' (SLT14-12 years). There were various terms used by the SLTs for this work - 'reimagining', 'reconceiving' and 'repositioning' - but all involved biopolitical reconceptualising and changing ideas of what it is to be a citizen, and of personhood. In some cases, their role involved deconstructing a hoped-for family member:

> We have to constantly temper against over-promising, while also ensuring that we get the best for and out of each child. In some cases, this can mean helping parents with the loss of their hoped-for son or daughter. Some, many grieve for the child they won't have, while at the same time learning how to relate to their child, and with how their child engages with the world. It's a lot to take in and we have to arbitrate is the wrong word, but mediate between their ways of being in the world (SLT26-16 years)

For some clients, the SLTs described that their way of 'being in the world' can be subject to stigma. For example, speech and language difficulties impair interpersonal interaction. It is discomforting to the person with the difficulty and those who may relate with him or her; as such, it is a social disability (Oliver, 1983). Goffman (1963:28) talks about three groups of people who engage with stigma: a) the individual subject to stigma; b) others who inflict it, intentionally or unintentionally; and c) the 'wise'. The wise are people who do not have the trait that is subject to stigma, but whether by virtue of personal or professional relationships

are involved with the often 'secret life' of the person who is subject to stigma (Goffman, 1963:28). The wise act as a buffer in the interactions between the individual and others. Acting as a buffer, while also sometimes being buffered by stigma-by-association, requires 'a certain knowledge, ability, skill - it's not easy, people struggle. I struggled, still do sometimes' (SLT17-10 years).

In their role, the SLTs (the professional wise) need to educate and support the client and the personal wise. Importantly, in most cases, due to the interactive nature of communication, SLTs' therapy cannot 'work' without the work of the 'other' wise. Participants spoke of having to consider the skills of the family or carers, the risk of them making any situation worse and, in the face of their assessment, working to educate them (Waring et al., 2016). Here, the SLTs drew on a range of resources, depending on the situation: sometimes highlighting their expert status and 'power' in the use of evidence-based knowledge; and other times emphasising knowing gained from clinical experience. Beyond the juggling of knowledges and practices, conducting the conduct of the personal wise resulted in tensions for many SLTs with regards to the governmentality of role re-categorisation (Sadler et al., 2018):

> Should they have to do it, isn't it our job, they're not carers; they're wives or husbands or mums or dads. It changes the whole relationship. It changes who they are to each other (SLT3-20 years)

In many ways, the SLTs were labouring against familial knowing (Murphy, 2003) - they were often making recommendations on how to communicate with or feed a family member based on medical knowledge - while struggling with its moral underpinnings and the shifting of personal power relations. Furthermore, alongside working on others, the SLTs spoke of the job requiring them to work on themselves - that is, as a personal labour process. They described needing to 'adjust' their own evaluation of personhood and of situated citizenship:

> I need to listen, what does being a mum mean to her, to this family. Not to me, not according to me, to her, to them. I might not start from the same place as them, but I need to adjust (SLT30-22 years)

Throughout, the SLTs spoke of their work as a multidimensional labour process, which involved reimagining people, across roles and time (e.g. old and new Bill) and managing what they themselves, as well as others, take being human to mean. The SLTs described rescuing clients from social exclusion; working on and, to some extent, changing self and others in the process of airing and reconceptualising what life, personhood and citizenship is. When considering the complexity of this labour, it is reminiscent of Foucault's (1982:783) discussion of the pastoral, which he describes as 'being coextensive and continuous with life' as a result of its efforts toward the interweaving of rights and responsibilities of personhood and citizenship: salvation and rescue; sacrifice of self for others; reflection and confession; and a focus on the individual as part of the collective, while also considering the collective.

6. Conclusion

This study sought to better understand the workings of speech and language therapy and the work of SLTs, an understudied profession (Pring et al., 2012). Given issues of power, knowledge and complex modes of governing, it is argued that a Foucauldian lens offered considerable value; as prior research in diverse health spheres (Cowley et al., 2004; Crawshaw, 2012; Lancaster et al., 2017; Murphy, 2003; Shih et al., 2017; Waring et al., 2016). As expected, some knowledges were privileged in the governing and enactment of therapy. Yet, it was knowing how to work 'the system' and the 'wise' that were key to the workings of speech and language therapy.

The findings show that evidence-based practice (EBP) is ever-present in speech and language therapy, despite its apparent absence: its power circulated in a multitude of ways (Munro, 2012); disciplining, emboldening and troubling. EBP acted as a conductor for much SLT practice. It offered an important counterpoint. When EBP discriminated against those clients who do not present or cannot be governed within its limited frame, new knowledge came to the fore: how to work 'the system'. This systemic knowledge involved the shifting of subject positions and led to governmental resistance that was biopolitical, with a twist (Foucault, 1982; 2004). The SLTs drew on their knowledge of the discourse and politics within EBP to reframe 'spoiled' lives; co-opting clients (previously subjects of therapy) and crafting them into (bio)political objects. As objects of science, with the prospect of being 'fixed', co-opted clients were given a political voice and valued as co-investigators in the search for evidence (while, of course, gaining support).

Yet, EBP is not the only system that SLTs work within. EBP sits alongside other forms of professional regulation and these systems of governance interact. Competent practice requires a) drawing on evidence, clinical practice and each client's needs and b) being reflective (RCSLT, 2006). The SLTs reflect on their practice in clinical review meetings. Every participant spoke of the review meetings as being customary, but they were also described as ceremonious in the way in which case files are opened and their content revealed while peers and supervisors listened. As an integral part of becoming and being a competent SLT, the meetings are sites where governmentality is enacted - entwining discourse, power, knowledge and meaning (Foucault, 1982) - and are therefore powerful rituals in building and maintaining identity.

In his discussion of rituals, Goffman (1956) notes that people guard and design the symbolic implications of their acts while in the immediate presence of an object that has special value to

them. This research skews Goffman's account. Here, it is seemingly the absence of a valued object (evidence) that is symbolic and has implications. Building on Goffman, Collins (2004) offers three conditions in which rituals are most powerful, when there is a) focused awareness, b) barriers to outsiders / insider status and c) shared emotion. All three conditions were spelled out by the SLTs. The meetings were spoken of as being focused on issues of concern in a collegial environment ('it's what speechies do') and where feelings on 'tough cases' are openly shared. Collins argues that the three conditions of 'ritualistic' gatherings make them emotionally charged and thus highly and personally impactful.

For the majority of SLTs, the meetings have personal impact; it is during the review meetings that EBP becomes 'real' in bodily experiences: experienced SLTs spoke of doubting if what they know is of value to their less experienced colleagues and the profession, and therefore questioning if this knowledge ought to be shared. At the same time, the less experienced SLTs described doubting what they were hearing; arguably, hindering their professional development. Here, data suggest that in the context of the pastoral/confessional review meetings, 'clinical practice knowledge' is subjugated (Foucault, 2004); and the relationship between knowledge and self-knowledge becomes a technology of the self (Foucault, 1986). More specifically, it is argued that, much like the historical view of therapy, the meetings serve to highlight the gap between SLTs' idealised selves (competent) and their realised selves (doubting and/or questioning) (Foucault, 1988). This finding raises questions about the way in which reflective practice might hinder the development of competent, pragmatic SLTs; so too for other contexts where reflective practice is lauded, such as healthcare, human resource management, education and social work.

The role of an SLT is to support and enable individuals to act as citizens; and to maintain or achieve citizenship. Indeed, the SLTs spoke of their work as involving 'making' people who

can achieve personhood within a situational frame; yet, what constitutes personhood is deeply personal and the frame temporal and context-specific, often influenced by biopower and biopolitics (Foucault, 1982). As such, SLTs are, by necessity, governed by and responsive to different views of what a valuable life is and what being a citizen means. Central to their work, therefore, is facilitating and invoking discussions; mediating conversations around and between different ways of being in the world; and, often, supporting people toward reimagining personhood, across roles and time.

In this undertaking, SLTs use a range of governmental apparatuses - power, knowledge, knowing and discourse - in framing, reframing and seeking to optimise lives (Foucault, 1982; 2004). Drawing on the 'right' kind of knowledge and utilising it in a way that is legitimated and can be known by the different audiences is key to this process (Sadler et al., 2018; Waring et al., 2016). As such, SLTs mediate and merge knowledges, whether evidence-based or not (Shih et al., 2017); moving between medical and familial knowledge and practice, while privileging neither but working both. Here, SLTs work with fellow professionals; on and with clients; and on, with and through others (the 'wise'), but they must also work on themselves. Much like emotional labour (Hochschild, 1983), SLTs' work effort necessarily involves labouring on self, while also labouring toward others who must act as interactants (Goffman, 1972). Specifically, for each client, family and circumstance, SLTs' labour to 'adjust' their idea of personhood and what they (and others) take being human to mean.

The SLTs spoke of undertaking this process of reconceptualisation while simultaneously working to 'make' people who can 'reveal their innermost secrets' (Foucault, 1982:783); know themselves; engage with others; and, sometimes, understand their changed role within the family or society. Thus, SLTs' work is productive of citizens, citizenship and of its meaning and is inseparable from it. The power drawn upon in carrying out this work is participative and

relational, individual and collective, productive and responsive, inherently and inescapably 'of all and of each' (Foucault, 2000:xxvii); as such, it is pastoral power (Foucault, 1982). Supporting, inspiring, responding to and circulating the power inherent within pastoral apparatuses is intricate, challenging and multidirectional labour without which speech and language therapy - given its interactional nature (Goffman, 1972) - is impracticable. Thus, it is argued that in drawing on pastoral power, mediating and merging knowledges while also paralleling the complexities of conceptualising, supporting and realising personhood and citizenship, this labour is best represented by the term 'pastoral labour': a form of labour that mediates understandings, knowledges and relations between parties, individually and collectively, with reference to the range of ways that life, personhood and citizenship might be conceptualised.

More work is to be done here to develop and build on this initial contribution. This study reflects the views of one community of allied health care professionals: speech and language therapists in the UK in a neoliberal climate with related procedures, practices and techniques. As such, the context, norms and location, along with the sample size, needs to be taken into account in considering the emergent themes. Yet, it is argued that this study sheds light on issues that are likely to resonate with other allied health professional groups, and maybe beyond. Given the rise in ageing population, post-stroke survival rates, dementia diagnosis, and recognition of neurodiversity, increasingly workers are going to need to engage with those who have different ways of being in the world, and their carers and/or families. Therefore, this study's findings are likely to be of interest to those of us who work in, are supported by or simply wish to better understand the labour involved in speech and language therapy, and health and social care more broadly.

References

Abbott, A. (1988). *The System of Professions: An Essay on the Division of Expert Labor*. Chicago, IL: University of Chicago Press.

Armstrong, L., & Stansfield, J. (1996). A content analysis of the professional journal of the British Society of Speech Therapists I: the first 10 years. Spotlight on 'Speech' 1935-1945. *European Journal of Disorders of Communication,* 31, 91-105.

Arney, W.R., & Bergen, B.J. (1983). The anomaly, the chronic patient and the play of medical power. *Sociology of Health & Illness,* 5, 1-24.

Baeza, J.I., Boaz, A., & Fraser, A. (2016). The roles of specialisation and evidence-based practice in inter-professional jurisdictions: a qualitative study of stroke services in England, Sweden and Poland. *Social Science & Medicine,* 155, 15-23.

Benoit, C. (1989). The professional socialisation of midwives: balancing art and science. *Sociology of Health & Illness,* 11, 160-180.

Berg, M. (1995). Turning a practice into a science: reconceptualizing postwar medical practice. *Social Studies of Science,* 25, 437-476.

Broom, A., Adams, J., & Tovey, P. (2009). Evidence-based healthcare in practice: a study of clinician resistance, professional de-skilling, and inter-specialty differentiation in oncology. *Social Science & Medicine,* 68, 192-200.

Broomfield, J., & Dodd, B. (2011). Is speech and language therapy effective for children with primary speech and language impairment? report of a randomized control trial. *International Journal of Language & Communication Disorders,* 46, 628-640.

Brosnan, C. (2017). Alternative futures: fields, boundaries, and divergent professionalisation strategies within the Chiropractic profession. *Social Science & Medicine,* 190, 83-91.

Butler, C. (2015). Making interview transcripts real: the reader's response. *Work, Employment and Society,* 29, 166-176.

Collins, R. (2004). *Interaction Ritual Chains*. Oxfordshire: Princeton University Press.

Cowley, S., Mitcheson, J., & Houston, A.M. (2004). Structuring health needs assessments: the medicalisation of health visiting. *Sociology of Health & Illness,* 26, 503-526.

Crawshaw, P. (2012). Governing at a distance: social marketing and the (bio) politics of responsibility. *Social Science & Medicine,* 75, 200-207.

Dunnet, C.P., Sellars, C., McKenzie, K., & Wilson, J.A. (1995). Voice therapy for dysphonia - still more art than science? *International Journal of Language & Communication Disorders,* 30, 157-158.

Foster, A., Worrall, L., Rose, M., & O'Halloran, R. (2015). 'That doesn't translate': the role of evidence-based practice in disempowering speech pathologists in acute aphasia management. *International Journal of Language & Communication Disorders,* 50, 547-563.

Foucault, M. (1976). *The Birth of the Clinic: an Archaeology of Medical Perception*. London: Tavistock.

Foucault, M. (1978). *The History of Sexuality, Volume I*. New York: Vintage.

Foucault, M. (1979). *Discipline and Punish: The Birth of the Prison*. Harmondsworth: Penguin Books.

Foucault, M. (1982). The subject and power. *Critical inquiry,* 8, 777-795.

Foucault, M. (1986). *The Care of the Self*. London: Penguin.

Foucault, M. (1988). Technologies of the Self. In L.H. Martin, H. Gutman, & P.H. Hutton (Eds.), *Technologies of the Self: A Seminar with Michel Foucault*. London: University of Massachusetts Press, pp.16-49.

Foucault, M. (1991). Governmentality. In G. Burchell, C. Gordon, & P. Miller (Eds.), *The Foucault Effect: Studies in Governmentality*. Chicago: University of Chicago Press, pp.87-104.

Foucault, M. (2000). "Omnes et Singulatim": Towards a Criticism of Political Reason. In J.D. Faubion (Ed.), *Power. Essential Works of Foucault: 1954-1984,* New York, New Press, pp. 298-325.

Foucault, M. (2004). *Society must be Defended : Lectures at the Collège de France, 1975-76*. London: Penguin.

Foucault, M. (2007). *Security,Territory, Population: Lectures at the Collège De France 1977-78*. London: Penguin.

Foucault, M. (2008). *The Birth of Biopolitics: Lectures at the Collège De France 1978-1979*. Basingstoke: Palgrave Macmillan.

Fourie, R.J. (2009). Qualitative study of the therapeutic relationship in speech and language therapy: perspectives of adults with acquired communication and swallowing disorders. *International Journal of Language & Communication Disorders,* 44, 979-999.

Gallagher, A.L., & Chiat, S. (2009). Evaluation of speech and language therapy interventions for pre-school children with specific language impairment: a comparison of outcomes following specialist intensive, nursery-based and no intervention. *International Journal of Language & Communication Disorders,* 44, 616-638.

Garrett, Z., & Thomas, J. (2006). Systematic reviews and their application to research in speech and language therapy: a response to T. R. Pring's ‘ask a silly question: two decades of troublesome trials’ (2004). *International Journal of Language & Communication Disorders,* 41, 95-105.

Goffman, E. (1956). Embarrassment and social organisation. *The American Journal of Sociology,* 62, 264-271.

Goffman, E. (1961). *Asylums*. New York: Doubleday.

Goffman, E. (1963). *Stigma: Notes on the Management of a Spoiled Identity*. London: Penguin.

Goffman, E. (1972). *Interaction Ritual: Essays on Face-to-Face Behaviour*. Allen Lane, London: The Penguin Press.

Green, J., & Thorogood, N. (2014). *Qualitative Methods for Health Research*. London: SAGE.

Greenhalgh, J., Flynn, R., Long, A.F., & Tyson, S. (2008). Tacit and encoded knowledge in the use of standardised outcome measures in multidisciplinary team decision making: a case study of in-patient neurorehabilitation. *Social Science & Medicine,* 67, 183-194.

Greenhalgh, T., Howick, J., & Maskrey, N. (2014). Evidence based medicine: a movement in crisis? *BMJ : British Medical Journal,* 348.

Health and Care Professions Council. (2013). Speech and Language Therapists: Standards of Proficiency. London: Health and Care Professions Council.

Hochschild, A. (1983). *The Managed Heart: The Commericialization of Human Feeling*. Berkeley, CA: University of California Press.

Isaacs, D., & Fitzgerald, D. (1999). Seven alternatives to evidence based medicine. *BMJ,* 319, 1618.

Jones, L. (2018). Pastoral power and the promotion of self-care. *Sociology of Health & Illness,* 40, 988-1004.

Justice, L.M. (2010). When craft and science collide: improving therapeutic practices through evidence-based innovations. *International Journal of Speech-Language Pathology,* 12, 79-86.

Lancaster, K., Seear, K., Treloar, C., & Ritter, A. (2017). The productive techniques and constitutive effects of 'evidence-based policy' and 'consumer participation' discourses in health policy processes. *Social Science & Medicine,* 176, 60-68.

Litosseliti, L., & Leadbeater, C. (2013). Speech and language therapy/pathology: perspectives on a gendered profession. *International Journal of Language & Communication Disorders,* 48, 90-101.

Madsen, O.J. (2014). *The Therapeutic Turn*. London, UK: Routledge.

Martin, G.P. (2008). Representativeness, legitimacy and power in public involvement in health-service management. *Social Science & Medicine,* 67, 1757-1765.

Martin, G.P., & Waring, J. (2018). Realising governmentality: pastoral power, governmental discourse and the (re)constitution of subjectivities. *The Sociological Review,* 66, 1292-1308.

McCurtin, A., & Roddam, H. (2012). Evidence-based practice: SLTs under siege or opportunity for growth? the use and nature of research evidence in the profession. *International Journal of Language & Communication Disorders,* 47, 11-26.

Miles, M.B., & Huberman, A.M. (1994). *Qualitative Data Analysis*. Thousand Oaks, CA: Sage Publications.

Moffatt, F., Martin, P., & Timmons, S. (2014). Constructing notions of healthcare productivity: the call for a new professionalism? *Sociology of Health & Illness,* 36, 686-702.

Moore, D. (2011). The benevolent watch: therapeutic surveillance in drug treatment court. *Theoretical Criminology,* 15, 255-268.

Munro, I. (2012). The management of circulations: biopolitical variations after Foucault. *International Journal of Management Reviews,* 14, 345-362.

Murphy, E. (2003). Expertise and forms of knowledge in the government of families. *The Sociological Review,* 51, 433-462.

Northcott, S., Simpson, A., Moss, B., Ahmed, N., & Hilari, K. (2018). Supporting people with aphasia to 'settle into a new way to be': speech and language therapists' views on providing psychosocial support. *International Journal of Language & Communication Disorders,* 53, 16-29.

O'Connor, S., & Pettigrew, C.M. (2009). The barriers perceived to prevent the successful implementation of evidence-based practice by speech and language therapists. *International Journal of Language & Communication Disorders,* 44, 1018-1035.

Oliver, M. (1983). *Social Work with Disabled People*. Basingstoke: Macmillan

Pickersgill, M. (2011). 'Promising' therapies: neuroscience, clinical practice, and the treatment of psychopathy. *Sociology of Health & Illness,* 33, 448-464.

Pilgrim, D. (2007). The survival of psychiatric diagnosis. *Social Science & Medicine,* 65, 536-547.

Pilgrim, D., & Rogers, A. (2009). Survival and its discontents: the case of British psychiatry. *Sociology of Health & Illness,* 31, 947-961.

Pring, T., Flood, E., Dodd, B., & Joffe, V. (2012). The working practices and clinical experiences of paediatric speech and language therapists: a national UK survey. *International Journal of Language & Communication Disorders,* 47, 696-708.

Randall, J., & Munro, I. (2010). Foucault's care of the self: a case from mental health work. *Organization Studies,* 31, 1485-1504.

Robertson, S., Kerser, M., & Davies, S. (1995). From the College of Speech Therapists to the RCSLT. A History of the College 1945-1995. London: RCSLT.

Rose, N., & Miller, P. (2008). *Governing the Present*. Cambridge, UK: Polity Press.

Roulstone, S. (2011). Evidence, expertise, and patient preference in speech-language pathology. *International Journal of Speech-Language Pathology,* 13, 43-48.

Royal College of Speech and Language Therapists. (2006). *Communicating Quality 3* : RCSLT's guidance on best practice in service organisation and provision: London.

Ruari-Santiago, M. (2017). On the advancement of therapeutic penality: therapeutic authority, personality science and the therapeutic community. *Sociology of Health & Illness,* 39, 1258-1272.

Sadler, E., Hawkins, R., Clarke, D.J., Godfrey, M., Dickerson, J., & McKevitt, C. (2018). Disciplinary power and the process of training informal carers on stroke units. *Sociology of Health & Illness,* 40, 100-114.

Sataloff, R.T. (2017). *Professional Voice: The Science and Art of Clinical Care, 3-Volume Set*: Plural Publishing.

Shih, P., Worth, H., Travaglia, J., & Kelly-Hanku, A. (2017). Pastoral power in HIV prevention: converging rationalities of care in Christian and medical practices in Papua New Guinea. *Social Science & Medicine,* 193, 51-58.

Timmermans, S., & Berg, M. (2003). *The Gold Standard: The Challenge of Evidence-Based Medicine and Standardization of Health Care*. Philadelphia, PA: Temple University Press.

Wahlberg, A. (2007). A quackery with a difference - new medical pluralism and the problem of 'dangerous practitioners' in the United Kingdom. *Social Science & Medicine,* 65, 2307-2316.

Waring, J., Latif, A., Boyd, M., Barber, N., & Elliott, R. (2016). Pastoral power in the community pharmacy: a Foucauldian analysis of services to promote patient adherence to new medicine use. *Social Science & Medicine,* 148, 123-130.