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Colloquium 'Art meets Medicine'

Title: VOICE – the science and art of self and social self.

Voice - the science and art of self and social self

The voice is often described as our most personal attribute. Caring for people with concerns regarding their voice is based on the understanding of the complexity and diversity of the forces affecting it. Although the unique qualities of our voices are determined to a great extent by our individual bodies, what distinguishes them from other personal attributes is that our voices are actively produced. Furthermore, our voices are actively shaped to achieve various social meanings. If we would speak to strangers who cannot see us, they might infer from our voices a lot and what different people would attribute to us varies a lot depending on socio-cultural forces affecting their perception of our voice. They might guess our age, our gender and our background or try to determine how we are feeling, and what kind of persons we are. A speaker can try to mold what people hear, achieve various social meanings, and project a particular image.

A comprehensive understanding of the forces affecting the voice, based on a transdisciplinary conceptual approach, can best inform clinical practice. What has the ability to influence the voice production, regarding voice function and the speaker's socio-cultural positioning has been a topic of discourse in the voice literature. The voice is defined in the medical literature as a product of respiration, phonation, and resonance. The voice production is being regarded as being shaped by the body structures, the physiological condition and functioning of the speaker. The anatomical structure and condition of the voice organ are seen at a biologically determinist view, to be shaped by genetic, biological, hormonal, neurological, mechanical, chemical, or thermal forces. Additionally, the voice can be shaped by the speaker's vocal behavior. Several patterns of habitual voice use are considered as harmful to the voice organ or inefficient and principles of motor learning are being used to modify voice misuse behaviors. Furthermore, socio-cultural forces affect the speaker's socio-cultural positioning which is viewed by social sciences as "something we actively do" in the context of interpersonal communication. As listeners, we are affected by our hearing and by our own sociocultural determinants to how we perceive a person's voice. Auditory features that can be measured objectively such as pitch and loudness, may be experienced and evaluated differently but the speaker and the listeners. Whether the pitch of a voice, is judged to be too high can be dependent on situational expectations, age, or gender, therefore determined by the listeners' expectations.

There is a longstanding discourse in the scientific voice literature about the bases for the classification of voice disorders and for the therapeutic processes that are expected to change people's vocal experiences. Professional interventions (behavioural, medicinal, surgical) mostly aim to change the biological condition and functioning of the speaker. A transdisciplinary conceptualization suggests that approaches to intervention should be informed by the speakers' lived experiences, and acknowledge and address all the forces that shape the production of voice. The stakeholder model of voice research in occupational voice

users, acknowledges the greater complexity to evaluate voice function when the voice is needed to engage the listener's attention and communicate a message.

People-centered care, a principle of contemporary medicine, must be respectful of and responsive to individual patient preferences, needs, and values and provided in ways that ensure that patient values guide all clinical decisions. Uncertainty is an inherent part of healthcare. Shared decision making is affected by our ability to gather, process, and communicate the available information. When taking care of people with voice concerns asking the person about what matters to them is the most critical step: "How does it affect you - What are you hoping to achieve from treatment - What are you not willing to risk". We can use the best available evidence to help inform the healthcare decisions we make with the people we are consulting with and we need to be aware of our own and their possible cognitive and affective biases and implement strategies to try to minimise their effect on our decision making.