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How Conceptual Frameworks Influence Discovery and Depictions of Emotions in Clinical Relationships

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Although emotions are often seen as key to maintaining rapport between speech–language pathologists and their clients, they are often neglected in the research and clinical literature. This neglect, it is argued here, comes in part from the inadequacies of prevailing conceptual frameworks used to govern practices. I aim to show how six such frameworks have served to blind clinicians to the positive and central role emotions play in therapeutic interactions. I will then turn to another set of frameworks that do emphasize emotions in clinical interactions. I draw from this second set of frameworks to devise criteria for what a reframed view of emotion needs to be able to depict within the context of rapport. My aim is to capture better and reveal the positive role of different emotions in clinical interactions. My hope is that a new construal of emotional interaction will keep us, as clinicians, from having to play a kind of hide-and-seek game where we are forced to look around, behind, or under our prevailing conceptual frameworks to see how emotions infuse our interactions and serve to create what we have called rapport. **Key words:** *affect attunement*, *conceptual frameworks*, *conduit metaphor*, *emotions in interaction*, *information processing*, *medical model*, *social-emotional model*

CLINICIANS and clients, when asked in ways that are nonthreatening, can easily convey how they feel about one another and their therapy interactions. Also, if asked, they are likely to indicate how emotions often have been key in achieving therapeutic success. Despite their felt importance, emotions are often neglected in the research and clinical literature on clinical processes. This article aims to explain this neglect by showing how typical conceptual frameworks used in the field of communicative sciences and disorders have little room for emotions. In those rare instances where emotions are considered, they tend to be framed as pathological, seen as either causing communication disorders or as resulting from them. This article aims to illustrate how six such conceptual frameworks have neglected emotions or cast them in a negative way. These frameworks are then compared with another set of six frameworks that portray emotions more positively.

FRAMEWORKS THAT HIDE EMOTIONS

Six frameworks prevail in the field of communication sciences and disorders that serve as guides to research and practice. I will show here how, in one way or another, all of them fail to consider the positive role of emotions in therapeutic interactions.

Linguistic framework

One popular framework for depicting communication and its disorders focuses on how

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messages are constructed linguistically. Most language research and practice since the 1970s has treated language as a multilayered set of boxes with each representing a different kind of linguistic knowledge. There are four or five levels shown: phonology, morphology, semantics, syntax, and sometimes pragmatics. Little space is made for emotions in this box-and-arrow construal of language.

An influential version of this classic linguistic framework is Bloom and Lahey's (1978) well-worn three-circle diagram of what goes on in child language acquisition and disorders (Bloom & Lahey, 1978). These authors divided language learning into *form* (including phonology, morphology, and syntax), *content* (semantics), and *use* (pragmatics). Twenty years later, Bloom and her colleagues began to study how emotion permeates children's earliest language expressions (Bloom, Beckwith, & Capatides, 1988; Bloom & Capatides, 1987). Finding the three circles of linguistic representation insufficient, Bloom added another circle to her framework—one she called *engagement*. This time, she included circles representing affect and social interaction. So, Bloom's way of inserting emotion into a linguistic framework was to add another circle, separated from other levels of language content (Bloom, 1998).

Message passing framework

Another preponderant framework often used to portray communication is to see it as a game of "catch" in which information, packaged as linguistic messages, is thrown from one person to another and back again. Communication in this view is seen as a nonoverlapping, turn-taking, back-and-forth message-passing activity.

Reddy (1979) offered a detailed description of how this game of catch depiction of communication works conceptually. He analyzed how ordinary people describe communication and found that they depict ideas as objects and that they portray communication of those ideas as objects being packaged in language containers and sent over an imagined conduit to a recipient. The recipient then unwraps or interprets the language to arrive at the ideas sent by the communication partner. Reddy focused on how people describe the communication process, revealing what he has called a conduit metaphor that is used to create conceptual coherence when describing different facets of communication.

This message-passing game of catch pervades our clinical practices. It underlies the production-perception dichotomy that we use in speech assessments (Baker, Croot, McLeod, & Paul, 2001), as well as the production-comprehension dichotomy underlying our language assessments. It also undergirds intervention that is designed to remediate comprehension and production of psycholinguistic units (Kovarsky & Walsh, 2011).

The message-passing view precludes thinking of communication as overlapping or synchronized, something like would be evident if one substituted a dance metaphor for the conduit metaphor (Duchan, 1993). The conduit view also forces one to think about clinical interactions in message-passing terms, rather than as involving emotional connections between clients and clinicians. That is to say, emotions in this framework, are messages that can either be expressed or interpreted by partners in a communication interaction.

Language processing framework

Even more elaborated forms of the conduit metaphor can be found in clinical and research tool-kits. These intricate conceptual frameworks focus not only on the back-and-forth part of communication, but also on ways that messages are created in the mind of the sender and how those messages are interpreted in the mind of the receiver. Such mental representations are also often cast as box-and-arrow drawings, where the boxes represent a kind of knowledge or processing and the arrows that enter or leave each of the boxes show the direction information travels as it goes from one box to another (Stackhouse and Wells, 1997). In so-called bottom-up processing, the direction of information and arrows proceeds from the periphery to central processing; in top-down processing,

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it goes in the reverse direction, from central to peripheral (Duchan & Katz, 1983).

Emotions usually get short shrift in these language processing frameworks. When emotions are represented, they have been depicted either as an add-on module in the processing schema, as was Bloom's (1998) approach, or they are portrayed as a domain independent of the other areas of language processing (Brinton & Fujiki, 1993). A detailed version of this separation is offered in Baker (2001), who created a full box-and-arrow model devoted to the processing of emotions. Neither the add-on nor independent approaches have been widely used in the research literature, nor have they been picked up in the clinical literature related to communication disabilities.

Medical model

Another way emotions have been depicted in the communication disorders literature is by adopting the medical model. This medical framework views communication breakdowns as impairments, usually pathological in origin. It calls for explaining the breakdown by identifying its etiology or cause. Once the etiology or multiple etiologies are identified, a remedial course is designed to remediate the symptoms, circumvent them, or eliminate the cause. (See Thagard, 1999, for a lucid and more detailed version of the causal chains that are used in medicine to conjure up the components of disease.)

In this medical framework, emotion "disturbance" is described as causing communication problems. The causal relationship has been portrayed in various ways (Prizant & Wetherby, 1990). One is as causal agent, another is as a symptom caused by other conditions. In each of these theories of causality, emotions are portrayed as a problem area in a causal chain, an area that deserves attention when designing remediation.

Among those communication problems that have been associated with emotional problems are elective mutism, schizophrenia, bipolar affective disorders, and conditions associated with autism spectrum disorders. Indeed, there is a literature in each of these types emotional problem in which the very nature of the relationship between emotion and communication disabilities is hotly debated. For example, autism was once regarded as an emotional psychiatric condition—as a lack of affective content that resulted in symptoms such as mutism, echolalia, or pronominal reversals (Kanner, 1943). This older psychiatric view has since been replaced by other emotionally based causal theories of autism. Among the most prevalent is a theory that autism and related disorders are caused by "mindblindness," otherwise known as a problem with creating a theory of mind (Baron-Cohen, 1995). That is to say, people with autism do not know that "other people know, want, feel, or believe things" (Baron-Cohen, Leslie, & Frith, 1985, p. 38). Prominent in the condition of mindblindness, according to its proponents, is the inability to detect the emotions of others—a condition that leads to their communication difficulties (Leslie, 1991; Baron-Cohen, 1995).

Emotional causes also have been used to account for other communication disabilities such as stuttering. These so-called emotionally based psychological etiologies have held sway throughout the history of stuttering, as is evidenced in the recent historical movie, *The King's Speech*, that takes place between 1925 and 1939. In it, Lionel Logue, an elocutionist, probes King George VI about his childhood fears to get at the root of his stuttering problem. Therapies based on emotional etiologies have often focused on getting clients to control the fears and anxieties that are seen as disrupting fluency.

The medical model not only provides a framework for casting emotions as etiologies, but also for portraying them as symptoms. For example, there are robust literatures showing how communication problems such as aphasia, traumatic brain disorders, or stuttering can cause emotional problems. These emotional symptoms are often referred to as psychosocial or socioemotional ramifications of a communication disability (Brinton & Fujiki, 1993; Prizant & Meyer, 1993). Prizant

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and Meyer (1993) have offered a succinct list of emotionally based symptoms that can result from language and social communication disorders in children, including "limited social initiation and withdrawal, disturbances of mood and affective expression, relationship disturbances with caregivers or peers, and irritable or noncompliant behavior" (p. 56).

Naming emotions

Once people have been identified as having emotional problems, therapeutic programs have been designed that target the problematic areas. For example, children who have difficulty detecting emotional states in others are provided with therapy programs to help them learn different types of emotions (Casserly, 2011). This is done by having the children name different feeling states such as *sad*, *mad*, or *happy*, and then matching the names of the states to pictures or scenarios featuring those states. The focus in this case is on helping children build a vocabulary that they can use to either express or interpret discrete categories of emotion.

Energy metaphor

Still another prevalent framework for construing emotions is the use of an energy metaphor (Kövecses, 2000). Therapies designed to help people control their emotions are based on the notion that emotions involve different states of arousal. When arousal levels are excessive, emotions, like energy, need to be regulated (e.g., Prizant, Wetherby, & Rydell, 2000, p. 212).

The SCERTS model, designed by Prizant and colleagues (2006) for children on the autism spectrum, has focused directly on ways to promote emotional regulation. The aim in the program is to attain *optimal arousal* "So that the child is not experiencing predominant patterns of arousal of being too 'high' or too 'low' with regards to the social and physical environment, or fluctuating too frequently between such extreme states of arousal" (Prizant, Wetherby, Rubin, Laurent, & Rydell, 2002, p. 8).

Among the methods for helping children regulate their high levels of arousal is the following recommendation:

> . . . of soothing activities such as listening to music or looking at favorite books, the application of a "sensory diet" throughout the day, and having quiet relaxing space may help a child to maintain emotional regulation throughout the day. (Prizant, Wetherby & Rydell, 2000, p. 213)

Therapeutic approaches incorporating the energy metaphor also infuse the counseling literature. Counseling methods have been designed to support people as they "work out" or "cope with" emotional reactions to disability in their family members or themselves. The idea is that the energy of the emotion needs to be vented or contained. Some counseling programs have targeted specific emotions, such as the grief and loss that parents experience when their child is diagnosed as having a disability (Friehe, Bloedow, & Hesse, 2003; Luterman, 2006; Tanner, 1980). Other programs have focused on controlling negative feelings, such as guilt, denial, anger, embarrassment, discomfort, demoralization, and depression that are caused by people's communication disorders (Clark & Martin, 1994; Fourie, 2011; Holland, 2007).

Among the most prevalent of the therapies based on an energy metaphor are the various desensitization approaches designed to face and then minimize the negative emotions associated with communication disabilities (Ham, 1986; Van Riper 1973). Van Riper, in his book on stuttering, argued as follows:

> Since the fears, avoidance, and struggle which characterize advanced stuttering stem from its unpleasantness, an unpleasantness which tends constantly to grow stronger, no therapy can hope for success unless it seeks directly to reduce it. (p. 434)

Desensitization is designed to help people recognize their anxieties and fears and face them head-on so as to overcome or control them. Van Riper (1973) explained this idea

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when promoting desensitization therapy with people who stutter:

> He comes to us full of anxiety and shame, unable to confront his problem, disguising it, avoiding contact with it. Through a preliminary period of desensitization we calm him and gentle him enough so that he can do this new learning. And as he realizes he is coming to grips with his problem and making progress, his morale goes up and his fears go down. And so does his stuttering. (p. 299)

Summary

As has been seen, emotions are often ignored in clinical practice because the frameworks used do not provide a comfortable place for them. When they are focused on, the emphasis is to treat emotions as impaired or problematic and as located inside an individual. None of the renderings captures the positive and dynamic role emotions can play when clinicians and clients engage with one another in the course of clinical interactions. None, therefore, provides the needed conceptual structure for understanding the positive role of rapport.

Table 1 depicts the six frameworks discussed and their limitations with regard to emotions and social interaction. Three commonly used frameworks that leave little room for emotions are those depicting communication as linguistic levels, message passing, and language processing. These frameworks occur in different varieties and are sometimes referred to collectively as psycholinguistic approaches. The diagnostic framework associated with the medical model does consider emotions, but in a negative role, as either causing or resulting from communication disorders. Approaches designed to remedy dysfunctional emotions have sometimes focused on teaching the vocabulary of feeling states, with the hope that such treatment will provide a way for people who lack emotions or are blind to them to experience and understand them. Other therapies such as those involved in emotional regulation or counseling base their approaches on energy metaphor and seek ways to release or control levels of excess emotional arousal or negative feelings.

Table 1. Frameworks that Obscure the Dynamic and Interactive Role Played by Emotions in Clinical Interactions

Framework	Limiting features
Linguistic framework	Depicts levels of language structure—with no level dedicated to emotions
Message passing, conduit metaphor—a game of catch	Depicts communication as a game of catch, with messages serving as the ball. Emotions, if included, could be seen as one type of message content that can be sent or received.
Language processing framework	Depicts different kinds of processing—There are no boxes showing emotions
Naming emotions	Depicts emotions as words. Words describing emotions are taught to children who have difficulty expressing their own emotions or understanding emotions of others.
Energy metaphor	Depicts emotions as energy forces that can get out of control and therefore require regulation, desensitizing, or counseling.

FRAMEWORKS THAT REVEAL EMOTIONS

The previous section focused on the failure of typical frameworks to provide a place for emotions. It also was argued that common frameworks that do consider emotions fail to capture their positive and central role in social interaction. In this section, the emphasis is on frameworks that better display the social impact of emotions. In particular, it describes six ways authors in speech–language pathology have portrayed the emotional dynamics of rapport in clinical interactions. They are ways that have been used

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to frame and describe the role of emotions in relationships so as to make them more positive, accessible, and understandable.

Everyday descriptors of emotion

A wide variety of nontechnical terms have been used to describe emotion of two partners in interaction. The everyday use of these terms when describing such interactions suggests that emotions are often seen as key when talking about rapport. Examples of commonly used descriptors are: *mutual trust, empathy, sympathy, mutual affection, mutual respect*, and *emotional intimacy*. Emotion-based terminology also has been employed in contexts warning novice clinicians to maintain their emotional distance, objectivity, and aloofness so as to avoid subjective bias in decision making (e.g., Fuchs, 1987). Warnings also are levied about the dangers of too much emotional intimacy between clinicians and clients for fear that close relationships can lead to clients' emotional dependency. Taken together, these ways of construing emotions as distance and intimacy work together in a systematic way, offering some beginnings for designing ways of thinking about the role of emotions in clinical interactions.

Clinicians' personal traits

Another way that emotional dynamics of clinical relationships have been treated is by identifying clinicians' emotions as expressions of empathy toward their client (Goldberg, 1997). Fourie (2009), for example, listed several such traits that adult clients highlight as desirable when describing their speech and language pathologists' performance. These include "being understanding, being gracious, being erudite, and being inspiring" (p. 1). These positive traits are portrayed as being located in the clinician (Fourie, 2009; Goldberg, 1997). That is, they are described as internal feelings or stances that clinicians take toward their clients. Clinicians convey their internal feelings to their clients as messages in much the same way that they would convey nonemotional information to their clients.

Emotional attachment

A third way emotion in clinical relationships is sometimes discussed is under the rubric of emotional attachment. The idea of attachment, drawn from the fields of psychoanalysis, ethnography, and infant development (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969; Stern, 1985; Trevarthen & Aitken, 2001), pertains to the emotional bonds and emotional communication between partners in a relationship. The focus here is on how partners feel about one another rather than on how one partner communicates an emotion to another. Associated with attachment is the idea of *intersubjectivity*, which is the common bond held between participants on the basis of common feelings and understandings. Geller (2011) has used intersubjectivity when talking about the "therapeutic alliance" between clinicians and clients. In her words, intersubjectivity is "the shared implicit relational knowledge that two people have concerning themselves and the other person, and how they are together" (p. 201).

Affect attunement

A related and more systematic way of depicting the role of emotion in interaction is with ideas associated with "engagement" (Simmons-Mackie & Kovarsky, 2009). Simmons-Mackie and Kovarsky have described *engagement* as an interactional achievement between participants in which "the engagement level of one party can affect the degree of involvement of other parties in a social exchange" (p. 6).

These authors focused their idea of engagement on how people tune in to each other's level of involvement, noting the following:

> If one party in a two-way conversation disengages, then the maintenance of this mutual functional state dissolves, and the conversation is likely to fail. In other words, during communicative exchanges, participants attend to what others say, and they also attend to the degree to which others are involved in activities (Simmons-Mackie & Kovarsky, 2009, p. 6).

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Stern (1985) also used the metaphor of being "in tune" in his discussion of "affect attunement." In Stern's studies of interactions between adults and infants, he offered detailed examples of how adults and infants emotionally engage with one another nonverbally. The partners pick up on one another's rhythms, sounds, and vocal and movement intensities as they create poetic, musical, and emotionally infused exchanges.

A 9-month-old boy bangs his hand on a soft toy, at first in some anger, but gradually with pleasure, exuberance, and humor. He sets up a steady rhythm. Mother falls into his rhythm and says, "kaaaaa-bam, kaaaa-bam" the "bam" falling on the stroke and the "kaaaaa" riding with the preparatory upswing and the suspenseful holding of his arm aloft before it falls. (Stern, 1985, p. 140)

Language attunement

Attunement of emotions also has been shown to happen through language. For example, Snow (1996) presented a number of ways that adults respond to their children's verbalizations by altering their language input to mesh with that of the child. She also included in her discussions of fine-tuning the ways that adults and children respond to the emotional content of the other's language.

Adult exchanges also can have these qualities of attunement, as is shown in the work of Tannen (1989). In her book, *Talking Voices,* Tannen described discourse devices that promote dialogic resonance between partners. These include repetition of another's words, rhythms, and imagery; poetic and repetitive refrains; synchrony in timing between speakers; and telling one another personal stories.

Language attunement is typically tucked into discussions of the techniques of counseling. For example, Flasher and Fogel (2004), in their book on counseling skills for speech–language pathologists and audiologists, devoted a chapter to what they called "therapy microskills." Included are ways of reflecting back to clients the feelings they have just expressed. Some know this technique as a Rogerian approach (after the psychotherapist Carl Rogers). Flasher and Fogle provided the following example:

Child with a repaired cleft lip and palate: Kids still tease me at school about how I look and my speech, so I just avoid everybody and play by myself.

Clinician: Michelle, you have been hurt a lot by kids and are trying to avoid getting hurt any more. Is that what's happening?

Child: Yeah. It just isn't worth trying to talk and have them make fun of me. (Flasher & Fogle, 2004, p. 144)

Climates promoting rapport

Lastly, there are a number of writers who have discussed positive emotional contexts, or what these authors have called *positive* or *safe climates* for fostering social engagement (Duchan, 2009; Geller, 2011; Pound & Duchan, 2007). In such climates, clinicians' assume an accepting, unhurried stance so as to allow clients to feel safe to express their personal experiences and to tell their life stories (Kovarsky, 2008). These are sometimes in contexts of troubles telling, small talk, playing with toys, or planning—all discourses and events in which the focus is not on the quality of the client's performance but on getting to know one another, accomplishing something, or playing together (Hewitt & Byng, 2003; Pattison & Powell, 1990; Walsh, Regan, Sowman, Parsons, & Mc Kay, 2007). These are the climates that are often recommended for building rapport (Pattison & Powell, 1990).

SUMMARY

Table 2 summarizes this second set of framing devices for representing emotions in clinical interactions. A key distinction between these depictions and those in Table 1 is that in this second set of frameworks, emotions are positioned as a necessary and positive part of the clinical relationship. Some of these depictions (everyday descriptors and clinicians traits) treat the source of positive emotions as residing in the clinician. Others, focusing on attachment as well as affect and language

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Table 2. Ways of Bringing the Emotional Side of Interactions Into View

Depictions of emotion	Examples
Everyday descriptors	When people use terms such as *empathy*, *mutual trust*, and *intimacy*, to describe feelings about relationships.
Clinicians' personal traits	When clients describe clinicians as being understanding, gracious, and inspiring
Emotional attachment	When partners co-construct emotional content of their interactions
Affect attunement	When an interactant displays rhythmic, vocal, verbal, and gestural resonances with the affect of another's talk.
Language attunement	When adults are said to fine tune their language to fit children's emotional state or when clinicians verbalize their clients' feelings.
Climates promoting rapport	When conversational partners engage in small talk, troubles talk, play—events that are familiar, relaxed, and free from evaluation.

attunement, locate emotions in the interaction and treat them as being coconstructed by the participants. The literature on emotional climates focuses on how contexts can best promote positive emotions between partners.

This second set of six frameworks, when taken together, can offer a glimpse of what reframing of emotions in interaction could look like. The model should be one that includes how different emotions might differentially impact interactions. To do this, it needs to have a vocabulary for describing different emotions, as well as an associated set of constructs, such as clinician traits that differentiate and promote positive emotions. The reframed model also should be able to represent mutuality in emotions such as trust, intimacy, and rapport. This focus on mutuality could draw from research on empathy and respect that communicative partners hold for one another. The model also can draw from the attachment and engagement literature and include a way of locating emotion in how partners achieve affect and language attunement. This locates the emotion in the relationship rather than within each separate partner. Finally, a complete understanding of the role of emotion in relationships would need to acknowledge the important role emotional climates can play in fostering positive interactions.

CONCLUSION

I began this article by arguing that the prevailing frameworks for rendering communication and its disorders make us blind to the pervasive, positive, dynamic, and interactive role that emotions play in rapport building. I then turned to a second set of constructs or frameworks for viewing the role of positive emotions in social contexts, ones drawn from various literatures. This second set, I have argued, offers more constructive ways of understanding what goes into rapport building. I ended with a brief sketch of what a framework would need to have to depict the dynamic nature of rapport between clinicians and their clients.

I included the following in these framing devices: (1) the need for a variety of constructs and vocabulary for depicting different kinds of positive emotions; (2) an ability to locate emotions in interactions not just in people, but between them; (3) a way of considering the dynamic and coconstructed nature of emotions in those interactions; and (4) a way of including the role of emotional climates that foster such interactions. It is my hope that we keep these ingredients in mind when finding

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ways of bringing emotion out of hiding and of giving its just due in our studies of rapport and of other emotions associated with clinical relationships.

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