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Counseling and Aphasia Treatment

Missed Opportunities

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During clinical interactions between speech–language pathologists and adults with aphasia, a variety of emotional issues arise. The literature suggests that while counseling is within the scope of practice, SLPs tend to avoid emotional issues in therapy (A. Holland, 2007a). The precise mechanisms employed for circumventing emotional issues in speech–language treatment sessions and the source of such behaviors have not been explored. An ethnographic microanalysis of 4 individual aphasia treatment sessions was undertaken to identify and describe discourse strategies associated with "missed" counseling opportunities. Several strategies for avoiding counseling were identified including focusing on "facts," engaging in superficial "staged" conversation, deflecting emotion with humor, and shifting to "objective" therapy tasks. Interpretation of these data suggest several possible reasons for these clinical behaviors including avoidance of awkward social situations and intimacy, narrow views of the job, and learned professional values. **Key words:** *aphasia*, *clinical interaction*, *counseling*, *emotion*, *therapy*

APHASIA is defined as a language disorder resulting from damage to the brain (Davis, 2007). However, in addition to the language disability, aphasia produces significant psychosocial consequences for the person with aphasia and family members (Brumfitt, 1993; Code & Herrmann, 2003; Gainotti, 1997; Herrmann & Wallesch, 1989; Holland, 2007a, 2007b; LaPointe, 1997; Muller, 1999; Sarno, 1993). For example, in a summary of investigations regarding aphasia, Herrmann and Fehr (2007) reported that "aphasic patients and their relatives suffer from a considerable amount of professional, social, familial, and psychological stress" (p. 18). Issues such as the loss of employment due to aphasia can impact social roles, relationships, and financial security. Difficulties with communication diminish self-esteem and confidence. Moreover, people with aphasia often experience coexisting deficits such as hemiplegia or visual impairments that further complicate their lives. Although speech–language treatment for aphasia is designed to improve language and communication, it is likely that the coexisting issues faced by people with aphasia will emerge during clinical interactions between the speech–language pathologist (SLP) and client with aphasia (Ireland & Wotton, 1996).

Issues that arise within the context of aphasia treatment range from relatively simple worries about a pending decision to pervasive problems such as serious financial, health, or marital issues. When such issues arise in treatment, SLPs are faced with the task of how to manage the clinical relationship and ensuing clinical interaction. Walsh (2007) and Walsh and Duchan (2011) have suggested that "troubles telling" can

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pave the way for more successful and positive therapeutic relationships when clients and clinicians engage in mutual discussion of troubles. Moreover, Walsh and Duchan noted that troubles sharing in treatment can facilitate rapport building. Thus, management of emotional issues or "troubles" would appear to be an important component of the clinical relationship.

In the SLP literature, the management of issues related to feelings, stress, or difficult personal decisions typically has been situated within the realm of counseling. Webster (1977) described counseling in speech–language pathology as listening to what people say, helping clients to express feelings, giving relevant information, and outlining options. Holland (2007a) suggested that counseling occurs "around the edges" of more direct communication treatment and urged SLPs to respond to counseling issues during sessions. The American Speech–Language–Hearing Association (ASHA, 2007) suggested that counseling of individuals with communication disorders is within the speech–language pathology scope of practice and counseling should be considered an integral part of clinical responsibility.

Although counseling individuals with communication disorders appears to fall within the SLP scope of practice and the aphasia literature supports the importance of addressing psychosocial consequences of aphasia, many SLPs appear to avoid delicate or emotional issues during aphasia treatment sessions (Dilollo, 2011; Holland, 2007b; Luterman, 2001). In a chapter on group treatment for aphasia, Penman and deMare (2003) reported that the therapist tended to feel "out of one's element" when a client raised delicate issues such as spousal relationships or personal finances. They described a typical treatment response as follows: "I would briefly acknowledge the personal comments but then quickly move back to the communication task at hand or else 'subvert' the comments into communication activities" (p. 93). Holland (2007b) reported that "SLPs often feel uncomfortable about the counseling role, and consequently tend to avoid it." She noted further, "This occurs even though most of the counseling opportunities in speech–language pathology relate to coping with lives that have been changed by communication disorder, not to psychopathology" (p. 2).

Although subjective reports have revealed that many SLPs resist the counseling relationship in clinical interactions, no research has specifically determined how SLPs manage delicate subjects, personal decisions, or the emotional issues of clients. Therefore, this project was designed to investigate clinician management of "counseling opportunities" in aphasia treatment sessions with a particular focus on "missed opportunities," in which the SLP avoids dealing directly with the potential counseling issue.

METHODS

Microanalysis of discourse in an ethnographic tradition (e.g., Agar, 1986; Hymes, 1966) was employed to investigate counseling opportunities in individual aphasia treatment sessions. This qualitative analytic perspective focuses on the context, structure, organization, and content of discourse in an effort to understand how people negotiate social actions and how these actions display and perpetuate cultural beliefs and social practices. Analyses in this tradition have investigated how individuals with communication disorders participate in clinical interactions (Kovarsky, Kimbarow, & Kastner, 1999; Kovarsky & Maxwell, 1992; Simmons-Mackie, Damico, & Damico, 1999).

Data collection

The data for this investigation were drawn from four videotaped aphasia treatment sessions collected as part of a large, ongoing project aimed at analyzing clinical interactions in aphasia treatment. In addition, qualitative interviews were conducted with two of the SLPs involved in the videotaped treatment sessions as part of the larger study. These interviews were designed to access clinician perspectives regarding clinical

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[Overlapping utterances or turns
= Contiguous utterances with no interval between utterances
- A short untimed pause within the flow of talk
: A prolongation or stretching out of a sound as in "bo:::y"
. Falling or stopping inflection
, Continuing inflection
? Rising inflection (not necessarily a question)
! Animated tone
CAPS Capital letters indicate that an utterance is much louder than surrounding talk.
° ° An utterance enclosed in degree signs is quieter than surrounding talk.
(()) Double parentheses enclose a description of the setting or some phenomenon

Figure 1. Transcription notations.

interactions and were not designed specifically to address counseling opportunities. Quotes have been included from interview transcripts only where they clarified clinician behaviors reported in the current results. All treatment sessions were naturally occurring individual sessions; that is, regularly scheduled sessions were not modified for purposes of the study or for recording. Settings included a rehabilitation facility, an outpatient clinic, and a university clinic. Sessions were videotaped using a stationary camera that captured all participants. All individuals were accustomed to being videotaped as part of routine clinical procedures. Sessions ranged from 45 to 73 min in length. Video segments of interest were orthographically transcribed (see the Figure 1 for transcription notations). The institutional review board approval was obtained from facilities participating in the study and procedures complied with ethical principles and guidelines for the protection of human participants in research.

Participants and setting

Treatment sessions included one SLP or SLP clinical practicum student and one client with aphasia. Session 1 also included the wife of the person with aphasia. Participants with aphasia exhibited no complicating communication conditions such as dementia, dysarthria, or hearing loss. Characteristics of clinicians and participants with aphasia are presented in Tables 1 and 2, respectively.

Data analysis

The primary investigator cycled through videotaped sessions in an attempt to identify "counseling opportunities" that naturally arose within the sessions. Counseling opportunities were defined as instances when an issue arose that was not directly related to a treatment task and to which the client oriented with a negative emotion (e.g., anxiety, frustration, and distress). Once a counseling opportunity was identified, the opening and closing markers of the segment were identified (i.e., the introduction and the termination of the topic). In addition, aspects of the setting, characteristics of participants, speech acts, affective tone, structural characteristics of the discourse, and semantic content of segments were analyzed (Hymes, 1966). In this way, descriptions of "counseling opportunities" were produced and patterns across segments were identified.

Although the larger corpus of data included segments showing SLPs engaging in

Table 1. Characteristics of Speech–Language Pathologist Participants in Aphasia Therapy Sessions

Sample number	Gender	Age (year)	Education	Experience	Setting
1	Female	~25	MS degree	2 years	Rehab facility
2 & 3	Female	~35	MS degree	10 + years	Outpatient clinic
4	Female	~30	Graduate student	2 months	University

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Table 2. Characteristics of Participants with Aphasia

Sample number	Client	Age (year)	Gender	Diagnosis	Aphasia type	Time post onset
1	"Pete"	67	Male	Left CVA	Severe Broca's	~1 month
2 & 3	"Clare"	50	Female	Left CVA	Moderate–Severe Broca's	~1 year
4	"Sandy"	52	Female	Left CVA	Anomic	~4 yrs

Note. CVA = cerebrovascular accident.

successful counseling behaviors, the data selected for this analysis focused on "missed" counseling opportunities in aphasia treatment. Moreover, the study was not designed to address the frequency of occurrence of missed counseling opportunities or their association with clinician experience; rather, the study aimed to demonstrate that missed counseling opportunities do occur and to raise awareness of this potential in clinical practice.

RESULTS

Examples of "missed counseling opportunities" were identified in clinical interactions conducted by an experienced SLP, a relatively new SLP, and an SLP student clinician. Clinicians within the missed opportunity segments did not display "active listening," nor did they orient to the concerns or feelings being expressed by clients; rather, they employed a variety of strategies to avoid dealing directly with issues. Characteristic of these interactive segments was an affective difference between the client and the clinician, with clients displaying an emotional orientation to the topic (such as heightened interest, anxiety, or worry), whereas the clinicians distanced themselves from these affective displays. In these instances, the clinicians did not help clients voice or explore their own attitudes, emotions, or beliefs regarding the issues, provide significant information or advice to allay concerns, or overtly assist clients in dealing with the issues raised—all actions that are considered important aspects of counseling (Holland, 2007b; Webster, 1977); rather, clinicians produced a variety of strategies for avoiding these counseling opportunities. These strategies included sticking to the "facts" or "known information," engaging in superficial or "sham" conversation that prevented in-depth discussion of issues, using humor to deflect emotion, and diverting attention away from the emotional issue and toward treatment tasks. Following are samples that demonstrate clinician management of missed counseling opportunities.

Sample 1: Focusing on the facts

In the first example, the SLP appears focused on imparting "facts" about a client's assessment results, while neglecting the emotional impact of the results on the client and his wife.

Activity: The SLP (CLIN) in session 1 has just completed an initial outpatient assessment of Pete, a person with severe aphasia, and the SLP is now relating the results to Pete and his wife.

1. CLIN: So his scores show that he has . . . uh . . . pretty seve::re aphasia and
2. something called apraxia of speech.
3. That . . . .that has to do with the motor movements . . .
4. moving your lips[and ..
5. Wife: [He can move his lips.
6. CLIN: Yea . . . he does but he has trouble making movements for speech . . . at least making
7. movements that are the right ones.. um . . . for speaking. So that is a big problem.
8. Wife: Oh mmm

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9. CLIN: He has a lot of trouble with word finding,
10. See here the score is only 20% on naming pictures.
11. Pete: ((eyes are starting to get tears))
12. CLIN: And his writing is very poor.
13. Pete: Why? Why? ((leans toward CLIN, gazing intensely))
14. CLIN: It's the aphasia Pete . . . that is what I'm showing you . . . it's because of the apha::sia
15. ((writes aphasia on paper)) . . .
16. Pete: ((Pete's eyes are red and tearful))
17. CLIN: The stroke damaged your language area in the brain ((points to head)).
18. And here are the comprehension scores . . . these look a bit better.
19. Wife: °Okay° ((reaches over to Pete and puts her hand on top of his))
20. CLIN: So do you have any questions?
21. Wife: He has gotten a lot better. He couldn't talk at all . . . nothing.
22. I mean . . . what ((XX)) expect?
23. CLIN: He probably will improve, but we can't really predict how . . . how much.
24. If I could do that I could make a fortune ((short laugh))
25. ((Closes folder and pushes back in chair))
26. ((Wife and Pete stand))
27. CLIN: So I'll call you and we'll get started soon.

This SLP describes Pete's communication disorder as revealed on her objective tests. Her utterances are designed to impart factual information as evidenced in the array of professional terms (e.g., *aphasia*, *apraxia of speech*, and *word finding*) and objective test results (lines 9, 17). Her utterances are dominated by acts of "informing." Furthermore, the informing moves of the clinician are designed to enumerate Pete's problems as exposed on the assessment. When the wife attempts to minimize one problem (line 5, "he can move his lips"), the clinician escalates the degree of the problem (line 7, "so that is a big problem"). The SLP supports the litany of problems with facts (e.g., line 10, "See here the score is only 20% on naming pictures").

By contrast, Pete and his wife appear to be participating on a more emotional level as indicated by Pete's tears, his wife's gesture (line 19), and questions indicating that the offered facts might not address their needs (lines 13, 22). When Pete emotionally asks "why why" in line 13, the clinician responds with a fact—the diagnosis. One might speculate that Pete's "why" is more than a request for a diagnosis; rather, on the basis of the tone and reiteration of the word, it is probable that it is a plea for discussing bigger issues—emotional issues that arise frequently among people with aphasia (e.g., Why me? Why is this happening?). In contrast to what is expected in clinical interactions oriented toward counseling, the SLP does not overtly respond to the emotional display of Pete and his wife by asking them about their experience with aphasia, by helping them to verbally identify and reflect on their emotions, or by supporting an exploration of their apparent fears for the future.

There is also a discrepancy in key or emotional tone between the SLP and the clients. This disconnect is apparent in lines 19 and 20 when Pete's wife places her hand on top of Pete's in a touching show of solidarity and support. Instead of acknowledging and echoing this sign of support, the SLP immediately proceeds in a professional tone to ask, "Do you have any questions?" This question, although superficially appearing to open the floor to Pete and his wife, actually serves as a form of closing. The SLP has related the facts and is making a perfunctory offer for any needed clarification of the facts. When the wife asks "what to expect," she is shifting the topic away from a litany of objective facts to a clinical "gray area." Prognosis is difficult for clinicians to address because definitive outcomes or specific stroke recovery trajectories and time lines do not exist. The SLP's closing attempt at humor serves to deflect the vague and emotionally loaded topic of the future and again demonstrates dissonance between the

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orientation of the clients and the seeming dispassion of the clinician.

Sample 2: The "staged" conversation

Aphasia treatment sessions typically begin with a period of casual conversation, usually initiated by the SLP. This opening represents rapport building between the client and the clinician (Ferguson & Elliot 2001; Horton, 2003, 2004; Simmons-Mackie & Damico, 1999). Walsh (2007) emphasized the importance of casual conversation or "small talk" for relationship building and cited Coupland, Robinson, and Coupland (1994), who suggested that small talk in medical encounters often serves as a bridge "into more troubles-oriented exchanges" (Walsh, 2007, p. 93).

In the following sample, the SLP opens with a relatively casual question that harkens back to a prior discussion of physical therapy scheduling; however, the SLP's subsequent behaviors suggest that the question is not, in fact, a genuine attempt to open a dialogue or small talk, but rather, a mechanical attempt at the obligatory conversational opening for a staged conversation. The sample occurs during the first few minutes of an individual's aphasia treatment session between Clare, a woman with moderate Broca's aphasia, and an experienced SLP (CLIN). At the time of the sample, Clare has been having a problem with her outpatient therapy schedule. The physical therapist had requested that Clare move her physical therapy session to the late afternoon. This would leave Clare with an unfilled gap of several hours between speech and physical therapy.

1. CLIN: Did you get your physical therapy schedule straightened out?
2. Clare: I don't know ((shrugs)) is yea ((hand out and shrugs))
3. I don't know ((hand out and shrugs)) Later . . . see
4. CLIN: They're gonna try and keep it the same I understand.
5. Clare: Yea ((shrugs, hand out))
6. CLIN: Okay alright. Let's run through ((clears throat)) and look at our pictures.

The SLP initiates the topic of the schedule with a question in line 1. Because the schedule has been a concern for Clare, it appears that the clinician is offering to discuss an important issue during the opening conversation. One might expect this to initiate a "counseling" interaction to ensure that the ongoing issue has been resolved. In her response in line 2, Clare appears to consider that scheduling remains unsettled. This is visible in Clare's intonation, her repetition of "I don't know," and her questioning gestures (shrugs and hand motion). Apparently, Clare continues to believe that physical therapy might be moved to a later time and continues to worry about this. The SLP perfunctorily reports that the therapy time will remain the same (line 4), and quickly moves on to introduce a treatment task in line 6. Thus, the SLP not only dismisses Clare's concerns by stating the "fact" that the schedule will remain the same (line 4), but also seems to reveal that she already knew the answer to her own question.

The interaction feels like a "staged" or "mock" conversation, with the SLP offering and quickly closing a topic to move on to the actual treatment tasks. Clare is not fully satisfied that the issue has been resolved, as evident in line 5, where Clare acknowledges the clinician's statement but layers questioning gestures on top of the acknowledgment. Although scheduling is not a major life problem, it is a topic of considerable concern to Clare. Yet, the clinician, who raised the issue herself, quickly dismisses Claire's apprehension and moves on to the scheduled tasks. The SLP's "conversational opening" is not a genuine attempt at conversation or discussion, and Clare's (possibly unexpected) concern has spoiled an effort to hold a quick and superficial chat before the work of treatment proceeds.

The sham conversational opening is consistent with Walsh and Duchan's (2011) concern that clinicians sometimes orient to "rapport building" as a simple and superficial exchange that is controlled by the clinician and typically introduces treatment. Walsh and Duchan argued that successful rapport building is more

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appropriately viewed as a "process" that pervades the treatment relationship and involves egalitarian and open exchanges between the clinician and the client.

Sample 3: Humor as an emotion deflector

In the following excerpt, Clare and her SLP (CLIN) are again discussing an issue of concern to Clare (part of a larger segment discussed in Simmons-Mackie & Damico, 1999). This session takes place months after the session in sample 2, at a time when Clare and her daughter are worrying that Clare will soon be discharged from occupational therapy, physical therapy, and speech–language therapy because insurance is running out. The SLP has spoken to Clare's daughter several days before and is now talking to Clare about the daughter's worry that Clare is being discharged.

1. CLIN: She is worried that I might discharge you real quick.
2. She said, "Are you going to discharge Clare?"
3. I said, "NO".
4. Clare: Yes? ((sits forward with an intense questioning look))
5. CLIN: She was asking if I was getting ready to discharge you.
6. Clare: Mmmm I don know. Money . . . I don't know ((shrugging))
7. CLIN: I don't know why she thought that.
8. Are you getting ready to get discharged from OT or PT?
9. Clare: I don't know, what? ((Shrug and nod))
10. CLIN: Not OT I know.
11. Clare: Is money I don't know?
12. CLIN: Oh Money? Like insurance?
13. Clare: yea ((brow knitted in serious expression, sitting forward in chair))
14. CLIN: How many times you going to OT?
15. Clare: Two
16. CLIN: How many times you going to PT?
17. Clare: Two
18. CLIN: Two too? Two too! ((breathy laughter))
19. Clare: Yea . . . here ((holds up 3 fingers)) three::::
20. ((intense look and leans forward more))
21. CLIN: And here three. Right! Good!
22. Okay, I'm gonna put 10 pictures out . . . .

The SLP opens the segment by raising the issue of potential discharge and initially seems to be reassuring Clare that she will not be discharged. Clare immediately shows heightened interest in the topic via her forward body lean and a questioning facial expression suggesting concern. In line 6, Clare raises the core of the issue—money (i.e., insurance coverage). Although the SLP demonstrates that she understands Clare's worry with a clarification question in line 12 ("Oh money? Like insurance?"), the SLP avoids addressing this concern and goes on to ask questions that do not appear to be directly related to the worry about discharge ("How many times you going to OT?"). Rather than exploring Clare's anxiety about discharge, the SLP guides the talk away from the topic and concludes in line 18 with breathy laughter and a humorous play on the homonyms "two too." Breathy laughter (line 18) is often a signal of discomfort (Fink & Walker, 1977; Jefferson, 1984; Jefferson, Sacks, & Schegloff, 1987; Simmons-Mackie & Schultz, 2003; Wilkinson, 2007). Although the issue of treatment discharge might not seem like a particularly weighty one, it is often difficult for SLPs to face client disappointment and anxiety regarding discharge. Thus, it is likely that this clinician is signaling her own discomfort with the line of talk although she attempts to lighten the tone with the silly repetition of "two too."

Notice that Clare does not take up the laughter (line 19); rather, she continues to look concerned with an intense facial expression. Clare's failure to laugh or join in the humor differs from the examples offered by Walsh, in which clients used humor or laughter themselves to mitigate embarrassment or discomfort, while telling about their own troubles. Here the client is communicating a

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"trouble" while the SLP is using laughter or humor to avoid taking up the troubles talk. The use of humor to deflect a difficult topic was also apparent in sample 1 (line 24). In fact, in sample 1 the probability that humor served to mask discomfort or embarrassment of the clinician was supported on interview of Clinician 1, who stated that she was very uncomfortable and felt embarrassed to see a man cry.

Sample 4: Introducing tasks

The next sample occurs within an individual session between an SLP practicum student and Sandy, a client with moderate anomic aphasia. At the start of the session the clinician has raised the topic of cooking and a conversation has ensued. As the sample opens, Sandy is describing cooking for her husband at their home.

1. Sandy: I fix somethin' and he eats it!
2. CLIN: Well, I think you're a good cook Miss Sandy.
3. Sandy: I don't know. Before the stroke I had a good hand
4. and I messed it up and I do my leg too ((pats right leg)).
5. And um they get me . . . ummm
6. They QUIT . . . Rehab QUIT
7. ((leaning forward, gazing steadily at CLIN, hand extended))
8. CLIN: Done with rehab! ((nodding))
9. Sandy: Yep
10. CLIN Did they give you exercises?
11. Sandy: NO::: I . . . no . . . I . . . no
12. One time I went to rehab and they give me exercise
13. and I don't do em . . . I fall down an =
14. CLIN: = I'm glad you're doin 'em.
15. That can make a difference.
16. ((opens folder with score sheets & plans))

After the student clinician compliments Sandy's cooking (line 2), Sandy raises concerns about her right hemiparesis. In line 6, Sandy expands the topic from her disability to her discharge from physical and occupational therapy. Her choice of phrasing "they quit, rehab quit" is interesting because it suggests that rehabilitation "quit her" versus "Sandy quit rehab." Her heightened emotion is conveyed (lines 6–7) in the increased loudness and repetition of "quit" as well as her forward body lean, gaze, and gesture. The emotion and the structure of the utterance suggest that Sandy feels abandoned by rehab. The clinician immediately reframes Sandy's utterance as "done with rehab." That is, she switches the "actor" from rehab to Sandy (Sandy is done with rehab). Also, the clinician brings the issue to the present tense, implying that "you are done with rehab in the present"; whereas Sandy refers to a past action or injustice. As the topic unfolds, it is clear that Sandy does not believe that she should be finished with rehabilitation. When the clinician asks, "Did they give you exercises?" Sandy responds with an exaggerated "NO:::" but then struggles to express her thoughts. This exaggerated loudness and lengthening of the vowel impart negative emotion—possibly frustration and disappointment.

As Sandy attempts to explain this, she struggles for the words to express herself and then gives a brief example of what happens when she does not do exercises. Although the semantic content of her utterances might lead to multiple interpretations, her emotional upset is apparent in this segment and she seems to be explaining a reason that she needs to be given exercises. The student clinician misinterprets Sandy's example of what happens when you do not do exercises and pulls the discussion back to the present, applauding Sandy for doing exercises ("I'm glad you're doing 'em"). Because Sandy has never said that she is doing exercises, and, in fact, seems to imply that she was not given exercises, this comment seems inappropriate. Quickly after these comments, the clinician signals nonverbally that a treatment task is about to ensue (opening the work folder), effectively closing the topic. One might wonder if the clinician's apparent misinterpretation of Sandy's comment about the exercises relates to Sandy's aphasia, to the clinician's distraction as she anticipates the treatment task, or to a desire to close the topic and get on with the work of treatment. Although this student clinician does follow-up on the factual basis of Sandy's

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concern ("Did they give you exercises?"), she does not explore Sandy's feelings about being discharged from treatment or discuss the issue in any depth. Rather, she exerts her control as therapist and moves quickly into planned treatment tasks.

This switch to the "work of treatment" is also apparent in sample 2, where the SLP effectively shifts from "discussion" of therapy schedules to the therapy task. In sample 2, the clinician recasts Clare's answer (the number of times she attends treatment) by evaluating the answer as a "performance" in line 20 ("And here three. Right! Good!"), effectively turning the series of utterances into a Request–Response–Evaluation sequence. This three-part sequence is typical of teaching and didactic treatment tasks and effectively places the therapist in full control of the sequence of talk (Cazden, 1988; Kovarsky & Duchan, 1997; Mehan, 1979; Panagos, 1996; Simmons-Mackie, Damico, & Damico, 1999). Thus, in both sample 2 and sample 4, the clinicians establish their role as SLP or teacher and shift to the planned task, effectively eliminating further discussion of the potential counseling topic.

DISCUSSION

Missed counseling opportunities were characterized by a variety of clinician strategies that successfully diverted talk from a potential counseling interaction. Throughout the examples of missed counseling opportunities, overt control of the session by the clinician was an overriding feature. Specific strategies for maintaining control included preferential selection of "factual" topics, staged conversational moves, invoking humor to deflect emotion, and shifting into treatment tasks. By controlling the topic, the discourse structures, and the focus of the discourse, clinicians avoided emotional or "vague" issues.

The literature is rife with descriptions of ways that SLPs exert control in treatment sessions, including choosing topics, allocating turns, orchestrating the timing of activities, and imposing specific discourse structures (e.g., Damico & Damico, 1997; Kovarsky & Damico, 1997; Kovarsky & Duchan, 1997; Leahy, 2004; Panagos, 1996; Simmons-Mackie & Damico, 1999). The SLP is the expert, the one offering help and the more "competent" communicator; these attributes create a power differential and are the source of the SLP's therapeutic control (Damico, Simmons-Mackie, & Hawley, 2005). Therapeutic control is not, of itself, a bad feature. It is purposefully employed to allow clinicians to create situations that will effect changes in the behavior of the client and fix the communication problem. However, examples have been offered of misuse of therapeutic control to the detriment of the treatment relationship between the client and the clinician (e.g., Simmons-Mackie & Damico, 1999, 2011).

In these missed counseling opportunity samples, therapeutic control is demonstrated in a variety of ways and is used on several occasions to derail the discussion of emotional issues. For example, in all four segments mentioned earlier, the clinicians use particular speech acts to divert the talk away from feelings. Speech acts of "informing" or "questioning" are deployed strategically within the segments. In all samples, the clinician chooses the timing and the manner of terminating the topic of interest. In samples 2, 3, and 4, the clinicians employ familiar treatment discourse patterns (task openings and request–response–evaluation sequence) that invoke the "therapist in control role" and shift the talk to planned tasks. Research suggests that clients readily recognize these structures and typically collaborate by assuming their "discourse place" within the interactive sequence (Bohkof & Panagos, 1986; Simmons-Mackie & Damico, 1999).

Another means of controlling the sessions and avoiding counseling opportunities involves the use of humor. Humor has the potential to divert attention away from difficult emotional situations and topics by changing the emotional "key" of the interaction from serious to more light hearted (Fink & Walker, 1977; Jefferson, 1984; Jefferson Sacks, & Schegloff, 1987; Simmons-Mackie & Schultz, 2003;

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Wilkinson, 2007). Thus, humor can work interactionally to help clinicians maintain control of the topic and tone of treatment, while simultaneously promoting rapport among the participants in emotionally charged circumstances (Walsh, 2007). Thus, clinicians employ humor as a means of controlling the tone of the interaction, while maintaining a level of rapport.

Clinicians were successful in taking control of clinical interactions and avoiding potential emotional or difficult topics in these samples. But why are counseling opportunities avoided? A variety of reasons can be inferred from our data and the relevant literature.

Dealing with awkward social moments

During interactions, people employ a variety of strategies in the context of "awkward" or embarrassing social encounters. Goffman (1959, 1967) has richly described social interactions and the propensity of people to behave in accordance with socially defined scripts and avoid awkward social moments. When a social convention is violated or when someone lacks a "script" to guide an interpersonal interaction, awkwardness, discomfort, and embarrassment can ensue (Keltner & Buswell, 1997; Goffman, 1959; Parrott & Smith, 1991). In clinical interactions, as individuals seek a way out of awkward or uncomfortable moments, rapport may be threatened or seriously damaged (Kovarsky & Walsh, 2011; Simmons-Mackie & Damico, 1999). During aphasia treatment, clinicians fulfill the expectations of the treatment "script" by opening with short conversations or "chit chat," introducing treatment tasks, managing tasks, and then closing the session (Ferguson & Elliot, 2001; Horton, 2003, 2004; Simmons-Mackie & Damico, 1999). Inherent in this scripted performance is familiarity with the social conventions of treatment and ability of the clinician to control the course of events. Discomfort may occur when the socially expected script is violated in some way, such as raising an issue that the clinician does not know how to solve or when the interaction deviates from typical treatment discourse sequences.

One clue to the discomfort of clinicians in the missed opportunity samples is the occurrence of nervous laughter. Nervous laughter can signal occasions when a participant orients to a topic or behavior as embarrassing or inappropriate (du Pre, 1998; Jefferson, 1984; Jefferson, Sacks, & Schegloff, 1987; Madden, Oelschlaeger, & Damico, 2002; Simmons-Mackie & Schultz, 2003; Stebbins, 1996). In both samples 1 and 3 mentioned earlier, the clinician engages in brief laughter that is not taken up by the client and likely represents the clinician's discomfort with the interaction. Fink and Walker (1977) suggest that humor or laughter is a technique used to "restructure the interpersonal interaction" when something has gone "awry" (p. 475). In samples 1, 3, and 4, humor is invoked by the clinician and involves a form of clinician control of the interaction, possibly to move the interaction back to a more comfortable course and reestablish some level of rapport.

Control also serves as a mechanism for avoiding unpredictable behavior and uncertain consequences. For example, expressions of emotion can be volatile and less easily managed than behavioral performance on objective tasks and rote conversations associated with superficial talk. Clinicians may fear that clients will become upset and "out of control" if they deviate from familiar interactive scripts and delve into potentially emotional topics. In an ethnographic study of compensatory strategies, Simmons (1993) reported an SLP who described client "outings" into authentic settings as difficult because of the sense of losing control, saying, "It feels like I always take responsibility for everything . . . like if they are going to need help or be upset I need to handle it . . . [] you just lose control of everything." This potential loss of control is an uncomfortable and possibly frightening experience. Thus, the multiple potential manifestations of clinician control within treatment sessions provide a powerful resource for clinicians who, whether consciously or

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unconsciously, avoid emotional or delicate issues, awkward social situations, and potentially "out of control" behavior in an effort to maintain a sense of positive rapport.

Issues of intimacy in clinical relationships

Related to avoiding awkward situations and discomfort, the issue of intimacy in clinical relationships is relevant to missed counseling opportunities. Discussion of personal topics or feelings tends to increase the closeness of a relationship and raises vulnerability and pain to the surface of the interaction. Once a problem is discussed on a subjective level, the parties engaged in the discussion become closer and tend to share in the associated emotions. In fact, neuroscientists have discovered physiological evidence that actions and emotions expressed by one person are experienced in "mirror cells" within the brain of other parties in the interaction (Rizzolatti & Craighero, 2004). It is possible that some SLPs have developed ways to insulate themselves from feeling the problems and emotions experienced by clients even as, paradoxically, they seem to promote rapport between themselves and their clients. Thus, clinicians might steer conversations away from "counseling opportunities" to diminish the intimacy of the relationship and the potential pain of sharing problems.

Doing the "job"

The American Speech–Language–Hearing Association (ASHA, 2007) has provided position statements and Scope of Practice documents that define various aspects of SLP practices. But how are these realized within each clinician's internalized "job description?"

Interestingly, clinical interactions provide a window into clinicians' conceptions of their roles and responsibilities. For example, clinicians use strategies to manage time and they allocate time to tasks or activities that are considered germane to client goals (Ferguson & Elliot, 2001; Horton, 2003, 2004; Simmons-Mackie, Damico, & Damico, 1999). Armstrong (1989) analyzed aphasia treatment sessions and reported that conversation was often truncated by clinician comments such as "let's get back to work," indicating that conversing is not "real treatment," and possibly considered as wasting time. Rather, real treatment consists of tasks aimed at remediating language impairment. Similarly, emotional or psychosocial issues that can surface during intense moments of interpersonal contact may not be considered within the definition of relevant treatment tasks that are eligible for prolonged attention within the treatment session (Simmons-Mackie, 1998). Thus, clinicians exert control to fulfill job expectations.

Also, it is possible that confusion exists regarding elements of the SLP scope of practice and professional roles. For example, SLPs have been trained to give information to clients as a primary role (ASHA, 2007). This role involves educating clients regarding their diagnosis and related issues. However, this educational role is often confused with the counseling role in speech–language pathology, also part of the scope of practice (ASHA, 2007; Luterman, 2001; Holland, 2007a, 2007b).

Thus, some clinicians offer information but fail to "receive" information from the client (Luterman, 2001). As Holland (2007a) suggested, "Counseling is primarily a listening process that is geared to understanding how the world looks to the person being counseled" (p. 215). Not until the clinician understands the perspectives of the client, can information be appropriately tailored to fit needs. Sample 1 is an instance of the SLP educating and giving information to clients, while simultaneously failing to fulfill the "listening" role, a necessary prerequisite to titrating the offered information to the needs of the client. Interestingly, during an interview at the conclusion of the session, the SLP stated, "I didn't know what to say." This statement is interesting because it might have been preferable not to "say" but to "listen."

Professional values

In the process of learning to be SLPs, SLPs are taught the importance of professionalism and they incorporate values consistent

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with the goal of being a professional (Worrall, 2000). Professional values and ways of acting influence SLPs' conduct in treatment. This involves not only aspects such as ethical conduct, appearance, and scope of practice but also more subtle enculturation of professional style and presentation. For example, professional values often include maintaining objectivity and professional distance. This is reflected in a manner of talk (e.g., using professional jargon) and in the topics suitable for discussion with clients.

Duchan (2001–2010) explored the rise of professionalism in speech–language pathology and notes the relationship of this professional discipline to the objective and dispassionate realms of science and medicine. By contrast, counseling requires subjectivity and passion, and decreasing professional distance from the client. Perhaps instantiated professional values of speech–language pathology as "hard science" create a conflict with the values inherent in a counseling orientation. Ironically, even though professionals recognize the importance of maintaining rapport in clinical interaction, they shy away from emotionally laden topics that have the potential to enhance the positive interpersonal relationships they are seeking to build.

SLP training

Clinicians often comment that they have not been trained as counselors and feel uncomfortable dealing with personal issues (Holland, 2007a, 2007b). Certainly when issues are raised that require a counseling professional (e.g., signs of psychopathology and deep-seated relationship problems), then clients should be referred elsewhere. However, as Holland (2007b) pointed out, most counseling in aphasia relates to the consequences of the communication disorder or to adjustment difficulties faced in life after stroke—difficulties such as asking questions of one's doctor, expressing concerns about rehabilitation, dealing with the loss of friends, or feeling excluded from conversations.

Although lack of training certainly might account for failure to address some issues in the course of treatment sessions, it is also possible that during "training" and clinical practicum, clinicians have actually been exposed to strategies for avoiding counseling opportunities. That is, clinicians may be inadvertently trained not to engage in counseling, possibly in favor of time management, "educating" clients, or other roles and responsibilities that have co-opted the counseling role. How many of us recall clinical supervisors imploring us to "get back on task" or "keep the client on track"? Have our training models emphasized the mechanics of task management at the expense of exploring the lived experience of aphasia—experiences that are lost as clinicians seek to control topics of conversation and build rapport in ways that do not fully recognize the personal lives of clients?

Studies of medical training suggest that medical students are "affectively socialized" via an unacknowledged curriculum through which they learn to remain visibly neutral or detached when faced with emotional patients (Francis, 2008; Lively, 2008; Smith & Kleinman, 1989). In this way, and often at the expense of positive outcomes, the "voice of medicine" comes to dominate the voice from the patient life-world (Mishler, 1984). "Objectivity, neutrality, and rationality have been considered the traditional role expectations for dealing with emotion in health care" (Apker & Ray, 2003, p. 356). Relatedly, many professions develop "display rules" regarding expression of emotion (Ekman, 1973); these rules are designed to help employees control clients and help promote organizational or professional goals (Sutton, 1991). It is likely that the communication disorders profession has incorporated unacknowledged display rules within professional training.

Incorporating counseling into sessions

The missed counseling opportunities reported herein are likely due to enculturated and habituated behaviors or avoidance of discomfort, rather than purposeful disregard of client needs. Moreover, the clinical samples presented here do not represent all SLPs and all therapy interactions. However, the study

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raises awareness of the potential for missed counseling opportunities and a need to consider this issue in clinical practice.

A range of strategies is available to clinicians to help incorporate counseling and sensitivity to client needs into clinical interactions. First, it seems imperative that SLPs explore and identify their own clinical values, beliefs, and habitual behaviors. Research describes differences in the underlying values and philosophical orientations of clinicians adopting "therapist-centered" versus "client-centered" treatment approaches (e.g., Simmons-Mackie & Damico, 2011; Worrall, 2000).

A clear understanding of the professional values underpinning one's treatment interactions is a foundation for modifying clinical behaviors. For example, the first excerpt discussed in the results section demonstrates a clinician who views her role as giving information and controlling the session. In a more client-centered collaborative approach, she might have started the diagnostic counseling session by telling the couple that she had learned a lot from the testing but would like to hear from Pete and his wife about their understanding of aphasia and how it has affected their lives. In this way, the clinician begins by "listening" to experiences and feelings and establishes a framework of respect for the knowledge and experience that clients bring to the session. A key tenet of counseling interactions is active listening on the part of the clinician; in fact "being heard" is an important aspect of healing (Holland, 2007a, 2007b). In the context of this collaborative interaction, the results of testing could have been layered in as needed to correct client misconceptions, expand on client knowledge, and allay fears. This would avoid the seemingly unfeeling and didactic educational stance adopted by the SLP in sample 1 and help the client and his wife better deal with both knowledge of and feelings about aphasia.

In fact, SLPs are uniquely qualified to help people with aphasia express their concerns, feelings, and opinions. As skilled "communication partners" during treatment interactions, clinicians can employ strategies for facilitating client communication by integrating principles of supported communication. A variety of strategies can help clients to participate in counseling interactions, such as additional response time, multimodality response options (e.g., gesture, drawing, or writing key words), pictographic supports, and verification of understanding (Kagan, 1998; Kagan & Gailey, 1993). For many clients, this is their only opportunity to discuss issues of importance with someone who is skilled in facilitating communicative participation. Although supported discussion of emotional issues might take time away from planned tasks, discussing emotionally difficult topics offers opportunities for relationship building, authentic communication practice, and successful experience with problem solving.

For clinicians, exploration of one's own responses to emotional topics in treatment helps build awareness of clinical practices. Strategies such as viewing videotapes of sessions or self-monitoring during sessions to consciously recognize moments of discomfort, embarrassment, or negative feelings help to identify emotional issues and counseling opportunities. Until such moments are raised to a new level of awareness, strategies for addressing missed counseling opportunities are difficult to implement. In addition, clinicians can become more vigilant when clients raise potential counseling issues. When potential "counseling moments" are recognized, then strategies typical of counseling, such as active listening, reflecting back what the client says, synthesizing stated issues, and exploring solutions in collaboration with the client, should be implemented (see texts such as Holland, 2007b; Luterman, 2001).

Another caveat for clinicians that is raised by the data reported herein relates to the importance and manner of rapport building in treatment. Rapport building should be viewed as an actual goal of treatment, instead of something incidental and superficial that occurs at the beginning of sessions. In samples 2, 3, and 4, the clinicians might have viewed the issues raised by clients as opportunities to

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engage in authentic dialogue about problems of importance to the clients. Thus, in sample 2, the clinician might have either avoided the topic of scheduling altogether or opened the session with a sincere statement and question such as, "I understand that your physical therapy schedule will remain the same; what have you heard?" In this way, the session opens with a respectful and natural discussion of the issue—a more appropriate approach to building rapport. If the client continued to express concern, collaborative problem solving might have resulted in a "joint" phone call from the SLP and client to the physical therapy department to verify the schedule. Collaborative problem solving and "supported" solutions not only allay anxiety but also provide practice in communicating and solving problems. Such actions position authentic communication activities (e.g., calling physical therapy) as an integral part of treatment rather than a "side activity" (Holland, 2007b; Simmons-Mackie, 1998).

CONCLUSION

People with aphasia face significant difficulties communicating with others. Because aphasia clinicians tend to have considerable skill in understanding and supporting the communication of people with aphasia, the aphasia treatment session serves as a potential outlet for the person with aphasia to voice worries and discuss decisions. In other words, aphasia treatment is a potential counseling situation. However, our aphasia treatment data support the observations of Luterman (2001) and Holland (2007a, 2007b) that some clinicians avoid counseling opportunities and emotional issues. Several mechanisms employed for avoiding counseling have been described and possible sources of this behavior have been offered. Further research is needed to access the perspectives of both clients and clinicians regarding counseling in aphasia treatment and explore the impact of these behaviors on outcomes.

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