Empathy as dynamic social meaning-making: Audience responses to patient-generated materials about endometriosis care

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Abstract

This article uses 25 Think Aloud interviews to investigate the ability of patient-generated multimodal materials about endometriosis health care in the National Health Service Wales, UK, to evoke empathy in others. Critically evaluating relevant findings from several disciplines, empathy is reconceptualized as a dynamic and context-dependent form of social meaning-making. The combination of thematic analysis with a dynamic-systems approach to discourse analysis enabled the distinction between four interactive processes involved in empathy – “recognition”, “resonance”, “alignment”, and “affiliation” – as well as revealing common linguistic resources used to express or withhold empathy in the data. Specifically, the study findings show that an individual’s socially situated identities, as well as their own experiences of a particular healthcare system, may encourage or impede their empathic responses to representations of other people’s suffering.

Keywords

Dynamic systems; empathy rules; health communication; National Health Service; reader responses; Think Aloud

1 Introduction

Empathy – broadly defined as recognizing, sharing, and responding with compassion to another's emotional state – is a key concept in several academic disciplines and fields of professional practice, including healthcare (Cuff et al. 2016; Jami et al. 2023; Zhang et al. 2024). Recently, there have been calls for a paradigm shift in how empathy is understood and studied. Eichbaum et al. (2022) criticize prevailing conceptualizations for being too focused on individuals, advocating instead for a "relational" understanding of empathy that is "dynamically attentive" to structural inequalities and social contexts (p. 644). Shapiro (2008) makes a similar point, arguing that people's ability and willingness to empathize with others is often shaped by cultural belief systems and ingrained institutional practices. While these authors are primarily concerned with empathy in interpersonal healthcare interactions, I argue that their criticism is equally applicable to research into audience responses to symbolic representations of illness experiences (Campbell and Babrow 2004; Peng et al. 2020; Shen 2019), as it, too, tends to concentrate on the message features that make an empathic response more or less likely, while ignoring the socially situated nature of any such effects. This makes it hard to know how to campaign effectively for the healthcare needs of particular patient groups to be recognized, for example.

This article uses the qualitative framework of "Think Aloud" (TA) (Van Someren et al. 1994) audience responses to a patient-generated, multimodal booklet about endometriosis to propose a more dynamic conceptualization of empathy. Endometriosis is a chronic gynecological disease affecting around 10% of women of reproductive age that is caused by endometrial tissue growing outside the womb and that is often associated with severe pain and other debilitating symptoms (Pugsley and Ballard 2007). Many sufferers report a lack of empathy on the part of others, including health professionals, which compounds the psycho-social impact of endometriosis and may delay diagnosis and treatment (Endometriosis UK 2024). These difficulties are reflected in the booklet used in the present study, which aimed to raise awareness of and increase empathy for women with this condition, with a focus on their experience of feeling insufficiently heard and understood by doctors working in the National Health Service (NHS) Wales.

The NHS occupies a unique place in the cultural imagination of the British people. When it was founded in 1948 by Clement Attlee's Labour Government, it was the first healthcare system in a western country to offer medical care that was free at the point of use to the whole population. Both working for the NHS and accessing its services are still seen by many through the lens of civic duty and patriotic sacrifice (Stewart 2023). However, rising costs associated with an aging population and ever more complex treatments, together with periods of systematic underinvestment, particularly by successive conservative governments, have led to a state of crisis. Although public commitment to the ideal of the NHS remains remarkably resilient, satisfaction levels are at a historical low (Morris et al. 2023). For people living in Britain, expressing a view about the NHS is thus inextricably bound up with their own values, social identities, and political affiliations.

Investigating empathy as a dynamic form of social meaning making requires a shift away from the survey-based quantitative research methods that currently dominate the field (see Wieck et al. 2022), toward a more qualitative approach that is context-sensitive and able to detect subtle changes and ambiguities in the way empathy is experienced and expressed. The present study uses a novel combination of TA interviews, thematic analysis (Braun and Clarke 2006), and a dynamic systems approach to discourse analysis (Cameron et al. 2009;

Cameron and Seu 2012), to examine both the content and the linguistic realizations of participants' responses to patient-generated materials about endometriosis.

The article starts by critically reviewing conceptualizations of empathy from a range of disciplines, arguing that crucial social and contextual factors are often neglected in empirical work in this field. Section 3 describes the data, methodologies and analytical procedures used in a small-scale qualitative study designed to address this gap in empathy research. In Section 4, representative data extracts are subjected to detailed thematic and linguistic analysis. The final chapter outlines the main findings and theoretical conclusions, as well as providing concrete suggestions for using TA interviews to investigate dynamic, social aspects of empathy.

2 Literature review

Empathy has been studied extensively from a wide range of disciplinary and theoretical perspectives, which has led to multiple distinct definitions of the concept (Cuff et al. 2016). Most scholars would agree, however, that empathy has at least three key dimensions: an instinctive emotional resonance with the other person's feelings; the more conscious and deliberate cognitive understanding and adoption of his or her perspective; and "empathic concern", involving "other-oriented feelings of care and compassion" (Fourie et al. 2017: 47).

A well-established finding in social psychology is that we are generally more likely to feel empathy for members of our own in-groups than for those we regard as 'other' (Fourie et al., 2017). However, perceived similarity does not guarantee an empathic response, nor is it a necessary precondition for empathy. In experiments that measured people's empathy for a fictional stranger in need, Batson et al. (2005) discovered that the target's appeal to instinctive nurturant tendencies (e.g., when the fictional stranger was a child or a puppy) was more highly correlated with empathy than perceived similarity (e.g., when the stranger was a fellow student). For another's perceived need for care and protection to trigger empathy, however, "the potential empathizer must value the target's welfare" (p. 24). In other words, if someone is considered unworthy of support, people may be less willing to respond empathically when confronted with their plight.

Sociological approaches emphasize the key role of "empathy rules", socially learned and internalized expectations about who should rightfully empathize with whom, and in which situations, in determining an individual's responses. For example, birth doulas may consider birthing women and their partners, but not hospital staff, to be unambiguously deserving of empathy (Ruiz-Junco 2017: 423). Similarly, male nurses in the US have been found to recognize and respond to opportunities for empathy less frequently than their female counterparts, despite being capable of the same levels of empathy in principle (Strekalova et al. 2019). This suggests that both neurobiological and social factors may be involved in the discovery of significant sex and gender differences in empathic responses, which appear to widen across the life span (Rochat 2023).

While the majority of work in empathy research focuses on empathic attitudes and behavior towards physically present others in everyday life and in the caring professions, there is also a growing body of research into empathy as an audience response to aesthetic or persuasive forms of communication, including feature films (Gallese et al. 2020), written narratives (Keen 2007), and public health messages (Campbell & Babrow 2004; Peng et al. 2020; Shen 2019). Indeed, it is becoming increasingly clear that there may be little functional difference between empathy in face-to-face situations and empathy in response to representations of the experience of physically absent or even fictional persons. Studies using brain imaging have led to the discovery of mirror neurons and embodied simulation processes that are activated in the brains of onlookers when they see, read about, or even just imagine, another's actions, perceptions, or emotional reactions (De Greck et al. 2012; Gallese 2009).

A common focus of research into empathic audience responses is on identifying any features of content or style that foster imaginative engagement with other people's experience, yet the effects of any such features are likely to be highly dependent on the medium and genre in which a message is conveyed. In audio-visual public health communication, for example, features that have been found to promote an empathic response include "vividness, gaze, realism, pain and suffering, social relationship, and emotion expression" (Shen 2019: 1335), as well as explicit realism or at least verisimilitude (Campbell & Babrow 2004). In the case of literature, by contrast, fictionality is considered by some to be more conducive to emotional responsiveness than factuality, because it releases readers from the felt need for skepticism regarding the author's sincerity (Keen 2007: 220).

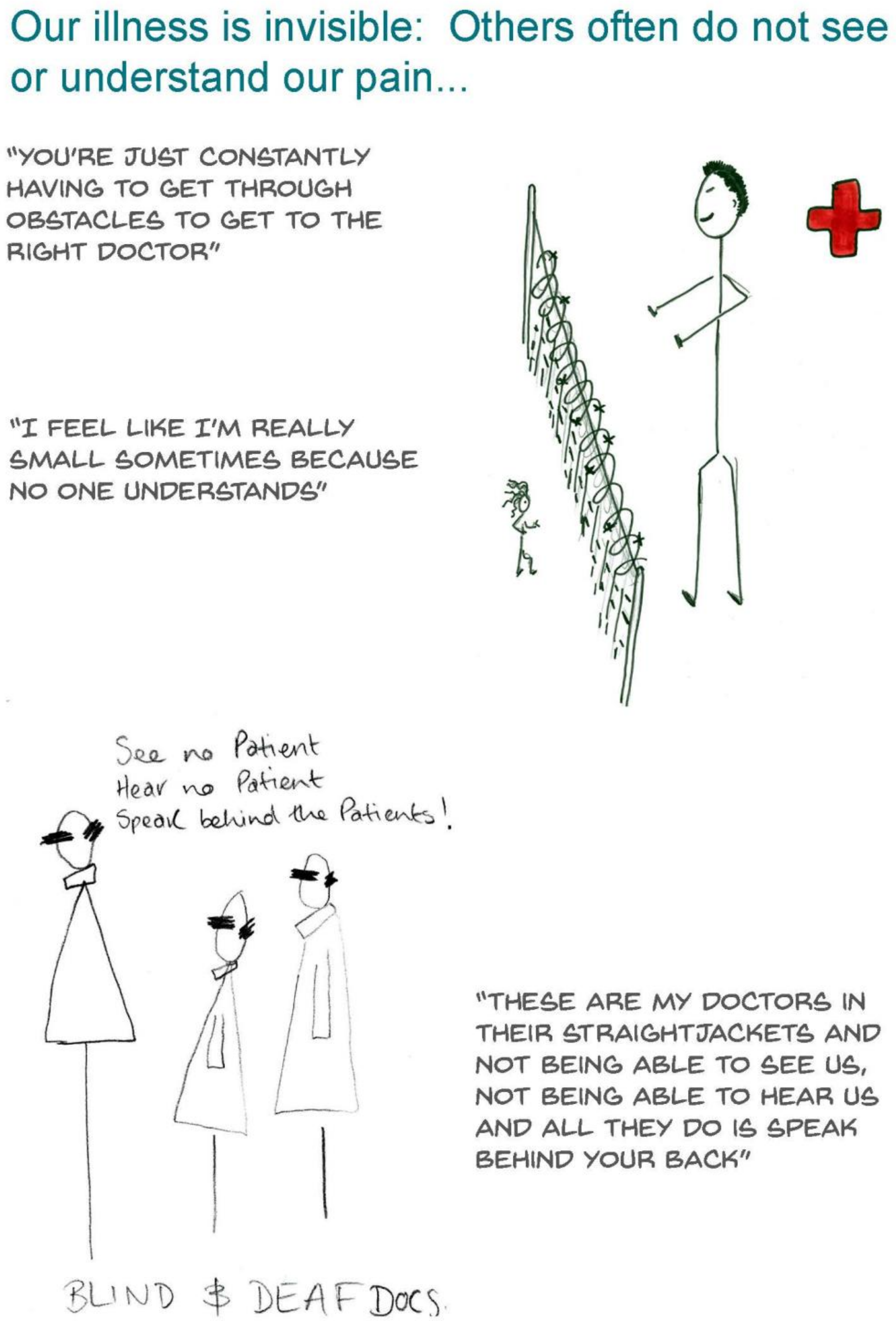
A critical review of the literature thus shows that empathy cannot be studied merely as the decontextualized response of one individual towards another. Rather, it is always related to a person's own social identities, their relationship with and sense of responsibility towards the target individual(s) in question, as well as the immediate situation and the cultural context within which a (real or symbolic) encounter takes place (Jami et al. 2023). Moreover, identities are not essential, stable properties, but contextually shaped constructions that are constituted in discourse, narratives, and social practices, and that can change over time (Bamberg et al. 2007). Our sense of allegiance with other individuals or groups, and our resulting willingness to empathize with them, is therefore also likely to be fluid and ever shifting.

It is this dynamic aspect of the empathic response that is often neglected in the relevant literature, where by far the most common research methods deployed to measure empathy are quantitative studies using post hoc self-report questionnaires (see Wieck et al., 2022). More qualitative approaches include the analysis of spoken interactions through particular coding systems (Bylund and Makoul 2002; Macagno et al. 2022) or Conversation Analysis (Ford et al. 2019; Weatherall 2023), though here again the focus tends to be on empathy as manifested in specific exchanges, without much consideration for the broader contexts within which these exchanges take place. A rare example of research that considers empathy as discursive meaning making is Cameron and Seu's (2012) analysis of focus group data to investigate empathy towards people affected by human rights abuses abroad. Their key finding is that witnessing beggars in the streets and being exposed to media reports of distant suffering lead participants to construct a symbolic landscape of empathic concern, with the optimal distance for empathy being one where the other is "near enough to be seen and understood but not entering the personal space" (p. 298). This demonstrates that individuals' responses are always embedded in wider socio-cultural discourses and power dynamics.

What is thus needed is an approach to the study of empathy that captures the context-sensitive nature of all human communication, especially where it pertains to something as complex as our willingness to engage imaginatively and emotionally with another's experience of a chronic health condition. Inevitably, this will be impacted by implicit cultural assumptions about the nature of illness, the perceived (gendered) roles and responsibilities of patients and medical professionals, and a person’s own experiences of accessing a particular healthcare system.

3 Data and methodology

The materials used as the basis for the present study were created during a DrawingOut (DO) workshop with 14 women with a diagnosis of endometriosis, run by a research team from Cardiff University led by Prof Jacky Boivin and including the author of this paper. DO invites participants to visualize their illness experience by drawing pictures of concrete creatures, objects, or places, and to share these with one another (Gameiro et al. 2018). An anonymized selection of the artwork and quotes from the women’s accompanying commentary was used to produce a 15-page long booklet, “Experiences of Endometriosis in Wales” (www.drawingout.uk/resources). Produced in partnership with the patient advocacy group “Fair Treatment for the Women of Wales”, it was designed to raise awareness among affected women’s friends, family members, and healthcare workers. Because of the present article’s thematic focus on endometriosis health care, detailed analysis will be restricted to reader responses to page 6 of the booklet (Figure 1), which consists of two drawings and three related verbal comments about the women’s sense of frustration over the poor standard of care they had experienced in the NHS Wales.



Our illness is invisible: Others often do not see or understand our pain...

"YOU'RE JUST CONSTANTLY HAVING TO GET THROUGH OBSTACLES TO GET TO THE RIGHT DOCTOR"

"I FEEL LIKE I'M REALLY SMALL SOMETIMES BECAUSE NO ONE UNDERSTANDS"

See no Patient
Hear no Patient
Speak behind the Patients!

"THESE ARE MY DOCTORS IN THEIR STRAIGHTJACKETS AND NOT BEING ABLE TO SEE US, NOT BEING ABLE TO HEAR US AND ALL THEY DO IS SPEAK BEHIND YOUR BACK"

BLIND & DEAF DOCS.

Figure 1: "Experiences of Endometriosis in Wales", p. 6.

The booklet subsequently formed the basis for 25 Think Aloud (TA) (Van Someren et al. 1994) interviews, which were conducted between March 2020 and June 2021 by seven Master of Arts students (six female, one male) as part of a credit-bearing "Research Experience" module at the School of English, Communication and Philosophy, Cardiff University, whose ethics committee approved the project. The 14 female and 11 male participants, with a mean age of 27 (range 19-59, one unknown), were recruited by the students, using convenience sampling. The only exclusion criteria were insufficient English and any direct personal or professional experience of endometriosis. The participants gave written consent in advance.

The purpose of the study was described to the participants as investigating how people respond to verbo-visual materials about endometriosis; the specific focus on empathy was not disclosed until after the interviews, via the debrief form. Because of restrictions imposed by the COVID-19 pandemic, some of the interviews were conducted online, while the others took place face-to-face in a private setting. The students received clear instructions and practiced the TA method on each other. They followed the same interview protocol, keeping their own interventions to a minimum (e.g., to remind interviewees to keep talking if they fell silent for too long, or to proffer reassurances that "there are no right or wrong answers").

After asking some basic demographic questions (age, gender, and occupation) and conducting a warm-up exercise to familiarize the participants with the TA method, the interviewers outlined the nature of endometriosis and gave the participants a copy of the booklet. The participants were then invited to leaf through the booklet at their own pace, saying what they were looking at and reading on each page, and continuously verbalizing all their thoughts and feelings. The interviews were audio recorded and transcribed, using a transcription key based on approximate intonation units (adapted from Cameron and Seu, 2012).[1] The names and any other identifying details were removed. The participants are distinguished by gender and numbered in the order they appear in the discussion below (F1, F2 etc. for females, and M1, M2 etc. for males), while the interviewers are indicated by the letter I.

3.1 Analytical procedure

The complete anonymized transcripts were imported into NVivo and subjected to thematic analysis (Braun and Clarke 2006), starting with the three main aspects of empathy identified in previous research (emotional resonance; cognitive understanding; and empathic concern) (Cuff et al. 2016; Fourie et al. 2017; Jami et al. 2023). During the coding process, these categories were refined and/or renamed, and a fourth category added in response to the data: "Recognition" refers to a person's ability to identify the emotional experiences of another person; "resonance" is defined as the spontaneous, vicarious sharing of another person's emotional experience; "alignment" describes the more conscious and deliberate imaginative act of taking another's perspective, and "affiliation" is the adoption of a supportive,

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[1] The extracts from the audio recordings are transcribed line by line as intonation units, which do not always coincide with syntactical clause boundaries: A comma denotes continuing intonation, a question mark rising intonation, a dash an incomplete intonation unit, a full stop final closing intonation, and an exclamation mark an animated/emphatic tone. Underlining indicates emphasis, a dot or numbers in brackets a micropause or pause measured in seconds, non-verbal responses such as laughter are described in square brackets, three full stops in square brackets indicate the omission of a section of the transcript, and words in italic represent quoted text from the booklet.

compassionate stance towards them, based on a sense of shared identity, values, or experiences. Thus, what other scholars have tended to subsume under the umbrella of cognitive understanding is split into the two separate processes, in order to distinguish more precisely between the ability to grasp another's experience at an intellectual level ("recognition") and the more imaginative endeavour of actively adopting their perspective ("alignment"). Furthermore, I choose to use the term "affiliation" instead of "empathic concern" (Fourie et al. 2017: 47), as the former has more explicit social connotations than the latter.[2]

In a second step, the subset of the data relating to the participants' responses to page 6 of the booklet was subjected to further detailed analysis, using a complexity/dynamic systems approach to discourse analysis (Cameron et al. 2009). This approach is sensitive to subtle shifts in people's discursive meaning making, which, in turn, is seen as indicative of the highly context-dependent and ever-changing nature of human cognition. Rather than regarding individual responses as being inherently empathetic or unempathetic, for example, they are broken down further into intonation units, each of which can then be examined for evidence of empathy on different scales and at different levels, while always paying close attention to the discourse context and the precise linguistic resources being used.

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[2] Some of these terms were inspired by film theorist Murray Smith's (1994) influential work, although he used them to refer to rather different phenomena, arguing that spectators would only fully identify with cinematic characters who are presented as unique individuals ("recognition"), who are visually aligned with the viewers through cinematic techniques like close-ups or point-of-view shots ("alignment"), and who embody similar values to their own ("allegiance").

Empathic responses have been found by previous research to take a wide range of verbal and non-verbal forms (Weatherall 2023). Cameron and Seu (2012) discover that the dialogic co-construction of empathy often involves metaphor and metonymy; personal stories, which are "usually told in the past tense" and tend to be signaled by discourse markers such as "*once*" (p. 287); and typifying scenarios, which involve imaginary characters, settings and conversations and which often use "you pronouns and present tense" (p. 287). Because of the focus of the present study on empathy as an expression of social identity, I am particularly interested in the use of personal pronouns, including the first-person plural "we" and generalized/impersonal "you", to convey category membership (Pearson 2023; Stirling and Manderson 2011).

4 Data analysis

The analysis of the 25 study participants' responses to page 6 of the booklet revealed that all of them were able to identify the negative valence of the experiences represented in the booklet, although they differed regarding how, exactly, they understood and evaluated these, and the extent to which they displayed empathy. All the excerpts discussed below are selected based on being representative of the whole data set. The following extracts (1-4) are examples of responses that show clear signs not just of recognition but also resonance, alignment and/or affiliation with women with endometriosis.

Extract 1

F1: erm and that quite it upsets me actually.
having dealt with medical professionals for my own issues,
and kind of experiencing (.) maybe a similar reactions,
not having them believe me either way you want them to
and not taking you seriously?

6 I imagine that’s what (.) they would perhaps feel like,
7 might feel similar to how I felt at that time.
8 so I can actually empathize in that aspect erm (.)
9 with what they might be,
10 like their frustrations about not being heard
11 their own pain,
12 because at the end of the day
13 you know your body better than anyone else.
14 so it just seems silly just because they have a degree
15 or trained in certain professions
16 that they think that they know you (.)
17 better than yourself.

F1 starts by expressing spontaneous resonance with the represented emotions, declaring herself from the start to be “upset” by the drawings and verbal commentary. She goes on to say that she has had similarly negative experiences with medical professionals, suggesting explicitly that this shared experience is helping her to “empathize” with the women represented in the booklet. Finally, she shows an affiliative stance by describing health professionals’ belief in their inherent superiority as “silly” (line 14). These processes of resonance, alignment, and affiliation are reflected in her pronoun use. She starts by mixing first person singular (“upsets *me*”, “not having them believe *me*” lines 1 and 4) and generalized “you” (“way *you* want them to and not taking *you* seriously”, lines 4-5) to represent the wider validity of her own feelings and experiences, and then moves on to the use of third person plural pronouns (“*their* frustrations”, “*their* own pain”, lines 10-11) to consider what women with endometriosis might be going through. Concluding her thoughts, F1 reverts to generalized “you” to express what she clearly feels to be self-evident truths, and third person plural pronouns to condemn uncaring medical professionals (“*they* think that *they* know *you* (.) better than *yourself*”, lines 16-17).

Another female respondent, F2, is prompted by page 6 of the booklet to tell the story of a previous co-worker who often used to call in sick and ask her to cover her shift. Although F2 always agreed to her colleague's requests, they made her feel resentful. It later transpired that this co-worker had endometriosis, but at the time no one else, including their manager, appreciated the seriousness of this condition. The respondent uses this "personal story" (Cameron and Seu 2012) to illustrate how poorly understood endometriosis is. The following extract (2) shows that her attitude towards endometriosis sufferers has since shifted.

Extract 2

F2: the NHS is already sometimes difficult
to get to if things are poorly (.) misunderstood
or like poorly diagnosed
or there's not enough teaching in it anyway,
but yeah (.) and then it seems like it's maybe
more effort than it's worth to try and get
somebody who understands (.)
or has any kind of experience in dealing with it,
[…]
yeah that is kind of like highlighting
the fact that doctors don't necessarily speak to you
on the level they speak to other medical professionals?
I: yes
F2: and that they kind of treat you as though I don't know
you're like a lesser person or whatever.
which is crazy because it's not really
what we hope they are doing,
but yeah maybe it's just a (4) yeah that's sad. (4)
yeah it just makes me feel
I guess sad is a pretty inadequate word but that erm (.)
and a little bit angry
that people just get kind of like brushed away.
and that's probably why it's not been,
it's been something that people struggle with undiagnosed
for so long because it's just not taken seriously enough
or because there's no like easy answer,
it's just like,
oh that's what it is!
here's some pain killers!

F2 starts by acknowledging widespread problems with timely access to specialist care in the NHS. She shows resonance by talking about her own feelings of sadness and anger in response to the materials. Again, the generalized "you" is used to express a sense of solidarity with the women ("the fact that doctors don't necessarily speak to *you* on the level they speak to other medical professionals?", lines 11-12, "they kind of treat *you* as though […] *you're* like a lesser person", lines 14-15). Making an overt value judgement, F2 describes such attitudes as "crazy" and says that they are "not really what *we* hope *they* are doing" (lines 16-17). Here, the first-person plural "we" seems to include not just herself and the interviewer, but potentially any patients in the unlucky position of being reliant on the inadequate care "they", i.e., the medical professionals, are providing. She concludes by recounting what Cameron and Seu (2012) would call a "typifying scenario", involving a medical professional making a rash diagnosis and just prescribing pain killers for symptoms that deserve to be investigated properly (lines 27-29).

Three of the female study participants explicitly refer to gender roles when discussing their thoughts and feelings about page 6. F3, for example, mentions "other stories" she has heard of women struggling to access appropriate medical care due to harmful stereotypes (Extract 3).

Extract 3

1 F3: the first comment,
2 you just *constantly having to get through obstacles*
3 *to get to the right doctor.*
4 erm it sort of amplifies you know other stories I've heard
5 of women not being taken seriously at the doctors.
6 I: mmhmm
7 F3: because apparently,
8 it's the high threshold for pain and they always,
9 we've been socialized to downplay it as well I feel.

F3 expresses a low level of confidence in the veracity of the notion of women having a higher pain threshold than men by qualifying it with the adverb “apparently” (line 7). She then switches to the first-person plural pronoun to talk about the way “*we’ve* been socialized to downplay it” (line 9), signaling affiliation with all women suffering from a patriarchal healthcare system.

Although the extracts discussed so far reflect a more general pattern in the data, whereby female respondents are more likely than males to express empathy for endometriosis sufferers on the basis of shared experiences, some men do also display obvious signs of resonance, alignment and/or affiliation with these patients. M1 (Extract 4) is a particularly clear example. As a student nurse, he has evidently learnt about the importance of patient-centered care, while also witnessing situations where this principle was not applied in practice. After taking in the drawing at the bottom of page 6 and reading the associated verbal comments about “*blind and deaf doctors*” out loud, he goes on to take a firm stance in support of the patients and in opposition to those doctors who do not deliver the quality of care he clearly believes patients deserve.

Extract 4

1 M1: which (.) to be fair
2 sounds quite like a doctor (.) to me. (1) [laughter]
3 um (2) um I (.) but (.)
4 as a nurse that makes me feel quite (.) sad,
5 because (1) um (1) really
6 it should be centered around the patient,
7 but I think (1) it should be centered around the patient
8 and um, (1) yeah (.) it m- makes me feel sad for them
9 because (.) if you imagine yourself not being able to be
10 (.) listened to or everyone ignoring you
11 that wouldn’t be very nice (.)
12 in any situation never mind in a hospital (1) um

M1 expresses his own emotional response twice using very similar wording (“that[it] makes me feel [quite] sad”, lines 4 and 8)) and shows alignment with patients by imagining how “you” might feel if you are not treated with respect, especially in a hospital setting (lines 9-10). The fact that he judges the criticism of doctors in the booklet to be “fair” and that he repeats the same explicit value judgement twice (“it should be centered around the patient”, line 7) shows that he is also explicitly affiliating himself with the women. This, in turn, indicates that M1 is heavily invested in his evolving identity as a caring, empathic health professional (“as a nurse”, line 4), and that he has similarly high expectations of his medical colleagues, particularly those in positions of power.

Two of the older male study participants (in their late 50s and early 40s, respectively) seemed to be very unsure of their interpretations of the materials and reluctant to talk about any thoughts or feelings that these may have triggered. M2’s and M3’s responses to page 6 of the booklet (Extracts 5 and 6) are given in full below.

Extract 5

1 M2: erm ok this is obviously the problems with (.)
2 the drawings are less (.) explicit,
3 (2) erm there’s obviously problems with
4 having it diagnosed and dealt with?
5 now looking at the doctor-patient drawings,
6 *see no patient hear no patient speak behind the patients,*
7 so there’s real frustration here about (.)
8 doctors not understanding what this is.

Extract 6

1 M3: so I guess obviously whoever wrote this
2 and drew this is feeling very erm let down,
3 by err by the NHS or the medical profession in general,
4 given that they’re feeling that their condition
5 is not being taken seriously and not being catered for.

While recognizing the represented women’s sense of exasperation and despondence, M2 and M3 display an “epistemic stance” (Roseano et al. 2015) that vacillates between the expression of a high level of confidence through the repeated use of the adverbial “obviously”, and a lack of certainty through the description of the images as “less explicit” (M2, line 2) and the use of terms such as “I guess” (M3, line 1), as well as rising intonation at the end of statements. M3 talks about the women’s experiences in the third person (“*they’re* feeling that their condition is not being taken seriously”, lines 4-5), while M2 uses “this” and “there” as “dummy subjects” (Peters 2004) (“*this* is obviously the problems with”, line 1, “*there’s* obviously problems”, line 3, “*there’s* real frustration here”, line 7) to describe the emotions manifested on this page, without referencing the persons whose experiences are being represented. Neither of these respondents describes their own reactions to what they are seeing, making it impossible to know whether they felt any empathy towards the women in this situation.

F4 is the only study participant to interpret this page as showing the patients’ sense of embarrassment and inadequacy, rather than their frustration with the inadequate healthcare they have received (Extract 7), which may be seen as a form of partial “misrecognition”.

Extract 7

1 F4: there's a picture here of one tiny little person
2 and then you have a super huge person
3 with a medical sign as well,
4 and they're kind of blocked off by a fence,
5 and I guess that's like the physical barriers
6 and mental barriers that you put up for yourself,
7 and you're not going to understand it,
8 like people might not actually want to as well
9 to go through and speak to their doctor.
10 there can be sometimes I guess,
11 people can feel embarrassed by it,
12 erm they might not want to discuss it,
13 erm they might not feel it's normal,
14 they might not know it actually happens to more people.
15 so I guess they just feel like it just happened to them,
16 and nobody else is gonna get it until they get over that,
17 […]
18 but on the other side that
19 there are people there with open arms,
20 it kind of looks like I don't know
21 a medical figure being like,
22 yeah we're here for you.

When describing the drawing at the top, F4 focuses on what she perceives to be the doctor's open arms and winning smile, and the smallness of the woman on the other side of the fence, which she takes to be an expression of "the physical barriers and mental barriers that *you* put up for *yourself*" (lines 5-6). This respondent initially employs this generalized "you" to signal a degree of alignment with the experience of being reluctant to seek medical help. Subsequently, F4 repeatedly uses the third person plural to refer to the patients' failure to "get over" (line 16) their misplaced embarrassment and to realize that they are not alone in suffering from the symptoms of endometriosis (or illness more generally, perhaps). Expanding on her reading of the drawing, F4 describes medical staff as welcoming patients with open arms and offering their support (lines 18-22). Although this shows imaginative engagement with the represented experiences, F4 seems to be aligning herself with the doctors rather than with their patients, which means that hers cannot be described as a truly empathic response to the plight of endometriosis sufferers.

In other cases, the respondents' failure to fully empathize with the women is due to disaffiliation rather than misrecognition. Throughout their interviews, two young, male respondents keep coming back to the idea that healthcare staff are doing their best and that it is wrong for patients with endometriosis to blame doctors for the poor treatment they have received. In the case of M4 (Extract 8), his defense of doctors is based on the limited resources available in the NHS.

Extract 8

1 M4: I mean the fact I'd never heard of this before
2 obviously shows that it's still sort of such a quiet,
3 or sort of (.) under regarded issue,
4 it needs more um
5 it probably needs more um (.) recognition perhaps,
6 but problem is so do so many things don't they,
7 there are so many issues out there that need recognition,
8 can't can't recognize all of them (.) no!
9 like there's not enough money to go round,
10 (.) not taking away from obviously these people,
11 but –

M4 starts by showing strong commitment to the proposition that endometriosis is "obviously" an "under regarded issue" (lines 2-3), but then qualifies this by hedging it through the modal adverbs "probably" and "perhaps" ("it *probably* needs more um (.) recognition *perhaps*", line 5) and going on to emphasize the many competing demands on resources. Although his final utterance appears to reiterate his compassion for the women whose experiences are represented in the booklet ("not taking away from obviously these people"), the fact that it ends in the conjunction "but", which typically introduces a contrasting idea, suggests that his empathic concern is, in fact, rather limited (lines 10-11).

A more explicit instance of disaffiliation can be seen in the following extract from the interview with another male respondent (Extract 9).

Extract 9

M5: I can (2) agree.
I like the drawing on the right.
understand feeling small and like people don't understand,
(2) not that I understand fully.
obviously reading this I'm getting more understanding of.
um (3) hard to get to the right doctor,
same with every illness.
everyone has their specialism
and it's just getting to the right place,
(2) not going to lie with the NHS and things like that,
(2) although it is brilliant
it is very ineffective sometimes with certain conditions.
(5) not sure about *the blind and deaf docs* bit.
I'm not sure about attacking the doctors!
because at the end of the day if doctors know
how to treat an illness that's vaguely medical
they'll try to fix and help things.
the idea of the doctors ignoring them.
I can understand that feeling
if there's nothing they can actually treat,
(.) but at the same time,
they are trying to treat the symptoms,
it's a bit bad to (1) fire at the doctors like that
because they definitely are (.) most doctors at least are,
or that they do give a shit and are trying to help,
so not sure attacking them is going to help anyone.

Like M4, study participant M5 starts by expressing qualified support for women with endometriosis, especially in relation to the universal experience of feeling small and misunderstood. However, he quickly switches to a more skeptical stance, emphasizing the difficulties all patients face when accessing NHS treatment. He accuses the women who created the materials in the booklet of unfairly maligning the doctors, using battle metaphors ("*attacking* the doctors", line 14, "*fire* at the doctors", line 23) to decry what he perceives to be the strident, exaggerated nature of their criticisms. When he says that doctors will always try to treat any illness "that's *vaguely* medical" (line 16), M4 appears to be insinuating that endometriosis is at least partially psychosomatic, thus echoing some of the same attitudes that the booklet is trying to challenge.

5 Discussion and conclusion

Empathy is a highly context-dependent process that is intricately bound up with people's social identities, values, and behavioral norms, as well as the broader social, cultural, economic, and political frameworks within which an encounter – whether interpersonal or mediated – takes place. The present study has provided empirical support for this argument. Using thematic analysis and a dynamic systems approach to the analysis of Think Aloud interview data, I have demonstrated that empathic responses often do not unfold in a linear, predictable fashion, and that they interact with both the individual's own values and experiences, and with prevailing attitudes towards healthcare in Britain.

Distinguishing between four distinct but closely related, dynamic processes involved in empathy has enabled the identification of specific factors that might encourage or impede an empathic response. For many female respondents, feelings of solidarity based on shared gender or having had similarly poor experiences of NHS care encouraged their alignment and affiliation with endometriosis patients (Extracts 1-3), whereas, for a male student nurse, his professional values clearly influenced his responses (Extract 4). The widespread admiration for the NHS, but also concerns about its current state of crisis, were reflected in the way that some participants rejected any criticism of doctors and disaffiliated themselves from endometriosis patients, implicitly accusing them of overstating their suffering (Extracts 8 and 9).

These findings suggest that empathy in health communication has an important socio-economic dimension, in the sense that it is harder to achieve empathy in a context where staff are struggling with low morale and service users may feel the need to compete with others for scarce resources. For a publicly funded healthcare system like the NHS to be sustained over time, it is important to find ways of encouraging both its staff and the general public to empathize with patient groups who may require prolonged and potentially resource-intensive medical care.

The patient-generated materials used in this study are intended to provide a relatively straightforward and cost-effective means of achieving this objective. Although the booklet does not tell a coherent story and lacks clearly identifiable, named characters, almost all respondents nevertheless displayed signs of at least some degree of empathy towards the represented women with endometriosis in response to it. This challenges the idea – prevalent across narrative and communication research – that audiences need to be able to engage with individual narrative characters for deep emotional engagement to be possible (e.g., Peng et al. 2020; Smith 1994).

The key role of what I have called "recognition" in the empathic process is often neglected in the literature, perhaps because it is less obvious in face-to-face situations than when people are responding to symbolic representations of some else's experience. As demonstrated in this study, reacting emotionally to another's suffering cannot be described as truly empathetic if the original experience is mis-recognized (Extract 7). The simple drawing style and metaphorical nature of the multimodal materials used in the booklet may have led to uncertainty and misunderstandings, thereby potentially hindering empathy. Conversely, these same properties may have increased the booklet's ability to enhance empathy, by being open to a range of different interpretations and thereby tapping into readers' own unique experiences. The question of whether the metaphorical nature and the specific multimodal stylistic features of the trigger materials may have shaped empathic audience responses goes beyond the scope of the present study, although it clearly deserves further investigation.

The linguistic analysis of the interview data confirms Cameron and Seu's (2012) finding that experiencing – or, in some cases, withholding – empathy is often expressed through personal stories, typifying scenarios, and metaphors. Additionally, I have discovered the central role played by personal pronoun use in conveying subtle shifts in the interviewees' attitudes. Respondents F1 and F2, for example, switched seamlessly from discussing the represented experiences in the third person plural, to using a generalized "you" to introduce facts or circumstances they held to be incontrovertibly true, to talking about their own emotions or those they shared with the women in the first-person singular or plural, respectively. Epistemic stance, hedges, and contrast conjunctions also appear to play an important role in empathy discourses, particularly as a way for people to express ambivalent or uncaring responses to another's experience.

TA protocols have been used previously to investigate how people interpret metaphors (Šorm & Steen 2013), and in a small-scale study of students' empathic responses to a graphic novel (Chisholm et al. 2017), for example. To the best of my knowledge, however, the present study is the first to use TA interviews to research empathy as an audience response in health communication. One of the advantages of this method is that study participants do not need to be made aware of the research objectives, nor do any potentially leading questions need to be asked. On the other hand, as Van Someren et al. (1994: 35) acknowledge, there are substantial differences regarding the ease with which people verbalize their thought processes. Some of the study participants expressed their thoughts and feelings about the content of the booklet freely and at great length, whereas others chose to comment on only a small subset of the material, often giving minimal responses (e.g., Extracts 5 and 6). The latter may well have had empathic thoughts and feelings that were just never voiced.

TA studies, like other interview or focus group studies, are also vulnerable to social desirability bias, i.e., “the tendency to give answers that make the respondent look good” (Paulhus 1991: 17). Participants may not want to flout implicit “empathy rules” and come across as uncaring, particularly if they know the interviewer personally. In our study, only two of the interviews were conducted by a male student; in all other cases, the interviewer was female, which may have discouraged the male participants from expressing overtly sexist views, for example. Indeed, there were several instances in the data where the respondents seemed to be addressing the interviewers directly and seeking their confirmation or approval. This can be seen, for example, in the questioning intonation used by the participant in Extract 2, which was followed by the interviewer’s minimal response (“yes”), a pattern that is more characteristic of a conversation (Fellegy 1995) than of a classic TA interview. While this may have been partly due to the interviewers’ lack of experience with the method, it is important to recognize that TA can never guarantee access to the interviewees’ unfiltered thoughts; inevitably, they will be aware of the interviewer’s presence and at least somewhat attuned to their reactions.

Researchers wishing to use TA to study empathy may thus wish to consider ways to put respondents at ease and reduce the potential impact of self-censorship, for example, by allowing more time for a practice run and ensuring that interviewers reduce their own responses to an absolute minimum. It may also be advisable to avoid pairing up interviewers with interviewees based on pre-existing relationships. Whether online TA interviews are more or less likely to introduce biases than face-to-face interviews is another important question that calls for further research. Finally, video recording the interviews would provide access to any non-verbal responses that might signal empathy, including in the absence of explicit verbal references to participants' feelings (see, for example, Weatherall 2023).

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References

Endometriosis UK 2024. "Dismissed, ignored and belittled": The long road to endometriosis diagnosis in the UK. https://www.endometriosis-uk.org/years-being-dismissed-ignored-and-belittled-endometriosis-uk-urges-improvement-deteriorating (accessed 5 April 2008).

Bamberg, Michael G. W., Anna De Fina & Deborah Schiffrin. 2007. *Selves and identities in narrative and discourse.* Amsterdam: John Benjamins Pub.

Batson, C. Daniel, David A. Lishner, Jennifer Cook & Stacey Sawyer. 2005. Similarity and nurturance: Two possible sources of empathy for strangers. *Basic and Applied Social Psychology* 27(1). 15-25.

Braun, Virginia & Victoria Clarke. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology* 3(2). 77-101.

Bylund, Carma L. & Gregory Makoul. 2002. Empathic communication and gender in the physician–patient encounter. *Patient Education and Counseling* 48(3). 207-216.

Cameron, Lynne, Robert Maslen, Zazie Todd, John Maule, Peter Stratton & Neil Stanley. 2009. The discourse dynamics approach to metaphor and metaphor-led discourse analysis. *Metaphor and Symbol* 24(2). 63-89.

Cameron, Lynne & Irene Bruna Seu. 2012. Landscapes of empathy: Spatial scenarios, metaphors and metonymies in responses to distant suffering. *Text & Talk* 32(3). 281-305.

Campbell, Rose G. & Austin S. Babrow. 2004. The role of empathy in responses to persuasive risk communication: Overcoming resistance to HIV prevention messages. *Health Communication* 16(2). 159-182.

Chisholm, James S., Ashley L. Shelton & Caroline C. Sheffield. 2017. Mediating emotive empathy with informational text: Three students' Think-Aloud protocols of *Gettysburg: The graphic novel*. *Journal of Adolescent & Adult Literacy* 61(3). 289-298.

Cuff, Benjamin M. P., Sarah J. Brown, Laura Taylor & Douglas J. Howat. 2016. Empathy: A review of the concept. *Emotion Review* 8(2). 144-153.

de Greck, Moritz, Gang Wang, Xuedong Yang, Xiaoying Wang, George Northoff & Shihui Han. 2012. Neural substrates underlying intentional empathy. *Social Cognitive and Affective Neuroscience* 7(2). 135-144.

Eichbaum, Q., C. A. Barbeau-Meunier, M. White, R. Ravi, E. Grant, H. Riess & A. Bleakley. 2022. Empathy across cultures - one size does not fit all: From the ego-logical to the eco-logical of relational empathy. *Advances in Health Sciences Education*. 1-15.

Fellegy, Anna M. 1995. Patterns and functions of minimal response. *American Speech* 70(2). 186-199.

Ford, Joseph, Alexa Hepburn & Ruth Parry. 2019. What do displays of empathy do in palliative care consultations? *Discourse Studies* 21(1). 22-37.

Fourie, Melike M., Sivenesi Subramoney & Pumla Gobodo-Madikizela. 2017. A less attractive feature of empathy: Intergroup empathy bias. In Makiko Kondo (ed.), *Empathy: An evidence-based interdisciplinary perspective*, 45-61. Rijeka, Croatia: InTech.

Gallese, Vittorio. 2009. Mirror neurons, embodied simulation, and the neural basis of social identification. *Psychoanalytic Dialogues* 19(5). 519-536.

Gallese, Vittorio, Michele Guerra & Frances Anderson. 2020. *The empathic screen: Cinema and neuroscience.* Oxford, England: Oxford University Press.

Gameiro, Sofia, Berit Bliesemann de Guevara , Elisabeth El Refaie & Alida Payson. 2018. DrawingOut: An innovative drawing workshop method to support the generation and dissemination of research findings. *PLoS One* 13(9). e0203197.

Jami, Parvaneh Yaghoubi, David Ian Walker & Behzad Mansouri. 2023. Interaction of empathy and culture: A review. *Current Psychology* 4. 2965-2980

Keen, Suzanne. 2007. *Empathy and the novel.* New York: Oxford University Press.

Macagno, Fabrizio, Chrysi Rapanta, Elisabeth Mayweg-Paus & Mercè Garcia-Milà. 2022. Coding empathy in dialogue. *Journal of Pragmatics* 192. 116-132.

Morris, Jessica, Laura Schlepper, Mark Dayan, Danielle Jefferies, David Maguire, Leonora Merry & Oliver, David. 2023. The latest Social Attitudes Survey on the NHS is a stark warning that we must act before it's too late. *British Medical Journal* 381, 760.

Paulhus, Delroy L. 1991. Measurement and control of response bias. In John P. Robinson, Phillip R. Shaver & Lawrence S. Wrightsman (eds.), *Measures of personality and social psychological attitudes*, 17-59. Academic Press.

Pearson, Hazel. 2023. Impersonal pronouns and first-person perspective. *Annual Review of Linguistics* 9(1). 293-311.

Peng, Lulu, Lijiang Shen, Rachel Reymann Vanderbilt, Youllee Kim & Kasey Ann Foley. 2020. The impact of fear versus state empathy on persuasion and social stigma. *Media Psychology* 23(1). 1-24.

Peters, Pam. 2004. *The Cambridge guide to English usage*. Cambridge: Cambridge University Press.

Pugsley, Zoë & Karen Ballard. 2007. Management of endometriosis in general practice: The pathway to diagnosis. *British Journal Of General Practice* 57(539). 470-476.

Rochat, Magali Jane. 2023. Sex and gender differences in the development of empathy. *Journal of Neuroscience Research* 101(5). 718-729.

Roseano, Paolo, Montserrat González, Joan Borràs-Comes & Pilar Prieto. 2015. Communicating epistemic stance: How speech and gesture patterns reflect epistemicity and evidentiality. *Discourse Processes* 53(3). 135-174.

Ruiz-Junco, Natalia. 2017. Advancing the sociology of empathy: A proposal. *Symbolic Interaction* 40(3). 414-435.

Shapiro, Johanna. 2008. Walking a mile in their patients' shoes: Empathy and othering in medical students' education. *Philosophy, Ethics, and Humanities in Medicine* 3. 10.

Shen, Lijiang. 2019. Features of empathy–arousing strategic messages. *Health Communication* 34(11). 1329-1339.

Smith, Murray. 1994. Altered states: Character and emotional response in the cinema. *Cinema Journal* 33(4). 34-56.

Šorm, Ester & Gerard J. Steen. 2013. Processing visual metaphor. *Metaphor and the Social World* 3(1). 1-34.

Stewart, Ellen. 2023. *How Britain loves the NHS: Practices of care and contestation.* Bristol: Policy Press.

Stirling, Lesley & Lenore Manderson. 2011. About *you*: Empathy, objectivity and authority. *Journal of Pragmatics* 43(6). 1581-1602.

Strekalova, Y. A., S. Kong, A. J. Kleinheksel & A. Gerstenfeld. 2019. Gender differences in the expression and cognition of empathy among nursing students: An educational assessment study. *Nurse Education Today* 81. 1-6.

van Someren, Maarten W., Yvonne F. Barnard & J. Sandberg. 1994. *The Think Aloud method: A practical guide to modelling cognitive processes.* London: Academic Press.

Weatherall, Ann. 2023. "Oh my god that would hurt": Pain cries in feminist self-defence classes. *Language & Communication* 90. 1-13.

Wieck, Cornelia, Susanne Scheibe & Ute Kunzmann. 2022. Development and validation of film stimuli to assess empathy in the work context. *Behavior Research Methods* 54(1). 75-93.

Zhang, Xin, Linzi Li, Quan Zhang, Long Hoang Le & Yijin Wu. 2024. Physician empathy in doctor-patient communication: A systematic review. *Health Communication* 39(5). 1027-1037.