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## 1. Background and Statement of Problem

When health professionals do not share the same first language as their patients, language barriers may exist, which may have varying negative effects on the quality of communication, and consequently, on the quality of health services rendered (e.g., Bowen, 2001; Robinson, 2002; Segalowitz & Kehayia, 2011). Moreover, these language barriers have a tendency to increase in more stressful and emotionally-charged health-communication situations (Isaacs, Laurier, Turner & Segalowitz, 2011). However, attempting to reduce potential language barriers by offering second language (L2) training to health professionals is not as straightforward as it seems because little is known about the actual language produced by native speakers in specific health-communication situations (French, 2012; French, Lapointe, & Bellemare, 2013). Corpus-based research of the actual language used between health-professionals and patients sharing the same first language would therefore seem to be an important endeavour.

Corpus-based research has been gaining ground in the field of health communication because it leads to a more evidence-based approach of identifying language that may go unnoticed by an intuition-based approach alone (Adolphs, Brown, Carter, Crawford & Sahota, 2004). There are many definitions of “corpus” because there are different types of corpora (McEnery, Xiao, & Tono, 2006). A general modern-day definition of a corpus, provided by McEnery et al., (2006) is “a collection of sample texts, written or spoken, in machine-readable form which may be annotated with various forms of linguistic information” (p. 4). The advantage of corpus-based research is that by using powerful computer software to scan and analyse linguistic corpora for patterns, reoccurrences, and concordances, it yields reliable quantitative data from authentic language (McEnery et al., 2006).

To our knowledge, there are currently no corpus-based linguistic studies focusing on health communication in more stressful and emotionally-charged situations, particularly those that focus on how empathy and sympathy are verbally communicated by health professionals. It is important, however, to point out that the findings of corpus studies are limited to the context under which the corpus was collected and the language forms and functions available in the corpus may be overrepresented or underrepresented. As such,

caution should be used when generalizing the findings reported in the present study to other healthcare contexts.

It is widely viewed that empathy is considered important for the delivery of care (Egan, 2010; Hojat, 2007; Segalowitz & Kehayia, 2011). The importance of sympathy in the provision of care, however, is an ongoing debate, but some researchers argue that at times sympathy would be more appropriate than empathy in facilitating the patients' acceptance of reality (Morse et al., 1992; Morse, Bottorff, Anderson, O'Brien, & Solberg, 2006). The line dividing empathy from sympathy is therefore fine, and despite their differences, they cannot be viewed as completely independent from the other (Hojat, 2007). In fact, the American Psychological Association Dictionary of Psychology (2007) defines empathy and sympathy as the following:

- ***empathy*** n. understanding a person from his or her frame of reference rather than one's own, so that one vicariously experiences the person's feelings, perceptions, and thoughts. Empathy does not, of itself, entail motivation to be of assistance, although it may turn into SYMPATHY or personal distress, which may result in action [...] (p. 327)
- ***sympathy*** n. 1. feelings of concern or compassion resulting from an awareness of the suffering or sorrow of another. 2. more generally, a capacity to share in and respond to the concerns or feelings of others. See also EMPATHY. 3. an affinity between individuals on the basis of similar feelings, inclinations or temperament. [...] (p. 916)

In health communication literature, there are numerous other definitions of empathy and sympathy. In fact, empathy is often used as an umbrella term that includes elements of sympathy (Hojat, 2007) and is much more researched and written about than sympathy. Sympathy, on the other hand, is often devalued, for it is deemed inappropriate because it does not allow the health professional to remain emotionally detached (Egan, 2010; Hojat, 2007; Morse et al. 1992). Regardless of the differences, similarities, and continual debate about the appropriateness of one term over the other, empathic and sympathetic communication can be present during the delivery of care, yet little is known of how

empathy and/or sympathy are actually communicated verbally by health professionals, particularly by nurses.

In an attempt to reduce language barriers between health professionals and their patients, the L2 training of health professionals should at least respect the pedagogical norms proposed by Valdman (1989): reflect the language that is used and accepted by native speakers in specific health communication situations and that is also easy for L2 speakers to acquire (Valdman, 1989). Considering that empathy and/or sympathy are vital to health professional-patient interactions (Morse et al., 2006) and that little corpus-based research of these two concepts exists, obtaining both quantitative and qualitative findings of the types of responses and linguistic forms used to verbally communicate empathy and/or sympathy would be beneficial for both theoretical and L2 training purposes.

### **1.1. Research Focus and Objectives**

The overall aim of this thesis is to gain a greater understanding of the types of responses and linguistic forms used by anglophone nurses from Quebec to verbally communicate empathy and/or sympathy during professional exchanges with patients. In the current study, a type of response refers to a categorical reply using one or several linguistic forms, and a linguistic form is considered “a meaningful unit of language, such as an affix, a word, a phrase or a sentence” (linguistic form, n.d.). Specifically, from an applied linguistics perspective, the objectives of this research are to:

- a. identify which types of responses are more frequently used to verbally communicate empathy and/or sympathy by anglophone nurses; and
- b. describe the most recurring linguistic forms of the types of responses.

The empirical value of the current study is to increase knowledge of the verbal communication of empathy and/or sympathy, notably for L2 training purposes.



## 2. Literature Review

### 2.1. Introduction

Understanding of the concept of empathy<sup>1</sup> has been in constant evolution. Even Rogers, whose definition of empathy has been frequently used in health communication literature, adapted his initial definition from that of a state of being (1957) to one that better reflects the process of empathy (1975). Although much attention and research has been allocated towards acquiring a better understanding of the concept of empathy, linguistic analysis of the verbal communication of empathy from spoken corpora remains limited. For this literature review, the concept of empathy is defined and then an overview of the types of responses and linguistic forms that have been identified in health communication and applied linguistics literature thus far will be provided.

### 2.2. Concept of Empathy

In order to teach L2 speakers the types of responses and linguistic forms used to verbally communicate empathy, one must first identify the most frequently used types of responses and linguistic forms from actual speech samples. To do this, one must have a clear understanding of the concept of empathy and how it is communicated. Unfortunately, the concept of empathy has no theoretical framework (Kristjánsdóttir, 1992), and there is no general agreement of a standard definition in health communication literature (Hojat, 2007; Pedersen, 2009). Nevertheless, it is increasingly accepted that empathic communication is cyclical (Barrett-Lennard, 1981; Bylund & Makoul, 2005; Rogers, 1975; Suchman, Markakis, Beckman, & Frankel, 1997) and multidimensional (Bylund & Makoul, 2005; Egan, 2010; Hojat, 2007; Morse et al., 1992).

Several studies have described the empathic cycle to varying degrees. The widely-cited Barrett-Lennard model (1981) consists of three stages: *empathic resonance*; *expressed empathy*; and *received empathy*. As per Barrett-Lennard, the cycle is initiated when a person in distress verbally or non-verbally sends an emotional signal to another, which is labelled as the empathic resonance stage. The second person receives the signal and verbally or non-verbally communicates his/her understanding of the signal back to the first

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<sup>1</sup> Distinguishing empathy from sympathy falls outside the scope of the current study, and thus, is not the object of focus in the literature review.

person, which is the expressed empathy stage. The first person then receives the expressed empathy and continues engaging with the other person; this stage is referred to as the received empathy stage. The cycle then continues.

The multidimensional aspect of empathy refers to the various components of empathy, which are labelled slightly differently across studies. Of the current research available, Morse et al. (1992, p. 274) provide a clear account of four components and define them in the following manner:

- **Cognitive:** “[...] *intellectual ability to identify and understand another person’s feelings and perspective from an objective stance.*”
- **Emotive:** “*the ability to subjectively experience and share in another’s psychological state, emotions or intrinsic feelings.*”
- **Moral:** “*An internal altruistic force that motivates the practice of empathy.*”
- **Behavioural:** “*Communicative response to convey understanding of another’s perspective.*”

In order to identify the types of responses and linguistic forms used to convey empathy, particularly for L2 training purposes, it would therefore be of particular importance to focus on the expressed empathy stage (Barrett-Lennard, 1981) because it is the stage where empathy is verbally communicated to the person in distress, and the behavioural component of empathy (Morse et al., 1992) because it is the only component related to the verbal communication of empathy.

### **2.3. Types of Responses Used to Verbally Communicate Empathy**

Only broad definitions of the types of responses used for the verbal communication of empathy are present in health communication models of empathy. In the Barrett-Lennard model of empathic communication (1981), the terms used to describe the types of responses are quite empirical. For instance, the response, “communicate a received cue,” provides no indication of how that received cue could be communicated, whether it would be in the form of a statement or a question. Furthermore, similar to the Barrett-Lennard model, the Suchman et al. model (1997) also provides general descriptions of the types of responses. For example, the cycle is initiated by a patient clue, which is termed as an

“empathic opportunity.” The “empathic response” to the “empathic opportunity” is described as “a clinician’s explicitly expressed recognition of a patient’s expressed emotion” (p. 679). Examples of dialogues and excerpts of linguistic forms, such as “uh-huh,” “I see,” “go on,” and “how do you feel about that?” (Suchman et al., 1997, p. 679) have been provided, but the linguistic forms have not been categorised based on the types of responses, which range from being a minimal response (e.g., “uh-huh”) to asking a question. There is also no interpretation of the differences between linguistic forms per type of response. The models of Barrett-Lennard (1981) and Suchman et al. (1997) describe cycles of empathic communication as a whole, but provide little details about the types of responses used to verbally communicate empathy.

In instruments that measure empathy, the definitions of the types of responses used to communicate empathy are also imprecise. Pedersen (2009) has provided examples of instruments that measure the observable aspects of empathic communication, which are: the Roter’s Interaction Analysis System (RIAS), Empathic Communication Coding System (ECCS), Rating Scales for the Assessment of Empathic Communication in Medical Interviews (REM), and Liverpool Clinical Interaction Analysis Scheme (LCIAS), among others. With the RIAS, verbal responses of health professionals can be coded as per 38 different categories, only one of which is labelled “empathy”. It has been noted that in the RIAS, the verbal responses used to communicate empathy, such as statements that paraphrase, interpret and name or recognise the emotional state of the patient, are clustered together in one category (Pedersen, 2009; Roter & Larson, 2002; Sandvik et al., 2002). For the ECCS, verbal responses can be coded per different levels; some levels are more specific than others. For instance, the highest level consists of coding responses that share feelings or experiences; whereas, at Level 3, the acknowledgement level, all types of responses that would acknowledge the other person’s feelings or emotions, such as making statements, giving advice, offering help, using verbal and non-verbal cues, are grouped together (Bylund & Makoul, 2002). For the REM tool, the first 1 to 6 items focus on one factor labelled “empathy”, in which broad questions, such as: “Did the physician show understanding of the patient’s point of view?” and “Did the physician show interest in the patient’s opinion?” (p. 373) are asked and no types of responses are listed (Nicolai, Demmel, & Hagen, 2007). For the LCIAS, only two the 55 codes available refer directly to

empathy and are broadly termed as *empathic reflection* or *non-empathic reflection* (Ring, Dowrick, Humphris, Davies, & Salmon, 2005).

Of the aforementioned instruments, only the ECCS focuses more on the behavioural component of empathy. Although the types of responses listed in the ECCS are at times grouped together per level, two studies, in which the ECCS was used, have presented interesting findings. In the two studies, the most frequent levels of empathic communication, presented in ascending order were:

- Bylund and Makoul (2002):
  - Acknowledgement Level (66.3%)
  - Confirmation/legitimation Level (14.1%)
  
- Bylund and Makoul (2005):
  - Acknowledgement Level (30.3%)
  - Pursuit Level (28.2%)<sup>2</sup>
  - Confirmation/legitimation Level (26.5%)

In both of the studies, the shared-feeling-or-experience level was the least frequently used: in the 2002 study, it was only used 1.6% of the time; in the 2005 study, it was used 2.1% of the time. Moreover, the shared-feeling-or-experience level occurred less frequently than the levels in which physician responses were classified as not being empathic, meaning the physician provided only implicit recognition, perfunctory recognition, or even denial.

As much as the findings of Bylund and Makoul revealed differences in the frequency of levels of empathic communication, the description, definitions and examples of some of the types of responses per level lack specification. For instance, the act of pursuit consisted of several different types of responses that ranged from asking a question to offering advice or support to elaborating on a point the patient raised (Bylund & Makoul, 2005). More precise definitions could have revealed which types of responses tended to be more frequently used.

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<sup>2</sup> In the 2002 version of the ECCS, there was no level of pursuit. The pursuit category was added in the 2005 version because two different types of acknowledgement had been distinguished, resulting in the creation of an acknowledgement category and pursuit category (Bylund & Makoul, 2005).

Due to a lack of theoretical framework and, more importantly, consensus on the types of responses used to verbally communicate empathy in health communication research, it is difficult to assess which types of responses tend to be more frequently used. Research from the field of linguistics, however, has provided a different perspective.

Often investigated under the title of “troubles talk”, empathic communication has been studied by Jefferson (1988) and Pudlinski (2005) using the qualitative approach of conversational analysis. *Conversational analysis* is an approach derived from the work of Goffman (1955) and Sacks, Schegloff, and Jefferson (1974) that investigates the sequencing and turn taking in conversations (Segalowitz & Kehayia, 2011). Jefferson’s research (1988) has focused on the sequencing of troubles talk. In terms of understanding the process and cycle of empathic communication, the investigation of the sequencing of conversation is fundamental. Sequencing alone, however, does not necessarily provide enough details to gain a better understanding of the types of responses. Pudlinski (2005), on the other hand, has identified seven types of responses used to communicate empathy and/or sympathy<sup>3</sup> in addition to describing their sequencing within conversations.

In all, Pudlinski identified 53 responses of expressed empathy and/or sympathy from 44 calls of a peer-run support line offered as a pre-crisis mental health service. The responses were grouped into the following seven different categories, which he labelled as “methods” of expressing empathy and/or sympathy, but could also be considered as *types* of responses:

- Naming other’s feelings
- Formulating the gist of the trouble
- Sharing similar experiences of similar feelings
- Reporting one’s own reaction
- Expressing one’s own feelings about another’s troubles
- Using an idiom
- Emotive reactions

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<sup>3</sup> Pudlinski makes no distinction is between empathy and sympathy because he suggests that the differences between the two concepts are too subtle to set clear distinctions. Again this conclusion underlines the difficulty in teasing apart the two constructs.

Pudlinski also mentioned other types of responses, such as minimal responses (e.g., “uh-huh”, “mm”), which were used to keep the conversation flowing, and use of assessments as response tokens that quantified the other’s trouble, among others. The identified types of responses were specific, simple, and straightforward and the central focus of the study. Moreover, Pudlinski’s “methods” can be compared with the types of responses identified in and scattered throughout health communication research on empathy. Table 1 provides a comparative overview of the different types of responses identified by Pudlinski and where near equivalents are found in health communication research.

**Table 1: Comparative Overview of the Different Types of Responses of Empathy and/or Sympathy**

Studies	<u>Types of Responses</u>								
	Naming feelings	Quantifying feelings or the trouble	Formulating the gist of the trouble	Sharing similar experiences or feelings	Reporting own reaction	Expressing own feelings	Using idioms	Emotive reactions	Validation
<b>Pudlinski (2005)</b>	<i>Naming of other's feelings</i>	<i>Assessments to quantify the trouble</i>	<i>Formulating the gist of the trouble</i>	<i>Sharing similar experience of similar feelings</i>	<i>Reporting one's own reaction</i>	<i>Expressing one's own feelings about another's trouble</i>	<i>Using an idiom</i>	<i>Emotive reactions</i>	
<b>Egan (2010)</b>	<i>Name the correct emotion</i>	<i>Name correct intensity of the feelings</i>	<i>- Summarising - Expressing hunches (advanced empathy)</i>	<i>Helper-self disclosure (not labelled as empathy, but included in helping process). Note: author strongly suggests that "sympathy" should not be used.</i>			<i>(Provided examples of idioms)</i>		
<b>Bylund &amp; Makoul (2005)</b>	<i>Level 3 &amp; 4: Acknowledgement and pursuit</i>			<i>Level 6: Shared feeling or experience</i>					<i>Level 5: Confirmation: legitimizing or validating</i>
<b>Suchman et al. (1997)</b>	<i>Effectively acknowledge the emotions</i>								
<b>Platt &amp; Keller (1994)</b>	<i>Name the affect</i>		<i>Name the patient's occult dilemma</i>						<i>Appreciate/ acknowledge the affect</i>
<b>Coulehan et al. (2001)</b>	<i>Identify the emotion</i>	<i>Identify nature and intensity of feelings, concerns or quandaries</i>							
<b><u>Different terms that refer to similar types of responses</u></b>									
<b>Morse et al. (2006)</b>	<i>Compassion: echoing of sufferers' sentiment</i>			<i>Commiseration: sharing mutual predicaments</i>		<i>Pity: feel sorry for</i>			<i>Sympathy: legitimizing</i>

## 2.4. Missing Element: Linguistic Forms

The previous section has revealed that a substantial amount of research has examined the communication of empathy. Although there is no consensus on the types of responses used to verbally communicate empathy, certain types of responses do recur throughout the health communication literature, yet they tend not to be the central focus of the studies. As much as the types of responses have been under-investigated, the linguistic forms of the types or responses have been analysed even less. In fact, it appears very much that intuition has been predominately called upon to suggest which linguistic forms can be used to communicate empathy.

In pedagogical material related to empathic communication, examples of types of responses used to convey empathy and some accompanying linguistic forms have been provided. For instance, Egan (2010) has provided step-by-step instructions for developing helping relationships. In fact, an entire chapter is dedicated to explaining empathic responding, in which general guidelines are provided, such as “use the right family of emotions and the right intensity,” “distinguish between expressed and discussed feelings,” “read and respond to feelings and emotions embedded in clients’ nonverbal behaviour,” and “be sensitive in naming emotions,” to cite a few (p. 169-170). There are specific examples of linguistic forms that illustrate each type of response as well. Most importantly, a basic “You feel...because...” formula, which consists of first naming “the correct emotion expressed by the person” and then indicating “the correct thoughts, experiences, and behaviours that give rise to the feelings” (p. 169) is presented. The author clearly states that people are to communicate the ideas of the formula *in their own words* and that they will know how to vary the types of expressions used in the formula with experience. Even though people are expected to use *their own words*, Egan gives several examples of how to adapt the formula to different situations. Regretfully, the authenticity of the formulated examples is not included; the reader is unsure if the examples are transcriptions of actual dialogue, what the author thinks is said, or even what the author thinks should be said.

Other pedagogical reference books related to building communication skills for patient care generally follow suit to Egan (2010), in that more focus is put on the concept of empathy as a whole, and types of responses and examples of linguistic forms are scattered

throughout the texts (for examples see Sully & Dallas, 2010; Hojat, 2007). Such materials are intended for native speakers and not developed to meet the needs of L2 learners. Should L2 learners use these materials, they are therefore left to themselves to conjure up their own expressions to fit in with a “*You feel...because...*”-type formula (Egan, 2010). Unlike native speakers, they do not share the same knowledge of the language; consequently, they may experience difficulty putting the formula *in their own words*.

Some studies in health communication have attempted to provide concrete examples of the linguistic forms used for empathic communication (Coulehan et al, 2001; Platt & Keller, 1994); unfortunately, once again, the authenticity and representativeness of the linguistic forms are questionable. For instance, Coulehan et al. (2001) have provided specific examples of what can be said, or done, to carry out communicative strategies such as active listening, framing or sign posting, reflecting the content, identifying and calibrating the emotion, and requesting and accepting correction. Unfortunately, no information has been provided concerning the corpus, namely whether it has been transcribed from actual dialogue or whether the authors themselves have written what they think is said, or what should be said. Comparably, Platt and Keller (1994) have provided explicit examples of linguistic forms regarding empathic communication, some were transcribed directly from recorded interactions and others were transcribed from recollection. Six steps of active empathy have been outlined and examples of what can be said between physicians and patients at the various steps have been given, however, the origins of the excerpts, whether transcribed from actual recordings or from recollection, are unspecified raising questions about the validity of the linguistic forms.

Based on a basic internet search for the terms “English for specific purposes,” “nursing” and “second language”, L2 pedagogical workbooks related specifically to teaching English for nursing are beginning to appear more and more but remain rather limited nonetheless, especially for a North American/Canadian context. To our knowledge, no workbook strictly focuses on teaching the verbal communication of empathy and/or sympathy for English L2 purposes. Moreover, considering that there is no theoretical framework for the concept of empathy and that the types of responses and linguistic forms have been under-investigated, the examples of responses and linguistic forms provided in such workbooks tend to be nonexistent (Wright & Cagnol, 2012), or provide a brief

overview of how to communicate empathy and are accompanied by some practice exercises (see Allum & McGarr, 2008; Allum & McGarr, 2010; Wright & Spada Symonds, 2011). For example, in two reference books that do have small sections on showing empathy, the types of responses proposed to communicate empathy vary from *using open questions, little medical jargon, talking about feelings* and *not putting up a barrier* (Allum & McGarr, 2010) to *using rising intonation with expressions to indicate understanding and support* and *giving advice sensitively* (Allum & McGarr, 2008). In Wright and Spada Symonds (2011), no types of responses that can be used to communicate empathy are proposed. Instead, audio dialogues are provided and students are asked to identify the degree to which empathy is expressed in the dialogues based on a simple definition of the term. Lastly, the origins of the linguistic forms proposed to communicate empathy, whether they were drawn from intuition or corpus analysis, are unknown in the three reference books that do have sections on empathy (Allum & McGarr, 2008; Allum & McGarr, 2010; Wright & Spada Symonds, 2011). The audio recordings provided with the aforementioned books are mostly of British dialogues, but there are some North-American dialogues. The cultural appropriateness of the proposed linguistic forms in these references books for a Canadian context is therefore also questionable.

To obtain a better understanding of the verbal communication of empathy and/or sympathy, it would therefore be beneficial to adopt an evidence-based approach to analyse the most frequently used types of responses and accompanying linguistic forms actually produced by native speakers.

### **3. Research Methods**

#### **3.1. Introduction**

The two research objectives of this study are directly linked to gaps in existing research. First, similar types of responses used to verbally communicate empathy and/or sympathy are referred to across numerous studies, yet few studies had investigated which types of responses are more frequent. Second, previous research has not adequately described the linguistic forms of the types of responses actually produced by native speakers. From an L2 training perspective, it would therefore be valuable to know what types of responses are more frequently used to communicate empathy and/or sympathy and how they are formulated linguistically. In the present study, the actual speech produced by nurses was examined by using the *Bilingual L2 Training Corpora (BL2TC)* (French, 2012), which consist of orthographic transcriptions of nurse-patient dialogues from simulated health communication situations. In the current section, the research design, corpus, selected speech task and participants are described, and finally, the framework for data analysis is provided.

#### **3.2. Research Design**

The advantage of corpus-based research is that it can offer “improved reliability because it does not go to the extreme of rejecting intuition while attaching importance to empirical data” (McEnery et al., 2006, p. 7). For a large part, in health communication literature, intuition seems to have influenced the identification of the types of responses and linguistic forms used to communicate empathy and/or sympathy (see Coulehan et al., 2001; Egan, 2010; Platt & Keller, 1994). The findings of the present study, which were derived using the evidence-based approach of corpus linguistics, complement and add value to what already exists in health communication literature.

The BL2TC, which is a collection of orthographic transcriptions of nurse-patient dialogues from simulated health communication situations, was used for analysis. Simulated data of health communication situations is often relied upon for research purposes because of the ethical issues concerning nurse-patient confidentiality, which make it difficult to gather and analyse real nurse-patient interactions from real clinical interventions. Furthermore, the anglophone nurses who participated in the role plays of the

BL2TC were highly experienced and have participated a great deal in the kind of nurse-patient conversations under study. The utterances the nurses used in these role plays were, therefore, likely to be those that they have used or have heard used in the workplace and therefore represent realistic language.

### 3.3. Data Collection

In the present study, the actual speech produced by nurses was examined by using the BL2TC (French, 2012), which is an orthographic transcription of nurse-patient dialogues from simulated health communication situations<sup>4</sup>. The BL2TC is based on simulated role plays designed specifically to elicit the language that nurses use during nurse-patient interactions. The role plays for this study were filmed in a nursing lab of Champlain College Lennoxville located in Sherbrooke, Quebec, Canada.

The overall corpus consists of the speech of three groups of nurses: native-French speaking nurses, native-English speaking nurses and L2-English speaking nurses. All nurses interacted with native-speaking patient/actors in three speech tasks inspired from the research of Isaacs et al. (2001). The selected speech tasks were previously rated by nurses in Quebec for their high level of difficulty and emotionally-charged factors related to caregiving (Isaacs et al., 2001). For the current study, only one of the three speech tasks – *supporting a patient who received bad news* - from the native-English corpus was chosen for analysis because of the high likelihood that nurses would communicate empathy and/or sympathy with the patient due to the nature of the task (see Appendix 7.1. for an example of a transcript). The patient in this speech task was described as a 56 year-old man who had suffered a stroke and learned from his doctor that he would no longer be able to walk. In the nurse transcripts (NT) of the selected role play, there were a total of 13,689 words.

In the BL2TC, the participants for the role plays were 15 anglophone registered nurses from the Eastern Townships of Quebec, Canada. All were women and their ages ranged from 37 to 68 with the average age being 57. Their years of nursing experience varied from 8 to 47 years, with an average of 34.7 years. All nurses were still working within the field

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<sup>4</sup> Although the interactions were simulated, the BL2TC is a collection of spontaneous speech samples that were orthographically transcribed. The speech samples are considered spontaneous because the participants had not practiced their interaction beforehand. The BL2TC is also referred to as corpora because it matches the definition provided by McEnery et al. (2006): “a collection of sample texts, written or spoken, in machine-readable form which may be annotated with various forms of linguistic information” (p. 4).

of nursing, except for two who had retired. All had completed a college-level degree in nursing, three of which had also completed bachelor's degrees in different subjects. Of the three with bachelor's degrees, two had completed master's degrees and one of the two had completed a doctorate degree. In terms of language abilities, on a scale of one to seven, all rated their reading, writing, listening and speaking abilities in English as excellent (7), except for one person who rated her writing ability in English as a 6. All also spoke French as a second language at varying levels of proficiency; the majority spoke well enough to work in a French environment.

For the role plays, the nurses were told that the purpose of the study was to create a corpus of the language nurses used with patients, which would be used for L2 training purposes. No nurses were informed that their verbal communication of empathy and/or sympathy would be analysed. They were provided a brief description of the scenario before starting the actual role-play. The description of the role-play provided the hospital institution in which the scenario took place, the name of the patient, his age, why the patient was in hospital and the bad news he had received. The description contained no medical or technical details or care plan. Nurses were instructed to *support a patient who received bad news*, and they were told that they were in charge of the interaction and that they were to decide when and how to end the conversation. They were asked to try to maintain interaction for at least eight to 10 minutes or longer. All role-plays were transcribed orthographically and input into the UAM Corpus Tool (Version 2.8.12) (O'Donnell, 2007), a multi-layer annotation tool for text corpora.

### **3.4. Framework for Data Analysis**

#### **3.4.1. Explanation and Justification of Method of Analysis**

Normally in discourse analysis, types of responses are determined after completing an analysis of the data. For the present study, however, and in effort to build on the pre-existing conversational analysis of Pudlinski (2005) and health communication research of Bylund and Makoul (2002; 2005), eight types of responses were pre-determined and then examples of those types of responses were identified from the data. The types of responses chosen to be annotated in the corpus were selected because of their recurrence and existence in the research from the field of linguistics and health communication (see Table

1). It is important to mention that it is impossible to determine whether the types of responses selected for analysis in the current project entail a complete representation of the verbal communication of empathy and/or sympathy because the concepts are not theoretically defined.

Pudlinski's types of responses (2005) were primarily chosen because: 1) they were the findings of a conversational analysis; 2) they were simple and straightforward; and 3) because most existed in other health communication research, particularly that of Bylund and Makoul (2002). The types of responses identified by Bylund and Makoul were taken into consideration because: 1) they were similar to Pudlinski's types of responses; and 2) statistical findings of the types of responses were available (Bylund & Makoul, 2002; Bylund & Makoul, 2005).

Pudlinski's types of responses were taken as a starting point, and two adjustments were made: inclusion of a "validating" response (Bylund & Makoul, 2002); and removal of "idiom" as a type of response (Pudlinski, 2005). First, validating was included for analysis because equivalent terms, confirmation and legitimizing, were included in the ECCS and were of the more frequently used responses (Bylund & Makoul, 2002; Bylund & Makoul, 2005). Second, the use of an idiom as a type of response (Pudlinski, 2005) was disregarded because an "idiom" was judged too difficult to identify, particularly in English, due to the vast amount of phrasal verbs that could be considered as idioms.

To be able to identify the types of responses in the corpus, specific definitions were attributed to each (see Table 2). The definitions were conceived based on the examples and/or definitions provided by Pudlinski (2005), Bylund and Makoul (2002), and the Oxford Dictionary of Current English (1998).

Using the UAM Corpus Tool, the NT of the corpus were annotated per type of response, which means that when an utterance of the NT fit any of the eight defined types of responses, that utterance was labelled as per the applicable type of response. It was possible that an utterance matched the definition of more than one type of response; in which case, there was more than one annotation per utterance.

<b>Types of Responses</b>	<b>Definitions and Examples</b>
1) Emotive reactions	A short emotionally-charged utterance expressing concern in reaction to news of another's trouble (e.g.: "Oh," or "Gee:s.") (Pudlinski, 2005).
2) Making assessments	Used to mark the news as troubling to the listener and quantifies the "badness" of the news (e.g.: "That's not fair" or "That's awful") (Pudlinski, 2005).
3) Naming other's feelings	Listener states how the other person feels about the 'bad' news (e.g.: "Clobbered") (Pudlinski, 2005).
4) Formulating the gist of the trouble	Listener states the root/essence of what is causing difficulties for the patient, underscoring the significance of the trouble. It is likely to encourage further discussion of this trouble as formulated (Pudlinski, 2005).
5) Expressing one's own feelings	Report of how one personally feels with regards to another's trouble (e.g.: "Sorry to hear that") (Pudlinski, 2005).
6) Reporting one's own reaction	Conditional statement indicating how one would feel in reaction to 'bad' news (e.g.: "I would feel pretty angry") (Pudlinski, 2005).
7) Sharing a similar experience	An assertion of similarity, a report of similar feelings/problems, and perhaps a report of attempts to remedy those feelings (e.g.: ""I feel that way too sometimes,""I know what you're talking about") (Pudlinski, 2005, p. 281).
8) Validating	To make valid (defensible) by normalising, agreeing, or giving importance (e.g.: "I understand," "I know," or "It's normal.").

The annotation process was executed in three distinct phases. First, by reading all transcripts and viewing the accompanying video recording when necessary, utterances that fit the various definitions of the aforementioned types of responses were annotated. The definition of an utterance was taken from Ring et al. (2005): "a piece of speech which has sufficient meaning to be coded" (p. 1508). When certain utterances are difficult to attribute to a certain type of response, they were tagged in a temporary category. After the entire corpus was annotated, a second series of annotations took place in which the temporarily tagged utterances were reviewed and either re-annotated as per the definitions of the type of responses, or their temporary annotation was simply deleted because the tagged utterance did not match with any of the definitions. Afterwards, a third series of annotations took place in which all utterances were scanned per type of response to determine whether any utterances had been improperly classified. If an utterance was improperly categorised, it was re-annotated as per the proper definition. If an utterance clearly did not fit any of the definitions of the type of responses, the annotation was deleted. The accuracy of the annotations was reviewed three times by reading over all the nurse-patient dialogues. If an

utterance had not been annotated or was discovered to have been improperly annotated, it was put in a temporary category prior to being added to or deleted from the previously annotated utterances. All annotated utterances underwent a final revision to ensure they had been properly classified per type of response. Appendix 7.2. provides some examples of linguistic forms annotated per two types of responses: validating and making assessments.

### **3.4.2. Analysis of Findings**

Once the annotation process was completed, a mixed methods (quantitative-qualitative) approach was used to analyse the corpus. First, all annotated utterances were extracted as per the types of responses, which generated descriptive statistics as to the number of utterances for each type of response. It was also possible to assess how many of the 15 nurses used each type of response by counting the number of types of responses per nurse. These descriptive statistics allowed examination of the first research objective, which was to assess which types of responses were more frequently used.

The second research objective consisted of comparing the most recurring lexical bundles of two-word phrases and surrounding variable slots per type of response. Due to the limited size of the corpus, it was impossible to normalise frequency counts in order to compare findings with a large corpus, which is standard practice in corpus linguistics (McCarthy & Carter, 2006). There was therefore no pre-determined cut off frequency point because the frequency of occurrence of two-word phrases varied too greatly in each type of response. Instead, the first, second and occasionally third most frequent two-word phrases were analysed per type of response. The most recurring two-word phrases and surrounding variable slots were selected for analysis because of the high likelihood that they would illustrate how nurses framed the type of response. Furthermore, it was decided to include analysis of grammatical words for two main reasons: 1) they can provide a great detail of information on how to formulate the syntactic structure of a type of response (Celce-Murcia & Larsen-Freeman, 1999); and 2) communicating empathy and/or sympathy is an abstract speech task, which may not necessarily be best conveyed through use of lexical or content words. The contextual meaningfulness of both grammatical words and content words per type of response was therefore considered when identifying which linguistic forms merited further investigation.

## **4. Findings**

The BL2TC is specialised corpora and is considered quite small from a corpus-linguistic perspective, in that a “small” corpus is defined as containing one million words or less (Sinclair, 1991). The particular corpus selected for analysis consisted of the NT of one role play, which contained only 13,689 words. Nevertheless, the information gathered from this corpus should not be automatically discredited, for:

Any source of information about language has to be evaluated carefully, but at least you will know what is in your corpus and where it came from; what is more, if any pattern or usage occurs more than once from apparently independent sources then there is a very strong possibility that it is a regular pattern in the language (Sinclair, 2004, p.288).

In the BL2TC, there is the advantage of knowing the origins of the corpus and that it is a collection of the spontaneous speech of fifteen independent sources (i.e., fifteen different nurses). In the present study, considering the limited size of the corpus, the findings should therefore not be over-generalised; instead, recurring usage and patterns of language from different nurses should be interpreted as statistical clues that are worthy of further investigation and could be considered for the development of pedagogical materials.

### **4.1. Type of Responses**

The first research objective was to identify which types of responses were more frequently used to verbally communicate empathy and/or sympathy by anglophone nurses. Table 3 illustrates the frequency of occurrence of each type of response and the number of nurses who actually used the type of response. Of the eight types of responses that were investigated, four types of responses represented 90% of the occurrences. The four most frequent types of responses were: formulating the gist of the trouble (32%); validating (29%); naming feelings (17 %); and making assessments (12%). All 15 of the nurses formulated the gist of the trouble and validated the patient. Only 13 of the 15 of the nurses named feelings and 11 made assessments. The other four types of responses constituted the remaining 10% of occurrences and were used by only a minority of the nurses: emotive reactions (4% rate of occurrence; used by 6 of the nurses); expressing one’s own feelings (3% rate of occurrence; used by 5 of the nurses); reporting one’s own reaction (2% rate of

occurrence; used by 5 of the nurses); and sharing a similar experience (1% rate of occurrence; used by 2 of the nurses) (see Table 3).

<b>Table 3: The Frequency of Occurrence of Each Type of Response</b>				
<b><u>Types of responses</u></b>	<b>N of utterances per type of response</b>	<b>% of utterances per type of response</b>	<b>N of nurses who used type of response</b>	<b>% of nurses who used type of response</b>
Formulating Gist	104	32%	15/15	100%
Validating	92	29%	15/15	100%
Naming Feelings	55	17%	13/15	87%
Making Assessments	39	12%	11/15	73%
Emotive reaction	12	4%	6/15	40%
Expressing one's own feelings	10	3%	5/15	33%
Reporting one's own reaction	6	2%	5/15	33%
Sharing a similar experience	3	1%	2/15	13%
<b>Total:</b>	321	100%		

## **4.2. Linguistic Forms per Type of Response**

The second research objective consisted of describing the most recurring linguistic forms per types of responses by focusing on the most frequent two-word phrases and the variable slots that preceded and/or followed the phrases. Findings are presented per type of response.

### **4.2.1. Formulating the Gist of the Trouble**

Formulating the gist of the trouble was the most frequently used type of response. Of the eight types of responses, it was used 32% of the time (104 occurrences). Formulating the gist of the trouble was a response that was used by all 15 nurses, and was defined as follows: listener states the root/essence of what is causing difficulties for the patient, underscoring the significance of the trouble. It is likely to encourage further discussion of this trouble as formulated (Pudlinski, 2005).

#### 4.2.1.1. “It is” and Variable Slots

The most frequent two-word phrase used to formulate the gist of the trouble was the non-referential subject “it is” + *S* (with *S* referring to a variable slot). There were 37 occurrences<sup>5</sup> in the formulating-the-gist type of response of the phrase “it is”, of which all but one<sup>6</sup> were in the contracted form of “it’s”. Moreover, in the NT, “it is” occurred 125 times, which means that “it is” was used 30% of the time to formulate the gist of the trouble. The variable slot following the “it is” phrase was most frequently filled by the following types of words:

- It is + ADV (54% - 20 occurrences by 7 nurses)
- It is + DET + [ADJ] + NOUN (16% - 6 occurrences by 2 nurses)
- It is + ADJ (14% - 5 occurrences by 5 nurses)

Table 4 provides a list of the words used in the variable slot following the “it is” phrase.

Table 4: Word List of “IT IS” and Variable Slots		
It is + ADV + <i>S</i> ( <i>S</i> being either ADJ; VERB; DET + NOUN; or CONJ )		
<b>it’s not (6/4)*</b> - easy (2/2) - gonna (1/1) - n/a (1/1)	- the end (1/1) - the same (1/1)	<b>it’s just (3/2)</b> - gonna (2/1) - that (1/1)
<b>it’s too (2/1)</b> - early (2/1)	<b>it’s very (2/2)</b> - early (1/1)- fresh (1/1)	<b>it’s like (2/1)</b> - when (1/1) - a period of grieving (1/1)
<b>it’s quite (1/1)</b> - difficult (1/1)	<b>it’s really (1/1)</b> - hard to figure out (1/1)	<b>it’s certainly (1/1)</b> - not the life (1/1)
It is + DET + [ADJ] + NOUN		
it’s a new reality (1/1)	it’s a matter of coming to terms (4/1)	it’s a process (1/1)
It is + ADJ		
<b>it’s hard (4/3)</b> - it’s hard to take (3/2) - it’s hard to see (1/1)	it’s early (1/1)	

\* (N of occurrences / N of nurses who said the occurrence)

Adverbs and adjectives most often followed the “it is” phrase, yet they tended to be limited to those of degree (e.g., adverbs: too, quite, just, very, really, certainly; adjectives: easy, difficult, hard) or time (e.g., adverbs: soon; adjectives: early, new). Three types of

<sup>5</sup> For all of the types of responses and in the NT, all occurrences, including false starts, were counted.

<sup>6</sup> In the utterance where “it is” was not in a contracted form, “it is” was in a subordinating clause: “If you let me know what it is, then maybe we can find other solutions.”

lexical bundles containing the word “hard” were also used: *hard to figure out*, *hard to take* and *hard to see*. The types of nouns that were used after the “it is” phrase often referred to a process (e.g., *a period of grieving*, *a matter of coming to terms*, *a process*) or to a change (e.g., *not the end*, *not the same*, *not the life*, *a new reality*). All excerpts are also available in Appendix 3.

#### 4.2.1.2. “You are” and Variable Slots

The second most frequent two-word phrase used to formulate the gist of the trouble was “you are” (21 occurrences); however, when compared to the rest of the NT, “you are” (always in the contracted form of “you’re”) was only used 17% of the time to formulate the gist of the trouble. It was followed by “going to” in 8 occurrences (by 5 nurses), which represented 38% of the cases. The 38% can be broken down further whereby 24% (5 occurrences by 3 nurses) consisted of the sequences “*you are*” + *negative* + “*going to*” and the remaining 14% (3 occurrences by 3 nurses) were simply “*you are*” + “*going to*”. Two different negations were used with the form “going to”, which were “not” and “never”. All other sequences that followed “you are” varied and only occurred once, except for when the present continuous verb tense was used, but it occurred only 3 times.

#### 4.2.1.3. “Going to” and Variable Slots

The third most frequent two-word phrase when formulating the gist of the trouble was “going to” with variable slots preceding and following the phrase. There were 18 occurrences to “going to” that were used to formulate the gist of the trouble, of which 10 (56%) were in the form “gonna”. In the NT, there were 67 occurrences of “going to” (“gonna” and “going to” combined), which means that “going to” was used 27% of the time to formulate the gist of the trouble. The most frequent words<sup>7</sup> that filled the variable slot preceding “going to” were:

- “You are” + [ADV] + “going to” (44% - 8 occurrences by 5 nurses)
- “It is” + [ADV] + “going to” (27% - 5 occurrences by 4 nurses)
- “That is” + [ADV] + “going to” (17% - 3 occurrences by 3 nurses)

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<sup>7</sup> There were two other occurrences where the subject of “going to” differed (i.e., “she is” [referring to the patient’s wife] + “going to”; “they are” [referring to the patient’s legs] + “going to”).

“Going to” was almost always directly followed by a verb, except for one case where it is followed by an adverb then a verb, and another case where it was followed by an inserted phrase and then a verb. In half of the utterances, “going to” was preceded by a negative adverb. Table 5 provides a list of the verbs used in the variable slot following the “going to” phrase.

All the verbs that were said are of the 1000 most spoken words of the English language (Longman dictionary of contemporary English, 2009). Half of the verbs that were used were put in a negative form. The verbs that were used with “it’s” were: *change* and *be* (state of being verbs), and *take some time* and *take a little time*, which are expressions related to time and process. The verbs that were used with “you’re” were: walk (action verb), accept and need (mental verbs), be able to (state of being verb), have to (modal of obligation). For the two remaining verbs that had subjects other than “it’s”, “you’re” or “that’s”, one was a phrasal verb indicating an action (e.g., *come back*) and the other was a state of being verb (e.g., *be*). All excerpts are also available in Appendix 4.

<b>Table 5: Word List of “Going to” and Variable Slots</b>			
<b>It’s + [ADV] + going to + VERB</b>	<b>You’re + [ADV] + going to + VERB</b>	<b>That’s + [ADV] + going to + VERB</b>	<b>S + going to + VERB</b>
- not...change (1/1)*	- not/never...walk (2/1) - not...accept (1/1) - not/never...be able to (2/2) - not...have (1/1)	- not...happen (1/1)	- <i>they [the legs of the patient] are not...come back (1/1)</i>
- change (1/1) - be (1/1) - <i>take a little time</i> (2/1)	- need (1/1) - have to tell (1/1)	- <i>take some time</i> (2/2)	- <i>She [the patient’s wife] is ...be (1/1)</i>

\* (N of occurrences / N of nurses who said the occurrence)

To summarise, the most frequent two-word phrases used to formulate the gist of the trouble when compared to the rest of the NT were “it’s”, “you’re” and “going to”. The phrase “it’s” was most often followed by an adverb and another variable slot filled by an adjective, verb or noun. The adverbs and adjectives tended to be limited to those of degree and time. The “you’re” phrase was most frequently followed by “going to”, which was the third most frequent phrase in this type of response. For “going to”, the most frequent preceding forms were “you’re”, “it’s” or “that’s”. In half of the utterances, a negative

adverb also preceded “going to”. The variable slot following the “going to” phrase was almost always directly followed by a verb.

#### 4.2.2. Validating

Validating was the second most frequently used type of response with a rate of occurrence of 29% (92 occurrences), and it was used by all 15 nurses. Validating was defined as: to make valid (defensible) by normalising, agreeing, or giving importance (e.g., "I understand..."; "I know..."; "It is normal...").

##### 4.2.2.1. “I know” and Variable Slots

For the validating type of response, the most frequent two-word phrase was “I know”, which was used by 11 of the 15 nurses. There were 38 occurrences of “I know” in the validating type of response and only 51 occurrences of “I know” in the NT; “I know” was therefore used 75% of the time to validate.

Of the 38 occurrences of “I know”, the two-word phrase was used as an independent clause 16 times (15 of which had no words in the object position of the sentence). In the remaining 22 occurrences, "I know" was used in a complex sentence 18 times (16 of which had an ellipse of the conjunction “that”), and in a compound sentence 4 times. Table 6 provides a list of the words in the variable slot following “I know”. All excerpts are available in Appendix 5.

Table 6: List of “I know” and Variable Slots		
Independent clause	Complex sentence	Compound sentence
- I know. (15/5)* - I know that. (1/1)	- I know it (10/7) - I know you (5/3) - I know that (2/1) - I know this (1/1)	- I know but (3/2) - I know and (1/1)

\* (N of occurrences / N of nurses who said the occurrence)

There were no recurring sequences that preceded or followed "I know" when it was used on its own as an independent clause; however, in all 15 occurrences, “I know” was used in response to a negative utterance made by the patient: he either explicitly made a negative sentence, used sarcasm (e.g., “Just friggen’ great”), or words with high degrees of negativity (e.g., “stupid”). Moreover, “I know” seems to be used to respond to a feeling,

emotion or intention that the patient had not explicitly stated (e.g., “I’m not hungry,” can imply that the speaker is upset).

When used in a complex sentence, “I know” was directly followed by “it is” (“it’s”) in 8 of the 10 occurrences<sup>8</sup>; there was an ellipsis of the conjunction “that” (e.g., “I know [that] it is ...”). The sequences following “I know it is” were not recurring and varied; however, all following sequences had a negative connotation because either the subjectivity of a word was negative (e.g., “hard,” or “difficult,”), a negative sentence was used, or it was implied that the situation was not ideal (e.g., “a big change,” or “it’s early”). In addition, there was also an ellipsis of the conjunction “that” in the phrase “I know you”, which recurred 5 times and was done in such a way that the patient’s feelings were named. The feelings were named either directly using “you are,” or “you feel” (e.g., “I know you are depressed,” “I know you feel like...,”) or indirectly (e.g., “I know you are not hungry,” “I know you are not ready to hear this,” and “I know you do [want your legs back].”) The subordinating conjunction “that” was only used twice by the same nurse (e.g., “I know that you feel...” and “I know that that’s not making you feel better...”).

The compound sentences containing “I know” were less frequent. There were only 4 occurrences of “I know” being used in a compound sentence with connectors “but” or “and”.

#### **4.2.2.2. “I understand” and Variable Slots**

The phrase “I understand” occurred 13 times in the validating type of response and was used by 7 different nurses. In the NT, “I understand” recurred 16 times; therefore, the phrase “I understand” was used 81% of the time to validate. There were three types of variable slots associated with the phrase “I understand” as shown in Table 7. All excerpts are also available in Appendix 6.

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<sup>8</sup> In the two remaining occurrences following “I know it,” the words “feels” and “does” were used.

Table 7: Types of Variable Slots Associated with “I understand”	
“I understand.”	- I understand. (3/3)*
“I understand” + S	- I understand that. (2/2)
“I” + S + “understand”	- I can understand (7/4) - I do understand (1/1)
“I” + S + “understand” + S	- I can understand that (3/2) - I can understand why <sup>9</sup> (1/1) - I can understand your (1/1)

\* (N of occurrences / N of nurses who said the occurrence)

“I understand” was most frequently used in a simple sentence (9 occurrences), less frequently used in a compound sentence (3 occurrences), and rarely used in a complex sentence (1 occurrence). On 2 occasions, 2 different nurses used the word “that” following “understand” to explicitly refer to something that the patient had previously said (see Appendix 6 for excerpts). Lastly, words like “can” and “do” were placed before the word “understand” as emphatic markers.

#### 4.2.2.3. Other Observations

There were two other words that frequently occurred in the validating response when compared to the rest of the NT that may be worth investigating in a larger corpus. They were “normal” (used 100% of the time to validate) and “important” (used 42% of the time to validate). The actual recurrence of the words “normal” and “important”, however, were low in the validating type response: “normal” was used only 7 times by 4 nurses and “important” was used only 5 times by 2 nurses.

To summarise, the most frequent two-word phrases and variable slots of the validating type of response were “I know + [S]” and “I + [S] understand [S].” For the preferred sequencing, “I know” was used most often in an independent clause with no complement, or it was used in a complex sentence. In contrast, variants of “I understand” were rarely used in complex sentences; they were mostly used in simple sentences. Moreover, “can” was used as emphatic markers with “I understand,” but that did not occur with “I know.” In addition, for “I understand,” the word “that” was used to refer to

<sup>9</sup> “I understand why” was the only utterance used in a complex sentence.

something that the patient had previously said; this did not occur with “I know.” Lastly, the words “normal” and “important” had a high frequency rate in the validating type of response when compared to the rest of the NT.

#### **4.2.3. Naming Feelings**

Naming feelings was the third most frequent type of response with a rate of occurrence of 17% (55 occurrences), and it was used by 13 of the 15 nurses. Naming feelings was defined as: listener states how the other person feels about the 'bad' news (e.g., "Clobbered") (Pudlinski, 2005).

##### **4.2.3.1. Two-Word Phrases and Variable Slots**

For the naming-feelings type of response, the most frequent two-word phrases were “you are” (“you’re”) (19 occurrences), “it is” (“it’s”) (11 occurrences) and “I know” (10 occurrences); however, when compared to the NT, the rate of occurrence of these three phrases in the naming-feelings type of response was low (15%; 9%; 20%). Other analyses were carried out in order to identify data that could be further investigated.

##### **4.2.3.2. Other Observations**

The use of “I know,” which, when compared to the NT, was used 75% of the time to validate and 20% of the time to name feelings, reveals that naming feelings may have been frequently done while validating at the same time. To further investigate the possibility of there being frequent simultaneous use of two types of responses, the number of times the naming-feelings response was used while validating was verified. Of the 55 occurrences of the naming-feelings type of response, 20 occurrences (36%) were done by validating at the same time by 9 different nurses (see Table 8).

Table 8: Excerpts of Utterances Annotated as Naming Feelings and Validating		
#	Excerpts	Nurse ID
1	And it's ok to grieve.	1
2	It's ok to be mad because that is part of the whole.	
3	because right now I know you're depressed,	2
4	I know you're not hungry.	
5	I know it's uh, not something you want to perhaps think about now,	3
6	I know it's hard for you to hear that at this time, and it will take time for you to come to terms with that.	5
7	I can understand your frustration.	
8	I know you're not ready to hear this,	
9	No, you're not ready to, to talk to anybody about that.	
10	I know it feels that way right now,	6
11	I know that that's not making you feel better,	
12	I know this is probably not what you wanna hear right now,	
13	So, you know, I know that you feel that you're going to be stuck in your house all day,	
14	Well, I know you feel like, you know, your independence has been taken away.	7
15	And and it's normal to feel that way.	
16	So it's, it's normal to be uh, upset and you know,	
17	No. No, I'm sure you're not.	8
18	You know that that's a very normal feeling that you have	10
19	I can understand why you don't feel like eating.	14
20	It's very normal to feel the way you're feeling.	

#### 4.2.3.3. Preferred Sequences

Considering that no two-word phrases and variable slots stood out in terms of their frequency of use for the naming-feelings type of response especially when compared to the NT, the preferred sequencing (i.e., the preferential order in which different types of words are combined to make an utterance) of all utterances of the naming feelings response was investigated instead.

In all, there were 55 different occurrences of naming the patient's feelings. Of these 55 occurrences, 22 (40%) were done by 8 different nurses in the form of a question. The

question was formulated by either using tag questions (8 occurrences (36%) by 5 different nurses), using rising intonation at the end of a statement (7 occurrences (32%) by 5 different nurses), or asking a direct question (7 occurrences (32%) by 5 different nurses) (see Table 9, Table 10 and Table 11 for excerpts).

Tag questions were done as formal tag questions, in which the auxiliary of the sentence is repeated in negative form, in only 3 of the 8 occurrences. In the remaining 5 occurrences, transformed tag questions were done by simply saying, “eh?” “right?” or “hm?” at the end of the statements (see Table 9). Statements with rising intonation and direct questions were also used to name the feelings of the patient (see Table 10 and 11).

#	Excerpts	Nurse ID
1	It's not the end for you, <u>is it</u> ?	1
2	Kind of frustrating, <u>isn't it</u> ?	
3	That's a big thing, <u>isn't it</u> ? Worry?	3
4	You're angry, <u>eh</u> ?	7
5	and uh, maybe once your wife gets here, you'll feel a little better as well, <u>right</u> ?	
6	Yeah, it's overwhelming, <u>eh</u> ?	
7	Just great, <u>hm</u> ?	10
8	You don't feel hungry, <u>eh</u> ?	14

#	Excerpts	Nurse ID
1	You don't think that it might help to talk with your friend?	3
2	Let him know what you're, suffering?	
3	And this is why you're so upset and you're not eating?	6
4	Not feeling uh, feeling a little depressed?	7
5	You feel angry?	
6	You feel angry?	10
7	So you're worried that you are not going to get the same respect at work?	15

<b>#</b>	<b><u>Excerpts</u></b>	<b>Nurse ID</b>
1	Are you uh, kind of disappointed that you're not getting better?	6
2	I'm saying depressed, but can you elaborate a bit?	7
3	What are you worrying about?	
4	Ok, you don't, do you feel you don't want to disturb her? Uh?	8
5	Are you angry?	14
6	How is it changing, how, how you feel, or how you think they're going react?	15
7	Is that what, is that uh, what's bothering you?	

To summarise, there were no two-word phrases and variable slots for the naming feelings types of response that stood out in terms of frequency when compared to the rest of the NT. It was discovered, however, that the naming feelings type of response was often done while validating because of the recurring use of the word “know”. Furthermore, analysis of the preferred sequencing of all utterances of this type of response revealed that feelings were often named in the form of a question as tag questions, statements with rising intonation, or as direct questions.

#### **4.2.4. Making Assessments**

Making assessments was the fourth most frequent type of response with a rate of occurrence of 12% (39 occurrences), and it was used by 11 of the 15 nurses. It was defined as: used to mark the news as troubling to the listener and quantifies the ‘badness’ of the news (e.g.: "That's not fair"; "That's awful") (Pudlinski, 2005).

##### **4.2.4.1. Two-Word Phrases**

For the making assessments type of response, the most frequent two-word phrases were “it is” (“it’s”) (12 occurrences) and “that is” (“that’s”) (5 occurrences). These phrases, which are similar in form because “it” and “that” are neutral subjects, represented a total of 44% of the occurrences for this type of response; however, when compared to the rest of the NT, the rate of occurrence of these two phrases was low (10%; 9%). Further analysis of all the 39 occurrences for the assessments type of response revealed that the other most frequently used subject of the sentence did not exist: there was an ellipse of the subject in

15 occurrences, which represented 38% of all occurrences. In 82% of the occurrences for the assessments type of response, the subject of the utterance was therefore either neutral (44% of the time) or missing (38% of the time).

#### **4.2.4.2. Variable Slots**

In 82% of the occurrences of the assessments response, the subject of the utterance was either neutral (“it” or “that”) or simply missing. Consequently, these neutral or missing subjects put more attention to the words that were, or would be, after the verb, which was what stood out from the annotation because a variety of words were used to quantify the badness of the situation. These words were in the form of adjectives, adverbs, and nouns. See Table 12, Table 13 and Table 14 for the lists of the different adjectives, adverbs, and nouns that were used.

The types of adjectives that were used were adjectives related to size (e.g., big, great, huge, major, tremendous), degree (e.g., difficult, hard, not easy, rough) and emotion (e.g., shocking, upsetting). The adverbs that were used were adverbs of degree (e.g., absolutely, certainly, exactly, etc.). The subjectivity of the nouns that were used often had more negative connotations (e.g., bummer, shock, challenge, load, pain), but some were more neutral (e.g., report, news, point, surprise) (O’Donnell, 2007).

**Table 12: List of Adjectives and Excerpts**

#	Adjectives	Excerpts	Nurse ID
1	Big	It's a <b>big</b> load. Mm-hm?	10
2	Difficult	Hm, very very <b>difficult</b> . Mm, very very <b>difficult</b> .	3
3	Great	I realise it's a <b>great</b> shock, losing your legs	9
4	Hard	It's <b>hard</b> news to digest, isn't it?	11
5		Hm, that is really, <b>hard</b> .	3
6	Huge	It's <b>huge</b> .	3
7	Incredible	That's an <b>incredible</b> shock, isn't it?	4
8	Major	<b>major</b> .	6
9	Not easy	It <b>can't be easy</b> .	2
10		<b>Not easy</b> to do.	7
11	Real	I know, and it's a <b>real</b> pain in the butt.	12
12	Right	That's <b>right</b> .	10
13		That's <b>right</b> .	12
14	Rough	<b>Rough</b> .	3
15	Shocking	maybe not today as it's pretty <b>shocking</b> news to hear.	3
16	Tremendous	Yes, and that's a <b>tremendous</b> challenge to you.	4
17	Upsetting	But it's an extremely <b>upsetting</b> report to receive from the physician.	3

Table 13: List of Adverbs and Excerpts			
#	Adverbs	Excerpts	Nurse ID
1	Absolutely	<u>Absolutely</u> .	7
2	Certainly	No, it <u>certainly</u> is not the point.	1
3	Exactly	<u>Exactly</u> .	6
4		<u>Yeah, exactly</u> .	7
5		<u>Exactly</u> .	
6		<u>Exactly</u> .	9
7	Extremely	But it's an <u>extremely</u> upsetting report to receive from the physician.	3
8	for sure	It is, <u>for sure</u> .	7
9	Perhaps	<u>Perhaps</u> not.	3
10	Pretty	maybe not today as it is <u>pretty</u> shocking news to hear.	3
11	Quite	That must have been <u>quite</u> a uh, quite a surprise.	13
12	Very	It is, <u>very</u> much so.	1
13		Hm, <u>very very</u> difficult.	3

Table 14: List of Nouns and Excerpts			
#	Nouns	Excerpts	Nurse ID
1	Bummer	It's a <u>bummer</u> .	12
2	Challenge	Yes, and that's a tremendous <u>challenge</u> to you.	4
3	Load	It's a big <u>load</u> . Mm-hm?	10
4	News	maybe not today as it's pretty shocking <u>news</u> to hear.	3
5		It's hard <u>news</u> to digest, isn't it?	1
6	Pain	I know and it's a real <u>pain</u> in the butt.	12
7	Point	No it certainly is not the <u>point</u> .	1
8	Report	But it's an extremely upsetting <u>report</u> to receive from the physician.	3
9	Shock	That's an incredible <u>shock</u> , isn't it?	4
10		I realise it's a great <u>shock</u> , losing your legs,	9
11	Surprise	That must have been quite a uh, quite a <u>surprise</u> .	13

To summarise, there were no two-word phrases in the assessments type of response that stood out in terms of frequency when compared to the rest of the NT. Many of the utterances of the assessments type of response, however, contained a neutral subject (i.e., “it” or “that”) or no subject at all. Neutral or missing subjects put emphasis on the words that were or would be after the verb. It was found that several adverbs, adjectives and nouns were used to quantify the badness of the news.

#### **4.2.5. Emotive Reactions**

Emotive reactions was the fifth most frequent type of response with a rate of occurrence of 4% (12 occurrences), and it was used by 6 of the 15 nurses. It was defined as: a short emotionally-charged utterance expressing concern in reaction to news of another's trouble (e.g.: "Oh"; "Gee:s") (Pudlinski, 2005).

##### **4.2.5.1. Recurring Utterances**

It was impossible to analyse recurring two-word phrases because there were only 12 occurrences of this type of response, and all utterances were one-syllable sounds, either “Oh” or “Mm”. “Oh” was said 7 times (one “Ohh” was longer and even more emotional than the others), but in the NT “Oh” was said 16 times; therefore, “oh” was used 44% of the time as an emotive response. “Mm” was used 5 times as an emotive response, but in the NT, “Mm” occurred 21 times; therefore, “Mm” was used 24% of the time as an emotive response. It was necessary to view the video recordings to determine which “Oh” and “Mm” were emotionally charged. All occurrences immediately followed something the patient had said. In 6 of the occurrences, the patient resumed talking after the nurse said her emotive reaction; in the remaining 6 cases, the nurse pursued talking (see Table 15).

To summarise, although there were not many occurrences of emotive responses, there were only two different forms that were used to respond to something the patient said. They were: “Oh” and “Mm”.

Table 15: Excerpts of Emotive Reactions				
#	Pre-text	Nurse:	Post-text	Nurse ID
1	<u>Patient</u> : About how I can't do anymore.	Mm.	<u>Patient</u> : Every simple step in a day changes.	1
2	<u>Patient</u> : No, she's uh, in Ottawa.	Oh.	<u>Patient</u> : I'll talk to her when her case is, is finished.	2
3	<u>Patient</u> : Yeah, but he's busy right now.	Oh.	It must be very difficult for you to be going through this by yourself. (Nurse)	
4	<u>Patient</u> : She is arguing a case in Ottawa.	Oh.	<u>Patient</u> : I don't want to interrupt her. It's a big deal.	
5	<u>Nurse</u> : Rehab, anything? When did you get this news? <u>Patient</u> : This morning.	Oh,	well I'm sorry about that. (Nurse)	
6	<u>Patient</u> : Fine.	Mm.	You look like you're upset. (Nurse)	3
7	<u>Patient</u> : Well apparently I'm not gonna be able to use my legs ever again. That's what he had to say.	Oh.	<u>Patient</u> : How's that for a visit?	
8	<u>Patient</u> : Well I don't know. What's the point? I can't walk.	Mm.	<u>Patient</u> : Can't bring my legs back.	
9	<u>Patient</u> : Tell me my legs aren't gonna work.	Ohh.	Do you remember specifically what he told you? (Nurse)	4
10	<u>Patient</u> : I felt like this is a change I didn't want.	Mm.	<u>Patient</u> : And nothing is ever gonna be the same again.	10
11	<u>Patient</u> : This is bad for business.	Mm.	Have you thought about what uh, could make things better for you right now? (Nurse)	
12	<u>Patient</u> : Uh, I I dunno know. He told me this morning and I kinda	Oh,	you just learnt this morning? [...] (Nurse)	12

#### 4.2.6. Expressing One's Own Feelings

Expressing one's own feelings was the sixth most frequent type of response with a rate of occurrence of 3% (10 occurrences), and it was used by 5 of the 15 nurses. It was defined as: report of how one personally feels with regards to another's trouble (e.g.: "Sorry to hear that") (Pudlinski, 2005).

##### 4.2.6.1. Two-Word Phrases and Variable Slots

Expressing one's own feelings was an infrequently used type of response; therefore there were little recurring two-word phrases. The most frequent phrase was "I am" ("I'm")

with 6 occurrences, and it was used by 3 of the 5 nurses who used this type of response. In the rest of the NT, “I am” was used 97 times; therefore, “I am” was used only 6% of the time to express one’s own feelings in the NT.

In 5 of the 6 occurrences with “I am,” 2 nurses used “I am” in combination with the word “sorry”. In the NT, the word “sorry” was used a total of 9 times; therefore, “sorry” was used 56% of the time to express one’s own feelings in response to a bad situation. The 4 remaining times in the NT, “sorry” was used as an actual apology for something that the nurse had said, or to ask the patient to repeat what he had said. See Table 16 for excerpts containing the word “sorry” in the expressing-one’s-own-feelings type of response.

<b>Table 16: Excerpts of “I am” with the Word “Sorry”</b>		
<b>#</b>	<b>Excerpts</b>	<b>Nurse ID</b>
1	I’m really sorry you received that news.	3
2	Mm, I’m very sorry.	
3	I’m very sorry that you had this happen to you.	
4	I’m sorry about that.	2
5	Well, I’m sorry about that.	

To summarise, although the response expressing one’s own feelings was infrequently used, the cultural expression “I’m sorry” was the recurring lexical bundle in this type of response.

#### **4.2.7. Reporting One’s Own Reactions**

Reporting one’s own reactions was the seventh most frequent type of response with a rate of occurrence of 2% (6 occurrences), and it was used by 5 of the 15 nurses. It was defined as: a conditional statement indicating how one would feel in reaction to 'bad' news (e.g.: "I would feel pretty angry") (Pudlinski, 2005).

##### **4.2.7.1. Two-Word Phrases and Variable Slots**

“I would” was the most frequent two-word phrase with 5 occurrences for the reporting-one’s-own-reactions type of response. In the NT, there were 12 occurrences of “I would”; therefore, “I would” was used 42% of the time to report one’s own reaction.

In 3 of the 5 occurrences, the three-word phrase “I would be” was used and was directly followed by the words “upset too” (1 time), by the words “very upset” (1 time) and by “pretty depressed myself” (1 time). For the 2 remaining occurrences, “I would” was framed by: “I don’t know what I would do,” and “I don’t know how I would feel.”

To summarise, the reporting-one’s-own-reaction type of response was infrequently used; however, the two-word phrase “I would” frequently recurred in this response.

#### 4.2.8. Sharing a Similar Experience

Sharing a similar experience was the least frequent type of response with a rate of occurrence of 1% (3 occurrences), and it was used by 2 of the 15 nurses. It was defined as: an assertion of similarity, a report of similar feelings/problems, and perhaps a report of attempts to remedy those feelings (e.g.: "I feel that way too sometimes," "I know what you're talking about," and "I know what it's like") (Pudlinski, 2005, p. 281).

##### 4.2.8.1. Two-Word Phrases and Variable Slots

Sharing a similar experience was the least frequently used type of response, and it was used by only 2 nurses; therefore, it was not possible to identify the most frequent two-word phrases. Moreover, when it was used, it could not be broken down into individual utterances because the type of response was told in the form of a story; hence, the preferred sequencing of the utterances could not be assessed either. See Table 17 for excerpts.

#	Excerpts	Nurse ID
1	And sometimes with a diagnosis like yours, people will avoid you because they don’t know what to say. And yet, here I am.	2
2	Well, even so, sometimes uh, old friends will come forward to help even if you haven’t communicated for a while. That has happened to me...	
3	Sometimes this happens with um, you know, very young people too. People that, you know, dive into a swimming pool or something and um, break their neck and	6

To summarise, the sharing-a-similar-experience type of response was infrequently used, and no recurring linguistic forms were worth mentioning.



## **5. Discussion**

The overall aim of this research was to obtain a better understanding of the types of responses and accompanying linguistic forms that anglophone nurses from Quebec used to verbally communicate empathy and/or sympathy. The specific research objectives were to 1) identify the frequency of use of the eight types of responses selected from the literature; and 2) describe the most recurring linguistic forms, specifically the most recurring lexical bundles of two-word phrases and variable slots, of each type of response. This section will summarise the findings associated with each objective by relating them to what had been identified in the literature review, provide conclusions as to how the findings have contributed to better understanding the concept of empathy and/or sympathy and suggest directions for future research.

### **5.1. Research Objective 1: Summary of Findings and Conclusions**

For the first research objective, the literature has shown that although no theoretical framework of the concept of empathy exists, there is some consensus as to the types of responses that are used to verbally communicate empathy and/or sympathy. In studies from the fields of health communication (Bylund & Makoul, 2002; Bylund & Makoul, 2005; Coulehan et al., 2001; Egan, 2010; Platt & Keller, 1994; Suchman et al., 1997) and linguistics (Pudlinski, 2005), similar types of responses have been mentioned among researchers. The findings of the present study concur with the literature in that the eight types of responses selected from the literature (Bylund & Makoul, 2002; Pudlinski, 2005) were also present in the BL2TC.

Although it appears generally accepted that certain types of responses are used to verbally communicate empathy, few studies, however, have attempted to identify which of the types of responses are more frequently used, which was the first objective of this study. Only two studies (Bylund & Makoul, 2002; Bylund & Makoul, 2005) have provided statistics in relation to the ECCS tool, which evaluated the occurrence of different levels of empathy. In these studies, the types of responses were similar but not exact to the ones defined in the current study. It was therefore impossible to directly compare findings of this study with those of Bylund and Makoul. However, there were trends worth investigating further, namely that there were four types of responses – formulating the gist of the trouble,

validating, naming feelings, and making assessments – that occurred much more frequently than the others. Another type of response, a shared experience, was not frequent in this study, nor was it attested frequently in the studies of Bylund and Makoul.

The findings of the current study and those presented in the literature therefore suggest that: 1) at least eight types of responses are used to verbally communicate empathy and/or sympathy; and 2) four of these types of responses are generally more frequent than the others. These conclusions raise that possibility that perhaps effective verbal communication of empathy and/or sympathy may require using all types of responses while focusing on the frequency of occurrence of each type of response, which has not been suggested in the literature to date.

## **5.2. Research Objective 2: Summary of Findings and Conclusions**

The second research objective consisted of examining the most recurring linguistic forms per type of response. To our knowledge, in health communication and linguistics literature, no thorough corpus-based study of the linguistic forms used to convey empathy and/or sympathy exists. As previously pointed out in the review of literature, the linguistic forms that have been suggested throughout the literature appear to be mostly generated from an intuitive approach. Intuition can certainly be insightful and accurate at times, however, it can also lack important elements (McEnery et al., 2006). The detailed findings of the current study illustrated how intuition alone could not provide a just representation of the linguistic forms of the types of responses used to verbally communicate empathy and/or sympathy. Examples with respect to this observation are illustrated below for each type of response.

For the formulating-the-gist-of-the-trouble type of response, the most frequent two-word phrases that were identified were “it’s”, “you’re” and “going to”. The phrase “it’s” was most often followed by an adverb and another variable slot filled by an adjective, verb or noun. The adverbs and adjectives tended to be limited to those of degree and time, and almost all are part of the 1000 most frequently spoken words of the English language (Longman dictionary of contemporary English, 2009). The “you’re” phrase was most frequently followed by “going to”, which was the third most frequent phrase for this response. For “going to”, the most frequent preceding forms were “you’re”, “it’s” or

“that’s”. In half of the utterances, a negative adverb also preceded “going to”. The variable slot following the “going to” phrase was almost always directly followed by a verb. All the verbs that were used are part of the 1000 most frequently spoken words of the English language (Longman dictionary of contemporary English, 2009).

The formulation of the gist of the trouble is a type of response that could be included in the second part of Egan’s (2010) “You feel...because...” type formula. The first part of the formula consists of first naming “the correct emotion expressed by the person” and the second part requires indicating “the correct thoughts, experiences, and behaviours that give rise to the feelings” (p. 169). “The thoughts, experiences and behaviours that give rise to the feelings” are essentially the gist the trouble. Moreover, another researcher, Pudlinski (2005), identified that the formulation of the gist of the trouble was generally done in such a way that it was likely to encourage further discussion of the trouble as formulated, allowing for an easier transition to propose a solution. It therefore seems logical that the most frequent two-word phrases were “it’s”, “you’re” and “going to”. “It’s” is a non-referential subject that could identify the trouble or the situation in general and “going to” would prepare the patient to think about the near future in relationship to the voiced trouble. Moreover, the subjects used with “going to” also indicate how to use this phrase. “You’re”, which was the most frequently used subject, would point out that the patient is facing a particular trouble whereas “it’s” or “that’s” are neutral subjects that take the focus away from the patient and put it more on the situation in general.

The findings of the current study, along with how Egan (2010) and Pudlinski (2005) have defined the formulation of the gist of the trouble, suggest that this type of response, which was the most frequently used response in the current study, may, in fact, require talking about the situation and the near future of the patient. In addition, Pudlinski (2005) identified that the formulation of the gist of the trouble may encourage further discussion of the trouble as it was formulated, essentially allowing the nurse to move towards working out a recovery plan with the patient. It is possible that the tense and aspect sequences of the verbs used to formulate the gist of the trouble and elaborate on that trouble as formulated may be supported by Suh’s (1992) frame-elaboration hypothesis (cited in Celce-Murcia & Larsen-Freeman, 1999). Suh suggested that during oral discourse, speakers of English tend to use one tense-aspect-modality form to introduce a type of narrative and then switch to

another form to elaborate on that narrative. Celce-Murcia and Larsen-Freeman (1999) have also provided examples of how this frame-elaboration hypothesis can be applied for future scenarios in that “going to” can be used to talk about a future plan and then “will” is used to elaborate on that plan. Further investigation is required to determine to what extent the nurses actually used this discourse frame. Preliminary analysis of the NT, however, does show that some nurses did in fact use “going to” to formulate the gist of the trouble and then used “will” to attempt to work out a plan with the patient. Should this discourse frame related to discussing future scenarios be frequently used by nurses, it would provide insightful information to pass along to L2 nurses.

For the validating type of response, the phrase “I know” was more frequently used than “I understand” (e.g., There were 38 occurrences of “I know”, but only 18 occurrences of “I understand”). When compared to the NT, however, “I understand” was used more frequently to validate than “I know” (e.g., “I understand” was 81% of the time, and “I know” was used 75% of the time). Due to the small corpus size, it would be premature to affirm which phrase is more frequently used to validate. Furthermore, it is difficult to distinguish significance of each phrase. For instance, The Longman Dictionary of Contemporary English (2009) defines “I know” as “used to agree with someone or to say that you feel the same way: ‘We have to talk about it, Rob!’ ‘Yeah, I know.’”; whereas, “I understand” is defined as “to realise how someone feels and why they behave the way they do, and to be sympathetic.”

Unfortunately, a limitation of corpus-based research is that corpora cannot explain why some forms are more frequent than others (McEnery et al., 2006). Researchers are therefore responsible for deducing use and meaning based on context. If the context is too limited because the corpus is too small, it is difficult to pinpoint explanations that would justify frequency counts. Nevertheless, general trends and patterns can be observed, which would point to directions for future research.

There were two uses of “I know” in the validating types of response that were more frequent than the others: 1) “I know” was used in an independent clause without a complement; and 2) “I know” was used in complex sentences. Variants of “I understand”, on the other hand, rarely occurred in a complex sentence.

Based on in-text usage in the BL2TC and the Longman Dictionary of Contemporary English (2009) definition, it is difficult to assess the difference in meaning between “I know” and variants of “I understand” because their meanings and use seem to be closely related. Based on examples in the BL2TC, “I know” may be used to agree with the patient and possibly to respond to non-stated emotions; “I understand” may be used more to respond to expressed feelings and behaviours. It would be premature, however, to confirm these differences in usage because of the limited size of the corpus. It is also possible that the difference in usage may be a result of the personal linguistic preferences of the nurses. What the findings do show is that “I know” and variants of “I understand” were two phrases that were frequently used to validate, and the associated sequences of the two phrases differed. These differences suggest that there may be different uses of and meanings associated with the two forms; however, more evidence-based research is required.

Naming feelings is a type of response that has been cited throughout health communication literature, and various ways of naming the feelings have also been suggested. In the current study, there were no recurring lexical bundles of two-word phrases with variable slots that were worth exploring, yet two other interesting observations were made. The first observation, which merits further investigation, was that the naming-feelings type of response was often done while validating. The second was that the naming of feelings was frequently done in the form of a question by using tag questions, statements with rising intonation or direct questions. The idea that feelings were named in a question form is particularly interesting because it was rather unexpected. It is assumed that naming a feeling would consist of simply identifying the feeling in the form of a statement. Naming a feeling in a question, however, would invite the other person to confirm whether or not the feeling was properly named, which supports an observation made by Pudlinski (2005). He mentioned that confirmation of the named feeling is often sought in order to move towards talking about reactions and solutions. Although it is of general consensus that the verbal communication of empathy and/or sympathy consists of naming feelings, more research should investigate how this type of response is formulated in actual speech and why questions, in particular, are important in the identification of a patient’s feelings.

For the making assessments type of response, which means to quantify the badness of the news, there were no frequently recurring lexical bundles; however, the preferred sequencing of the utterances of this response showed that a majority of the utterances contained a neutral subject (e.g., “it” or “that”) or no subject at all. A neutral or missing subject puts emphasis on the words that were or would be after the verb. In fact, it was found that several adverbs, adjectives and nouns were used to quantify the badness of the news, which is a finding that concurs with suggestions made by Coulehan et al. (2001).

Coulehan et al. suggested using a variety of words to quantify the emotions of the patient<sup>10</sup>, and they added that the words can have different degrees of intensity. Sometimes weak affective words like “annoy,” “upset,” and “uneasy” were appropriate, but other times they suggested using “red-blooded adjectives such as ‘infuriated,’ ‘enraged,’ ‘tormented,’ ‘overwhelmed,’ and ‘terrified.’” (p. 223). The intensity of the adjectives, adverbs and nouns used to make assessments in the current study was not analysed but could be done in the future. Instead, an attempt was made to identify the limitations of the types of adjectives, adverbs and nouns that were used. For instance, the types of adjectives that were used to make assessments tended to be those of size, degree and emotion. The types of adverbs that were used tended to be of degree. The types of nouns that were used either had negative connotations or were more neutral. Moreover, the adverbs, adjectives and nouns that were used by the nurses are almost all part of the 1000 most spoken words in English (Longman dictionary of contemporary English, 2009). Seven of the words (i.e., challenge, extremely, pain, rough, shock, tremendous and very) are of the 2000 most spoken words of the English language, and three (i.e., surprise, shocking and incredible) are of the 3000 most spoken words of the English language (Longman dictionary of contemporary English, 2009). There were only three words that are not part of the 3000 most frequent words of spoken English (i.e., bummer, for sure and upsetting) (Longman dictionary of contemporary English, 2009). For L2 teaching purposes, more research could be done to analyse the intensity and limitations of the formulaic constructions used to make assessments and determine which words make up the most frequent words of spoken English.

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<sup>10</sup> Coulehan et al. (2001) suggested quantifying the emotions, whereas Pudlinski (2005) suggested making assessments by quantifying the badness of the news, which is the definition that was taken for the current study. Although the definitions between Coulehan et al. and the current study vary slightly, the idea of quantifying a lived-reality of the patient is the same.

For the four remaining types of responses - emotive reactions, expressing one's own feelings, expressing one's own reaction, and sharing a similar experience - there were not enough occurrences in the corpus to present substantial findings. Some linguistic forms that did occur in these types of responses, however, can also be found in the research by Pudlinski (2005), they were: emotive reactions such as "Oh" or "Mm"; the use of the cultural expression "I'm sorry" for expressing one's own feelings; and the use of conditional sentences "I would" for expressing one's own reaction. For the response sharing a similar experience, however, there were no recurring linguistic forms in the BL2TC to compare with those presented by Pudlinski (2005). More evidence-based research is required to assess the recurrence of the linguistic forms of the four least frequently used types of responses.

As interesting as these detailed findings are, they raise several questions that remained unanswered. For instance, to what extent do patients expect to hear these forms, and why? What effect does the use of these forms have on patients? What happens when these forms are not said as expected, particularly by non-native speakers? Would a patient reject an empathic attempt based on the linguistic forms that are used? It would be therefore worthwhile to determine whether a correlation exists between linguistic forms of the types of responses and if the patient accepts or rejects the empathic/sympathetic attempt.

In conclusion, the findings of the present study add depth and detail to the knowledge that currently exists on the verbal communication of empathy and/or sympathy. They provide examples of types of responses and linguistic forms that illustrate the verbal communication of empathy and/or sympathy. Although the findings can be insightful for several spheres of research, this study was primarily conducted from an applied linguistics perspective in response to a problematic that exists in the field of L2 teaching. In essence, little evidence-based research of the verbal communication of empathy and/or sympathy exists; thus, L2 pedagogical materials do not reflect what is actually said to convey empathy and/or sympathy. In the following and final section, pedagogical implications of the findings are presented and recommendations are made on how to improve current L2 teachings of the verbal communication empathy and/or sympathy.



## 6. Pedagogical Implications of Global Findings

In this section, pedagogical implications related to the main findings will be discussed based on the notions of pedagogical norms, which consist of selecting and teaching forms of language that are used and accepted by native speakers and easy for L2 learners to acquire (Valdman, 1989). At times, future research is suggested because the findings are too limited.

### 6.1. Types of Responses

In this study, the findings show that there were four types of responses that were used 90% of the time to verbally communicate empathy and/or sympathy. The four most frequent types of responses were formulating the gist of the trouble, validating, naming feelings and making assessments. The remaining four types of responses – emotive reactions, reporting one's own reaction, expressing one's own feelings, and sharing a similar experience – were therefore only used 10% of the time. Although these results cannot be directly compared with those reported in the studies by Bylund and Makoul (2002; 2005) because the types of responses and definitions varied, certain trends did exist. One trend, in particular, that stood out in the present study and was also documented by Bylund and Makoul (2002; 2005) was that the response *sharing a similar experience* was the least frequently used response in all three studies. This similarity suggests that the findings of the current study may not reflect an isolated case, and that perhaps there are types of responses for communicating empathy and/or sympathy that are much more frequently used than others.

Considering that certain types of responses may be more frequently used than others, pedagogical materials for L2 teaching could reflect this frequency of use. It would be helpful for L2 learners to know that formulating the gist of the trouble, validating, naming feelings and making assessments are the types of responses that tend to occur the most; therefore, perhaps more exposure, attention and practice could be put towards learning these responses and related linguistic forms.

## **6.2. The Four Most Frequent Types of Responses**

### **6.2.1. Formulating the Gist of the Trouble**

The three most frequent phrases for formulating the gist of the trouble were “it is”, “you are” and “going to”, which were often in the reduced forms of “it’s”, “you’re” and “gonna”. The first pedagogical implication is that the reduced forms of the phrases would be important to teach in order to make L2 speakers aware that the contracted forms are acceptable in such a context. Moreover, as mentioned in the discussion section, these phrases appear to have different purposes for formulating the gist of the trouble. The different purposes may be that “it’s” might be used to talk about the situation, “you’re” may be used to talk about the patient and “going to” might be used to talk about the near future. To be most effective, the phrases should perhaps be taught in relation to the purpose they may play while formulating the gist of the trouble.

The pedagogical implication of the use of the “it’s” phrase is that focus should perhaps be put on explaining how “it’s” is a non-referential subject that does not clearly refer to anything in particular (Celce-Murcia & Larsen-Freeman, 1999). Consequently, “it’s” may be used to refer to the situation in general, being that something bad happened, which has physical and emotional implications and consequences for the patient. “It’s” can also refer to the bad news or the emotional challenges that a patient is facing. Most importantly, “it’s” refers to something other than the patient thereby not putting any form of blame on the patient, which would make it easier to build a trusting relationship with the patient (Gottlieb, Feeley, & Dalton, 2006). Focus could then be put on explaining how to use the “it’s” phrase with adverbs and adjectives of degree and time and nouns related to a process or change to talk about the situation while formulating the gist of the trouble.

The pedagogical implication for “you’re” may be that the patient needs to be included in the formulation of the gist of the trouble because he/she is experiencing the trouble. It should be mentioned, however, that “you’re” was only used 17% of the time in the NT to formulate the gist of the trouble, which is rather infrequent. Furthermore, it could be explained that “you’re” was most often followed by a negative word (either “not” or “never”) and then “going to” (e.g., “You’re not gonna walk like you have before.”). Further

discussion of the “you’re” phrase should perhaps focus on how it is used with the “going to” phrase.

The pedagogical implication for “going to” is to explain that the phrase may be used to talk about the near future while formulating the gist of the trouble. It would be important to highlight that “going to” recurs much more frequently while formulating the gist of the trouble than “will”.<sup>11</sup> A particular difference between “going to” and “will” in spoken discourse is that “going to” can be used to first talk about future planned actions and afterwards, “will” can be used to elaborate on the newly established plan (Celce-Murcia & Larsen-Freeman, 1999). In the role play, the patient learned he would no longer walk, which basically established a newly formed plan of the future and may explain why “going to” was frequently used. Pudlinski (2005) mentioned that formulating the gist of the trouble allowed further discussion of the trouble as formulated. It is hypothesised that nurses therefore used “going to” to formulate the gist of the trouble, and then used “will” to discuss the trouble as they had formulated it. Students could do a corpus analysis to determine whether nurses did, in fact, use “will” to further discuss the trouble that they had previously formulated.<sup>12</sup> Such a corpus-driven exercise conducted by the students themselves could be useful to highlight the differences between “going to” and “will” and explain why “going to” is the ideal form to use in this type of context.

Lastly, students can learn that “going to” can be used to talk about the situation in general by using neutral subjects such as “it” and “that”, or “going to” can involve the patient directly by using the subject “you”. Students can also examine the types of verbs (e.g., action verbs, mental verbs, state of being verbs, modal verbs and phrasal verbs) that were used with “going to”. Lists of other verbs that share similar meanings with the ones provided in the corpus could be provided and students could be asked to sort the verbs based on their type and with which subject - “you” or “it” – they would use the verb. Further research, however, is required to validate to what extent the “it’s”, “you’re” and

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<sup>11</sup> Out of the 84 occurrences of “will” in the NT, only 5 occurrences were used by 4 different nurses to formulate the gist of the trouble, representing a frequency rate of 6%. “Going to”, on the other hand, was used 27% of the time to formulate the gist of the trouble.

<sup>12</sup> Preliminary analysis of the corpus does show that some nurses did in fact use “going to” to formulate the gist of the trouble and then used “will” to discuss the trouble as they had formulated it.

“going to” phrases with accompanying variable slots are used to formulate the gist of the trouble.

### 6.2.2. Validating

The most frequent two-word phrases with variable slots for the validating type of response were “I know” and “I understand”. The words “normal” and “important” were also frequently used for this response, however, there were not many occurrences of these words; therefore, no pedagogical implications will be made for “normal” and “important”.

It is difficult to distinguish the meaning and use of “I know” from “I understand”, because these phrases seem to be closely related. Pedagogical implications are therefore limited to describing the different occurrences that were observed, which were:

- 1) “I know” was roughly 3 times more frequently used than “I understand” in the validating type of response;
- 2) “I know” was used in independent clauses without a complement, and it was used in complex sentences; whereas, almost all phrases with “I understand” were in simple sentences and rarely in complex sentences; and
- 3) “can” was used as an emphatic marker as in “I [can] understand,” but this did not occur with “I know”.

Future research could focus on trying to distinguish meanings and uses of “I know” from variants of “I understand” to be able to better explain their different uses to students. For the time being, the use of the word “can” may provide the most insight as to how “I know” and “I understand” differ. For instance, attempting to use the word “can” in the same manner with “I know” as is done with “I understand” sounds extremely odd.<sup>13</sup> For

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<sup>13</sup> It is difficult to explain why “I can understand” is acceptable, but “I can know” is not. Perhaps “understanding” is like an ability, such as walking, which a person is either *able to (can)* do or *unable to (cannot)* do; whereas, “knowing” is not an ability, therefore, it is not a question of being *able to know\** or *unable to know\**. Instead, a person *does know* or *does not know*; “knowing” is much more like a state. Surprisingly, “know” and “understand” are both described as cognitive states (Celce-Murcia & Larsen Freeman, 1999). Based on the examples in this corpus, however, “understand” appears to be, for lack of a better word, perhaps a *controllable* state because a person is able or unable to do it, whereas “know” appears *uncontrollable*. These observations raise important questions that would need to be investigated in future research. For example, if “I know” were to refer to an *uncontrollable* state and “I understand” to a *controllable* state, would “I know” have more empathic weight than “I understand” because there would be an automatism associated with “I know”? Would the automatism be the reason why “I know” tends to be more frequently used to verbally communicate empathy and/or sympathy? More research is required to answer these questions.

example, a native speaker would never say, “I can know,” yet “I can understand” is acceptable. The unstressed pronunciation of “can” in this context would also be important to highlight. It could therefore be explained to students that the variable slots and the types of sentences associated with “I know” and “I understand” are different and not always interchangeable.

Another example of how “know” and “understand” differ is that “I know that,” does not have the same implied meaning as “I understand that.” “I know that” allows the speaker to refer to something the he/she previously said, implying that the speaker is correct about something; in the corpus, there were only two examples of this use. One was by Nurse 8: “You need to be able to talk to somebody, {puts her hand on his shoulder} *I know that.*” The other was by Nurse 6: “[...] sometimes a stroke destroys a lot of things, you know, besides your mobility. *I know that that's* not making you feel better [...].” On the other hand, “I understand that,” refers to something that someone else said, which is how it was used in the corpus:

PATIENT: No, I have no appetite.

NURSE: No. Well, I can understand that.

Furthermore, it can be pointed out to students that in the corpus, “I know” was frequently used in complex sentences yet, in almost all cases, there was an ellipse of the word “that”. The ellipse of the word “that” is related to informal speech and it is an omission that L2 learners frequently notice and inquire about (Celce-Murcia & Larsen-Freeman, 1999). L2 students could be shown how the word “that” is used differently with “I know” than it is with “I understand”.

The observed differences between “I know” and variants of “I understand” suggest that there are certainly some differences in meaning and use. More investigation and examples, however, are required to be able to obtain a better understanding of how and when “I know” and “I understand” are used and what they imply. Research could also investigate the use of “I know” from a pragmatic perspective. The use of “I know” in this type of context, validating while supporting a patient who received bad news, may be driven by Grice's rules where two locators essentially try to cooperate with each other by picking up on the other's non-stated intentions and responding to them (Archer, Aijmer, &

Wichmann, 2012). Analysing the tone of voice that was used to say “I know” would reveal important information as well. Pragmatic analysis, however, falls out of the scope of the current study.

In effort to try to distinguish the meaning of “I know” from “I understand”, some patterns of use could be considered and pedagogical implications are suggested. Base on the Longman dictionary (2009) definition (see Discussion section) and contextual uses in the BL2TC, “I know” may have the following meanings:

- 1) **To agree with the patient.** Nurses used “I know” to let the patient know that they agreed with him, as illustrated in the following excerpt:

PATIENT: It’s um, nice of you to paint a rosy picture but it’s not a rosy picture.

NURSE: I know it’s not. No.

- 2) **To respond to non-stated feelings.** By saying “I know”, nurses acknowledged that a feeling existed<sup>14</sup> even though the exact nature of the feeling was unknown by either the patient or the nurse, for example:

NURSE: [...] How’re you doing?

PATIENT: Oh, just friggen’ great.

NURSE: I know. I know.[...]

Based on the Longman dictionary (2009) definition (see Discussion section) and contextual uses in the BL2TC, variants of “I understand” may have the following uses:

- 1) **To respond to expressed feelings,** for example:

NURSE: Mm-hm. You’re in a wheelchair. How do you feel about that?

PATIENT: Well, I hate it.

NURSE: Mm-hm. I can understand.

<sup>14</sup> Feelings do not have to be labelled for them to exist. Moreover, sometimes, labels do not accurately define the feelings.

**2) To respond to behaviours, for example:**

PATIENT: He may have, I dunno. He came in and told me that I'm paralysed, and that I'll never be able to walk again. Said something else, but you'll excuse me if I can't remember what he said.

NURSE: Uh, I can understand.

As mentioned, the distinction between the meanings and use of “I know” and “I understand” is not yet clear. Nevertheless, for pedagogical purposes, focus could be put towards illustrating the different preferred sequences associated with “I know” and variants of “I understand” and explaining that the meanings of both phrases are closely related, but may have slight differences. Moreover, attention should be put towards explicitly teaching the ellipse of the word “that” in complex sentences containing “I know” and the pronunciation and stress of the word “can”, which is usually pronounced /kən/, in the phrase “I can understand.”

### **6.2.3. Naming Feelings**

In the literature, naming the feelings of the patient seems to be a core element of communicating empathy and/or sympathy because it has been cited by several different sources (see Table 1). Moreover, the act of naming feelings is included in Egan's (2010) “You feel...because...” formula, which consists of first naming the “the correct emotion expressed by the person” and then indicating “the correct thoughts, experiences, and behaviours that give rise to the feelings” (p. 169). In the corpus, the “You feel...because...” formula was never used verbatim, which is expected because, as per Egan (2010), it is not to be used verbatim; instead, the essence of the formula should be transformed into the speaker's *own words*.

There were no phrases that had a high frequency rate in the naming feelings type of response, but the preferred sequencing of the utterances was the most revealing. Feelings were most often named in the form of a question either by using tag questions, statements with rising intonation or direct questions. These findings are particularly relevant for several reasons. First, the findings indicate that tag questions were used, however, transformed tag questions (i.e., where the nurses interjected single words like “right” or

non-words like “eh” and “hm”) were more frequent than formal tag questions, which consisted of using the negative auxiliary of the main clause (e.g., “That’s a big thing, isn’t it?”). Based on these findings, it might therefore be important to show how, when and why tag questions are used and the different meanings associated with informal tags such as *right*, *hm* and *eh*. Moreover, using transformed tag questions may be easier for L2 learners because producing formal tag questions is cognitively challenging and, as such, is generally difficult for L2 speakers. Second, using statements with rising intonation to ask a question is common during spoken interactions in general (Celce-Murcia & Larsen-Freeman, 1999); therefore, it may be something important to teach for oral discourse. Third, direct questions are also used to name the feelings of the patient. Pedagogical materials should therefore reflect these findings by showing how to use tag questions, statements with rising intonation in addition to direct questions to name the feelings of patients.

The findings also revealed that nurses often name the feelings of patients while validating them at the same time. “I know” was mostly used to name feelings and validate at the same time, but other words were used as well, they were: “It’s ok,” “normal,” and “I can understand” (see Table 20). A possible reason why validating and naming feelings were done simultaneously may be to help the patient accept how he felt, but further research is required to confirm this.

#### **6.2.4. Making Assessments**

The most important finding for the making assessments type of response was that the majority of utterances had either a neutral subject (“it” or “that”) or no subject at all. Neutral or missing subjects put more emphasis on the words that follow, or would follow, the verb. Consequently, nurses used a limited variety of adjectives, adverbs and nouns to quantify how troubling the situation was, basically generating a vocabulary list. For L2 teaching, it would be valuable to show learners which types of adjectives, adverbs and nouns were used. For example, most of the adjectives were related to size (e.g., big, great, huge, major, tremendous), degree (e.g., difficult, hard, not easy, rough) and emotion (e.g., shocking, upsetting). The types of adverbs were mostly adverbs of degree (e.g., absolutely, certainly, exactly). The nouns had either negative connotations (e.g., bummer, shock, challenge, load, pain), or were more neutral (e.g., report, news, point, surprise). Students

could also be shown how to use the adjectives, adverbs and nouns in an utterance that has a neutral or missing subject. Lastly, students could also conduct a semantic feature analysis (Celce-Murcia & Larsen Freeman, 1999) to try to decipher the meaning of the words and assess to what extent the meaning of the words overlap.

### **6.3. The Four Least Frequent Types of Responses**

#### **6.3.1. Emotive Reactions**

There were not a lot of emotive reactions most likely because the nurses knew of the bad news before engaging with the patient. In a situation where the patient is informing a nurse of bad news, it is expected that there would be more emotive reactions; however, more investigation is required. The twelve occurrences that existed in the corpus were all done in reaction to additional news that the patient presented. For example, the nurses had emotive reactions after the patient mentioned that he had had no visitors and was alone, or that the patient's story was not exactly the situation that the nurse thought it was. The nurse was therefore reacting emotionally to new bad news. L2 learners might therefore be encouraged to compare the emotive reactions of the nurses with their own emotive reactions in their native language to assess how and whether they differ. Considering that emotive reactions are in fact *reactions*, which may or may not be controllable, students could then discuss whether they can and should try to change their emotive reactions to align with the L1 norm, for research has shown that some patients actually prefer that L2 speakers do not align with the L1 norm (Beaulieu, 2011). Determining to what extent L2 speakers should use L1 speakers as a benchmark for their own oral production is an ongoing debate and one in which students should be encouraged to engage.

#### **6.3.2. Expressing One's Own Feelings**

Expressing one's own feelings was not a frequently used response, and there were not many recurring linguistic forms. Only two nurses used as the cultural expression "I'm sorry" to react to the bad situation of the patient for this type of response. For L2 learners, it would be important to explain the different uses of "I'm sorry", which, in the corpus, were used to react to a bad situation, to apologise for something that was said or done, and to ask the patient to repeat what he/she had said.

### **6.3.3. Reporting One's Own Reactions**

Although there were not many examples, reporting one's own reaction was almost always done using conditional statements with "I would". In three of the five occurrences, nurses said that they would be "upset too," or "very upset", which is a rather neutral type of response. For future research, it would be interesting to investigate under which circumstances stronger reactions would be cited in this type of response. It is also interesting to note that two nurses said, "I don't know what I'd do," or "I don't know how I'd react," which seems to create distance between the nurse and the patient while leaving the patient the freedom to react as he normally does. Perhaps, in the reporting-one's-own-reaction type of response, nurses tended to report neutral reactions or no reactions at all to allow the patient to express how he was reacting without there being any form of judgement. Unfortunately, there were not enough examples in the corpus to draw clear conclusions regarding this type of response and therefore, there are no pedagogical recommendations.

### **6.3.4. Sharing a Similar Experience**

The utterances identified as sharing a similar experience were quite different than what had been suggested in the definition of the type of response. There were no incidences of utterances that took the form of "I feel that way too sometimes," "I know what you're talking about," or "I know what it's like," as suggested by Pudlinski (2005, p. 281). Instead, the nurses told a story. The findings of this study probably differed from those of Pudlinski's due to the nature of the "bad news"; all the nurses still had their mobility and it would have been inappropriate for them to say something to the effect, "I know what it's like," because they never physically lived what the patient was living. More examples would be required to assess which linguistic forms tend to be most frequently used for this type of response.

## **6.4. Concluding Remarks**

In conclusion, the two objectives of the current study, to identify the frequency of eight types of responses used to verbally communicate empathy and/or sympathy and describe the most recurring linguistic forms associated with each type of response, have revealed findings that have never been investigated to date.

For one, it was discovered that four types of responses (i.e., formulating the gist of the trouble, validating, naming feelings and making assessments) tended to occur much more frequently than the four others (i.e., expressing one's own feelings, emotive reactions, reporting one's own reactions and sharing a similar experience).

Second of all, it was discovered that recurring lexical bundles of two-word phrases with variable slots were associated with some of the types of responses. For instance, for formulating the gist of the trouble, three phrases, "it's," "you're" and "going to," stood out because they were most likely used to talk about the situation, the patient and the near future. For validating, two phrases, "I know" and "I understand", stood out yet, although their frequency of use was different, it was difficult to distinguish their use because their meanings seemed to be closely related. For naming feelings and making assessments, the preferred sequencing of these two types of responses seemed to have more importance than any recurring lexical bundles. Indeed, it was discovered that feelings were often named in the form of a question, either by using tag questions, statements with rising intonation or a direct question; the preferred sequencing of assessments tended to have a neutral or missing subject, which put more emphasis on the words that would be after the verb.

All of the aforementioned findings add to the knowledge of what currently exists on the concept of empathy and/or sympathy because the findings provide a descriptive account of the behavioural component (Morse et al., 1992) of the construct of empathy and/or sympathy, which is useful for pedagogical purposes.

The findings of the current study, however, do carry several limitations and must not be over generalised. The limitations are that: 1) the corpus was very small and the number of occurrences was low; therefore, it was futile to conduct a statistical analysis of the findings, and it would be worth analysing the same types of empathic/sympathetic responses in other role plays and language functions; 2) the nurse participants were limited to a specific English-speaking region of Quebec; therefore, it is unsure to what extent their responses reflected the linguistic patterns of English nurses outside of Quebec; 3) all nurse participants were female; therefore, findings did not reflect the dialect of male nurses; 4) only one researcher analysed the corpus; therefore, there was no cross-evaluation of the findings; 5) data from only one specific role play was analysed; therefore, it is unsure to

what extend the findings would be valid in other situations requiring the verbal communication of empathy and/or sympathy; and 6) the patient response to the utterances was not evaluated; therefore, it is unknown whether the nurse utterances were perceived as being empathetic.

Nevertheless, regardless of the limitations, this study is one of the first to have adopted an evidence-based approach to specifically analyse the types of responses and linguistic forms used to verbally communicate empathy and/or sympathy. It is important to remember that the findings of this study were extracted from spontaneous speech, not intuition, of 15 different nurses. Moreover, certain types of responses and linguistic forms did recur between speakers even though the corpus was small. As Sinclair (2004) mentioned, no corpus, no matter what the size, is 100% reliable, comprehensive and representative and that “if any pattern or usage occurs more than once from apparently independent sources, then there is a very strong possibility that it is a regular pattern in the language.” (p. 288) In this regard, the findings of this study do indeed highlight possible regular patterns of language use in the verbal communication of empathy and/or sympathy that would benefit from further investigation.

Future research could expand on the current study by analysing a much larger corpus and investigating whether these patterns of language are replicated by other anglophone health professionals while they are trying to verbally communicate empathy and/or sympathy. Future research, however, could also take a different direction. For instance, in order to gain a greater understanding of the construct of empathy and/or sympathy and the importance of saying *the right thing at the right time*, future research could examine how patients respond to the frequency and use of, or lack thereof, the types of responses and recurring linguistic forms identified in the current study. Such research would not only be useful for native speakers of English, but would also provide information on the verbal communication of empathy and/or sympathy for L2 speakers of English as well. Moreover, in order to gain greater understanding of cross-linguistic differences and similarities, analyses similar to those of the current study could also be conducted in corpora of different languages. Lastly, for L2 pedagogical purposes, it would be beneficial to identify which types of responses and linguistic forms L2 speakers use and the degree to which patients perceived them as being empathic and/or sympathetic.

Considering that there is currently no theoretical framework for the concept of empathy or sympathy, there are many avenues for future research. Currently, little is known about actual language use between native speakers in emotionally-charged health-communication situations. The more research that investigates what is actually said between health professionals and patients who share the same first language during difficult moments, the better L2 pedagogical materials can follow the notions of pedagogical norms, in which they present language forms that are used and accepted by native speakers and can be easy for L2 speakers to acquire (Valdman, 1989). Health professionals who seek out L2 training in order to reduce language barriers that they experience with patients will then hopefully be given suitable information required to improve the quality of their communication. Even though the findings of the current study are mostly qualitative descriptions, they do indeed point out possible regular patterns of language use that are good starting points for L2 pedagogical purposes.

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## 8. Appendices

### 8.1. Appendix 1: Example of a Transcript

Turn	Speaker	Nurse speech	Speaker	Patient speech
1-	Nurse:	Mr Auger?		
2-			Patient:	Mm-hm.
3-	Nurse:	Hello there. My name's {XXX}.		
4-			Patient:	Hello.
5-	Nurse:	How are you?		
6-			Patient:	Oh, just peachy.
7-	Nurse:	Not hungry?		
8-			Patient:	Not hungry.
9-	Nurse:	No. Don't feel like eating? No. Don't like the food?		
10-			Patient:	Just not hungry.
11-	Nurse:	No? How come? Why aren't you hungry? Can you tell me why? Mm? I just got back from vacation there so uh, I'm assigned to you. So I'd like to know how you are. They tell me you're not eating very much these days.		
12-			Patient:	I have no appetite.
13-	Nurse:	Because? The hospital food?		
14-			Patient:	Have you read my file?
15-	Nurse:	Mm-hm.		
16-			Patient:	Well you'll know then.
17-	Nurse:	I see you've been told. Mm? What did you use to do as a, I don't know your his, your ba, your history. How, what did you use to do for work?		
18-			Patient:	Well hopefully what I'm gonna continue to do for work.
19-	Nurse:	Which is?		
20-			Patient:	Run my company.
21-	Nurse:	Mm-hm. What sort of a company do you have?		
22-			Patient:	I started an insurance company about thirty years ago.
23-	Nurse:	Ok. Lots of employees?		
24-			Patient:	Mm-hm.
25-	Nurse:	Yeah. You make a lot of house visits? Or are you basically in the office?		
26-			Patient:	What I make a lot of is money.
27-	Nurse:	Mm-hm.		
28-			Patient:	And I run the company, so I'm mostly in my office and travelling.
29-	Nurse:	Ok. So what have they told you about how you're, they're gonna help you get around now so, now that you can't walk?		
30-			Patient:	Uh, I Idunno. He told me this

				morning and I kinda.
31-	Nurse:	Oh, you just learnt this morning? That wasn't in my dossier. Ok, you've just learnt this morning. How long have you been in the hospital?		
32-			Patient:	I dunno. Uh, um, I think they brought me in a few days ago but that's all kind of a blur.
33-	Nurse:	Yeah. Children? Do you have children? Grandchildren?		
34-			Patient:	No.
35-	Nurse:	All by yourself?		
36-			Patient:	My wife's outta town.
37-	Nurse:	Ok. She travels a lot?		
38-			Patient:	{Sigh} Um, I guess so.
39-	Nurse:	You guess so. Was she around when you had your stroke?		
40-			Patient:	{Shakes head no}
41-	Nurse:	No. Does she know what's going on?		
42-			Patient:	No, I'll tell her in a few days.
43-	Nurse:	Does she know you're in the hospital?		
44-			Patient:	No. She's arguing a case in Ottawa. And um, I don't wanna disturb her.
45-	Nurse:	She's a lawyer?		
46-			Patient:	Yeah, she's a really good lawyer.
47-	Nurse:	Do you have any close friends?		
48-			Patient:	Uh, yeah. I got a buddy in North Hatley.
49-	Nurse:	And were you, does he know what's going on? Sort of?		
50-			Patient:	No, I'll call him in a couple days.
51-	Nurse:	Maybe you need somebody now?		
52-			Patient:	I don't need anybody now. What I need is my legs back.
53-	Nurse:	We'll they're not coming back. That's the reality.		
54-			Patient:	Exactly right.
55-	Nurse:	I know and it's a real pain in the butt. It's a bummer. But that's the reality. I know it's hard to take. I'm not in your situation, but I know it's hard to take. Have they talked to you about rehabilitation, uh, what they can do for you to, how to accommodate?		
56-			Patient:	II
57-	Nurse:	Not right, it's too early. It's too early to talk about that.		
58-			Patient:	He may have said something, but it was uh, kinda enough for me to get my head around what he told me about my legs.
59-	Nurse:	Yeah. Yeah.		
60-			Patient:	So I dunno what else he said.

61-	Nurse:	One step at a time. Mm?		
62-			Patient:	I wish it were one step at a time.
63-	Nurse:	Well, one thing at a time. I know. Sorry.		
64-			Patient:	It's not your fault.
65-	Nurse:	But you know we're, we're always here to help you, mm? I know.		
66-			Patient:	I just don't want help.
67-	Nurse:	Well, you know what?		
68-			Patient:	I've done it by myself all my life.
69-	Nurse:	Well now it's time you		
70-			Patient:	I don't want help. I don't want people to talk to me to make me feel better.
71-	Nurse:	I'm not trying to make you feel better. I'm trying to find out where you are.		
72-			Patient:	Well, you're doing a good job.
73-	Nurse:	Well I'm sorry if I'm not, I'm not trying to do that. I'm trying to find out where you are right now.		
74-			Patient:	Ha, right here in this friggen' wheelchair. That's where I am.
75-	Nurse:	That's right. But it's not the end of the world. Right now it might be, but it's not. There's a whole lotta of things that can be uh, that can help you. But we're here to help. It's amazing what they can do these days. But it's not gonna change the situation. You're not gonna have the use of your legs.		
76-			Patient:	Thanks for sharing that. Appreciate that.
77-	Nurse:	Well.		
78-			Patient:	Well done.
79-	Nurse:	Mm-hm. Sometimes it's good to get pissed off.		
80-			Patient:	What good will it do? My legs won't work. What I want is my legs back. I don't wanna get mad. I don't wanna feel. I don't wanna talk to anybody. I want my legs back.
81-	Nurse:	But they're not coming back.		
82-			Patient:	Thank you.
83-	Nurse:	Mm-hm. But maybe you need a little support from your family, mm? You need some, some help from them. A little support.		
84-			Patient:	Right now I'm supporting my wife. It takes years for a case to get to the Supreme Court. I don't wanna distract her now. She'll be done in a week or two. I'm not

				going anywhere.
85-	Nurse:	Yeah, but ch'ya got other people you can talk to.		
86-			Patient:	I don't feel like it right now, thanks.
87-	Nurse:	Oh. Have you had any visitors? Does anyone know you're in the hospital?		
88-			Patient:	As far as I know, no.
89-	Nurse:	Well what happened, like when you had your stroke? Were you by yourself?		
90-			Patient:	You know, I really can't remember. I might have phoned somebody. I think, I can't remember. It's all kind of a blur.
91-	Nurse:	Are you from Sherbrooke here or um, have you lived here in Sherbrooke all your life?		
92-			Patient:	That's where my business is.
93-	Nurse:	Mm-hm. So you must have some pretty close contacts around here. Some people you could talk to or maybe come and visit. Take you out.		
94-			Patient:	I don't want anybody right now. Just like I don't want the food. I will eat. I will talk to my friends, eventually, today, tomorrow. Just let me be.
95-	Nurse:	Who's running your business while you're here?		
96-			Patient:	I hired well.
97-	Nurse:	Yeah. You're not concerned about that at all?		
98-			Patient:	{Shakes head no}
99-	Nurse:	Mm-hm. No. No one wonders why you're here?		
100-			Patient:	I haven't told them yet.
101-	Nurse:	They think you're away on a business uh trip?		
102-			Patient:	Yeah.
103-	Nurse:	Mom and dad still around?		
104-			Patient:	No.
105-	Nurse:	No. Passed away?		
106-			Patient:	Yeah.
107-	Nurse:	Do you wanna try a little coffee or tea or something? Can I get you something from downstairs?		
108-			Patient:	A good cup of coffee would be very nice.
109-	Nurse:	A good cup? And what do we put in it?		
110-			Patient:	A little milk please.
111-	Nurse:	All right. I'll see what I can do.		
112-			Patient:	You can maybe get me an English language newspaper too?

113-	<b>Nurse:</b>	That would be, that would be nice too, huhh? Has everything been explained to you in French mostly, or English or? I imagine you're perfectly bilingual with a company?		
114-			<b>Patient:</b>	I prefer English. It's the language of business.
115-	<b>Nurse:</b>	Yeah.		
116-			<b>Patient:</b>	Yes, I understand. But I don't think there's a French version of the Globe and Mail, is there?
117-	<b>Nurse:</b>	No, but there's probably one downstairs. I can go pick it up with your coffee.		
118-			<b>Patient:</b>	Ok, if you could get me the Globe and Mail, that would be very nice.
119-	<b>Nurse:</b>	All right. Well, I'll do that for you, ok? Until the next time.		

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## 8.2. Appendix 2: Examples of some Linguistic Forms per Two Types of Responses<sup>15</sup>

Type of response: Validating	Type of response: Making assessments
And and it is normal to feel that way.	I know and it is a real pain in the butt.
And if you do not want to eat that is great,	Rough.
And it is ok to grieve.	Hm, that is really, hard.
And that is normal. Very normal.	Mm, very very difficult.
and that is, you know, that is, can be important for you.	maybe not today as it is pretty shocking news to hear.
And yes, I acknowledge that you are not going to be able to walk anymore.	Hm, very very difficult.
because right now I know you are depressed,	But it is an extremely upsetting report to receive from the physician.
but I know it is hard to take.	Perhaps not.
but, I do understand	It is huge.
I can understa, I can uh, that is what I thought.	It is a bummer.
I can understand that.	That is right.
I can understand why you do not feel like eating.	No they are not.
I can understand your frustration.	It cannot be easy.
I can understand.	No, this is not.
I know and it is a real pain in the butt.	It is. Very much so.
I know but you still have your feelings.	Well no.
I know it does.	No it certainly is not the point.
I know it feels that way right now,	No.
I know it is a very difficult time,	No it is not.
I know it is early.	No. No.
I know it is going to be a big change for you.	It is a big load. Mm-hm?
I know it is hard for you to hear that at this time, and it will take time for you to come to terms with that.	It is.
I know it is hard to take.	No, they are not.
I know it is not. No.	Exactly.
I know it is uh, not something you want to perhaps think about now,	I realise it is a great shock, losing your legs, That must have been quite a uh, quite a surprise.
I know that that is not making you feel better,	It is hard news to digest, isn't it?
I know this is probably not what you want to hear right now,	Absolutely.
I know you are not ready to hear this,	It is. For sure.
I know you do.	
I know, doctors uh think that they should uh, just approach a patient and tell them like it is.	Not easy to do.

<sup>15</sup> All contractions have been removed from these excerpts.

Type of response: Validating (continued)
I know, you are not hungry.
I know.
I realise it is a great shock, losing your legs
I understand.
It is important that you feel that you are being uh, well treated.
It is important.
It is not the same, I know,
It is ok to be mad because that is part of the whole.
It is very normal to feel the way you are feeling.
No, I can imagine it is not.
No, you are not ready to, to talk to anybody about that.
No. No, I am sure you are not.
Now, I realise that this is a difficult time for you and that you are adjusting to the news obviously.
So it is, it is normal to be uh, upset and you know,
So, you know, I know that you feel that you are going to be stuck in your house all day,
That is good.
That is ok.
That is understandable.
The mourning period is important because it is, well, you go through it anyway, but it is a matter of coming to terms with, with your loss, you know.
Unfortunately right now, you do not see it that way,
Well I can understand that.
Well I think what you are going through is also a big deal.
well that is normal.
Well, I understand that.
Yeah I understand that.
Yeah, I know.
Yeah, yeah I understand.
You are allowed.
You are right.
You are very correct,

Type of response: Making assessments (continued)
exactly. Exactly.
That was it.
That is an incredible shock, isn't it?
Yes, and that is a tremendous challenge to you.
major.

### 8.3. Appendix 3: Excerpts of “It is” and Variable Slots

8.3.1. Excerpts of “it is” + ADV		
#	Excerpts	Nurse ID
1	And it's <b>very</b> early yet for actually, me to uh, try and uh, help you deal with all that.	2
2	You know and for me to say it's <b>not</b> easy is uh, a little bit redundant,	
3	but, um, it's <b>just</b> gonna take a little time, and you have got to give yourself the time, to come to terms with this, and uh, to think about the, the ways that you can adjust to it.	6
4	It's <b>like</b> when you lose something that you, you know like your legs, you feel that uh, you know, you're never going to be able to do, have a life like you had.	
5	It's <b>like</b> , it's <i>like</i> a, it's <i>like</i> um, period of grieving.	
6	The thing is, it's <b>just</b> gonna take a little time, for you to um, come to terms with this.	
7	But, like I said, it's <b>soon</b> and it's going to be a process of one day at a time.	7
8	Since it has been so recent, it's <b>quite</b> difficult then to have had a chance to speak with anyone	
9	It's <b>really</b> hard to figure out where to start rebuilding.	
10	It's a matter of coming to terms with it, it's <b>not</b> easy.	
11	All of this has to be absorbed, and uh, it's <b>very</b> fresh, for you, right now.	8
12	You still have your legs, it's <b>just</b> that they are not functioning the same.	10
13	Well, it's <b>certainly</b> not the life that you are going to, that you normally, be able to continue now.	11
14	It's <b>too</b> early to talk about that.	12
15	But it's <b>not</b> gonna change the situation.	
16	But it's <b>not</b> the end of the world.	
17	Right now it might be, but it's <b>not</b> .	
18	Not right, it's <b>too</b> early.	
19	If you let me know what exactly it is, <b>then</b> maybe we can find other solutions.	15
20	It's <b>not</b> the same, I know, but you can still retain you independence if you are willing for us to help you, show you.	

8.3.2. Excerpts of “It is” + DET + [ADJ] + NOUN		
#	Excerpts	Nurse ID
1	It’s <b>a new reality</b> you have to face without wanting to let go of the other one.	3
2	And, it’s <b>a matter</b> of coming to terms with that and then moving on.	7
3	It’s <b>a matter</b> of coming to terms with it, it’s not easy.	
4	So it’s <b>a matter</b> of, eventually, you know, coming to terms with that and figuring out how to rebuild your life.	
5	The mourning period is important because it’s, well, you go through it anyway, but it’s <b>a matter</b> of coming to terms with, with your loss, you know.	
6	Well, like I said, it’s <b>a process</b> .	

8.3.3. Excerpts of “It is” + ADJ		
#	Excerpts	Nurse ID
1	I know it’s <b>early</b> .	6
2	And it’s <b>hard</b> to see the, the forest for the trees, right?	7
3	I know it’s <b>hard</b> to take.	12
4	At first when it’s <b>hard</b> to, to take everything in all at once.	13
5	It’s <b>hard</b> , at first, to take, all that in.	

#### 8.4. Appendix 4: Excerpts of “Going to” and Variable Slots

8.4.1. Excerpts of “Going to” + VERB		
#	Excerpts	Nurse ID
1	You’re not gonna <b>walk</b> like you have before.	1
2	*No, you’re never gonna probably <b>walk</b> that well again	
3	And that’s not gonna <b>happen</b> in the first 24 hours.	
4	But now you’re gonna <b>have to tell</b> it how to move because that synapses just kind of broken right now.	
5	You’re not, you’re not going to <b>accept</b> the situation until you’ve worked it over in your own mind.	
6	She’s going to <b>be</b> very upset when she finds out what has happened to you and that you’re dealing with it by yourself.	2
7	and that’s going to <b>take</b> some time to getting used to.	5
8	but, um, it’s just going to <b>take</b> a little time, and you’ve got to give yourself the time, to come to terms with this, and uh, to think about the, the ways that you can adjust to it.	6
9	The thing is, it’s just gonna <b>take</b> a little time, for you to um, come to terms with this.	
10	It’s like when you lose something that you, you know like your legs, you feel that uh, you know, you’re never going to <b>be able to do</b> , have a life like you had.	
11	But, like I said, it’s soon and it’s going to <b>be</b> a process of one day at a time.	7
12	But, the reality of the situation is that they are possibly not gonna <b>come back</b> .	9
13	And that’s gonna <b>take</b> some time to think about too.	10
14	Mm-hm, which means that uh, you’re going to <b>need</b> a wheelchair now to get around.	
15	*Well, it’s certainly not the life that you’re going to, that you normally, <b>be able to</b> continue now.	11
16	But it’s not gonna <b>change</b> the situation.	12
17	You’re not gonna <b>have</b> the use of your legs.	
18	You think it’s gonna <b>change</b> your role and your position with your employees?	15

\* “going to” is indirectly followed by another verb in this excerpt.

## 8.5. Appendix 5: Excerpts of “I know” and Variable Slots

8.5.1. Excerpts of “I know” (Independent Clause)				
#	Pretext	<u>Nurse:</u>	Post-text	Nurse ID
1	<u>Nurse:</u> Maybe we can find something more interesting for supper.	I know.	Food’s not on your list. [...] (Nurse)	1
2 + 3	<u>Patient:</u> Oh, just friggen’ great.	I know. I know.	My colleagues told me that uh, you received some bad news. [...] (Nurse)	2
4	<u>Patient:</u> He just told me I can’t use my leg, are you saying I might be able to use my legs? <u>Nurse:</u> I don’t know. You haven’t started rehab yet. <u>Patient:</u> {Sigh}	I know.	Doctors, uh, think that they should uh, just approach a patient and tell them like it is.	
5	<u>Patient:</u> Not hungry.	I know.	Well, maybe your friends can bring you in something that you do like to eat. [...] (Nurse)	
6	<u>Patient:</u> I will eat sometime. I’m not hungry.	I know.	Well, I understand that. Any other feelings you’d like to tell me about. (Nurse)	
7	<u>Patient:</u> It doesn’t matter who I talk to. I can’t use my legs.	I know.	<u>Patient:</u> And that’s what matters.	
8	<u>Patient:</u> And that’s what matters.	I know.	<u>Patient:</u> And counsellors and whoever the hospital hires isn’t going to let me bring my legs back.	
9 +1 0	<u>Patient:</u> I don’t want a different life. I want my legs back. <u>Nurse:</u> Mm-hm.	I know. I know.	Have you been eating at all? Up until now? (Nurse)	6
11	<u>Patient:</u> Oh, I’m not gonna off myself. It’s just, this changes everything.	Yeah, I know.	I know it does. (Nurse)	
12	<u>Patient:</u> Well, they’re just being stupid.	I know.	<u>Patient:</u> This isn’t my fault.	
13	<u>Patient:</u> I just don’t have any appetite right now. I’m not about to starve myself to death.	I know.	You feel angry? (Nurse)	7
14	<u>Nurse:</u> you need to talk to somebody {puts her hand on his should}	I know that.	<u>Patient:</u> I just don’t want help.	8
15	<u>Patient:</u> I wish it were one step at a time. <u>Nurse:</u> Well, one thing at a time.	I know.	Sorry. (Nurse)	12
16	<u>Patient:</u> It’s not your fault. <u>Nurse:</u> But you know we’re , we’re always able to help you, mm?	I know.	<u>Patient:</u> I just don’t want help.	

### 8.5.2. Excerpts of “I know + S (Complex Sentence)

#	Pretext	Nurse: “I know” + post-text	Nurse
1	<p><u>Patient</u>: And counsellors and whoever the hell the hospital hires isn't gonna let me bring my legs back.</p> <p><u>Nurse</u>: No they're not.</p> <p><u>Patient</u>: That's what matters.</p>	I know, but um, a counsellor can help you deal with the steps, with the grieving steps, because right now, <b>I know you're</b> depressed, I don't know how you feel, I'm not sitting in the wheelchair, but I've been a nurse for a long time, and I've helped a lot of patients through different things, and when you're ready, when you're ready, and you will be, talking to someone who's impartial, [...]	2
2	<p><u>Nurse</u>: We'll be working on, for sure, something comfortable you can get around in easily.</p>	<b>I know it's</b> uh, not something you want to perhaps think about now, but in the next few days, in the next couple of weeks [...]	3
3	<p><u>Nurse</u>: We've had many people in similar situations and we've been able to help them, to gain such upper body strength, that they've been able to, to become quite mobile.</p>	<b>I know it's</b> hard for you to hear at this time, and it will take some time to come to terms with that. [...]	5
4	<p><u>Nurse</u>: [...] In the meantime, just do a little bit of thinking about what I mentioned, having you go to physiotherapy.</p>	<b>I know you're</b> not ready to hear this, but I'll say it and I'll say it again tomorrow. We've had many people in similar situations [...]	
5	<p><u>Nurse</u>: [...] There are lots of people who do your kind of job, um, in a wheelchair. It, it is possible.</p>	<b>I know it's</b> early. You've just gotten this bad news today. [...]	
6	<p><u>Patient</u>: I'm not going to off myself. It's just, this changes everything.</p> <p><u>Nurse</u>: Yeah, I know.</p>	<b>I know it does.</b>	
7	<p><u>Nurse</u>: I'm sure, but um, have you ever seen.</p>	<b>I know this is</b> probably not what you wanna hear right now, but there are lots of people who have had the same thing happen as you [...]	6
8	<p><u>Nurse</u>: [...] But for right now, we just need to, try and, feel better and think about the possibilities that um, you know, this is not the end of the world.</p>	<b>I know it feels</b> that way right now, but um, it's just gonna take a little time, and you've got to give yourself the time to come to terms with this, and uh, to think about the the, the ways that you can adjust to it.	
9	<p><u>Nurse</u>: [...] I guess you don't like the food much, do you?</p>	<b>I know you're</b> not hungry.	
10	<p><u>Patient</u>: Thank you {says the nurse's name}, but I don't want help. I want my legs back.</p>	<b>I know you do.</b> And you know what? With a new diagnosis, like the one you've been given, you need time to grieve and you need time to sort through it. [...]	

11	<u>Patient</u> : Oh I have a few neighbours. <u>Nurse</u> : Mm-hm	Well, <b>I know you</b> feel like your independence has been taken away.	
12	<u>Nurse</u> : [...] sometimes a stroke destroys a lot of things, you know, besides your mobility.	<b>I know that that's</b> not making you feel better, but you have your speech, you have your mind, you still can think and talk.	
13	<u>Nurse</u> : [...] Most places are wheelchair accessible now.	So, you know, <b>I know that you</b> feel that you're gonna be stuck in your house all day, but that's not the case. [...]	
14	<u>Nurse</u> : But you could wheel in. What about, thinking of uh, of uh, I, it's just a thought that I'm putting to you, what about thinking of your, a wheelchair as an extension of you? That you use it as a tool? Just like we use our legs as tools? <u>Patient</u> : {Sigh} <u>Nurse</u> : Have you thought about it that way?	<b>I know it's</b> a very difficult time, but obviously I'm trying to see if there is anything that I could do that would help you understand what you're gonna have to deal with moving forward, and whether there's any possibility of you getting around to being able to accept it. [...]	9
15 + 16	<u>Nurse</u> : I know, and it's a real pain in the butt. It's a bummer, but that's the reality.	<b>I know it's</b> hard to take. I'm not in your situation, but <b>I know it's</b> hard to take. [...]	12
17	<u>Patient</u> : [...] The simplest little thing is now a major, a major deal.	<b>I know it's</b> gonna to be a big change for you, but I think with uh, with help. It won't be easy.	13
18	<u>Patient</u> : It's um, nice of you to paint a rosy picture, but it's not a rosy picture.	<b>I know it's</b> not. No.	15

### 8.5.3. Excerpts of "I know" + S (Compound Sentence)

#	Pretext	<u>Nurse</u> : "I know" + S	Nurse ID
1	<u>Patient</u> : It doesn't make any difference. I can't get my legs back.	<b>I know, but you</b> still have your feelings. It's important.	2
2	<u>Patient</u> : And counsellors and whoever the hell the hospital hires isn't gonna let me bring my legs back. <u>Nurse</u> : No they're not. <u>Patient</u> : That's what matters.	<b>I know, but</b> um, a counsellor can help you deal with the steps, with the grieving steps, because right now I know you are depressed. [...]	2
3	<u>Nurse</u> : [...] There's many ways for you to get around. It's not the same,	<b>I know, but</b> you can still retain your independence if you're willing for us to help you, show you.	15
4	<u>Nurse</u> : Well, they're not coming back. That's the reality. <u>Patient</u> : Exactly right.	<b>I know, and</b> it's a real pain in the butt. [...]	12

## 8.6. Appendix 6: Excerpts of “I understand” and Variable Slots

8.6.1. Excerpts of “I understand” + [S]				
#	Pretext	Nurse:	Post-text	Nurse
1	<u>Patient</u> : I’ll eat some time. I’m not hungry. <u>Nurse</u> : I know.	Well, I understand that.*	Any other feelings you’d like to tell me about? (Nurse)	2
2	<u>Patient</u> : Now it’s gonna take forever just to get into the car, and then to get out of the car, and walk down four steps to the office. All of a sudden, the simplest things become <u>Nurse</u> : Yeah, major.	Yeah I understand that.**	but um, there’s always something that can be done to make things easier. [...] (Nurse)	6
3	<u>Patient</u> : What used to be so simple is now very complicated.	Yeah, yeah. I understand.*	Sometimes, this happens with um, you know, very young people too. [...] (Nurse)	
4	<u>Patient</u> : Well, I appreciate the sentiment, but my feelings really don’t matter. I can’t use them, it doesn’t matter how I feel.	I understand.*	<u>Patient</u> : I can’t use them, so what do I do now?	4
5	<u>Patient</u> : I don’t have my legs.	I understand.**	but the reality of the situation is that they are possibly not gonna come back.(Nurse)	9

\* simple sentence; \*\* compound sentence; \*\*\*complex sentence

8.6.2. Excerpts of “I + S + understand + [S]”				
#	Pretext	Nurse:	Post-text	Nurse
1	<u>Nurse</u> : Well it says that um, there’s a good possibility that you won’t be able to walk, again. And this is why you’re so upset and not eating?	I can understand that.*	I’d be upset too. (Nurse)	6
2	<u>Patient</u> : No, I have no appetite. <u>Nurse</u> : No.	Well I can understand that.*	Today, we’re not going to worry about food, and uh, is your wife coming in to see you? (Nurse)	
3	<u>Nurse</u> : Mm-hm. You’re in a wheelchair. How do you feel about that? <u>Patient</u> : Well, I hate it. <u>Nurse</u> : Mm-hm.	I can understand.*	Mm-hm. Did your doctor discuss any type of therapy or anything you can have? (Nurse)	10
4	<u>Patient</u> : Yeah, well, I um, I’ll eat eventually. I think you’ll understand, I don’t have much of an appetite right now.	I can understand that.*	Mm-hm. Mm-hm. Just a little concerned, you told me your wife hasn’t been in since you got news from the doctor? (Nurse)	

5	<u>Nurse</u> : Yeah, ok. Just a little concerned that you're here and uh, you know um, perhaps there is people out there who don't know where you are right now. Mm-hm.	I can understand why you don't feel like eating.*** Mm.	<u>Patient</u> : Frankly, at this time, I'm less concerned about them than about me.	
6	<u>Patient</u> : Because it's still gonna be a wheelchair. It doesn't matter what anybody says.	I can understand your frustration.*	You've been an active man in your life. [...] (Nurse)	5
7	<u>Patient</u> : He may have, I dunno. He came in and told me that I'm paralysed, and that I'll never be able to walk again. Said something else, but you'll excuse me if I can't remember what he said.	Uh, I can understand.*	It's hard, at first, to take all that in. You came into the hospital, uh, how long ago? (Nurse)	13
8	<u>Nurse</u> : [...] You know and for me to say it's not easy is uh, a little bit redundant,	but I do understand, **and I'm sympathetic and	<u>Patient</u> : I don't need help. I don't need sympathy. I need my legs.	2

\* simple sentence; \*\* compound sentence; \*\*\*complex sentence

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