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Pedagogies of Rhetorical Empathy-in-Action: Role Playing and Story Sharing in Healthcare Provider Education

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Role Playing and Story Sharing in Healthcare Education

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Since successful healthcare relies heavily on a practitioner's ability to empathize with the patient, the allied health professions—like nursing and speech therapy—have long considered the possibilities and limitations of a pedagogical practice that centers empathy. In this essay, we analyze two such pedagogies: role playing with simulated patients in nursing and story sharing in a multimodal memoir group with aphasic clients in communicative sciences and disorders (CSD). Comparing theories of empathy in these fields as well as interviews with the future nurses and speech therapists participating in these experiences, we show how students engage in what we call "empathy-in-action" through both reflection and enactment and what rhetorical scholarship can gain from attending to these practices. Ultimately, we argue that putting rhetoric, nursing, and CSD in conversation deepens each field's understanding of how empathy can be taught and learned.

From Aristotelian triangles to Burkean pentads, it is clear that understanding the other is foundational to successful rhetoric. In order to engage in

persuasion, we must be able to understand another person's worldviews, values, and goals. We must be able to stand in their shoes and anticipate their wants and needs. In essence, we must have empathy for their experiences. Rhetoricians have theorized empathy's role in communication and identification, introducing the concept of "rhetorical empathy," which Lisa Blankenship (2019) defines as "a topos and a trope, a choice and a habit of mind that invents and invites discourse informed by deep listening and its resulting emotion, characterized by narratives based on personal experience" (p. 5). A growing body of work has also begun to interrogate how empathy works in communication in various interdisciplinary contexts from cadaver labs to law clinics to nursing classrooms (Britt, 2018; Campbell, 2017; Fountain, 2014). These discussions, however, are largely removed from the day-to-day teaching of rhetorical empathy in writing classrooms.

In this article, we highlight the fact that rhetoric and writing studies is far from the only field that centers empathy in its pedagogy and practice. Healthcare providers are always by necessity working to understand and identify with the needs of their patients. Going beyond "sympathy" or "compassion," which call for feeling *for* an other, and which can devolve into pity and sustain damaging power imbalances, empathy requires healthcare providers to practice the kind of responsive reflection that is also central in rhetorical training. Rhetoricians of health and medicine, then, are well-positioned to bring together conversations in the allied health professions with our field's work on rhetorical empathy.

To contribute to those efforts, we examine pedagogical models in two different healthcare fields: role playing with simulated patients in nursing and story sharing in a life story group with aphasic clients in communicative sciences and disorders (CSD). Turning to the extensive bodies of literature in the fields of nursing and CSD, as well as interviews with the future nurses and speech therapists participating in hands-on learning and reflection, we ask: What can rhetoricians and teachers of writing learn from studying experiential contexts in CSD and nursing where patient empathy is a focus? And, what can theories of rhetorical empathy offer these practices? From this analysis, we forward the concept of "pedagogies of rhetorical empathy-in-action": experiential teaching approaches that center discursive practices of perspective-sharing (storytelling) and perspective-taking (role playing). We show how pedagogies such as role playing and story sharing engage students in both empathetic reflection and practice and are key to the development of students' professional roles. This study

reinforces how rhetorical empathy is an experiential practice and helps to grapple with the affordances and limitations of different modes of pedagogical empathy-in-action.

Literature Review

In this section, we synthesize scholarship defining and relating to empathy in the three fields we are drawing into conversation: rhetoric, nursing, and CSD. We analyze provocative overlaps and divergences in these bodies of literature by asking: How does each field enact empathy and understand its nature? Is it innate or learned, purely cognitive or also embodied, enmeshed in imbalances of power? How can we avoid pitfalls, including overidentification and erasure? By tracing the parallels and disconnects across these conversations, we set the groundwork for our analysis of interviews with nursing and speech therapy students.

EMPATHY IN RHETORIC

The field of rhetoric and writing studies recognizes that empathy is central to the exchange of meaning between individuals, or as Blankenship (2019) put it, "engaging with the Other is one of the primary purposes of rhetoric" (p. 28). Thus, empathy is integral to how we teach writing (Lindquist, 2004; Richmond, 1999) and what we expect our students to do as ethical writers (Blankenship, 2019; Leake, 2016). This section brings together key threads of rhetorical scholarship that theorize empathy as complexly innate and learned, deeply embodied, and enmeshed in power dynamics and differentials. We also describe prior research on interdisciplinary pedagogies of rhetorical empathy.

For writing teachers, a central question is whether empathy can be learned at all or whether it is an inadvertent affective response. Drawing on Eric Leake's (2016) framing of empathy as "a rhetoric and disposition," rhetorical scholars emphasize the possibility that empathy is something that can be learned, but also that repeated practice can turn empathy into a "habitus," to use Pierre Bourdieu's (1990) term, or an embodied way of living and being that has become second nature. Along with this notion of habitual empathy, both Julie Lindquist (2004) and Sharon Yam (2018) draw on Arlie Hochschild to argue that through deep acting and deep stories the empathizer creates the possibility of change for themselves by truly experiencing the other's world.

Thus, rhetorical scholars tend to highlight how empathetic practice is not only cognitive or emotional, but also embodied as the empathizer must attempt to physically take on the experiences of another. However, as one strives to embody the feelings and experiences of others, they inevitably encounter what Leake (2016) called "a recognition of unknowability." Dennis Lynch (1998) similarly argued that one of the main problems of empathy is that stepping into someone else's shoes paradoxically necessitates that person being absent or erased. He proposed a rhetorics of proximity, drawing on examples of Cornel West and Temple Grandin who highlight "the particularities of their respective bodies to hold us at a distance" (p. 19).

In line with this research on embodiment, rhetorical scholars have also examined pedagogies of empathy in experiential professional training contexts, like cadaver labs and legal clinics. T. Kenny Fountain's book *Rhetoric in the Flesh* detailed the strategies used during dissection labs to both distance students from the cadaver and also to remind them of its humanity, asking: "Can the experience of the gross lab facilitate a kind of detachment that is neither emotionless nor depersonalizing?" (2014, p. 155). Meanwhile, Elizabeth Britt's book *Reimagining Advocacy* examined how law students develop empathy for victims of domestic abuse in a program that integrates classroom, clinical, and courtroom experiences. Britt described empathetic learning as immersive and embodied. Especially in the clinical setting, this learning comes in large part from the law students setting aside their impulse to intervene (or advocate) for clients in order to be better listeners.

Meanwhile, a number of rhetors have highlighted the risks associated with empathetic practice and its intersections with social hierarchies and systems of power. Empathy necessitates vulnerability and "obviously is riskier and more costly for those in nondominant subject positions" (Blankenship, 2019, p. 121). In tabling their own needs, desires, and experiences and working to understand those of another, marginalized individuals may silence themselves. Meanwhile, when individuals in positions of power seek to practice empathy by taking on the experiences of the marginalized, this can also serve as a form of erasure. Todd DeStigter (1999) proposed "critical empathy" as a counter to these risks while Ratcliffe (2005) pointed to the importance of emphasizing both similarity and difference in critical empathetic practice in her theory of rhetorical listening. She used the metaphor of "standing under" to describe experiencing others' perspectives without necessarily responding or acting immediately: "letting [others'] discourses wash over, through, and around us and then letting them lie there

to inform our politics and ethics" (p. 28). Across rhetorical theories, then, the power dynamics of empathetic practice remain in the forefront with authors highlighting strategies for countering erasure and silencing of marginalized groups even as they recognize the complex cognitive and embodied dimensions of empathetic practice.

Empathy in Nursing

The field of nursing has prioritized empathy as a concept to theorize, practice, and teach for over half a century. This section traces the origins and evolution of empathy in nursing scholarship and pedagogy, with particular attention to the relationship between communication and empathy and the role of embodiment in empathetic exchange. While most nursing scholarship considers empathy to be primarily mental—cognitive and affective—we argue that embodiment plays a critical role in nursing practice.

Most nursing scholarship begins discussions of empathy with therapist Carl Rogers, who argued that empathy between provider and patient was essential to successful psychotherapy (Kelley et al., 2011, p. 25). Rogers' theory highlights how "[empathy occurs] when the therapist is sensing the feelings and personal meanings which the client is experiencing in each moment . . . and when he can successfully communicate something of that understanding to his client" (Bas-Sarmiento et al., 2020, p. 43). Nursing scholarship similarly centers communication, describing a give-and-take between patient and nurse and arguing that attention to communication helps to distinguish professional clinical empathy from subjective experience (Bas-Sarmiento et al., 2020, p. 44).

More specifically, Yulia Strekalova et al. (2017) argued that empathy is demonstrated through a nurse's ability to bridge technical medical language with the patient's personal experience, tying empathy to health literacy (p. 62). They describe three tiers of empathetic communication; the most advanced mode, "rhetorical," "identif[ies] actions that could enhance the patient's well-being" (p. 71). Karen Dearing and Sheryl Steadman (2009) similarly linked redirection of the patient's feelings and actions to successful communication of nursing empathy (p. 174). But while nursing scholarship privileges these interventions, rhetorical scholars highlight the importance of letting another's perspective "wash over" you (Ratcliffe, 2005). This perspective calls nursing scholarship to an alternative vision of empathy that is both rhetorically responsive, but also less solution-oriented.

Currently, most nursing theory considers empathy to be a primarily mental phenomenon, highlighting both cognitive and affective components and considering embodied elements tangentially (Brunero et al., 2010). For example, C. Daniel Batson's (2009) eight views of nursing empathy included only one that is specifically related to embodiment—imitating or mimicking a patient's posture. This is particularly surprising given how central experiential empathy training is in nursing, like live-action simulation that places students in the position of patients. Simulations capture one embodied approach to teaching empathy-in-action: role play. While scholarship in disability theory (Siebers, 2008) cautions against the risks of disability simulations that ask students to embody patient experiences, we recognize there is a wide range of potential outcomes depending on how well simulations are contextualized and immersed in student experience (see Dearing and Steadman, 2009 and Panosky & Dias, 2009 for two nursing examples). As we discuss below, attending more to the embodied experience of empathy could help nurse educators to design critical empathy experiences for students and to consider alternatives to direct patient intervention.

Empathy in Communicative Sciences and Disorders

In CSD, empathy has long been an important tool for practice, but has only recently been adopted into educational standards. Empathy has been integral since the field's move toward the "personal impact" experienced by individuals with communicative disorders and their families (Brumfitt, 1993, p. 569). Audrey Holland and Pelagie Beeson (1993) highlighted "the intense and often devastating effects that aphasia can render upon psychosocial and emotional well-being" and urged clinicians to center empathy by attempting to "truly understand what aphasic patients are interested in sharing" and to express it (p. 583). This section traces empathy in CSD as an incredibly important, but often vaguely defined, competency.

Attention to empathy has stimulated discussion about counseling in CSD, encapsulated in David Luterman's (2020) call for clinicians to offer not only informational counseling, but also emotion-focused "personal adjustment counseling" (p. 905; Simmons-Mackie & Damico, 2011). In 2017, the Council on Academic Accreditation in Audiology and Speech-Language Pathology (Council) added a Professional Practice Competency that stipulates that CSD graduate students must "show evidence of care, compassionate, and appropriate empathy during interactions with

each individual served, family members, caregivers, and any others involved in care" (Council, p. 21). However, recent research (Luterman, 2020; Sekhon et al., 2019; Sylvan, 2019) finds that very few CSD graduate programs require a counseling course, and there is no generalized agreement on what skills should be taught to fulfill these empathy-focused objectives.

Despite this lack of clarity, empathy pervades the person-centered counseling strategies in recent CSD literature, and clients value empathy highly in speech therapists (Fourie, 2009). Active listening is the most strongly recommended CSD counseling tool (Luterman, 2020; Riley, 2002). As Audrey Holland and Ryan Nelson (2018) explained, CSD counseling is "a listening process," and "involves *trying to understand how the world looks to clients*" (p. 12, emphasis original). This practice necessitates "careful self-examination" of the clinician's own "subjective worldview," and effort to set biases aside (p. 12). Empathetic listening is embodied, requiring culturally appropriate nonverbal behaviors: "leaning forward, appropriate eye contact, nodding in agreement occasionally" (Holland & Nelson, p. 96). Lisa Abbott Moore (2010) encouraged clinicians to consider the communications environment by minimizing distracting note-taking and ensuring a "welcoming, inviting, and nonsterile" environment" (p. 26) and to "fake empathy" through embodied actions, facial expressions, and tone of voice. Empathetic listening also requires willingness to "be there in the service of the other, witnessing and not prescribing, being selfless, and having no judgment" (Luterman, 2020, p. 905). CSD clinicians (in contrast with nursing's focus on intervention) are advised to hold off on offering solutions—to avoid invalidating a client's perspective or discouraging them from working through emotions (Luterman, 2020).

While witnessing shared humanity is essential, scholarship in CSD highlights the limits of empathy in ways similar to rhetorical scholarship: "Empathy still stops short of being in another's skin. You can only know just how *you* feel" (Holland & Nelson, 2018, p. 96). Recent scholarship proposes various methods for exposing clinicians-in-training to experiential, self-reflective exercises to build empathy. Luterman (2020) argued for integration into graduate education while Holland & Nelson (2018) proposed myriad self-reflective exercises, including acknowledging one's biases and recording negative behaviors one is trying to change. Classroom and practicum experiences such as reading memoirs of individuals who have acquired communicative disorders (Sylvan, 2019) are also offered

as ways to build clinicians' empathic capacities. These recommendations informed the life story groups analyzed in this study.

Overall, rhetorical scholars have richly theorized both empathy and its limitations, recognizing the importance of embodied knowledge to empathetic practice and emphasizing the role of power differentials. Pedagogically, however, rhetoricians have yet to center empathetic learning through experiential models like in nursing or course competencies like in CSD. In contrast, nursing scholarship offers an array of models for experiential teaching of empathy, but has paid limited attention to its embodied nature in its theory and often highlights intervention. Finally, CSD's scholarship is more attuned to these embodied elements of empathetic practice and calls us to table intervention, but it is also less clear as a field about how empathy should be defined or positioned in its curriculum. Many of these differences were also borne out as we examined pedagogical contexts in Nursing and CSD for this study.

Methods and Context

Here, we overview our approaches to data collection as well as our collaborative coding process. We are scholars in rhetoric and composition who formed personal relationships with faculty in the health sciences that supported our access to these contexts (see Campbell, 2018 and Miller, 2019 for more details on this relationship-building). We also introduce background on the two approaches to teaching empathy-in-action—the life story groups and the clinical nursing simulations—with a focus on how each context immersed speech pathology and nursing students in the emotional and embodied aspects of their professional roles.

Data Collection and Analysis

Notably, neither of these projects began with the intention to study pedagogies of empathy. Lilly was primarily interested in how nursing students were being taught embodied communication in simulation contexts, whereas Elisabeth was studying how participants with aphasia navigated multimodal communication. However, when we met and discussed our projects at a qualitative research seminar in summer 2017, we began to recognize our overlapping interest in health provider pedagogy and empathetic learning that ultimately led to this research. We decided that by comparing nursing and CSD students' experiences, we could offer a richer understanding of

both the similarities across healthcare contexts as well as the wide breadth of empathetic learning that was happening.

Both researchers conducted interviews with the practitioners in their studies and regularly observed the role playing and story sharing sessions, in addition to collecting video recordings of the experiences. Lilly interviewed five junior year nursing students after each nursing simulation (for a total of 20 interviews) with a focus on understanding their experiences with communication and writing in the simulation context. Meanwhile, Elisabeth interviewed nine speech pathology MA students following their participation in the life story groups to understand its impact on their views of speech pathology and aphasia.

While we began analysis by looking for empathetic moments in our video data, we recognized that "seeing" empathy enacted during role playing and story sharing was quite challenging. Arguably, most interactions between students and patients had empathy at their heart, but whether a student was taking a patient's pulse "empathetically" was difficult to determine. In contrast, we found that during interviews, students routinely described their efforts and failures to build empathetic connections with patients. Thus, we chose to focus on coding interview transcripts using a set of shared codes and then selectively returned to video recordings to supplement the analysis.

Interviews ranged from 20 to 60 minutes and covered a wide variety of topics, some more closely related to empathy than others. Ultimately, we coded 67 excerpts in the Nursing data and 38 in the CSD data as related to empathy. Key interview questions from Nursing that elicited responses related to empathy included:

- What do you think are the three to four most important traits for a nurse to have?
- What did you learn about nursing communication from this simulation?
- What did you learn about the physical movements, gestures or actions of a nurse from this simulation?
- What did you learn about a nurse's orientation towards patients and others from this simulation?

Key interview questions from CSD that elicited responses related to empathy included:

- How would you describe a typical session in the life story group with your client?
- What have you learned about people with aphasia from participating in this group?
- What have you learned about communication from participating in this group?

Codes were developed collaboratively and iteratively, building on Lillian Campbell and Elizabeth Angeli's (2019) call for cross-contextual research in the rhetoric of health and medicine. Both authors began with individual in vivo coding of empathy-focused talk in their interviews and then compared codes and built categories applicable across both contexts. Ultimately, we saw that talk about empathy fell into two broad categories: 1) Reflection and 2) Enactment. Within the Reflection code, Humanizing, Identification, and Role were subcategories. Within the Enactment code, we included Communication, Being-There, and Intervention as subcategories. Code definitions and examples are available in Table 1.

Overall, we used qualitative coding as an analytic heuristic: "an exploratory problem-solving technique without specific formulas to follow" (Saldaña, 2009, p. 8) and our end goal was identifying themes across data sets, not counting instances of each code. This focus aligns with the overall aim of the paper to better understand student learning during experiential empathy-based activities. Because there was substantial overlap across codes, we allowed for double-coding. In addition, we were not rigorous about the size of our coding units, which also makes quantitative arguments less useful. Instead, our analysis in the next section draws on themes that emerged through comparing instances of these codes, including key similarities and differences in how they appeared for our nursing and speech pathology students.

Life Story Group: Taking on the Counseling Role of the Speech Therapist

The life story group for aphasic people offered an innovative approach to speech therapy for aphasic clients and training for clinicians enrolled in a Speech Language Pathology MA program at a large Midwestern university. Elisabeth, then a PhD student in rhetoric and writing studies, collaborated with a speech pathologist and clinical professor to create and

Table 1: Empathy Codes, Definitions, and Examples

		Definition	Example
Reflection—Retrospective discussion of empathy in their field, with a focus on navigating similarities/ differences with others	Humanizing	Recognizing the patient as individual person rather than as their disease, as a manikin, and/or as their larger racial, ethnic, gender, age (etc.) group	"It's so basic, but people are people are people. I mean, everyone's got a different a personality, just because they have a disorder, that is like one part of their whole life." (CSD)
	Identification	Drawing parallels between student's experiences and the patient's in order to bridge differences	"I have to really put myself in her perspective. I was thinking, 'Well if I were sort of wanting to disengage from my community and my family, what would I want?'" (Nursing)
	Role	Describing how empathy is tied to professional performance in the field	"I feel like care is so very little of what you do. Like it's a big part because that's what your job is. But I feel like it won't work if you don't actually talk to the person." (Nursing)
Enactment—Retrospective discussion of how students practice empathy with patients, including specific strategies and approaches	Communication	Practicing empathetic verbal and/or written discourse with the patient	"My job is narrowing in, confirming that she understood or that I understood what she was trying to communicate. 'I know you know'; acknowledge competence. 'This is frustrating; I know.' 'Forgive me. Thank you; I'm glad we got it.' Always encouraging." (CSD)
	Being-there	Immersing themselves in the moment with the patient and avoiding immediate impulses to intervene	"Sometimes going into a session, I think I have this kind of agenda [. . .] Often Bill wanted to talk about stuff in the present tense too, things that had happened to him. That was a really important thing for him as well." (CSD)
	Intervention	Balancing empathetic care with accomplishing specific tasks related to the patient's unique needs	"There were times when we kind of bombarded that patient [. . .] we were all around the bedside doing something different and the patient in real life would have been like, 'Oh my gosh, what's going on?'" (Nursing)

facilitate this group, funded in part by grants designed to support public humanities programming and interdisciplinary collaboration. MA students participated in this group as part of their Clinical Practicum requirements. Students engage in hands-on clinical work at the university Speech and Hearing Clinic, hospitals, and schools around the community for the three semesters after an initial semester of observation. After graduation, they go on to work as speech pathologists in a range of sites—from elementary schools to in-patient rehabilitation facilities for stroke patients.

Given its focus on aphasia, the life story group offered clinical experience with adult neurogenic communication disorders—disorders acquired in adulthood, affecting the production and reception of language. In addition to its focus on adult clients, the life story group exposed students to a growing therapeutic philosophy: a "life participation approach to aphasia," which aims to "produce meaningful real-life outcomes leading to enhanced quality of life" (Chapey et al., 2000, p. 4). To focus on real-life communication needs, the life story group met 90 minutes per week for 12 weeks in Spring 2013, pairing ten aphasic individuals with MA students to compose "life books," scrapbook-like texts sharing important aspects of aphasic clients' lives. Individuals included childhood photos, old newspaper clippings, drawings, maps, and online images that represented their careers or hobbies.

This life participation focus challenged student clinicians to build emotional and embodied capacities, specifically for the counseling aspects of speech therapy. Clinicians reflected on story sharing's value as a therapeutic tool for supporting the emotional needs of aphasic clients, describing the life book itself as "an impetus for conversation." One clinician explained how "the book served as a centerpiece" for discussion about a client's life experiences and starting point for "processing the changes that he's going through now." Learning that clinicians must listen to and support clients sharing a range of emotions, particularly after experiencing a major life change like aphasia, was one of the most important lessons of the group.

As in the CSD literature on empathy and counseling (Moore, 2010; Holland & Nelson, 2018), clinicians in the life story group also learned to attend to the importance of physical environments and embodied listening and communication. Attention to effective methods for communication permeated clinicians' interviews, including using gestures, drawing, not giving too many options, and not speaking too quickly. Moments of embodied interaction mattered a great deal in the group environment, as clinicians

described "sitting back," "nodding," and encouraging each other to share. Clinicians also reflected on the power of learning about clients' embodied experiences, including the ways they've creatively adapted to right-side weakness or occasional seizures.

Nursing Simulations: Embodying the Role of the Nurse

The interviews and simulation videos analyzed in this study were collected during the 2014-2015 academic year at a small, private university in the Pacific Northwest. After forming a relationship with the director of the simulation lab through a mutual friend, Lilly followed a group of approximately 80 junior-year nursing students through a series of three simulation scenarios during the year: a geriatric simulation with a diabetic female patient; a medical-surgical simulation with a young male patient who was recovering from surgery; and a pediatric simulation involving an infant with a respiratory infection. Students were also enrolled in clinical sites throughout the city, so they frequently made connections between the simulation events and their experiences in other clinical contexts.

Simulation pedagogy has been a hallmark of nursing education for decades and typically involves "sequential decision-making classroom events" during which students negotiate medical intervention and communication with both the patient and other practitioners (Hertel & Millis, 2002, p. 15). While outsiders often believe simulations focus primarily on technical skills like catheter insertion, the goals are much more wide-ranging, encompassing communication, cultural understanding, and patient advocacy (Campbell, 2017). The simulations in this study involved high fidelity robotic manikins that are controlled by a computer system run by the instructor on the other side of a one-way mirror. The instructor can prompt the manikins to spike a fever, have an irregular heartbeat, have dilated pupils, and even cry. The instructor can also speak as the patient through a microphone connected to a voice box in the mannikin's mouth.

Simulations were structured to occur over a two-hour time period, during which three groups of 2–3 nursing students would practice caring for the simulated patient for 20 minutes each, followed by a 10 minute debrief with the rest of the class and the instructor. Typically, the patient's condition would worsen over the course of the two hours. Overall, the simulation experiences were designed to allow students to practice the emotional and embodied experience of being a nurse. Students who participated in

interviews agreed that their embodied experiences in simulations felt more authentic and did more to elicit empathy than activities that asked them to simulate disability, like an in-class simulation of old age where they wore weighted suits and vision goggles.

On the one hand, students had practice in trying to unpack and understand their patient's emotions. One student noted the importance of concealing her own feelings of nervousness in order to keep the patient calm in times of heightened anxiety. On the other hand, students practiced embodying the role of the nurse and reflected on how their bodies could be used as a source of connection or a source of disruption in their interactions with patients. For example, students noted how crowding patients during care or not observing their need for modesty could overwhelm or upset a patient. Of course, simulations were not a perfect replication of a clinical environment, and the robotic patient often did not physically feel like a real patient (Campbell, 2017, 2021). Students reflected on these disruptions as well, but in ways that emphasized how they might use physical encounters to build connection in a real-life situation. Overall, verbally and physically interacting with the robotic patient in simulations prompted thoughtful connections to and reflection on the patient experience, even if these were occasionally interrupted by the strangeness of the simulation environment.

Findings

This section is organized around our two overarching coding categories: Reflection and Enactment. Within each of these categories, we compare and contrast how students talked about learning empathy-in-action in both the story-sharing and role-playing experiences.

Reflecting on Empathetic Experiences

Performing empathy requires constant reflection on what one shares, and does not, with others. One must attempt to understand others' experiences and perspectives without conflating them with one's own. We saw that complex balance, or push-and-pull, in interviews with nursing and CSD students as they reflected on the "humanizing" elements of their learning experiences (learning about others) and the ways they "identified" with patients/clients (linking patients'/clients' experiences to their own). These reflections are also closely tied to students' understanding of their professional "role" in the fields of nursing and speech therapy.

Humanizing the Patient. The life story group encouraged students to reflect on what we call the "humanizing" aspects of speech therapy, particularly seeing beyond the "client" to the person. "I mean it's so basic, but people are people are people," Lindsey observed of the life story group, "Everyone's got a different personality. Just because they have a disorder, that's like one part of their whole life." Sam, likewise, observed that in addition to getting a sense of the diverse ways aphasia may manifest, she appreciated how "everyone has a story, which is just so important." The humanizing focus of the life story group was especially apparent in clinicians' reflection on the value of clients' "willingness to share a lot of details," including often emotional life events. This sharing provides evidence of what Kaitlin called "a good rapport." Lindsey described moments in which a client "opened up" as a "really unique and lovely" exchange. This human connection, Abbey reflected, was something the group made room for that individual clinical sessions may not—in turn facilitating the counseling, empathy-building goals of CSD clinical training.

For the nursing students, the "human" nature of simulations also stimulated reflection around the importance of seeing the patient as a person—rather than, as Kira reflected, "a creepy robot person that is actually my instructor." The instructors encouraged students to see the humanity of the simulated patient by signaling pain or discomfort in response to students' actions. For instance, Michelle described forgetting to warn the patient before touching her genitals to insert a catheter, and when the simulated patient reacted with alarm, it made her realize, "Okay, this is real. I need to actually warn her." The human components of "care" are vital in this work, as nurses must focus on and talk to patients as people. Patient care, Kira reflected, "Won't work if you don't actually talk to the person."

Identification with the Patient. Similar to humanizing, simulations also supported nursing students in drawing parallels between their own experiences and their patients' in order to bridge differences, or what we coded as "identification." Kira identified with a very stressed patient returning from surgery and how putting lotion on the patient's legs calmed her. Kira reflected, "I have pretty sensitive skin and so like if my skin's itchy or just not feeling it, like I'll know and I'll be really, really irritated." More broadly reflecting on the stressed reactions of a simulated patient, Kira ruminated on how it would "be so terrifying to be old," losing memory or not being recognized as competent.

Identification sometimes functioned by students drawing parallels between their own experiences and patients' to better understand unfamiliar situations. Simulations supported Liz's attempts, for instance, to imagine the experience of distancing oneself from community and family, even though she was "not the type of person that would want to disengage." Michelle also attempted to imagine the desires of patients for certain kinds of communication by considering what she would want: "the nurses to be communicating with me, letting me know what's going on. If they go and huddle in the corner to talk about what they're going to do, I'd want to know what they're talking about." In contrast, the life story group rarely prompted CSD clinicians in this study to "identify" with their aphasic clients, as discussed below.

Understanding Professional Role. Reflections on the humanizing and identification elements of the life story groups and simulations tied directly to CSD and nursing students' reflections on how empathy is a part of their professional roles. For instance, CSD students reflected on how the life story group helped them to understand, as Lindsey said, the importance of their "counseling role." The role of the clinician is directly tied to this ability to humanize the patient through a story sharing exchange. For instance, Abbey recounted her client Debbie wanting to share some personal letters and pictures from childhood about the death of her father. Abbey noted this as a "bonding moment" wherein the client felt comfortable sharing human experience. For nursing students, the simulations similarly reinforced how the nursing role is tied to responsibility for the whole patient experience, including attending to the patient as a person. Simulations helped students to understand how significant and challenging that work is: Kira reflected on wishing she had two selves, "One that could talk and go at the same time." Discussions of "identification" also frequently co-occurred with discussions of "role" in the nurse's talk about simulations. Liz's effort to identify with her patient led her to imagine what care she would want from a nurse: "someone to be there and be caring and nurturing."

Enacting Empathetic Practice

Given the different models of the life story group and the nursing simulations, enacting empathetic care also looked different across the two contexts. Nursing students struggled to balance clinical interventions with patient-centered communication and empathy, while CSD students came

to recognize their presence as conversation partners with aphasic patients—"being there"—as a key part of their intervention as counselors.

Balancing Intervention and Empathy. The nursing simulations were structured around a set of tasks that students needed to accomplish (articulated in the physician's orders) and, thus, many students described interventions as the things that got in the way of providing more empathetic care. Michelle explained how the list of interventions could dominate a group's conversation: "It's kind of hard at the very beginning [to focus on the patient] when everyone's trying to figure out what to do . . . You kind of forget that the patient's there." Similarly, Kira noted how in moments of crisis during the simulation, it was easy for a group to lose sight of the patient's emotional needs while they dealt with medical needs: "It was really good [the nurse] got to know about his heritage and his parents but then they completely disconnected [during the pulmonary embolism] and meanwhile he's over there . . . like, 'What is going on? Come talk to me!'"

In contrast, because the goals of the life story group were learning about their partner and finding ways to effectively communicate with one another, the CSD students practiced tabling their instincts to intervene in the form of counseling or an agenda, in order to let their partner's needs guide the conversation. Laura noted, "Sometimes going into a session, I think I have this kind of agenda for this kind of a session. And I think that it was not really great to go in with a super kind of agenda in my head. Often Bill wanted to talk about stuff in the present tense too—things that had happened to him. That was a really important thing for him as well." Thus, while interventions were brought up frequently by nursing students as guiding the patient exchange in simulations, the CSD students' interactions in the life story group were more driven by the goal of "being-there."

"Being-there." The life story group was built around the goals of letting the aphasic partner's needs guide the conversation, encouraging CSD students to learn how to be a supportive presence without dominating the interaction or even really directing it. This code resonates with Ratcliffe's (2005) discussions of rhetorical listening and her emphasis on "standing under" the discourses of others to understand their experiences without moving immediately to intervention. Laura described struggling to take on this counseling role, but found that her clinical supervisor Darla's advice clarified its importance: "You just have to treat them with respect and actively listen to what they're saying, and you know how important it is for them 'to cough up the hairball' was the way she put it." CSD students learned how to "be

there" to support their partner's often emotional realizations and to understand their strategies for communicating. Thomas discussed the value of learning "to be a silent partner" in the conversation, noting that often when he was inclined to take the lead as a therapist, "you think you're helping, but you're really being kind of a jerk," potentially shutting down communication. Abbey reflected more broadly on the value of being a "communication partner" whose goal was to "help her [client] get her message across and help understand what she's trying to say." Interestingly, nursing students described "being-there" most often in the context of their clinical placements, where they do not have the knowledge yet to practice active interventions and, thus, are encouraged to have extended conversations with their patients instead. These opportunities were much less frequent during simulations.

Communicating Empathy. The differences in how each activity prioritized intervention and being-there also showed up in students' understandings of good patient communication. Nursing students noted the importance of making sure their patients could understand what they were saying and were not overwhelmed or confused. Often, in order to do this, nursing students relied on strategies of identification. Ryan recalled asking himself, "What would I tell myself as a freshman?" as he was working to explain a procedure to his young adult patient. Instructors played a key role in prompting this learning in the nursing simulations as well, responding (as the patient) with confusion or fear when students used overly jargon-filled language. This helped students to recognize when they were not empathizing with the patient's experience, but also put forward a view that there is a right way to communicate and a wrong way.

Meanwhile, CSD students expressed a lot more flexibility in their views of communication during the life story group, highlighting the importance of situated practices that were responsive to their partner's needs. For example, Sam described a wide variety of communication strategies: "There are so many different ways to communicate. And communication is like—I mean, I know this already but [the life story group] kind of cemented it and made it hit home—communication is like who we are." Laura, too, reflected on how her client Bill "taught [her] how to communicate with him," including preferences for not providing too many options and maintaining a non-cluttered workspace, as he frequently has migraines. The strategies that CSD students discussed learning during the groups were often focused around supporting their aphasic partner's communication and affirming its value.

Thomas described a number of specific strategies including, "Narrowing in, confirming that I understood what she was trying to communicate. 'I know you know'—acknowledg[ing] competence. 'This is frustrating, I know.' 'Forgive me.' 'Thank you, I'm glad we got it.'" Similar to the different emphases on intervention vs. being-there, then, the role-playing structure of simulations prioritized a specific kind of goal-centered communication whereas the story sharing model highlighted modes of communicating presence and support less focused on transactional exchange.

Analysis

This section draws on our findings about how empathy is discussed in relation to the life story groups and simulations, considering both strengths and weaknesses in how these activities emphasize different aspects of empathy. In addition, we consider what theories of "critical empathy" (DeStigter, 1999) and "rhetorical empathy" (Blankenship, 2019; Leake, 2016) discussed earlier in this article might offer to conversations about teaching provider empathy in nursing and CSD. Empathetic practice is all about rhetoric: determining the context one is in and how that context may change moment-by-moment and responding accordingly. In this way, an understanding of empathy as rhetorical offers ways to resolve some of the tensions in the reflection and practice of empathy for nursing and CSD students.

Overall, we find that the two approaches—simulations and life story groups—emphasize different areas of student reflection. Life story groups support humanizing and simulations support identifying. We also find that each approach may benefit from the other. While these reflections on what nursing students share with patients—or imagine they might share—are generative forms of identification leading to strategies for care, we also observe that identification may be a barrier to empathy. That is, if students feel they do not share anything in common with the patient, then they may feel they cannot connect or relate, inhibiting their creation of empathetic care strategies. Kira compared interactions she had with a younger male and those with an older female simulated patient. The "generation gap" she felt with the older patient still meant she retained "respect for your elders," but she felt a disconnect and had a harder time communicating. With the younger patient, Kira described talking about TV shows and sports, finding it "easier to talk to him because he was our age," comparing the interaction to "a Facebook conversation or like a phone call or something."

Some of the gaps in identification may be cued by instructors guiding the simulation experience. Liz encountered a male simulated patient, for instance, who requested a male nurse to insert a catheter. Liz reflected that she did not want to impose and had a harder time interacting with and figuring out the patient's needs. Rhetorical empathy pushes back on too much reliance on relating to, or identifying with, a patient, instead highlighting the inevitable distance between self and other and the importance of grappling with that distance (Leake, 2016; Lynch, 1998). Further, it encourages students to contextualize their understanding of patients as always engaged in "social and cultural institutions"—families, careers and workplaces, communities, and cultures—that may or may not intersect with their own experiences (Britt, 2018, p. 41).

We observed similar limits to identification from the CSD students. The life story group emphasized the humanity of clients, encouraging clients to share their experience and clinicians to support that sharing. However, the CSD clinicians interviewed in this study rarely identified with their aphasic clients during groups. Laura, for instance, acknowledged that she cannot possibly "know what it's like" to have aphasia and feared that "it would be disrespectful for me to think that I did." This acknowledgment of what's beyond one's experience or understanding may encourage respectful interaction, keeping clinicians from making assumptions about or speaking for aphasic people. However, the treatment of aphasia as so outside of one's experience, as completely other, may also inhibit empathetic communication.

Recent literature in CSD (Holland & Nelson, 2018; Luterman, 2020) argues for increased self-reflection on behalf of clinicians-in-training to develop empathetic responses to clients' challenges. For instance, Laura did briefly reflect on how her client Bill and she both shared "perfectionist" tendencies. For CSD, a rhetorical view of empathy encourages students to go beyond recognizing the humanizing function of the story sharing in the groups. Recognizing the humanity of others is essential, particularly when working to support individuals who are often dehumanized, such as aphasic clients. However, rhetoricians (Blankenship, 2019; Lynch, 1998) remind us that empathy is also self-focused, insisting that we "undo any belief that empathizing affects only the one receiving the empathy" (Lynch, 1998, p. 20). Understanding oneself in the context of another, identifying shared connections with clients, and examining one's own life story, is an important step for CSD clinicians, and one for which rhetorical empathy offers a path.

Meanwhile, the life story groups and simulations also led to different views of enactment. In nursing simulations and the role-playing model more broadly, a clear advantage is the direct connection to clinical experience. Students have to practice the empathetic care and communication that they are learning about in real-time alongside a long list of tasks. The conflicts they discussed between empathetic patient care and accomplishing their tasks will continue and multiply as they move into clinical practice. Thus, having the opportunity to experience these conflicts alongside opportunities for instructor intervention and group debrief can prove invaluable; it is ultimately a chance to practice empathy-in-action.

That said, simulations provide much more limited opportunities for "being-there" with the patient and really digging deeply into the patient's needs. Students also left the experiences with a clear sense of the "right" and "wrong" way to communicate empathetically. For nursing students, further understanding empathy as rhetorical may help them to view good communication more flexibly, as always in context and changing, and as requiring contextual analysis: what does a particular patient need at a particular time? Providing empathetic care is not just about "getting the information right," but is also about listening to patients (including their embodied actions and cues), at times delaying a desire to move immediately to intervention and solution, *and* translating jargon and concepts into understandable and approachable language.

In contrast, CSD students articulated a much more flexible and rhetorical approach to communicating with their patients borne of the story sharing model. As we can see in their reflections, their impetus towards intervention was pushed aside early on in the process as they learned to let their partner's needs guide the conversation and project. "Being-there" for the patient was ultimately the most important intervention they could provide. And while they did not necessarily practice conversations that mirrored the ones they might have in other speech therapy sessions, they did have the opportunity to use specific conversational strategies like acknowledging competence that will show up in their future work. This capacity for strategy-building moved the life story group beyond the model of empathy as hearing someone else's stories that is often put forward in medical humanities curriculum, towards practicing empathy-in-action.

Still, understanding the life story groups as opportunities for rhetorical empathy pushes CSD clinicians to grapple with when "being there" or "intervention" are the most appropriate approaches. The complexity of when

to "be there" and when to intervene has parallels with the law students in Britt's (2018) study of a law clinic. In order to learn how to be better advocates for victims of domestic abuse, these students would engage in conversations with women in emergency rooms about their experiences. Britt noted that this experience was often frustrating for the budding lawyers: "Students in the hospital program had equated helping with the advocacy practices of offering advice and connecting clients with services" (p. 67) and, thus, being asked to simply listen to these women's stories was disorienting. We argue that this disorientation is potentially productive, as CSD clinicians, for instance, could be asked to reflect on the most appropriate moments for, and relative values of, being present, witnessing clients' concerns, and intervening with clinical strategies.

Implications for Rhetoricians and Teachers of Writing

As previously discussed, rhetorical scholars have offered significant contributions to the theorizing of empathy. But what does this actually *look* like in the context of writing classroom practices? This is where turning to two fields that have long centered empathy in their pedagogy can prove particularly useful. Nursing and CSD offer us complementary pedagogical models of rhetorical empathy—role playing and story sharing—and delving into student learning in each of these models can help us to think more strategically about their implementation in our writing classrooms. Both contexts point to the importance of providing students with opportunities to experience what we call "empathy-in-action," activating student knowledge in real-time through conversation and engagement with another.

Role playing is certainly not new to writing teachers, especially in the context of writing for professional and public audiences (Freedman et al., 1994). However, the nursing students' discussions in this article show the importance of carefully considering who we ask our students to be as part of the role play experience. When students are asked to embody disability, even with the help of elaborate physical modifications (fat suits, goggles, recordings of voices, etc.), the experience is inauthentic and does little to broaden their learning, just as we might expect from disability scholars' critiques of disability simulations (Siebers, 2008). In contrast, the simulations in this study asked students to role play as their future professional selves. In doing so, they were not being asked to take on an identity significantly

distanced from their previous experience, but instead to build on professional learning already happening in classroom and internship contexts. The empathetic component of this role play came through by providing them with patients and tasks that would challenge them to balance the many interventions they would perform as nurses with the nursing mission of patient-centered care.

In a similar way, writing and rhetoric instructors can consider how we might help students to encounter audiences inside and outside of the classroom that will challenge their rhetorical empathy. Of course, role playing tasks are complicated in many of our writing classrooms because students may be pursuing a range of different professions or be in fields without a clear professional destination. However, one can also see that diversity of perspectives and interests as an asset (not all of our students will need to role play nurse) and their classmates can act as authentic non-expert audiences with whom students can practice sharing disciplinary expertise (Clark & Fischbach, 2008). External partnerships that provide public audiences for students are also an effective and popular way to bring in pedagogy that is similar to role playing (Swacha, 2018). As with classroom audiences, there will likely be more flexibility (and also more scaffolding needed) in letting students identify skills they will need and roles that might support that skill development in external partnerships. Role playing in writing classrooms, then, will rarely be as simple as providing students with a scenario/community partner and asking them to enact a clearly defined role. However, by bringing students into designing scenarios and roles for themselves, we can both create more flexibility for the kinds of skills they develop and double the opportunities for rhetorical empathetic learning.

Story sharing will likely feel even more familiar to writing and rhetoric instructors. After all, many of us find ourselves in English departments where reading stories is frequently equated with learning empathy (Charon, 2006). The CSD model of story sharing goes beyond an exposure approach to teaching empathy, however, by putting students in conversation with patients and, thus, necessitating that they learn not only how to listen to these stories, but also how to actively elicit, support, and value them. As conversational partners, CSD students learn to be responsive listeners, foregoing their own agendas in favor of letting their partners' needs for the session drive the exchange. In the process, they come to understand their partners as full, agentive human beings, each of whom experiences aphasia differently in the context of their lives. Again, this approach challenges

writing and rhetoric instructors to consider how we might help students to practice being active listeners through story sharing, whether this is just learning to elicit stories from their classmates or through outreach to populations in the community that might be searching for opportunities to have their stories heard. Colum McCann's "Narrative 4" (https://narrative4.com) program could serve as a useful model, since it is founded on the idea of story exchange and empathy, and instructors might also find ways to contribute to existing archives, like the Digital Archive of Literacy Narratives (https://www.thedaln.org) or the Archive of Workplace Writing (https://www.workplace-writing.org).

As we found, though, in our analysis of clinicians learning empathy in the life story groups, eliciting and listening to stories is only part of empathetic practice. Approaches to empathetic communication and active listening in CSD (Holland & Nelson, 2018) remind us that any approach to storytelling and sharing in the writing classroom must also include purposeful reflection on one's own position. Yam (2018) drew on Hochschild's work on "deep stories," arguing that leveraging these stories in the rhetoric classroom includes guiding students to "approach their own opinions, lived experiences, and feelings as objects of analysis" as they aimed to listen to others. Pedagogies of rhetorical empathy-in-action require this kind of focus on both self and other: most importantly, on the gaps, distances, overlaps, and commonalities between the two. Writing teachers would do well to learn from, and share with our students, Holland & Nelson's (2018) reminder that "no one can ever know just how another person feels. Empathy stops short of being in another's skin. You can only know just how *you* feel" (p. 96). We observed a need for this kind of self-analysis in the life story group—to push back on potential othering of aphasic clients' experiences. For the writing classroom, the life story group similarly points to the importance of ongoing opportunities for self-reflection, conversation and sharing, open-ended goals and processes, and participant-led design in story exchanges.

Conclusion

Overall, this article has highlighted the important contributions that all three fields— rhetoric, nursing, and CSD—can offer any conversation about pedagogies of rhetorical empathy. Rhetoricians recognize the careful balance that needs to exist to avoid over-identifying and bodily erasure (Leach, 2016; Lynch, 1998), to socially situate our understandings of others' experiences

(Britt, 2018; DeStigter, 1999), and to approach empathy with openness as an opportunity to learn (Ratcliffe, 2005). Nursing and the role play experience point us to the important translational and communicative aspects at the center of empathetic practice (Strekalova, 2017) and the value of giving students opportunities to balance professional interventions with person-centered practices and build bridges through identification. CSD and the life story group model demonstrate the value of "being-there" and eliciting others' stories, encountering individuals as they are, focused on what they need in that moment. They highlight the necessity of humanizing each person to see them as individuals rather than as their illness.

By bringing these three fields into conversation, rhetoricians can move towards more specific strategies for teaching empathy-in-action, balancing the strengths and weaknesses of role playing and story sharing models. We hope that in pursuing this work, rhetoricians will feel encouraged and empowered to turn to healthcare educators who have long engaged in this work for models and for inspiration. And we are confident that rhetoricians will bring much to these conversations as well.

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