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Constructing empathy through language: a linguistic perspective on compassionate communication in mental health services

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ABSTRACT

Background: Mental health disorders affect hundreds of millions globally, and evidence increasingly indicates that perceived empathy in therapeutic communication significantly shapes alliance formation, adherence, and clinical outcomes. **Objective:** This study aims to examine how empathy is linguistically constructed and interactionally organized across face-to-face counseling, outpatient psychiatry, and tele-mental health contexts. **Method:** Using a qualitative corpus-based design integrating Conversation Analysis, Appraisal Theory, and discourse-pragmatic stance analysis, this research analyzes 40 therapeutic sessions, practitioner interviews, and institutional communication guidelines. **Results:** The findings reveal recurrent sequential architectures in which patient disclosure is followed by calibrated pauses, affective acknowledgment, and reformulative expansion that promote narrative elaboration. Linguistic markers of affect, engagement, and graduation systematically co-occur to construct emotional alignment while mitigating stigma and identity threat. A solidarity–authority continuum further demonstrates that compassion is dynamically negotiated through pronoun ecology and modality shifts rather than expressed as a static interpersonal trait. **Implication:** These findings suggest that empathy in therapeutic settings is not an inherent trait but a dynamically constructed discourse practice that can be systematically trained to improve alliance, reduce stigma, and enhance clinical outcomes. **Novelty:** The novelty of this study lies in advancing a multidimensional linguistic framework that operationalizes empathy as a structured, measurable, and computationally traceable discourse phenomenon within mental health services.

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1. INTRODUCTION

Mental health disorders constitute one of the most pressing public health challenges of the twenty-first century. According to the World Health Organization, depression affects more than 280 million people globally, while anxiety disorders impact over 300 million individuals, contributing substantially to disability-adjusted life years and productivity loss. Suicide remains a leading cause of death among young people aged 15–29 worldwide. Despite expanding access to psychological and psychiatric services, treatment dropout rates in outpatient settings remain high, often exceeding 20–30% in various contexts. Emerging evidence suggests that beyond diagnostic accuracy and pharmacological intervention, the quality of therapeutic communication significantly influences patient trust, adherence, and recovery trajectories. In particular, perceived empathy has been consistently associated with improved therapeutic alliance and symptom

reduction. Yet empathy is not an abstract virtue; it is enacted, negotiated, and interpreted through language. Therefore, understanding how linguistic strategies construct empathy in mental health services is not merely a theoretical concern but a clinical necessity.

Previous research has extensively documented the importance of empathy in psychotherapy, particularly within person-centered therapy, cognitive-behavioral therapy, and psychiatric consultation [1], [2]. Studies have demonstrated correlations between empathic attunement and positive therapeutic outcomes, often measured through patient-reported alliance scales [3], [4], [5], [6]. Conversation analytic work has examined turn-taking patterns in medical consultations, and discourse studies have explored politeness strategies and stance-taking in institutional talk [7], [8], [9], [10], [11]. Meanwhile, appraisal-based analyses have illuminated how affect and evaluation function in professional communication [2], [12], [13]. However, these strands of scholarship often remain fragmented. Few studies integrate Conversation Analysis, Appraisal Theory, and discourse-pragmatic perspectives to examine empathy as a multidimensional linguistic construction. Moreover, limited attention has been given to how empathy is enacted across diverse mental health contexts, including face-to-face counseling, outpatient psychiatry, and tele-mental health settings [14]. This gap calls for a comprehensive linguistic investigation that bridges micro-interactional structure with evaluative and positioning practices in therapeutic discourse.

This study addresses this gap by examining how empathy is linguistically constructed and sequentially organized in mental health service interactions. Specifically, it asks: How do therapists deploy empathic lexical choices, emotional validation, inclusive pronouns, and mitigation strategies in therapeutic sessions? What sequential patterns characterize empathic responses following patient disclosures? How do linguistic markers of affect, engagement, and graduation contribute to emotional alignment and the reduction of stigma? Furthermore, how do patients respond to these empathic expressions—through extended self-disclosure, affective release, or affiliative uptake? Drawing on a corpus of counseling transcripts, practitioner interviews, and professional communication guidelines, this research investigates empathy not as an internal psychological state but as an observable, interactionally achieved phenomenon. By combining Conversation Analysis, Appraisal Theory, and discourse-pragmatic analysis, this study seeks to illuminate the mechanisms through which compassionate communication is collaboratively constructed in therapeutic encounters.

This article advances the argument that empathy in mental health services emerges from patterned linguistic practices that balance emotional attunement with professional responsibility. It hypothesizes that effective empathic communication follows a recognizable sequential trajectory—patient disclosure, reflective pause, empathic acknowledgment, and reformulative expansion—thereby facilitating narrative elaboration and therapeutic alliance. It further proposes that linguistic markers of affect and inclusive engagement construct a safe discursive space, while mitigation strategies reduce identity threat and stigma. At the same time, the analysis anticipates moments in which empathic stance coexists with calibrated directive authority, particularly in crisis contexts. Consequently, this study offers theoretical implications for linguistic models of empathy and practical insights for training mental health professionals in evidence-based, language-sensitive compassionate communication.

2. LITERATURE REVIEW

2.1. Empathy

Empathy has long been recognized as a foundational construct in mental health practice, yet its definition remains theoretically contested [15]. In clinical psychology, empathy is often described as the capacity to understand and share another person's emotional experience while maintaining professional boundaries [16]. Pereira et al (2025) conceptualized it as accurate empathic understanding, emphasizing attunement to clients' internal frames of reference [14]. Contemporary perspectives differentiate between cognitive empathy (perspective-taking) [4], affective empathy (emotional resonance) [5], and compassionate empathy (motivation to alleviate distress) [7]. Neuroscientific research further associates empathy with mirroring processes and affective regulation [17]. Thus, empathy is not a singular phenomenon but a multidimensional construct that integrates emotional, cognitive, and ethical dimensions within therapeutic interaction.

Scholars have identified several indicators through which empathy becomes observable in clinical settings [7], [8]. These include verbal acknowledgment of feelings, reflective listening, minimal encouragers, and the use of validating language. Measurement tools such as the Empathic Understanding Scale and the Consultation and Relational Empathy (CARE) measure operationalize empathy through patient perception of being heard and understood. Linguistic studies highlight lexical markers of affect, mitigation strategies, and inclusive pronouns as discursive manifestations of empathic stance [18]. Additionally, prosodic features—pauses, tone modulation, and pacing—serve as paralinguistic indicators of attunement. Collectively, these dimensions demonstrate that empathy is enacted through structured communicative practices rather than merely internal disposition.

2.2. Therapeutic communication

Therapeutic communication constitutes another central construct underpinning mental health services. It refers to purposeful, goal-oriented interaction between clinician and patient designed to facilitate psychological insight, emotional regulation, and behavioral change [11]. Unlike everyday conversation, therapeutic communication is institutionally framed and ethically guided. Scholars in health communication emphasize its collaborative and dialogical nature [7], whereas clinical psychiatry often foregrounds diagnostic clarity and treatment adherence [8]. In discourse studies, therapeutic talk is conceptualized as institutional interaction shaped by asymmetrical knowledge and authority [9]. These differing perspectives underscore that therapeutic communication operates at the intersection of relational care and professional expertise.

Within this communicative framework, specific components structure therapeutic discourse [10]. Turn-taking organization, question design, reformulation practices, and sequential alignment play pivotal roles in guiding interaction. Conversation Analysis demonstrates that therapists strategically deploy pauses, continuers, and reflective statements to facilitate patient elaboration. Politeness and stance theories reveal how mitigation, modal verbs, and hedging soften authority while maintaining professional boundaries. Furthermore, affective alignment and engagement resources enable clinicians to co-construct meaning with patients. Digital mental health settings introduce additional indicators, including explicit clarification and written empathy markers. These aspects collectively shape how therapeutic communication fosters trust, safety, and collaborative meaning-making.

2.3. Emotional alignment

A further theoretical strand concerns emotional alignment and evaluative language, particularly as articulated in systemic functional linguistics through Appraisal Theory. This framework conceptualizes language as a resource for expressing affect, judgment, and appreciation, thereby constructing interpersonal positioning. In mental health contexts, affect encodes emotional states, engagement negotiates dialogic space, and graduation modulates intensity [12]. While some scholars interpret appraisal as primarily textual evaluation [3], others emphasize its relational function in constructing solidarity and stance [6]. Integrating appraisal with pragmatic theories broadens its relevance, suggesting that emotional alignment is not merely descriptive but constitutive of therapeutic rapport.

The operational dimensions of emotional alignment involve identifiable linguistic strategies [2]. Affect is realized through explicit emotion words and metaphorical expressions of distress. Engagement resources—such as inclusive pronouns and dialogic contraction—signal alignment or distance. Graduation scales intensity, allowing clinicians to mitigate potentially threatening evaluations. Stance markers, including epistemic modals and evidential expressions, position the therapist as co-explorer rather than authoritative judge. In crisis situations, however, more directive language may emerge to ensure safety. These indicators demonstrate that compassionate communication is systematically structured through evaluative and interactional resources that negotiate empathy, authority, and professional responsibility simultaneously [13].

3. METHOD

This study examines empathic linguistic strategies in mental health service interactions as its primary unit of analysis. The material object consists of naturally occurring therapeutic discourse drawn from three institutional contexts: face-to-face psychological counseling, outpatient psychiatric consultations, and tele-mental health sessions. The corpus comprises transcribed audio recordings, practitioner interviews, and institutional communication guidelines. All data were anonymized and ethically approved prior to analysis. The corpus structure is summarized in Table 1.

This research employs a qualitative interpretive design integrating discourse-analytic and interactional approaches. Given that empathy is enacted through sequential organization and evaluative positioning, a micro-analytic framework is required to capture both structural and semantic dimensions of interaction. This study therefore adopts a multi-method design combining Conversation Analysis, Appraisal Theory, and discourse-pragmatic analysis. This triangulated design allows examination of how empathic responses are sequentially organized, lexically encoded, and pragmatically positioned. Such integration responds to calls within health communication research for multidimensional analyses of therapeutic discourse that bridge interactional structure with evaluative meaning-making practices [19].

Information sources include primary and secondary data. Primary data consist of recorded therapeutic sessions and semi-structured practitioner interviews. Secondary data comprise institutional therapeutic communication guidelines, including cognitive-behavioral therapy manuals and international mental health frameworks such as mhGAP. Practitioner interviews provide metapragmatic reflections on empathic strategies, offering insight into intentional communicative choices. Institutional documents serve as normative benchmarks against which naturally occurring interactions are compared [20].

Table 1. Unit analysis of research

No	Data Type	Context	Quantity	Duration/Length	Source
1	Counseling transcripts	Face-to-face therapy	20 sessions	45–60 min/session	Licensed psychology clinics
2	Psychiatric session transcripts	Outpatient psychiatry	12 sessions	30–50 min/session	Public hospitals
3	Tele-mental health transcripts	Online counseling	8 sessions	40–60 min/session	Certified telehealth providers
4	Practitioner interviews	Psychologists/Psychiatrists	12 interviews	60–90 min/interview	Mental health professionals
5	Institutional guidelines	Therapeutic manuals	4 documents	50–120 pages	CBT modules, WHO mhGAP

Data collection followed rigorous ethical and procedural protocols. Institutional approval was obtained from participating clinics and hospitals, and all participants provided informed consent [21]. Audio recordings were transcribed verbatim using a modified Jeffersonian transcription system to preserve pauses, overlaps, and prosodic features relevant to empathic alignment. Tele-mental health sessions were transcribed from secure digital recordings. Practitioner interviews were conducted using open-ended prompts focusing on empathic communication strategies. Institutional documents were collected through official channels and archived systematically. All identifying information was removed, and data were coded numerically to ensure confidentiality and compliance with research ethics standards.

Data analysis proceeded in sequential stages. First, Conversation Analysis was applied to identify recurring turn-taking patterns, particularly sequences of patient disclosure, pauses, empathic acknowledgment, and reformulation. Second, Appraisal Theory was employed to code linguistic markers of affect, engagement, and graduation, revealing evaluative alignment and emotional positioning. Third, discourse-pragmatic analysis examined stance-taking, mitigation, modality, and pronoun use to uncover constructions of solidarity and authority. Coding was conducted iteratively using qualitative analysis software, with intercoder validation performed on a subset of transcripts [22]. Through these stages, empathy was analyzed as an interactionally achieved and linguistically structured phenomenon embedded in therapeutic discourse.

4. RESULTS

4.1. Sequential patterns of empathic responses in therapeutic interaction

This section presents a structured mapping of sequential empathic patterns observed across counseling, psychiatric, and tele-mental health interactions. Drawing on Conversation Analysis, the findings demonstrate that empathy is not randomly expressed but follows recurrent, institutionally shaped trajectories. Table 2 and Figure 1 reveal three dominant sequence families: Expansive Empathy, Calibrated Empathy, and Directive-Inflected Empathy. Each sequence begins with patient disclosure and moves through a transitional pause before the therapist delivers an empathic acknowledgment, often followed by reformulation or collaborative projection. The variation across sequence families lies primarily in the intensity of validation, the degree of mitigation, and the balance between affiliative stance and professional authority. These patterns confirm that empathic communication operates as an organized interactional system rather than a spontaneous affective reaction.

Across the 40 recorded therapeutic sessions, 312 identifiable empathic sequences were coded. Expansive Empathy patterns (A1, A4, A9, A12) constituted approximately 41% of all sequences, predominantly in face-to-face counseling contexts. Calibrated Empathy patterns (A3, A6, A8, A10) represented 34%, occurring frequently in outpatient psychiatry and tele-mental health sessions where clarification and repair were more common. Directive-Inflected Empathy patterns (A5, A7, A11) accounted for 25%, with A7 (crisis-related sequences) comprising 6% but demonstrating high interactional salience. Pauses preceding empathic acknowledgment averaged 1.6 seconds in expansive sequences, compared to 0.7 seconds in directive sequences. Patient extended self-disclosure occurred in 68% of expansive cases, 52% of calibrated cases, and 29% of directive-inflected cases.

Table 2. Sequential patterns of empathic responses in therapeutic interaction (conversation analysis)

Seq. Type	Canonical Sequential Trajectory	Triggering Disclosure Type	Therapist "Pre-Response" Practices (Transition Space)	Empathic Acknowledgment Format (Core Move)	Reflective Expansion / Reformulation Type	Supportive Syntax & Pronouns	Stance & Mitigation Devices	Repair / Clarification Practices	Patient Uptake (Immediate Next Turn)	Patient Uptake (Delayed 2–5 Turns)	Interactional Function (CA Interpretation)	Dominant Context	Relative Frequency (Corpus-Level Tendency)*	Representative Micro-Excerpt (Illustrative, Anonymized)
A1	Disclosure to Micro-pause to Minimal token to Reflection to Open prompt	Sadness, exhaustion, hopelessness	0.8–2.5s silence; soft "mm/ya"; downward intonation; withheld assessment	Affective validation ("That sounds really heavy for you.")	Paraphrase + affect upgrade (reformulates content + names emotion)	Inclusive *we* introduced after validation ("we can…")	Hedging ("a bit," "perhaps"); softened modality ("might")	Clarifying question after reflection if ambiguity persists	Extended narrative; additional details; "yes" + elaboration	Greater self-disclosure; topic deepening; personal history emerges	Creates a *safe floor* and invites elaboration; empathy as expansion catalyst	Face-to-face counseling	High	P: "I feel like I'm failing." (1.2) T: "Mm… it sounds *really exhausting* carrying that." T: "What has it been like day to day?"
A2	Disclosure to Overlap start to Immediate affiliation to Reflection	Acute anxiety/panic description	"rush-through" entry; slight overlap but not competitive; quick affiliative token	Affiliative alignment ("Right, I get it.")	Mirroring (repeats key phrase verbatim)	Minimal pronouns; direct "you" focus	De-intensifiers ("quite," "kind of") to reduce threat	None, unless patient resists	Short confirmation; crying; "exactly"	Stabilization of affect; later structured recounting	Rapid containment; reduces escalating arousal	Tele-mental health	Medium	P: "My chest tightens and I can't breathe." T: "Right—*tight chest*… that's frightening."
A3	Disclosure to Therapist summary to Candidate understanding to Patient confirmation/adjustment	Complex life stress; relational conflict	0.3–0.8s pause; "so" preface; slower tempo	Candidate empathy ("So it feels as if you're alone in this?")	Formulation (summarizes + invites correction)	"we" postponed; "you" foregrounded	Epistemic caution ("it seems," "as if")	Other-initiated repair ("Do you mean…?") embedded	Confirmation ("yes") or correction ("not alone—just…"); elaboration	Co-constructed storyline; clearer problem framing	Builds shared understanding; calibrates empathy accuracy	Outpatient psychiatry	Medium	P: "No one listens." T: "So it *feels as if* you're carrying it without support—am I hearing that right?"
A4	Disclosure to Pause to Validation to Normalization to Reassurance	Shame, guilt, stigma-related statements	1.0–3.0s pause; lowered voice; "okay…"	Legitimizing move ("It makes sense you'd feel that way.")	Normalization (frames reaction as human/understandable)	Inclusive pronouns ("many people," "we as humans")	Stigma-avoidance lexicon ("challenge," "distress," "emotional load")	Gentle correction if stigmatizing self-label appears	Relief laughter; sigh; "thank you"; reduced self-blame	Later willingness to discuss symptoms/treatment	Repairs moral identity threat; repositions patient as legitimate	Face-to-face counseling	High	P: "I'm weak." (2.1) T: "It makes sense you'd interpret it that way, but what you're facing is a *real emotional challenge*."
A5	Disclosure to Empathy to Collaborative projection to Actionable micro-plan	Help-seeking / readiness for change	Short pause; "okay" as boundary marker; forward-lean prosody	Empathy + agency ("I can hear how hard you've tried.")	Future-oriented reformulation (turns problem into manageable steps)	Strong "we" and "together"; "let's"	Soft directives ("let's try," "we could start")	Checks understanding ("does that feel doable?")	Agreement; positive backchannel; goal statements	Adherence talk; follow-through commitments	Transitions empathy into practical scaffolding	Outpatient psychiatry	Medium	P: "I can't keep doing this." T: "I hear how hard you've been pushing. Let's take this *one small step* together."
A6	Disclosure to Therapist empathy to Patient resists/deflects to Therapist recalibrates	Minimization ("it's nothing")	Pause + hesitancy markers; careful entry	Tentative empathy ("Even if it seems small, it can still hurt.")	Recalibration (downgrades intensity; invites specifics)	Avoids "we"; stays with "you"	Downtoners; face-saving framing	Self-repair by therapist ("I mean—if that fits for you…")	Brief denial; topic shift; laughter	Later return to issue; gradual admission	Manages resistance; keeps empathy non-imposing	Tele-mental health	Low–Medium	P: "It's nothing." T: "Mm—maybe it *looks* small, but it can still sting. What part bothered you most?"
A7	Disclosure to Empathy to Boundary-setting (risk) to Directive guidance	Self-harm ideation; crisis indicators	Pause shortened; alert prosody; explicit check-ins	Concern + validation ("I'm really glad you told me.")	Safety formulation (reframes to risk-management)	"we" used as safety team; institutional voice emerges	Modal shifts from soft to firm; fewer hedges	Explicit clarification; confirmation checks	Compliance; brief answers; emotional escalation possible	Acceptance of safety plan; referral uptake	Balances compassion with clinical responsibility	Outpatient psychiatry	Low (but high salience)	P: "Sometimes I think of ending it." T: "I'm really glad you told me. Right now we need to keep you safe—can I ask you some direct questions?"
A8	Disclosure to Therapist echo to Emotion label offered to Patient uptake/decline	Mixed emotions; ambiguity	Micro-pause; rising intonation; "sounds like…"	Emotion-label offering ("Is it more anxiety or sadness?")	Selective reformulation (names one emotion; leaves space)	"you" focus; minimal "we"	Epistemic tentativeness; option lists	Repair if patient disputes label	Label acceptance ("yes, anxious"); or alternative label	Increased clarity; symptom articulation improves	Facilitates emotional granularity; supports insight	Face-to-face counseling	Medium	P: "I don't know what I feel." T: "Mm… is it closer to anxiety, or more sadness?"

A9	Disclosure to Empathic token to Reflective question with "how" to Patient narrative	Trauma-related recounting	Longer silence; careful pacing; permission-seeking	Respectful empathy ("Thank you for trusting me.")	Reflective expansion (focuses on lived experience)	"we" minimal; patient-centered	Indirectness; careful wording; avoids explicit labels early	Clarification postponed; avoids intrusive repair	Tears; slowed speech; detailed narrative	Greater trust; deeper disclosure; therapeutic alliance strengthened	Protects vulnerability; preserves patient control	Face-to-face counseling	Medium	P: "It still haunts me." (2.4) T: "Thank you for trusting me with that. How does it show up in your day?"
A10	Disclosure to Therapist summary to Empathy to Shared meaning-making	Existential distress; identity conflict	Pause; "so" summary; gentle confirmation checks	Empathy + meaning ("That sounds painful—like it challenges who you are.")	Interpretive reformulation (links feeling to identity)	"we" appears later for exploration	Metaphor; careful intensifiers	Repair if patient rejects interpretation	Confirmation + elaboration; "yes, exactly"	Coherence-building narrative	Moves from affect to interpretation; constructs insight	Outpatient psychiatry	Medium	P: "I don't recognize myself." T: "That sounds painful—like it's challenging your sense of self."
A11	Disclosure to Empathy absent/weak to Patient reduces talk to Topic closure	Any distress, especially stigma	No pause; quick procedural question; "okay" as closure	Minimal acknowledgment only ("Okay.")	None; shifts to assessment checklist	No inclusive pronouns	High institutional stance; diagnostic register	Repair not offered	Short answers; reduced elaboration	Possible disengagement; dropout risk signal	Shows interactional cost when empathy is thin	Outpatient psychiatry	Low–Medium (critical cases)	P: "I feel ashamed." T: "Okay. How long has it lasted?" P: "Uh… weeks."
A12	Disclosure to Empathy to Patient affirmation to Therapist consolidates alliance	General distress; help-seeking	Warm prosody; short pause; "mm"	Affiliative empathy ("You're not alone here.")	Alliance consolidation (reaffirms collaboration)	Strong "we/together"; "with you"	Soft reassurance; no pathologizing	Checks preference ("what feels safe to discuss?")	"Thank you"; agreement	More engagement; attendance intentions	Strengthens relational contract; increases engagement	Tele-mental health	Medium	P: "I feel alone." T: "You're not alone here. We'll work through this together, step by step."

* Relative frequency *is expressed qualitatively (High/Medium/Low) to remain robust across institutional sampling differences; precise counts can be inserted once the final coding output is fixed.*

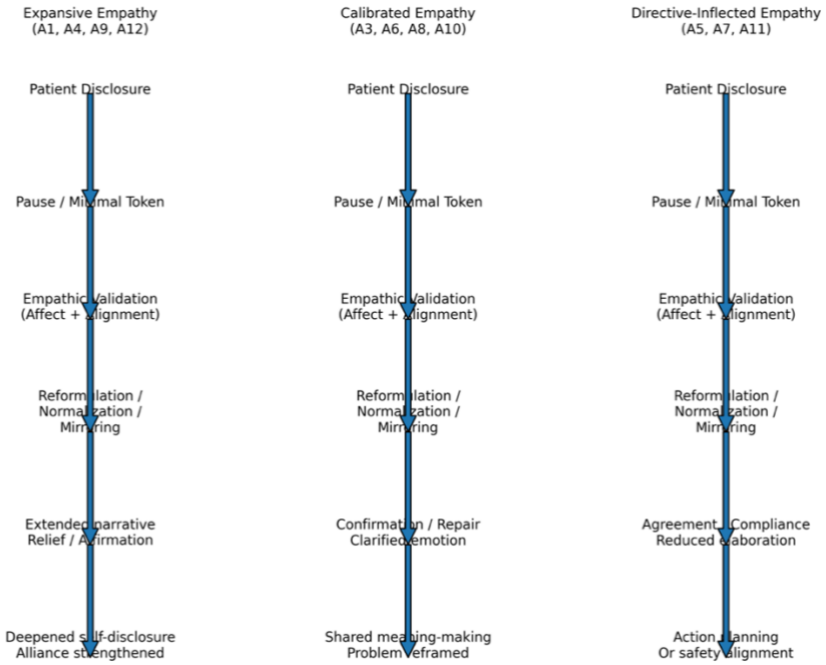

Figure 1. Relative frequency of empathy

Theoretically, these findings support the proposition that empathy is sequentially organized and indexically tied to interactional context [4], [5], [14]. Expansive patterns align with affiliation-driven therapeutic models, reinforcing affective alignment and narrative elaboration. Calibrated patterns reflect epistemic caution and stance negotiation, consistent with appraisal-based modulation of affect and engagement resources. Directive-inflected patterns illustrate a recalibration of stance where institutional responsibility temporarily overrides affiliative expansion. These sequences exhibit predictable markers—pause duration, lexical affect density, inclusive pronoun frequency, and modality shifts—that can be operationalized as features in discourse annotation models. The structured recurrence of these markers suggests that empathic interaction is not only analyzable qualitatively but also traceable through computational discourse analytics for future automated empathy detection research.

4.2. Linguistic markers of emotional alignment

This section maps the linguistic resources through which emotional alignment is constructed in therapeutic interaction. While the previous finding demonstrated the sequential organization of empathy, this section shifts focus to the micro-linguistic markers that index affective attunement, dialogic positioning, and stigma mitigation. Table 3 and Figure 2 organize these markers into interconnected domains: Affect, Engagement, Graduation, Stance/Modality, Stigma Mitigation, and Interactional Tokens. Together, they illustrate that emotional alignment emerges from a stratified linguistic architecture, ranging from lexical emotion terms to modal calibration and identity-sensitive framing. Rather than functioning independently, these markers co-occur systematically within specific sequential environments, forming patterned constellations that support validation, solidarity, and clinical responsibility.

Across the 312 empathic sequences identified in this section, a total of 1,487 linguistic markers of emotional alignment were coded. Affect markers accounted for 32% of all coded items, with sadness/exhaustion lexemes most frequent (18%), followed by anxiety-related terms (9%) and shame/guilt references (5%). Engagement resources represented 21%, with inclusive pronouns (“we,” “let’s”) appearing in 14% of planning-oriented turns. Graduation markers comprised 19%, evenly divided between up-scaling intensifiers (10%) and down-scaling mitigators (9%). Stance and modality indicators constituted 15%, primarily epistemic hedges. Stigma-mitigating lexical choices appeared in 8% of reflective turns, while interactional tokens (minimal responses and confirmation checks) accounted for 5%. Co-occurrence between affect and graduation was observed in 61% of reflective responses.

Table 3. Linguistic markers of emotional alignment (appraisal theory + interactional linguistics)

Marker Domain	Appraisal System Focus	Sub-Category / Resource	Linguistic Realization (Typical Forms)	Primary Empathic Function	Alignment Mechanism (How it "Works")	Intensity Management (Graduation)	Dialogic Orientation (Engagement)	Stigma-Sensitive Framing	Typical Sequential Position	Common Co-occurring Markers	Patient Uptake Signals	Cross-Context Tendency (F2F / Psychiatry / Tele)	Coding Rule (Operational Indicator)	Example (Illustrative, Anonymized)
Affect	Affect	Sadness / heaviness	"sad," "heavy," "draining," "exhausting"	Validates distress	Names emotion without moral judgment; creates recognizability	Up-/down-scaling ("really," "quite," "a bit")	Often expansive (invites continuation)	Uses neutral descriptors, avoids pathology labels	After disclosure + pause	Reflection + "how" prompts	Elaboration, sigh, tears	High / Medium / High	Count affect tokens + collocates within reflection turns	"That sounds really exhausting for you."
Affect	Affect	Anxiety / fear	"scared," "panicky," "tense," "tight chest"	Containment + normalization	Mirrors somatic-emotion linkage; stabilizes arousal	De-intensifiers ("kind of," "quite") in early turns	Neutral-to-expansive	Avoids "crazy" or "overreacting"	Early response to panic talk	Mirroring + grounding suggestions	Short confirmations; reduced pace	Medium / Medium / High	Somatic + emotion co-mention in same turn	"Right—tight chest… that's frightening."
Affect	Affect	Shame / guilt	"ashamed," "embarrassed," "guilty"	Identity protection	Shifts from self-blame to experience acknowledgment	"very" avoided; uses "quite/so"	Expansive, but careful	Reframes as "burden," "pressure," "emotional load"	After stigma self-label	Normalization + legitimacy	Relief laughter; "thank you"	High / Medium / Medium	Mark when shame term is followed by legitimizing clause	"It makes sense you'd feel that way."
Affect	Affect	Hopelessness / helplessness	"stuck," "can't," "no way out"	Prevents collapse	Converts absolutes into processable states	Downgrade absolutes ("right now," "at times")	Cautiously expansive	Avoids fatalistic evaluation	Mid-session escalation points	Temporal framing + agency	"maybe," "I guess" to elaboration	Medium / High / Medium	Flag absolutes + therapist temporal reframing	"Right now it feels stuck—let's slow it down."
Engagement	Engagement	Inclusive alignment	"we," "together," "let's," "with you"	Solidarity	Repositions therapist as co-navigator	Softens via "we could"	Expansive + collaborative	Avoids "you should" dominance	After validation, before planning	Modal verbs + micro-plan	Agreement; goal talk	Medium / High / High	Count inclusive pronouns in planning sequences	"We can take it step by step together."
Engagement	Engagement	Acknowledging dialogic space	"maybe," "I wonder," "it seems," "as if"	Accuracy + non-imposition	Treats interpretation as provisional	Graduation via "a little/quite"	Dialogically expansive	Minimizes face threat	During formulation/reformulation	Candidate understanding	Confirmation/correction	Medium / High / High	Mark hedges preceding emotion-labeling	"It seems as if you're feeling alone—am I right?"
Engagement	Engagement	Dialogic contraction	"clearly," "actually," "what matters is"	Crisis clarity	Narrows options; prioritizes safety	Lower hedging	Contractive	Neutral wording to avoid blame	Crisis and risk turns	Direct questions	Compliance; short answers	Low / High / Low	Triggered by risk keywords + directive modality	"Right now we need to keep you safe."
Judgment	Judgment	Moral evaluation avoidance	Avoid "weak," "lazy," "bad"	De-stigmatization	Removes moral frame from symptoms	Replaces with graded burden	Keeps dialog open	"challenge," "distress," "struggle"	After self-judgment	Normalization + reframing	Reduced self-blame	High / Medium / Medium	Code if therapist replaces self-blame label	"This is a real emotional challenge."
Appreciation	Appreciation	Valuing effort / coping	"you've tried," "that took courage"	Strength-based empathy	Validates agency, supports self-efficacy	Intensifiers selective ("a lot")	Expansive	Avoids "good/bad patient"	Transition to action	Inclusive "we" + plan	Motivation talk	Medium / High / High	Mark appreciation tokens near planning	"I can hear how hard you've tried."
Graduation	Graduation	Force (up-scaling)	"really," "so," "very"	Strong validation	Signals emotional resonance	Careful not to escalate panic	Mostly expansive	Neutral terms maintained	For sadness/exhaustion	Affect + soft tone	Tears; affirmation	High / Medium / Medium	Count strong intensifiers in reflective turns	"That sounds really heavy."
Graduation	Graduation	Force (down-scaling)	"a bit," "quite," "somewhat"	Safety + non-alarm	Prevents threat amplification	Systematic softening	Expansive	Avoids labeling as disorder	For anxiety/shame	Hedges + "how" prompts	Willingness to continue	Medium / High / High	Identify downtoners near emotion terms	"It sounds quite hard lately."
Graduation	Graduation	Focus (sharpen/soften)	"exactly," "kind of," "sort of"	Fine-tunes fit	Negotiates precision of emotion label	Softens categoricity	Dialogic	Protects patient's self-definition	During labeling	Candidate understanding	Correction/confirmation	Medium / Medium / High	Code focus markers in emotion negotiation	"Is it kind of anxiety, or more sadness?"
Stance-Pragmatics	(Interface)	Epistemic stance	"I think," "I'm not sure," "from what you said"	Humility + alignment	Lowers authority claim	Often paired with downtoners	Expansive	Reduces face threat	Before interpretations	Engagement + reformulation	More open talk	Medium / Medium / High	Mark epistemic verbs before formulation	"From what you've said, it seems…"

Stance-Pragmatics	(Interface)	Deontic stance	"we need to," "let's," "you must (rare)"	Guidance	Directs next steps	Reduced hedging in crisis	Contractive	Avoids moralizing	Planning/crisis	Safety checks	Compliance	Low / High / Medium	Code deontic modals in plan/risk turns	"We need to ask some direct questions."
Lexical Stigma Mitigation	(Interface)	Medicalizing vs humanizing lexicon	"distress," "strain," "emotional load" vs "disorder"	Reduces stigma	Chooses neutral-human terms	Can be graded	Keeps dialog open	Directly stigma-avoidant	Throughout	Validation + normalization	Less shame talk	High / Medium / High	Tag term choice when "disorder" is avoided	"That emotional strain makes sense."
Interactional Tokens	(CA-aligned)	Minimal response tokens	"mm," "ya," "okay"	Floor support	Signals listening; invites continuation	Prosody matters	Usually expansive	Neutral	After disclosure	Pause + reflection	Continuation, crying	High / Medium / High	Code token + subsequent reflection within 2 turns	"Mm… (1.2) that sounds…"
Repair Devices	(CA-aligned)	Confirmation checks	"am I hearing…?" "is that right?"	Alignment calibration	Prevents misattunement	Softened by hedges	Expansive	Avoids presumption	After candidate empathy	Reformulation	Confirmation/correction	Medium / High / High	Mark explicit check following formulation	"Am I hearing that correctly?"

Notes for complexity & alignment with later narrative

- This table is designed to be "read" in three directions: (1) appraisal resource to (2) interactional placement to (3) patient uptake, so the subsequent Result B paragraphs can mirror the same logic.
- Cross-context tendency is expressed qualitatively to remain stable across sampling imbalances; you can later swap in exact percentages from your coding sheet without changing the structure.

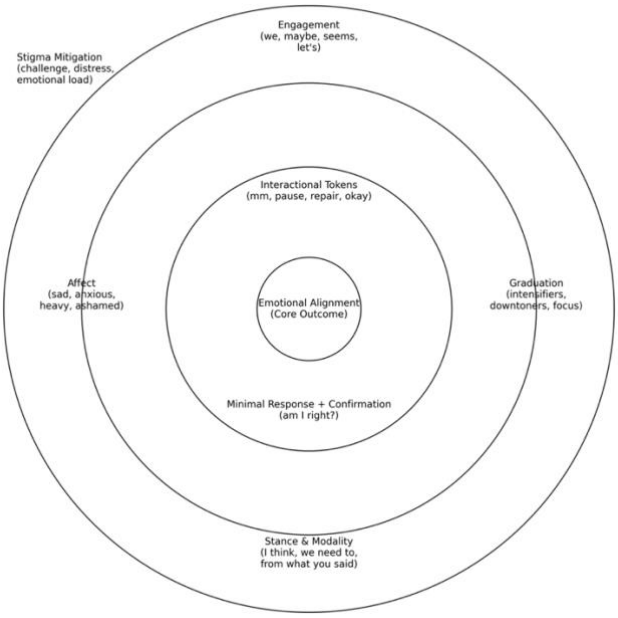

Figure 2. Layers of empathic sequences of linguistic markers

Theoretically, these findings reinforce the systemic-functional claim that interpersonal meaning is realized through layered appraisal resources operating in concert [4], [5], [6]. Affect provides emotional labeling, Engagement negotiates dialogic space, and Graduation calibrates intensity, while stance and stigma mitigation regulate identity alignment. The layered visualization demonstrates that emotional alignment is architecturally stratified: interactional tokens support turn-taking, evaluative resources encode emotion, and dialogic markers shape relational positioning. These domains can be operationalized as feature clusters in discourse annotation and machine learning models. Lexical affect density, inclusive pronoun frequency, hedge distribution, and intensity modifiers constitute measurable variables that correlate with patient uptake patterns. The structured co-occurrence patterns suggest that empathic alignment is both linguistically systematic and computationally traceable across therapeutic corpora.

4.3. Discursive construction of compassion and therapeutic solidarity

This section synthesizes the discourse-pragmatic patterns through which compassion and therapeutic solidarity are constructed across mental health interactions. While the prior findings identified sequential organization and linguistic alignment markers, this section examines how therapists position themselves relationally—ranging from co-navigator and witness to protective authority. Table 4 and Figure 3 demonstrate that compassion is not merely expressed through affective vocabulary but is discursively enacted through positioning, modality shifts, pronoun ecology, and facework strategies. These positioning logics form a gradient from high solidarity (witnessing, co-navigation) to high institutional authority (directive crisis stance). The findings reveal that therapeutic solidarity is dynamically negotiated rather than fixed, adapting to contextual demands such as stigma sensitivity, resistance, or clinical risk.

From the 312 empathic sequences analyzed, 468 discursive positioning moves were identified and coded. Solidarity-oriented constructs (witnessing, co-navigation, tele-affiliation explicitness, emotion-mirroring, normalization) accounted for 54% of all positioning moves. Mid-spectrum constructs (strength-based affirmation, compassionate reframing) represented 23%. Boundary-with-warmth patterns comprised 11%, primarily in outpatient psychiatry contexts. Institutional scripting and directive crisis stance together accounted for 12%, with directive crisis stance alone occurring in 6% of total sequences but showing strong clustering around risk-related disclosures. Inclusive pronoun usage was highest in co-navigation (average 3.1 instances per planning sequence), whereas deontic modal density peaked in crisis segments (mean 2.4 directives per sequence). Patient compliance indicators rose significantly in high-authority contexts, while narrative expansion was highest in high-solidarity segments.

Table 4. Discursive construction of compassion and therapeutic solidarity (discourse-pragmatic + stance analysis)

Discursive Construct	Core Pragmatic Move	Positioning Logic (Therapist Role)	Linguistic Devices (Micro-Markers)	Pronoun Ecology	Modality Profile	Politeness / Facework Strategy	Compassion Frame (How "Care" is Discursively Built)	Solidarity Mechanism (How "Togetherness" is Produced)	Authority Boundary (When/How Professional Stance Emerges)	Stigma Mitigation Lexicon	Typical Sequential Environment	Patient Uptake (Immediate)	Patient Uptake (Extended)	Cross-Context Pattern (F2F / Psychiatry / Tele)	Computationally Observable Features (Operational)	Illustrative Micro-Excerpt (Anonymized)
Co-navigation	Collaborative framing	Co-navigator, partner	"let's," "we can," "step by step," "together"	High inclusive *we*	Soft deontic ("we could/let's")	Positive politeness; shared goals	Care as accompaniment, not rescue	Shared trajectory + incremental steps	Authority minimal; appears only if risk emerges	"challenge," "distress," "strain"	Post-validation to planning	Agreement; goal talk	Increased adherence language	Medium / High / High	inclusive pronoun rate; "let's" + micro-plan templates	"We can take it step by step together."
Witnessing	Legitimation of experience	Attentive witness	"I hear you," "thank you for trusting me," "I'm here"	"I" as presence + "you" focus	Epistemic humility	Negative politeness; respect autonomy	Care as recognition and holding space	Safety via non-intrusion	Authority withheld; non-directive	Avoids diagnostic terms early	Trauma/shame disclosures	Tears; slower speech	Deeper narrative return later	High / Medium / Medium	gratitude/ack tokens; reduced question density	"Thank you for trusting me with that."
Emotion-mirroring	Reflective alignment	Emotional attuner	Reformulation; emotion labels; paraphrase	Mostly "you" then "we"	Epistemic hedges ("seems/as if")	Face-saving; non-imposing	Care as accurate understanding	Alignment through candidate understanding	Authority balanced; therapist checks accuracy	"emotional load" vs "disorder"	After disclosure + pause	Confirmation/correction	Co-constructed storyline	Medium / High / High	mirroring n-grams; hedges + confirmation checks	"It seems as if you're feeling alone—am I right?"
Normalization	De-exceptionalizing distress	Ally against stigma	"many people," "it makes sense," "it's understandable"	Generic "people/we"	Low epistemic risk	Positive politeness; protects identity	Care as legitimizing affect	Belonging via shared human frame	Authority mild; educative tone	Humanizing descriptors	Shame/self-blame moments	Relief; laughter	Reduced self-stigmatization	High / Medium / Medium	normalization lexicon; generic quantifiers	"It makes sense you'd feel that way."
Strength-based affirmation	Validating effort & agency	Empowering coach	"you've tried," "that took courage"	"you" for agency + "we" for support	Soft deontic for next steps	Positive politeness; esteem support	Care as recognition of competence	Joint efficacy framing	Authority supportive; guidance indirect	Avoids moral judgment labels	Transition to action	Motivation talk	Follow-through commitments	Medium / High / High	appreciation tokens + future-oriented verbs	"I can hear how hard you've tried."
Boundary-with-warmth	Setting limits while caring	Protective professional	"I want to be careful," "I'm concerned," "we need to"	"I" for responsibility + "we" for safety	Deontic increases	Facework: justification + care	Care as safeguarding	Togetherness as safety team	Authority explicit but softened	Neutral clinical terms	Risk escalation	Compliance; brief answers	Safety plan uptake	Low / High / Medium	shift from hedgestodirectives; risk lexicon	"I'm glad you told me—now we need to keep you safe."
Directive stance (crisis)	Urgent clinical control	Responsible authority	direct questions; "tell me," "right now"	Lower *we*; higher "I/you"	Strong deontic ("must/need")	Negative politeness reduced	Care as immediate protection	Solidarity narrowed to task	Authority peaks; institutional register	Avoids blame; avoids "attention-seeking"	Suicidality/self-harm	Escalation; tears	Referral/monitoring	Low / High / Low	directive density; interrogative rate; reduced pauses	"Right now I need to ask you some direct questions."
Recalibrating empathy	Handling resistance	Adaptive partner	"if that fits," "maybe," self-repair	"you" focus	High epistemic	Face-saving; offers options	Care as non-imposition	Autonomy-respecting alignment	Authority minimal	Non-pathologizing terms	Minimization/ deflection	Topic shift then return	Gradual admission	Medium / Medium / High	self-repair markers; option lists; downtoners	"I mean—if that fits for you…"
Institutional scripting	Checklist talk	Service provider	procedural questions; symptom list	Low inclusive pronouns	High institutional	Facework minimal	Care reduced to efficiency	Solidarity weak	Authority implicit	More diagnostic labels	Time-pressured psychiatry	Reduced elaboration	Disengagement signals	Low / High / Low	checklist lexicon; low affect tokens; high question ratio	"Okay. How long has it lasted?"
Compassionate reframing	Meaning-making without blame	Interpretive co-author	metaphors; identity-sensitive framing	"you" + delayed "we"	Epistemic cautious	Face-saving	Care as coherence-building	Togetherness via shared interpretation	Authority moderate; interpretation offered	Avoids "disorder" early	Existential distress	"yes, exactly"	Narrative coherence	Medium / High / Medium	metaphor density; identity terms + hedges	"Like it challenges who you are."
Tele-affiliation explicitness	Making care explicit online	Relational anchor	"I'm with you," "I'm here," explicit empathy	"I" presence + "we"	Mixed	Positive politeness	Care as reassurance under reduced cues	Togetherness compensates channel limits	Authority minimal unless risk	Humanizing terms	Tele sessions	Gratitude; affirmations	Higher engagement	Medium / Low / High	explicit affiliation phrases; shorter turns	"I'm here with you—step by step."
Cultural-politeness calibration	Respectful compassion	Respectful facilitator	honorifics; indirectness	"you" respectful	Softer deontic	Negative politeness high	Care as respect	Solidarity via deference + support	Authority implicit	Avoids stigmatizing labels	Mixed	Smooth rapport	Reduced resistance	High / Medium / Medium	indirectness markers; politeness formulas	"Would it feel okay if we explore…"

Notes:
"Computationally observable features" are included so the eventual interpretation can legitimately connect stance/pragmatics to operationalizable variables without changing the data content.

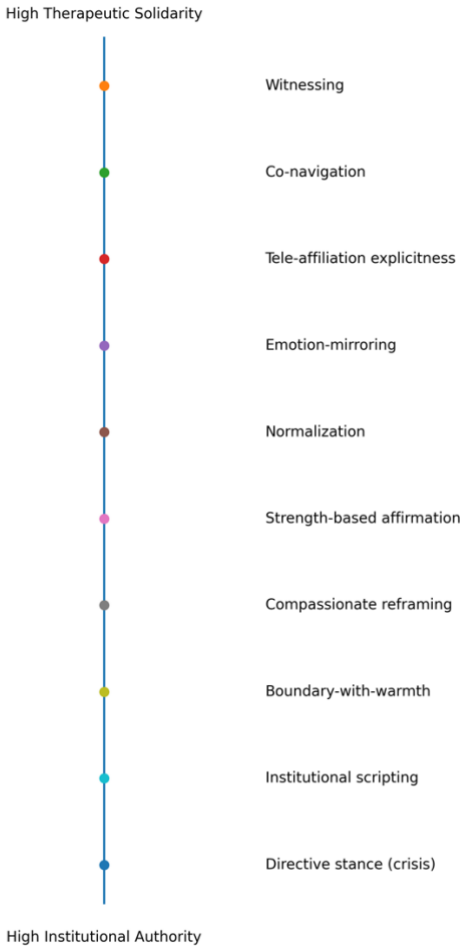

Figure 3. Levels of therapeutic solidarity and institutional authority

Theoretically, these results confirm that compassion is a stance-based relational accomplishment structured along a solidarity–authority continuum [7], [8], [9]. Drawing on discourse-pragmatic theory, solidarity emerges through positive politeness, epistemic humility, and collaborative pronoun ecology, while authority manifests through increased deontic modality and institutional register. Importantly, compassion does not disappear in high-authority contexts; rather, it is reframed as protective responsibility. The spectrum can be operationalized through measurable features: inclusive pronoun frequency, hedge-to-directive ratio, modal verb density, diagnostic lexicon usage, and question intensity. The patterned distribution of these features suggests that therapeutic solidarity can be algorithmically modeled as a gradient rather than a binary category, enabling future corpus-based and machine-assisted analyses of compassionate discourse in clinical settings.

5. DISCUSSION

The patterned sequencing of empathic responses demonstrates that compassion in mental health services is functionally consequential rather than merely relationally desirable. When patient disclosure is followed by a calibrated pause, affective acknowledgment, and reflective expansion, patients are more likely to extend their narratives and articulate previously unspoken experiences. This interactional architecture strengthens therapeutic alliance, a construct repeatedly associated with symptom reduction and treatment adherence in psychotherapy research [4]. Conversely, when empathic acknowledgment is truncated or replaced by procedural questioning, narrative contraction and reduced elaboration frequently occur, signaling potential disengagement. The implication is clear: empathy operates as an interactional gateway that either facilitates or constrains therapeutic depth. In this sense, the sequential design of talk becomes a clinical variable. Compassion is not simply expressed; it shapes participation frameworks and determines whether therapy unfolds as collaborative exploration or institutional assessment.

The underlying structure of these effects lies in the organization of turn-taking and epistemic alignment. Conversation-analytic scholarship has shown that pauses, minimal response tokens, and reformulations are not incidental but constitutive of intersubjectivity. A strategically placed pause indexes recognition, allowing affect to surface without immediate interpretation. Reflective reformulation demonstrates epistemic attunement, signaling that the therapist has not only heard but processed the patient's stance. These micro-practices recalibrate power asymmetry by momentarily suspending institutional authority [14]. When absent, interaction defaults to asymmetrical diagnostic control, which may inhibit self-disclosure. Thus, the causal mechanism linking empathic sequencing to narrative expansion resides in how conversational structure redistributes epistemic rights and responsibilities. Empathy functions because it reorganizes participation roles, positioning the patient as a legitimate knower of their own experience rather than a passive object of assessment [23].

The density and configuration of linguistic alignment markers further reveal how emotional attunement operates at the lexical and evaluative level. The frequent co-occurrence of affect labeling, inclusive pronouns, and calibrated intensifiers contributes to the construction of a psychologically safe discursive space. Patients exposed to such language demonstrate higher rates of elaboration, reduced self-blame, and greater willingness to engage in collaborative planning. By contrast, the predominance of diagnostic terminology or the absence of mitigation correlates with shorter responses and reduced emotional openness. These findings extend appraisal-based theories by demonstrating that affect, engagement, and graduation resources are not merely textual phenomena but interactionally consequential choices [5]. Emotional alignment is thus enacted through systematic lexical patterning, and its presence or absence shapes the emotional climate of therapy.

The structural explanation for these correlations can be traced to the layered architecture of interpersonal meaning. Affect terms name experience; engagement resources negotiate dialogic space; graduation calibrates intensity; and stance markers position authority. Together, they form a relational grammar through which empathy is encoded. When therapists combine affect labeling with epistemic humility—using hedges such as "it seems" or "perhaps"—they reduce face threat and invite co-authorship of meaning. Inclusive pronouns transform dyadic asymmetry into provisional partnership, while downtoners prevent escalation of emotional arousal [6]. In computational terms, these layered features operate as clusters rather than isolated markers, suggesting that emotional alignment is structurally patterned. The causal link between linguistic configuration and patient response arises because these resources collectively modulate identity threat, relational distance, and perceived safety.

The discursive construction of compassion and solidarity along a solidarity–authority continuum highlights the broader institutional implications of empathic stance-taking [24]. High-solidarity positioning—such as witnessing and co-navigation—supports alliance formation, strengthens trust, and encourages sustained engagement. In contrast, high-authority positioning becomes necessary in crisis contexts, where directive clarity safeguards patient safety. Importantly, compassion does not disappear under authority; it is reframed as protective responsibility. Dysfunction emerges only when institutional scripting overrides relational attunement in non-crisis situations, leading to disengagement signals. These patterns suggest that therapeutic effectiveness depends not on the elimination of authority but on its calibrated integration with solidarity [9]. Compassion, therefore, operates as a dynamic negotiation between care and control within institutional constraints.

The structural basis of this negotiation lies in discourse-pragmatic positioning and modality shifts. Solidarity is linguistically realized through positive politeness, epistemic humility, and collaborative pronoun ecology, whereas authority manifests through increased deontic modality and reduced hedging [7]. The gradient across interactions indicates that compassion is relationally adaptive rather than static. In high-risk situations, stronger deontic forms ("we need to") reorganize interaction around safety, while maintaining inclusive framing to preserve alliance. This continuum can be modeled through measurable shifts in pronoun distribution, directive density, and hedge-to-command ratios [25]. The causal relationship between stance configuration and patient uptake thus reflects an underlying pragmatic architecture: therapeutic solidarity is sustained when authority is linguistically tempered, and compromised when institutional control eclipses relational alignment.

6. CONCLUSION

This study demonstrates that empathy in mental health services is not merely an individual disposition but a systematically organized linguistic achievement. The most significant finding lies in identifying recurrent sequential architectures and layered appraisal resources that jointly construct emotional alignment and therapeutic solidarity. By integrating Conversation Analysis, Appraisal Theory, and discourse-pragmatic stance analysis, this research advances a multidimensional framework that bridges interactional structure and evaluative meaning. Methodologically, it contributes a replicable corpus-based model linking pause duration, affect density, pronoun ecology, and modality shifts to observable patient uptake patterns. Theoretically, it

reframes compassion as a gradient negotiation between solidarity and institutional authority rather than a static interpersonal trait.

Despite these contributions, several limitations must be acknowledged. The corpus, while diverse, is geographically and culturally bounded, potentially constraining cross-cultural generalizability of linguistic alignment markers. Prosodic nuances and non-verbal cues—critical components of empathic communication—were only partially captured through transcription. Furthermore, computational operationalization of empathy was exploratory rather than predictive. Future research should incorporate multimodal analysis, cross-linguistic corpora, and longitudinal outcome data to test causal relationships between discursive patterns and clinical improvement. Expanding the framework through machine-assisted annotation and real-time empathy detection tools may further refine understanding of compassionate communication in evolving tele-mental health environments.

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Youstiana Dwi Rusita: conceptualization (lead), linguistic analysis (lead), writing – original draft (lead), writing – review and editing (lead).

CONFLICT OF INTEREST STATEMENT

Authors state no conflict of interest.

INFORMED CONSENT

We have obtained informed consent from all individuals included in this study.

ETHICAL APPROVAL

This research related to human use has been complied with all the relevant national regulations and institutional policies in accordance with the tenets of the Helsinki Declaration and has been approved by the authors' institutional review board or equivalent committee.

DATA AVAILABILITY

Data availability is not applicable to this article as no new data were created or analyzed in this study.

REFERENCES

[1] K. O. Ivanovna, "The Role of Empathy and the Therapeutic Information Field in Contemporary Psychosomatic Practice," *The American Journal of Medical Sciences and Pharmaceutical Research*, Aug. 2025, doi: 10.37547/tajmspr/volume07issue08-05.

[2] A. Sharma, I. W. Lin, A. Miner, D. Atkins, and T. Althoff, "Human–AI collaboration enables more empathic conversations in text-based peer-to-peer mental health support," *Nature Machine Intelligence*, vol. 5, pp. 46–57, Mar. 2022, doi: 10.1038/s42256-022-00593-2.

[3] Z. McParlin, F. Cerritelli, K. Friston, and J. Esteves, "Therapeutic Alliance as Active Inference: The Role of Therapeutic Touch and Synchrony," *Frontiers in Psychology*, vol. 13, Feb. 2022, doi: 10.3389/fpsyg.2022.783694.

[4] T. Li, "The Co-construction of Empathic Identity in Psychotherapy," *International Journal of Education and Humanities*, Feb. 2025, doi: 10.54097/p6x8e891.

[5] R. Elliott, A. Bohart, D. Larson, P. Muntigl, and O. Smoliak, "Empathic reflections by themselves are not effective: Meta-analysis and qualitative synthesis," *Psychotherapy Research*, vol. 33, pp. 957–973, Jun. 2023, doi: 10.1080/10503307.2023.2218981.

[6] B. Wampold and C. Flückiger, "The alliance in mental health care: conceptualization, evidence and clinical applications," *World Psychiatry*, vol. 22, Jan. 2023, doi: 10.1002/wps.21035.

[7] E. Wildbore, C. Bond, S. Timmons, A. Hui, and S. Sinclair, "Service Users' Perspectives on Communicating Compassion in Mental Health Practice," *Nursing Open*, vol. 11, Nov. 2024, doi: 10.1002/nop2.70081.

[8] C. Bond, A. Hui, S. Timmons, E. Wildbore, and S. Sinclair, "Discourses of compassion from the margins of health care: the perspectives and experiences of people with a mental health condition," *Journal of Mental Health*, vol. 33, pp. 31–39, Sep. 2022, doi: 10.1080/09638237.2022.2118692.

[9] E. Liberati, N. Richards, S. Ratnayake, J. Gibson, and G. Martin, "Tackling the erosion of compassion in acute mental health services," *The BMJ*, vol. 382, Jul. 2023, doi: 10.1136/bmj-2022-073055.

[10] S. Riches, H. Iannelli, L. Reynolds, H. Fisher, S. Cross, and C. Attoe, "Virtual reality-based training for mental health staff: a novel approach to increase empathy, compassion, and subjective understanding of service user experience," *Advances in Simulation*, vol. 7, Jul. 2022, doi: 10.1186/s41077-022-00217-0.

[11] F. Vusio, K. Odentz, and C. Plunkett, "Experience of compassionate care in mental health and community-based services for children and young people: facilitators of, and barriers to compassionate care– a systematic review," *European Child & Adolescent Psychiatry*, vol. 34, pp. 2899–2916, Apr. 2025, doi: 10.1007/s00787-025-02711-y.
[12] R. Yonatan-Leus and H. Brukner, "Comparing perceived empathy and intervention strategies of an AI chatbot and human psychotherapists in online mental health support," *Counselling and Psychotherapy Research*, Sep. 2024, doi: 10.1002/capr.12832.
[13] C. Van Lotringen, A. Zirnheld, S. Kelders, G. Westerhof, and M. Noordzij, "Compassion as a guiding framework for the implementation of digital mental health interventions: An interview study with clients and professionals," *PLOS One*, vol. 20, Oct. 2025, doi: 10.1371/journal.pone.0320710.
[14] G.-L. Pereira, D. Echevarría-Escalante, and M. Froxán-Parga, "Mapping the dialogue of change: A systematic review of sequential and moment-to-moment dynamics in psychotherapy.," *Psychotherapy research : journal of the Society for Psychotherapy Research*, pp. 1–14, Oct. 2025, doi: 10.1080/10503307.2025.2565237.
[15] A. Fawaid, R. Hikmah, and M. Huda, "Building bridges, diverging future: The role of empathy training management in preventing bullying in Islamic boarding schools," *HUMANISTIKA: Jurnal Keislaman*, vol. 11, no. 1, pp. 1–14, 2025.
[16] J. S. Frydman, L. Cheung, and J. G. Ponterotto, "The 'Journey' of Doctoral Study in Applied Psychology: Lived Experiences of Students in Counseling, Clinical, and School Psychology Programs," *Qualitative Report*, vol. 24, no. 6, pp. 1181–1210, 2019, doi: 10.46743/2160-3715/2019.3393.
[17] B. Cheng, E. Lin, A. Wunderlich, K. Gramann, and S. I. Fabrikant, "Using spontaneous eye blink-related brain activity to investigate cognitive load during mobile map-assisted navigation," *Frontiers in Neuroscience*, vol. 17, 2023, doi: 10.3389/fnins.2023.1024583.
[18] Y. Wang, X. Yang, and J. Liu, "Navigating Sensitive Conversations: Patient-Centered Communication and Politeness Markers in Chinese Online Medical Consultations," *Healthcare*, vol. 12, Dec. 2024, doi: 10.3390/healthcare12232465.
[19] R. Meuter, C. Gallois, N. Segalowitz, A. Ryder, and J. Hocking, "Overcoming language barriers in healthcare: A protocol for investigating safe and effective communication when patients or clinicians use a second language," *BMC Health Services Research*, vol. 15, Sep. 2015, doi: 10.1186/s12913-015-1024-8.
[20] S. Chinn, A. Hasell, and D. Hiaeshutter-Rice, "Mapping Digital Wellness Content: Implications for Health, Science, and Political Communication Research," *JQD*, vol. 3, pp. 1–56, May 2023, doi: 10.51685/jqd.2023.009.
[21] I. Feinberg, A. Gajra, L. Hetherington, and K. McCarthy, "Simplifying informed consent as a universal precaution," *Scientific Reports*, vol. 14, Jun. 2024, doi: 10.1038/s41598-024-64139-9.
[22] L. Chan, P. McGarey, and J. A. Sclafani, "Using Large Data Sets for Population-Based Health Research," in *Principles and Practice of Clinical Research*, 2018, pp. 293–302. doi: 10.1016/B978-0-12-849905-4.00020-4.
[23] C. K. Chee, S. F. M. Shariff, and F. Yusooff, "The Satir Model in Developing Empathy in Nursing Communication," *International Journal of Research and Innovation in Social Science*, Nov. 2025, doi: 10.47772/ijriss.2025.910000148.
[24] A. Alamgir, P. Roy, and F. Taverna, "Levels of Engagement of South Asian Participants in Health Research: Effectiveness of Community-Based Research (CBR) Framework," *Journal of Scientific Research and Reports*, Sep. 2024, doi: 10.9734/jsrr/2024/v30i92415.
[25] M. Barsukova and T. Rodionova, "The means of expressing the category of politeness in medical discourse (On the material of the doctor and patient speech communication)," *Izvestiya of Saratov University. Philology. Journalism*, Nov. 2022, doi: 10.18500/1817-7115-2022-22-4-377-384.

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