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Interpreters as facilitators of emotional expressions in multilingual medical interactions: Observations from Italian healthcare practices

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ABSTRACT

This article discusses insights from a research on the management of emotions in medical interactions involving Italian healthcare providers, Arabic speaking interpreters and Arabic speaking patients. The findings suggest that the possibility for patient's emotions to become relevant in the medical encounter is affected by the activity of interpreters as mediators of the inter-linguistic interaction. While this contribution also considers examples of interpreters' choices excluding the emotions of the patients from the interaction, the discussion focuses on affective formulations of patient's expression of emotions, as an interactional resource to make doctors aware of patients' emotional expressions emerged from dyadic monolingual interactions. This article concludes by suggesting that interpreters as linguistic mediators may effectively promote emotional literacy in healthcare interactions, promoting a patient-centred model of multilingual healthcare.

1. Interpreting as interaction and the management of emotions in medical encounters

Over the last four decades, the promotion of emotive expressions during medical encounters has become an area of primary interest for healthcare professionals. Healthcare providers' engagement in the patients' *lifeworld* (Mishler, 1984), including the sphere of personal emotions, has become widely acknowledged as a key component leading to the successful outcome of medical treatment and care (Mead & Bower, 2000; Zandbelt et al., 2006). Doctors' affective involvement in the interaction is considered of primary importance in helping patients comply with treatment (Barry et al., 2001; Heritage & Maynard, 2005; Krystallidou et al., 2020; Robinson & Heritage, 2005; Theys et al., 2020, 2022). As a result, healthcare providers are invited to observe illness through the patient's lens and "treat the patient, rather than just the disease" (Heritage & Maynard, 2006: 355).

Following the influential and pioneering contribution from Mishler (1984), this approach to doctor-patient relationship is defined *patient-centred*, as it considers the lifeworld and the lived experience of illness of the patients. However, numerous studies show that the patient-centred approach may encounter difficulties in multilingual medical interactions. Migrant patients struggle to express their emotions and to present their case histories and medical concerns (Angelelli, 2004; Baker, 2006; Baraldi & Gavioli, 2011; Pöchhacker, 2022). This communicative challenge can significantly impact the success of medical intervention as well as patients' motivations to follow a prescribed course of treatment (Davidson, 2001; Hsieh, 2010; Theys et al., 2022).

One of the most important practices used by institutions to support migrant patients in accessing healthcare services is interpreter-mediated interaction. The term *interpreter-mediated interaction* refers to triadic interaction involving an interpreter as the third party in a communication process between individuals who do not share a common language. In these situations, there are two primary participants, the service provider and the service user, along with a third participant, the interpreter. The interpreter is expected on the one hand to allow the user to access the service by translating between the provider's language and the user's language, and on the other making both parties aware of cultural differences, thus allowing the provider to offer a culturally sensitive service (Angelelli, 2004; Baker, 2006; Baraldi & Gavioli, 2011; Mason, 2006; Pöchhacker, 2022). Therefore, the integration between these activities is complex: different choices of the interpreter in the translation of turns at talk provide the participants in the interactions with different spaces and opportunities to express their personal positions and cultural views (Baraldi, 2023).

Earlier research approached interpreter-mediated interaction from the perspective of interpreters as "translation machines", who are expected to produce renditions of the original utterances in a way that is as true to the original as possible, thus avoiding any omission or adaptation, except for those imposed by lexicon or grammar rules. Over the last

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20 years, however, research on interpreter-mediated interaction has abandoned a mechanical understanding of interpreting to include analysis of interpreter-mediated interactions (Angelelli, 2004; Davidson, 2000; Wadensjö, 1998; Baraldi, 2023).

Wadensjö (1998) proposes a distinction between explicit and implicit coordination of interaction. Her distinction is useful to understand language mediation. Explicit coordination includes interpreter actions which organize the interaction, including requests for clarification, comments on renditions, requests to comply with the turn-taking order, invitations to start or continue talking. Explicit coordination is performed in dyadic phases of interactions where interpreters negotiate the meanings of information and relationships either with service providers or migrants. Implicit coordination includes interpreters' renditions which select who speak next and expand, reduce, substitute, or summarize the content of communication. It provides the interpreters with opportunities for choosing the next speaker as well as for transforming previous utterances through renditions. Drawing on the recognition of explicit and implicit coordination in translation practices, the concept of *language mediation* includes the acknowledgement that during medical encounters the interpreters' position exceeds the one of 'translating machines'. The concept of language mediation describes the complexity of the linguistic work of interpreters who combine renditions that transform the content of utterances (implicit coordination) with an engagement in dyadic interactions with the different participants, to clarify and complete unclear or complex utterances (explicit coordination).

This article presents the result of an ongoing research on conversations between interpreters, migrant patients and doctors in Italian healthcare settings, in order to investigate how mediators empower, or inhibit, migrant patients' expression of emotions. The discussion presented in this contribution considers the linguistic aspects of interpreted-mediated interactions and the consequences (direct and indirect) for the transactional and interpersonal relations between the participants involved in this institutional encounter.

2. The study

2.1. Context and outline of the study

The most recent census (2022) indicates that immigrants in the Modena district are 93,239 (13.3 % of the population); in the Reggio Emilia district the number is 65,029 (12.4 % of the population). In both districts, the majority of migrants comes from Morocco, Romania and Albania. In the two districts, healthcare services are reorganizing their services towards migrant-friendly models, in particular for women who may encounter different and unfamiliar cultural constructions of health, disease, therapy, sexuality, and motherhood. Healthcare services in the contexts of the research are among the most advanced in Italy in their attention to migrant patients (Gavioli, 2015a; Baraldi & Farini, 2024). Both Modena district and Reggio Emilia district are characterized by high immigration rates that result in a number of residents with a migration history which is higher that the Italian average (Baraldi & Gavioli, 2020a). Modena district and Reggio Emilia district operate under the Region Emilia-Romagna Social and Healthcare Plan 2017–2019 that identifies migrants, and migrant women in particular, as vulnerable groups whose access to healthcare provision and social care the Region is committed to empower (Luisi & Hämel, 2021). A major driver for healthcare provision in the Modena district and the Reggio Emilia district, is thus the provision of inclusive services for migrant women. When using healthcare services, migrant women encounter different and unfamiliar cultural constructions of health, disease, therapy. As a result, healthcare districts in Region Emilia-Romagna are encouraged to organise their services towards migrant-friendly models, which may potentially be extended to all patients.

The interpreters involved in the recorded interactions were appointed by the General Hospital Board and Local Health Board in Modena to help in reception, obstetrics, nursery, paediatrics, gynaecology, neonatology. Reggio Emilia Local Health Board uses interpreters in the outpatient departments and specialized units for the care of women and children.

Since the early 2000s, the Modena district and the Reggio Emilia district have developed an evidence-based, data-driven approach to the organisation of their healthcare services for migrant patients. A long-standing partnership between the University of Modena and Reggio Emilia and the health care services in Modena and Reggio Emilia, coordinated by Claudio Baraldi, Laura Gavioli and colleagues, has produced a wide array of training in intercultural mediation, based on primary research. Within this partnership, this contribution discusses the results of a research titled *Interlinguistic and intercultural communication: Analysis of interpretation as a form of mediation for the bilingual dialogue between foreign citizens and institutions*.

The aims of the research were: (1) to create a method of analysis of healthcare practices, drawing up specific criteria to identify good practices; (2) to develop criteria to evaluate these practices, pointing out the indicators of effectiveness concerning their functionality, correspondence to patients' needs, and opportunities of access; (3) to develop instruments to monitor these models, with the goal of reducing inequalities and institutional and linguistic barriers; and (4) to develop guidelines to be used in personnel training.

2.2. Ethical considerations

The research project was reviewed by a Management Coordination Committee, composed of the research coordinator and the coordinators of healthcare services who are in charge of decision making on ethical and legal issues. Written information about the project was provided to doctors, mediators and patients. The consent form offered information about the aim of the project, request for permission to audio-tape conversations, and explanation of how the results would be used. Written permission was requested from patients, interpreters and doctors. The privacy of participants was preserved according to the GDPR 2018.

Before any medical encounter, participants were reminded about the aims of the research and their right to withdraw and reassured about the anonymization of data. However, removing or changing any personal reference was not always enough to ensure complete anonymity. In such cases the ethical need for anonymity was prioritized over scientific considerations of documentation. These ethical considerations are not, and cannot possibly, be exhaustive. Ethical research practice requires continuous reflexivity and addressing ethical problems as they arise. This requires dialogue on two levels: among the scholarly community and between researchers and participants in the ongoing research project.

2.3. Participants

Four doctors, four nurses and four mediators cooperated to the research. All the healthcare professionals are native speakers of Italian. The mediators are Arabic speakers (two from Tunisia, one from Morocco and one from Jordan). All the mediators had lived in Italy for more than 5 years at the time of data collection. In accomplishment of Resolution

265 of the Regional Government of Emilia-Romagna (2005), which establishes training standards, all mediators had followed formal training to be registered as intercultural mediators in public services. The minimum duration of the training course is 200 h, including at least 40 h of supervised traineeship.

It is important to highlight that the use of 'intercultural mediation' suggests that enhancing positive intercultural communication in public services, including health care services, is viewed as a primary function of mediation (Merlini, 2009; Pittarello, 2009; Baraldi & Gavioli, 2012). This approach is not unique in the European Union; in Belgium, for example, the function of promoting intercultural communication is as important as interpreting for intercultural mediators (Verrept, 2012). The use of intercultural mediation to describe the work of mediators shows sensitivity towards the need to develop positive intercultural relationships as a response to the increasing demand for public services from migrants, consequent to large inward migration flows.

In both Modena and Reggio Emilia districts, mediation services are used predominantly in the Maternity and Neonatal Wards and Obstetrics Gynaecology; therefore, most of the patients involved in the research were women. With regard to the corpus of data discussed in this study, 51 patients (92.72 %) are women, and 5 (7.28 %) are men. It is important to note that, in some cases, women are accompanied by their husbands to medical consultations. These women are frequently newly arrived in Italy and have been permitted to enter the country on account of their pregnancy. They often do not speak any Italian and have no knowledge of the Italian health care system. For these reasons, it is not uncommon for husbands to participate actively in the mediated interactions. Mediators always provide renditions in Arabic for the benefit of the women. The active role of husbands should not be seen as silencing the voice of the patient; rather it is suggested that it is instrumental in producing mutual understanding which, in turn, is key to promoting migrant women's participation (Baraldi & Farini, 2024).

2.4. Data collection and analytical procedure

The analysis presented here is based on 55 multilingual medical encounters in Arabic-Italian, audio-taped in two public healthcare services in region Emilia Romagna of Italy: the *Centro per la salute delle famiglie straniere* (Healthcare support centre for foreign families) in Reggio Emilia and the *Consultorio* (Local centre for health and social services) in Vignola (Province of Modena). Most of the encounters concern obstetrics, nursery, paediatrics, gynaecology and neonatology (47 cases, 85,4 %). The Law of Region Emilia Romagna Regional (Law 5/2004), commits the Region to promote the development of informational interventions aimed at immigrant foreign citizens, along with activities of intercultural mediation within the social-health field, finalized at facilitating access to health and social-health services.

Therefore, in light of the Regional guidelines the interpreters involved in this research are not only expected to translate what participants say but to promote the coordination between healthcare professionals and patients, as essential to the functionality of the healthcare system. The expectation for interpreters to promote the coordination between healthcare professionals and patients positions them as linguistic mediators who negotiate the meanings of information and relationships with service providers and migrant patients.

A number of studies (Hancox et al., 2023; Hsieh & Soo, 2010; Niemants, 2013; Theys et al., 2020, 2022) highlight that the attention for the emotions of the patient is necessary for the achievement of effective coordination, evidencing the impact of mediators' actions on the construction of affectivity in medical interactions. Research suggests that mediators' questions may encourage the production of personal narratives by the patients. Mediators' facilitation of coordination includes e expansions, feedback on patients' turns at talk and follow up comments that may promote more complex stories, including emotional expressions, which are co-authored by patients and mediators. The impact of mediators' actions on the development of a patient-centred healthcare is widely acknowledged in the field of interpreting studies, where linguistic mediation refers to the work of interpreters who position themselves as facilitators of coordination rather than "translation machines" as in the traditional approaches to interpreting (Pöchhacker, 2022).

In the following sections I will discuss two types of interaction: those in which the mediator excludes or inhibits patients from communicating their emotions, doubts, and concerns to the doctor, and those in which mediation supports emotion-sensitive triadic interactions. All interactions in the corpus, involve at least one Italian healthcare provider of the institution (D), an Arabic-speaking mediator (M), and an Arabic-speaking patient (P). All conversations were audio-recorded and transcribed according to the conventions of Conversation Analysis. The researcher carried out transcription with the assistance of translators (not involved in the medical encounters). The Arabic language was transcribed using the Latin font type-set. Transcription of Arabic posed some challenges because of the variety of dialects used by the patients. In some cases, the transcriber understood the sense of the utterance but could not transcribe it precisely. In these instances, an approximate translation of the turn is provided. Table 1 illustrates the transcription notations mutated from Jefferson (2004) to reproduce para-verbal elements, pitch and intonation of interactions.

All personal details that are mentioned in the talk have been altered in the transcription to protect participants' anonymity. Due to the sensitive nature of the data and interaction, only audio recordings were authorized, which did not allow observation of gesture, gaze, facial expression, body posture, or other non-verbal behaviour.

All transcripts have been analysed using conversation analysis (CA)) as a methodology to interpret the corpora of data. In the most general terms, the object of CA is to discover the procedures which allows a certain degree of predictability in the way in which social actors

Table 1
Transcription notations.

[	Brackets mark overlapping speech
(.)	A micropause, hearable but too short to measure
Te:xt	Colons show degrees of elongation of the prior sound
Tex-	Hyphens mark a cut-off of the preceding sound
((comment))	Additional transcriber's comments
Text	Italics is used for *English translations*
Text	Emphatic utterance
>Text<	Right/Left carats indicate increased speaking rate
Text	Emphatic utterance
°Text°	Degree signs indicate syllables or words distinctly quieter than surrounding speech by the same speaker
Text	Emphatic utterance
.h	Inbreath. The number of letters indicates the duration, with one 'h' for short inbreath
=	End of a turn at talk and beginning of next with no gaps/pause in between

understand and respond to one another. CA looks at the mechanisms employed by participants in interaction to achieve understanding, to manage their access to the roles of speaker and listener, and to connect to previous turns of talk (Schegloff, 1980; Pomerantz, 1984; Sacks et al., 1974).

Interactionist studies of emotions in medical interactions (Baraldi, 2023; Baraldi & Gavioli, 2020b; Cirillo, 2010; Zandbelt et al., 2006) demonstrate that interpreters may facilitate or inhibit expressions of emotions, active listening and appreciation of the participants' contributions. Interpreters can thus help in promoting distribution of active participation, addressing participants' interests and needs. Baraldi and Gavioli (2020b) demonstrate that also in the frame of patient-centred medicine, where support and appreciation are expressed by interlocutors towards each other's actions and experiences, a failure to translate such support and appreciation leads to construction of distance between doctor and patient.

In analysing the data, I have identified how patients' display of emotions is promoted or marginalized by mediators' actions. Utilising the 'next turn proof procedure', I have inspected turns at talk to analyse how current speaker reacts, and makes use of, what has been uttered in previous turns at talk. The core analytical concept of CA is that people's understanding of each other's actions can unfold as sequences of talk unfold. According to Schegloff (2006), any next turn in a sequence displays the understanding of the prior turn; *responses to contributions are very important in explaining how each participant orients to the activity and how they achieve a shared understanding of the business at hand* (Mason, 2006: 364). Consistently with the approach adopted by CA, I have explored how the relevance of emotions is *talked into being* (Heritage, 1984: 290), rather than connecting it to social or psychological traits of the participants. Participants in interactions act according to what has been said and done previously, and to what they perceive as the intentions of others. These intentions are visible in participants' actions and hence their role performances, which are fundamental in interaction; Baker suggests that interpreters *step in and out of professional and other roles numerous times during the course of a single conversation* (Baker, 2006: 326).

I have approached the importance of patients' emotions in the medical interactions as interactively 'co-constructed' by participants turn after turn, towards their promotion or exclusion. The extracts discussed in this contribution are representative of dataset in terms of participants involved, expression of emotions (or expression of attention to emotions) by doctors, patients and mediators, and the treatment of such expression in the interactions, especially with regard to the actions of interpreters.

3. Interactions that exclude or inhibit patients' expression of emotions: zero- and reduced renditions

The most common types of mediators' actions that exclude patients' expressions of emotions from the medical encounter consist of *reduced renditions* or *zero renditions* (Wadensjö, 1998) of both patient's and doctor's turns of talk. In these situations, the mediator either cuts out some (reduced renditions) or all (zero renditions) contents of utterances from the translated material. Reduced or zero renditions usually occur when the mediator passes medical information from the patient to the doctor and vice versa, but they may also involve the expression of emotions.

Excerpt 1 (taken from one of the few encounters involving a male patient) is utilized to illustrate occurrences of zero renditions. The patient is lamenting a persistent insomnia and in this phase of the medical encounter he has already expressed concern about having contracted HIV. In the course of the excerpt the patient makes three attempts to start a narration of his personal experience of insomnia (lines 3, 6 and 31, 33–34) but such attempts are not supported by the mediators, who operate to exclude patient's emotions from the medical encounter.

(1 Arabic-Italian).

```
1 D  Di notte dormi?
     At night sleep?
          Can you sleep at night

2 M  yemkenk alenwem fey alelyel a::w?
     Can     sleep   you  night  o::r?
          Can you sleep at night or

3 P la  eda lem  tekn   qed 'emelt khelal alenhar (.)
          Not if  have worked  not during the  day (.)

4    la asettey'e.  [ana la
     I can not.     [I do not
          No if I haven't worked during the day I can't [I don't

5 M                 [quando quando non è stanco non dorme=
                    [when   when   not is tired not sleep=
          When when he's not tired he can't sleep

6 P =wasemhewa ley an  [aqewl lek
     =Some let   me to  [tell   you
          Can I say something

7 D                    [Quando non è stanco  e  non
                       [When   not is tired and not
8    lavora,
     work,
               When he's not tired and hasn't  worked

9 M  Quando non  è  stanco e  non  ha lavorato
     When   not is  tired and not  has  worked
          When he's not tired and hasn't  worked

10 D Quando non  ha  lavorato. Per questo=
     When   not  has worked.   For  that=
          When he hasn't worked.    For that

11 M  =Non riesce  a  dormire
      =Not  can   to sleep
          He can't sleep

12 M eda   kent  la  t'eb la    tenam?

     when tired  you  not  you  not sleep?
          When you are not tired, don't you sleep?

13 P la asettey' alenwem   heta   alesbah la::
     cannot    sleep    until  morning I::
          I can't sleep until morning  I

14 M >Cioè     tutta la notte  dice fino   alla
     >That is  all the  night  says until to the
15   mattina<
     morning<
          So, he says all night long until morning

16 P fey al'emel welqed terk lemdh sa'eteyn  lelnewm
     At  work    and    leave for  two hours to sleep
          At work, I have to leave for two hours to sleep

18 M E    quando  lavora deve per forza andare via per due
     And   when   works must by  force  go    away for two

19   orette        per  riposare
     small hours   to    rest
          And at work he has to take a break for two hours
          to rest

20 D Ascolta vuoi che        ti diamo qualcosina
     Listen  want that       you give something

21   per riposare alla notte  (.) Sempre (.)
     to   rest    at   night (.) always  (.)

22   indipendentemente dal  lavoro e::   non lavoro?
     independently     from  work and::  not work?
          Listen do you want us to give you something to sleep
          at night (.) whether you have to work or not?

23 M  betqewlek (.) theb    nedyek  hajh  nedyek   dewh
      says      (.) want   make you some make you sleep

24    hajh tenam  beyha balelyel? t'eban  mesh t'eban (.)
      some makes sleep  at night  ired     not tired

25    tenwemk     balelyel   walh?
      helps you   at night   or?
          He says (.) do you want us to give you something to sleep at night?
          That helps you at night whether you are tired or not?

26 D una  compressina,  (.) ((to the nurse)) dammi  del::
      a   little tablet,(.) ((to the nurse)) give me some::

27 P  areyd
     °I would like°

28 M  Sì  (.) sì  (.) >magari    dice<
          yes (.) yes (.) >if only  says<
```

(continued on next page)

(*continued*)

29 D Eh?
Eh?

30 M re::yd
Wo::uld like

31 P agew1-
I say-

32 M ,'?
mmh?

33 P ala astty'e= alnwm adhb dhaba
I can't sleep=I go to balcony

34 weyaba ela alshrfh
forth and back
I can't sleep I go back and forth to the balcony

35 (3.0)

36 D Allora:: lui viene mercoledì pomeriggio
So:: *he comes Wednesday afternoon*

37 alle due:: due=e mezza che gli facciamo
at two:: two=and half that to him we make

38 il prelievo poi per l'Aids così abbiamo
sample taking then for HIV so we have

39 fatto tutto (.) eh?
done everything (.) eh?
So he comes Wednesday afternoon at 2, 2:30 for the sample taking then everything will be done about HIV, eh?

The patient's initial attempt to describe his experience of insomnia (lines 3–4) is halted by the mediator. The mediator produces an early translation that overlaps with the ongoing patient's narration, forcing it to a temporary closure. The application of the next turn proof procedure to patient's turn in line 6 ('Can I say something?'), that is, the examination of how the patient reacts to the previous mediator's turn at talk, suggests that the patient sees the early beginning of the translation as unwanted interruption. In line 6, the patient accesses the role of speaker without being prompted by any question and without waiting for the doctor to react to the translation. The patient is committed to fulfil his conversational agenda: in order to create interactional space for the completion of the interrupted narration, the patient explicitly requests the mediator to align with the role of recipient of his storytelling.

However, a second overlapping utterance deprives the patient of the status of current speaker. In this occasion it is the doctor who intervenes summarizing the mediator's translation (lines 7–8). From a healthcare perspective, the doctor is performing the role of technical expert. The doctor is exploring possible physiological reasons for insomnia (e.g., the patient "is not tired enough"). From an interaction point of view, the early translation produced by the mediator assigns to the doctor the role of next speaker, who is expected to react to the information passed. The doctor intervenes because the translation provided by the mediator can be taken as a signal that the patient's account, which the doctor cannot follow, had reached completion.

The patient tries a third time to express his personal experience of the disease, when a dyadic interaction between the mediator and the doctor encounters some problems. The doctor, who is engaged in two different lines of conversation (the second one with a nurse, line 26), misses a turn of the mediator, therefore initiates a repair sequence to recover a minimum level of mutual understanding (line 29). This instability offers an opportunity for the patient, who produces a *preliminary turn* (Schegloff, 1980) to signal he is accessing the role of speaker (line 31). After the preliminary turn, the next relevant action for the mediator is to either accept or refuse to take on the role of recipient of patient's telling. In line 32, the mediator encourages the patient's with a short turn ("mmh?") which indicates that she is accepting the role of recipient. Therefore, the patient is now in the sequential position to initiate a *troubles-telling* (Jefferson and Lee, 1981; Jefferson, 1988). Rather than providing details of his *objectified symptoms* in biomedical terms (Heritage and Lindström, 2012), the patient offers an account emphasizing his personal experience with the difficulties that insomnia produces in his everyday home life. In lines 33–34 the patient is speaking his *disease*, rather than providing a description of his *illness* (Mishler, 1984). The completion of a first account of the troubles caused by insomnia creates a *transition-relevance place* (Sacks et al., 1974), making possible a transition between speakers. After the patient's turn, there are different available options for the mediator. The mediator may translate to the doctor, may support the continuation of the troubles-talk by providing another continuer, or she may request clarifications. However, the mediator remains silent (line 35), producing a zero rendition (Wadensjö, 1998). By applying the turn proof procedure, the long pause in line 35 suggests the zero rendition was unexpected; the patient does not take the turn of talk, waiting for a mediator's action. After a three-second silence, the doctor intervenes to advance the interaction to the treatment phase (lines 36–39). In this phase of the medical encounter, it becomes more difficult for the patient to express his personal experience of the disease. In the treatment phase, and in the following prescriptions phase, it becomes inappropriate for the patient to pursue the completion of a trouble talk, because the doctor is the only ratified active participant in these phases (Heritage & Maynard, 2006). Rather, in the course of the treatment phase and prescription phase the patient is expected to take the role of recipient of the doctor's instructions. The patient's active participation is limited to possible requests for clarification.Lindström

Troubles tellings is co-authored through interactional moves and activities between teller and recipient(s). Thus, they need to be collaboratively sustained by all participants. Recipients influence the details that make up the telling, and the ways it is told, through their contributions, for instance by producing a go-ahead response when the speaker offers a pre-telling, prompting the telling through questions, displaying they have recognized the end of the telling, and in some cases producing related trouble tellings (see Monzoni & Drew, 2009).

In the context of medical encounters, the patient's troubles tellings are likely to be supported only if they contribute to the explanation of the disease. In Excerpt 1, the mediator (but not the doctor) assesses the irrelevance of the patient's troubles telling for the treatment. Although the mediator accesses the role of recipient when prompted by the patient, she subsequently fails to support the patient's trouble telling.

4. When interpreters as mediators promote the expression of emotions

4.1. Supporting patient's expressions in dyadic sequences

Mediators' actions can promote patients' in expressing their emotions within monolingual dyadic sequences (patient-mediator) or in the triadic dimension of the multilingual interaction (patient-mediator-doctor). In interactions organized as dyadic exchanges, the mediator supports the voice of the patient through *recipient tokens* (Gardner, 2001). Recipient tokens are short conversational markers which in the corpus are used to signal that the stated information has been received (acknowledgment tokens, for instance "yeah", "OK") (Norrik, 2012) or to maintain the flow of conversation and offering the current speaker an opportunity to keep this interactional position (continuers, such as "hmmm", "mhm") (Pope, 2019).

An example of mediator supporting the patient in expressing her emotions is presented in Excerpt 2. At the end of her first medical visit in the district, while the doctor is moving the encounter towards its conclusion, the patient expresses her worries about a recently received invitation to a uterus check.

(2 Arabic-Italian):

113P alnmra btaa almhmol btaak btktbiliaha
Number of your mobile, can you write for me
Your cell phone number, can you write it for me?
114M ه!
Eh

115P .hhh °oatoni shi haja orqa mshan alfhs°
.hhh °I have received the paper examination°
I have received a letter saying I should come in for a check-up

116M ه! (.) ه!
Ah (.) ah

117P kl thlath snoa:t adoz alfhs llrhm
Every three year:s pass the examination uterus
I have to have a uterus check-up every three years

118M ه!
Mmh

119P .hh jtni alorqa oma bghit nmshi lan lazm
.hh received paper and don't go want because I would
nfhamham ani amlt alamlia
have explained I had the operation
*I received the letter and I don't want to go, because I would have to explain I had an *operation*

120M ah (.) fhmt aliki
ah (.) understood you
ah (.) I understand you

121P knt astna
You waiting to ask
I was waiting to ask you

122M °khfti° .hh ank tiji otkoni,
°Afraid° .hh were come and being,
so you were afraid to go and being

123P ah ano iqlboni almkina oala shi alamlia (.) alahsn
yes me examine machine and move the operation (.) I need

124 Ano itni orqa oiqolo ani mshan alml (.) bs ano iani
Me better you give me paper says (.) I did the

125 iqlboni
operation
Yes that they examine me and injure the part where I had an operation done before so it's better if you give me a letter saying I had the operation so they examine me because they examine the uterus

*Note: The precise nature of the previous operation or surgery is not specified.

The mediator responds to the patient's announcement (line 115) with a news receipt (line 116) and to the patient's subsequent account (117) with a continuer (line 118). In this way, the mediator constructs as role in the interaction as the one of recipient, encouraging the patient to proceed with her telling.

When the patient expresses her concerns (line 119), the mediator reacts with an explicit formulation of empathy (Heritage & Lindström, 2012), which supports the patient to further express her emotions (line 121). In line 122, the mediator advances her understanding of the patient's fears by producing an *upshot formulation* (Antaki et al., 2005). Upshot formulations include speaker's interpretation and reconstruction of the possible implicit meanings of previous turns at talk. In this interaction, the upshot formulation is used to support a reticent patient to express the reason for her concerns and makes relevant the expression of either agreement or disagreement by the patient in the following turn. In both cases, the upshot formulation brings more knowledge about the patient's emotions.

The upshot formulation is not a close rendition; rather it is a discursive initiative taken by the mediator, which successfully promotes the patient in expressing her emotions and concerns. In lines 123–125, the patient confirms the mediator's upshot formulation, by asking for the doctor's support.

4.2. Giving voice to patients' emotions in triadic interactions: affective formulations

In the movement from dyadic to triadic interaction, the crucial aspect is the way in which the doctor re-enters the interaction. In the data analysed, the main conversational resource whereby mediators involve doctors in the interactions is *gist formulations* of patient contributions. *Gist formulations* are summaries of prior utterances that redevelop their gist, making something explicit that was previously implicit, or by making inferences about its presuppositions or implications (Heritage, 1985).

In medical mediated interaction, mediators' formulations consist of renditions of patient-mediator dyadic sequences. Formulations are not close renditions; rather, research has demonstrated that formulations are an interaction resource employed to: (1) provide an interpretation that highlights content from prior sequences (Baraldi, 2018); (2) display active listening (Mao et al., 2023); (3) propose inferences about presuppositions or implications of the participants' contributions (Licoppe & Boéri, 2021). As a specific type of formulations, *affective formulations* may be understood as discursive initiatives undertaken by the mediator to give voice to patients' emotions when they manifest themselves implicitly (van Braak et al., 2023). Patients rarely talk about their emotions directly and without prompting; more frequently, they provide clues about their feelings, thus providing health professionals and mediators with potential empathic opportunities (Baraldi, 2018), as shown in Excerpt 3.

Affective formulations focus on the emotional aspects of patients' utterances, offering the doctor an opportunity to understand and participate in the affective dimension of the interaction. In this way, doctors are made aware of patients' concerns, and patients assume an identity that goes beyond their standardized role within the medical institutions. In Excerpt 3, the patient, who is in her seventh month of pregnancy, complains about abdominal pain which forced her to go to the emergency room (line 1).

(3 Arabic-Italian).

```
1P:  rhuti     almasha (.) ((Arabic untranscribable))
     emergency went to (.) ((I had pain in my belly))
          I went to the emergency room (.) ((I had pain in my belly))

2M:  ehm  dolori  forti  crampi: (.)
     ehm  pains  strong cramps: (.)
     ((to P)) igiaki        iluagiaa?

3          contractions  did you have?
          ehm, she had a lot of pain with cramps,
          ((to P)) did you have  contractions?


4P:   mhm  uagiaa
      mhm  yes

5M:   mmh mmh  ((to D)) è  andata   al    pronto soccorso,
      mmh mmh ((to D)) is  gone   to the  emergency room,

6     perché   ha  avuto  del  dolore
      because  has  had  some  pain
          Mmh mmh
          ((to D))she went to the emergency room because she had pain-

7D:   ah un' altra volta?
      ah one other time?
         ah, again?

8M:   sì
      yes

9D:   ((to P))  ti     volevo  chiedere (.)
                to you  wanted   ask    (.)

10    come mai  hai  la faccia così sofferente?
      how  ever have the  face  so suffering?
          ((to P)) I wanted to ask you (.) why do
          you look like you are suffering?

11M: lesh uigihik hek  tabaan bain aleki
     why  face    your  tired is   much
          why is your face so tired?

12P: .hhh °((Arabic untranscribable))°
     .hhh  °((Partly for this pain))°

13M: fi hagia    muaiana  mdaiktk
     is  there   something wrong

14    uiani  mdaiik,  blbit    mushkila?
     in your house,  that you   worries?
          Is there anything wrong that worries
          you at home?

15P: lha (.) [khaifa hhhh.
     No  (.) [frightened hhhh.
         No (.)[I'm frightened

16D:         [>no   mi sembra a  me:< che abbia
             [>no to me seems to me:< that  has

17   la  faccia sofferente
     the face   suffering
         [No it seems to me that she has a
         suffering face

18M: .hh  un po'spaventata perché diciamo pe::r
     .hh  a bit frightened because we say fo::r

19   la pancia
     the belly
         hh a bit frightened because let's say
         for her belly

20D: £e:h  ma  è   belli(H)ssima  la tua pancia£!
     £e:h but  is  beauty(H)ful  the your belly£!
         e:h but your belly, it's beautiful!

21M: btul shitabii   btiilik    £ma   tilaiif
      all  normal everything you £is    fine£
         she tells you that everything is
         normal, everything is fine
```

The patient's complaint is followed by a complex turn, with a translation as the first turn unit, and a question as the second unit (line 3: 'did you have contractions?'). The question at the end of the turn makes relevant an answer from the patient, confirming a possible physiological reason of her disease. In line 4 the patient validates the mediator's hypothesis, and in line 6 the mediator contributes to the co-construction of a narration of the patient's experience by an acknowledgment token (*mmh mmh*), translating that narration to the doctor in the second part of the turn. By doing this, the mediator addresses the doctor's epistemic authority in this matter, avoiding claiming the role of medical co-expert.

The doctor's acknowledgement in line 7 comes as a news-receipt marker (*ah again?*), displaying that the information made a difference in her cognitive status. In lines 9–10, the doctor displays her interest in the patient's personal discomfort ('why do you look like you are suffering?'), in form of a question that makes relevant a translation by the mediator and further explanations from the patient. The doctor's question is followed by a short dyadic sequence (lines 11–15) between the mediator and the patient. The mediator translates the doctor's question, substituting "suffering" with "tired", and then affiliates n with the patient's expression of emotional stress, asking for other possible reasons behind her complaint.

The doctor then interrupts the dyadic sequence in Arabic (line

1D: quando é stata l'ultima mestruazione?
When is been the last menstruation?
when was her last period?

2M: bandma kan aakhr dora shhria lk?
when was your last period?
when did you have your last period?

3P: .h jtni tlatash:: mn shhr ashra
.h *was thirtee::n in month ten*
It was October thirteen

4M: tlatash ashra?
Thirteen ten?
October thirteen?

5P: °ai°
°*yes*°

6M: l' ultima mestruazione è il tredici ottobre
The last period is October thirteen

7D: °mmh°
°*mmh*°

8M: ora siamo: al tredici novembre
now we are: to thirteen november
now it's November thirteen

9P: °kant thbt ali kl shhr nisha (.)
°*arrive here each month exact (.)*

10 aldma hbt sar shhr lliom°
blood not felt month today°
It comes each month exactly (.) now it's a month
today that it's not

11M: mhm
mmh

12P: .hhh astna tlat aiam oala arba aiam aiati rbma
.hhh wait three days or four days, .hh comes maybe
I will wait three or four days, may it .hh will come

13M: ((to D)) ah (.) può darsi che tra quattro o cinque
ah (.) can be that in four or five

14 giorni al massimo (.) arriva (.) però (.) lei è un
days at most (.) comes (.) but (.) she is a

15 po' preoccupata
bit worried
Ah (.) maybe in four or five days at the latest (.)
it will come (.) however (.) she's a bit worried

16–17) to express her concern for the patient, albeit in a downgraded form. The doctor's turn is not translated by the interpreter, who formulates her own understanding of the patient's worries in Italian (lines 18–19: 'a bit frightened because, let's say for her belly'), making relevant the doctor's reassurance in the following turn (line 20). Finally, the interpreter translates the doctor's reassurance and provides support to the patient's emotional status (line 21).

In Excerpt 4, the patient reports a delay in her period, but mitigates the relevance of this information by assuming she will pass it in the following days.

(4 Arabic-Italian).

Affective formulations are a resource for the mediator to bring the patient's emotions to the fore, when they have remained implicit, thus promoting them a topic for the medical encounter. The mediator's affective formulation in line 13–15 ('she's a bit worried') makes current symptoms available to the doctor but also highlights the patient's emotional state, which may have been overlooked. The mediator's formulation successfully involves the doctor in the affective exchange and promotes a shift from a dyadic to a triadic interaction.

5. Discussion

The excerpts presented in the previous Sections 3 and 4 illustrate two different social situations. Excerpt 1 is an example of the exclusion of patients' emotional expressions from the translation. Excerpts 2, 3 and 4 lend themselves as examples of the role of interpreters as mediators who successfully facilitate patients' emotional expression, both in dyadic interactions involving the mediator and the patient (excerpt 2) and in triadic interactions with the (re) inclusion of the healthcare professional.

This study reinforces the conclusion advanced by previous research: when interpreters access the double function of interpreters *and* mediators, they can make positive contributions to a patient-centred healthcare. When the interpreter acts effectively as a mediator, otherwise hidden factors such as patients' emotional expressions can be reported to the doctor thus creating opportunities for him/her to respond within an affective frame. The complexity of the interpreting as mediation needs to be acknowledged. In triadic interactions the interpreters are never neutral conduits and errors are not the only issue: interpreter as mediators co-ordinate the contingent construction of affectivity in medical interactions.

In the data analysed, interpreters as mediators support the patients in expressing their emotions accessing two different roles: *responders* in dyadic interactions, *coordinators* when they involve the doctors in triadic interactions. As *responders*, mediators check and echo the patients' perceptions and emotions, providing positive feedback. However, the interpreters' affective support needs to be made relevant in the medical encounter. By accessing the role of coordinators, the mediators transform dyadic sequences in triadic sequences. As coordinators, mediators capitalize potential empathic opportunities offered by the patient in the course of dyadic sequences. In particular, interpreters access the role of coordinators producing *affective formulations*. In the data analysed, mediator's renditions of emotional expressions through formulations promote reciprocal involvement between the patient and the doctor, in a patient-centred perspective.

These results support previous research on the interactional functions of formulations in mundane settings (Bolden, 2010), in monolingual medical contexts (Antaki et al., 2005) and in multilingual medical interactions (Baraldi, 2016, 2018; van Braak et al., 2023).

The corpora of data suggest that a specific type of formulations, affective formulations, are particularly effective in bringing the emotional expressions of the patient, often initiated within dyadic exchanges, to the healthcare professional. The role of mediators as facilitator and translators of patients' emotional expressions is an essential component of a patient-centred healthcare (Mishler, 1984). This is particularly important in case of migrant patients with a limited proficiency in the language used by healthcare professionals, who, as convincingly demonstrated by Angelelli (2004), Baker (2006), Baraldi and Gavioli (2011) and Pöchhacker (2022) may find additional challenges in expressing their emotions and presenting their case histories and medical concerns.

However, as illustrated by excerpt 1, the corpora of data include interactions where the mediator does not facilitate, but rather inhibits and excludes, patient's emotional expression. During these interaction, the healthcare professional is prevented from the possibility to consider the patient's in his, or her, practice.

In all types of interpreted interactions, including medical interactions, the participation framework is necessarily co-constructed through interactional moves and activities between all the speakers involved. As shown by the discussion of excerpt 1, mediators zero renditions may prevent the personal experience of the patient to reach the medical expert, thus creating a less than favourable local context for a form of healthcare sensitive to the personal and social meanings of the disease for the patients, as indicated by previous research (Farini, 2016).

Analysis of interpreter-mediated healthcare encounters show that zero renditions can contribute to the creation of protected micro social spaces in form of dyadic sequences of interaction where language is shared. These social spaces offer the patient and the interpreter safe spaces to negotiate what is to be shared with the third participant (Gavioli, 2015b). For instance, negotiation applies when the interpreter and another participant contribute to reach an agreement on shared objectives, as suggested by Baraldi (2023). Research published by Leanza et al. (2010) show the efficacy of zero rendition to keep the flow of medical interaction coherent, for instance by censoring a part of the medical discourse that might not be comprehensible or manageable by the patient, or a part of the patient's discourse which might be irrelevant to healthcare treatment. However, Lanza and colleagues also argue that zero renditions that excludes part of patient's contributions may hinder the trust-building process between patient and the healthcare provider. Because they can create more distance between the doctor and the patient, zero and reduced renditions pose risks to the therapeutic process and, paradoxically, compromise the core values (e.g., self-determination and informed decision-making) of the Western medical system (Hsieh, 2010).

Excerpt 2, 3 and 4 illustrates situation where mediators facilitate patients' emotional expressions. These process of facilitation develops in two stages that refer to two different, albeit related, micro social contexts: the promotion of emotional expressions is initiated in monolingual dyadic sequences, then translated for the healthcare professional in multilingual triadic interactions, in line with the findings of previous research (Baraldi & Gavioli, 2020b). In the first phase of the facilitation of patients' personal expressions, within monolingual dyadic sequences, translatable turns at talk are followed by the mediator's production of produces minimal responses (acknowledgment tokens and continuers) that transcend and suspend the turn-by-turn translation model. Gavioli's suggestion that minimal responses play an important in coordinating participation, for instance by expressing understanding and inviting the expansion of narratives (Baraldi and Gavioli, 2012) resonates with the corpora of data analysed.

In the second phase, where patients' emotional responses are brought to the multilingual triadic interaction including the healthcare professional, a pivotal interactional resource consists in affective formulations.

Affective formulation highlight the emotions of the patients while including the healthcare professionals in the progressive construction of patient-centred medical encounters. By producing affective formulations, the mediators develop and emphasise emotional expressions as a topic for subsequent triadic exchanges, as already discussed by Baraldi and Gavioli (2007), Cirillo (2010), Farini (2016), Farini and Niemants (2016) and Baraldi (2017) among others. Affective formulation reveals the interpreter as an active mediator who supports the patient in expressing her emotions, at the same time providing a way for inclusion of such expression in the triadic sequence. By producing affective

formulations, interpreters as mediators introduce patients' emotions to healthcare providers, producing a translation that facilitate access accessing the many facets of the patient's experience towards a patient-centred medicine.

6. Conclusion

Analysis of data suggests that the double role of interpreter-mediators is crucial in enabling patients to make their voices and emotions heard in medical encounters. I have observed how *reduced* and *zero renditions* may exclude the patient or the doctor from the conversation. For instance, the patient may be prevented from understanding the rationale of the medical procedure, or the doctor may be deprived of relevant information about the emotional status of the patient. In the subsequent part of the contribution, I have discussed situations when *affective formulations* improve the emotional rapport between patients and doctors, taking the medical encounter well beyond an exchange merely based on normative institutional roles.

Flores and colleagues argue that training for interpreters may have a major impact on reducing interpreter errors and their consequences in healthcare, improving the quality of care and patient safety (Flores et al., 2012). This articles suggests that professional training should include consideration of the complexity of the interpreters's roles as mediator, which is essential for the construction of patient-centred healthcare provision. However, in triadic interactions the interpreter is never a neutral conduit, therefore errors in translation are an important aspect, but not the only one. Interpreters as mediators co-ordinate the contingent and changeable construction of multilingual medical interactions, where emotional expressions offer to the healthcare professionals the opportunity to acknowledge the meaning and impact of health and illness in the patients social world.

Declaration of Competing Interest

The author declares that he has no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

Data will be made available on request.

References

Angelelli, C. (2004). *Medical Interpreting and Cross-cultural Communication*. Cambridge: Cambridge University Press.

Antaki, C., Barnes, R., & Leudar, I. (2005). Diagnostic formulations in psychotherapy. *Discourse Studies, 7*(5), 627–647.

Baker, M. (2006). Contextualization in translator- and interpreter-mediated events. In *Journal of Pragmatics, 38* pp. 321–337).

Baraldi, C. (2016). Ad hoc interpreting in international educational settings: The problem of renditions. *Interpreting, 18*(1), 89–119.

Baraldi, C. (2017). Language mediation as communication system. *Communication Theory, 27*, 367–387.

Baraldi, C. (2018). Formulations as way of providing renditions in mediated interactions: A single case analysis. *Journal of Applied Linguistics and Professional Practice, 11*(3), 248–269.

Baraldi, C. (2023). Agency in and for mediating in Public Service Interpreting. In C. Wadjenso, & L. Gavioli (Eds.), *The Routledge Handbook of Public Service Interpreting* (pp. 46–62). London: Taylor and Francis.

Baraldi, C., & Gavioli, L. (2007). Dialogue interpreting as intercultural mediation. An analysis in healthcare multicultural settings. In M. Grein, & E. Weigand (Eds.), *Dialogue and Cultures* (pp. 155–175). Amsterdam: John Benjamins.

Baraldi, C., & Gavioli, L. (2011). Interpreter-mediated interaction in healthcare and legal settings: talk organization, context and the achievement of intercultural communication. *Interpreting, 13*(2), 205–233.

Baraldi, C., & Gavioli, L. (2012). Introduction. In C. Baraldi, & L. Gavioli (Eds.), *Coordinating participation in dialogue interpreting* (pp. 1–21). Amsterdam: John Benjamins.

Baraldi, C., & Gavioli, L. (2020a). When clinicians and patients do not speak the same language: A preface to interpreting in health care. *Health Communication, 36*(9), 1057–1058.

Baraldi, C., & Gavioli, L. (2020b). Effective communication and knowledge distribution in healthcare interaction with migrants. *Health Communication, 36*(9), 1059–1067.

Baraldi, C., & Farini, F. (2024). Can intercultural mediation promote greater equity in health care? In J. Crichton, & G.Martin (Eds.), *Handbook of Intercultural Communication in Health Care*. Berlin: De Gruyter Mouton.

Barry, C. A., Stevenson, A., Britten, N., Barber, N., & Bradley, C. (2001). Giving voice to the lifeworld. more human, more effective medical care? A qualitative study of doctor-patient communication in general practice. *Social Science and Medicine, 53*, 487–505.

Bolden, G. (2010). Articulating the unsaid via and-prefaced formulations of others' talk. *Discourse Studies, 12*, 5–32.

Cirillo, L. (2010). Managing affect in interpreter-mediated institutional talk: examples from the medical setting. *The Journal of Specialised Translation, 14*, 55–79.

Davidson, B. (2000). The interpreter as institutional gatekeeper: the social-linguistic role of interpreters in Spanish-English medical discourse. *Journal of Sociolinguistics, 4*(3), 379–405.

Davidson, B. (2001). Questions in cross-linguistic medical encounters: the role of the hospital interpreter. *Anthropological Quarterly, 74*(4), 170–178.

Farini, F. (2016). Affective Formulations in Multilingual Healthcare Settings. In G. Kasper, & M. Prior (Eds.), *Talking emotions in multilingual settings* (pp. 179–204). Amsterdam: Benjamins.

Farini, F., & Niemants, N. (2016). Plurilingual communication in healthcare: Interlinguistic and intercultural mediation. In S. Vecchiato, S. Gerolimich, & N. Komninos (Eds.), *Plurilingualism in Healthcare* (pp. 81–100). London: Bica.

Flores, G., Abreu, M., Pizzo Barone, C., Bachur, R., & Lin, H. (2012). Errors of medical interpretation and their potential clinical consequences: A comparison of professional versus ad hoc versus no interpreters. *Annals of Emergency Medicine, 60*, 545–553.

Gardner, R. (2001). *When Listeners Talk: Response Tokens and Listener Stance*. Amsterdam: John Benjamins.

Gavioli, L. (2015a). Negotiating renditions in and through talk: Some notes on the contribution of conversation analysis to the study of interpreter-mediated interaction. *Lingue Culture Mediazioni/Languages Cultures Mediation, 1*. https://doi.org/10.7358/lcm-2014-0102-gavi

Gavioli, L. (2015b). On the distribution of responsibilities in treating critical issues in interpreter-mediated medical consultations: The case of 'le spieghi(amo)'. *Journal of Pragmatics, 76*, 159–180.

Hancox, J. A., McKiernan, C. F., Martin, A. L., Tomas, J., & MacArtney, J. I. (2023). The emotional effects on professional interpreters of interpreting palliative care conversations for adult patients: A rapid review. *Palliative medicine, 37*(7), 931–946.

Heritage, J. (1984). A change-of-state token and aspects of its sequential placement. In J. Heritage, & M. J. Atkinson (Eds.), *Structures of Social Action* (pp. 299–345). Cambridge: Cambridge University Press.

Heritage, J. (1985). Analysing News Interviews: aspects of the production of talk for an overhearing audience. In T. Van Dijk (Ed.), *Handbook of Discourse Analysis, Vol. 3. Discourse and Dialogue* (pp. 95–117). London: Academic Press.

Heritage, J., & Douglas, W. M. (Eds.). (2005). *Communication in Medical Care: Interactions between Primary Care Doctors and Patients*. Cambridge: Cambridge University Press.

Heritage, J., & Douglas, W. M. (2006). Problems and prospects in the study of doctor-patient interaction: 30 years of research. *Annual Review of Sociology, 32*, 351–374.

Heritage, J., & Lindström, A. (2012). Knowledge, empathy, and emotion in a medical encounter. In A. Peräkylä, & M-L Sorjonen (Eds.), *Emotion in Interaction* (pp. 256–273). Oxford: Oxford University Press.

Hsieh, E. (2010). Provider–interpreter collaboration in bilingual health care: Competitions of control over interpreter-mediated interactions. *Patient Education and Counselling, 78*, 154–159.

Hsieh, E., & Soo, J. H. (2010). Not all are desired: Providers' views on interpreters' emotional support for patients. *Patient Education and Counselling, 81*(2), 192–197.

Jefferson, G. (1988). On the sequential organization of troubles-talk in ordinary conversation. *Social Problems, 35*(4), 418–444.

Jefferson, G. (2004). Glossary of transcript symbols with an introduction. In G. Lerner (Ed.), *Conversation Analysis: Studies from the First Generation* (pp. 13–23). Philadelphia: John Benjamins.

Jefferson, G., & Lee, J. R. E. (1981). The rejection of advice: Managing the problematic convergence of a 'troubles-telling' and a 'service encounter'. *Journal of Pragmatics, 5*(5), 399–422.

Krystallidou, D., Bylund, C. L., & Pype, P. (2020). The professional interpreter's effect on empathic communication in medical consultations: A qualitative analysis of interaction. *Patient Education and Counselling, 103*(3), 521–529.

Leanza, Y., Boivin, I., & Rosenberg, E. (2010). Interruptions and resistance: A comparison of medical consultations with family and trained interpreters. *Social Science and Medicine, 70*, 1888–1895.

Licoppe, C., & Boéri, J. (2021). Is there such a thing as summary interpreting? "Cross-linguistic formulation", facilitation and mediation in French asylum proceedings. *Language and Communication, 77*, 56–69.

Luisi, D., & Hämel, K. (2021). Community participation and empowerment in primary health care in Emilia-Romagna: A document analysis study. *Health Policy, 125*(2), 177–184.

Mao, Y., Wang, X., & Wei, S. (2023). From interactional manifestations to interpersonal motives: A pragmatic study of attentiveness by Chinese doctors during online medical consultations. *Language and Health, 1*(2). https://doi.org/10.1016/j.laheal.2023.08.001

Mason, I. (2006). On mutual accessibility of contextual assumptions in dialogue interpreting. *Journal of Pragmatics, 38*, 359–373.

Mead, N., & Bower, P. (2000). Patient centredness: A conceptual framework and review of the empirical literature. *Social Science and Medicine, 51*, 1087–1110.

Merlini, R. (2009). Seeking asylum and seeking identity in a mediated encounter: The projection of selves through discursive practices. *Interpreting, 11*(1), 57–92.
Mishler, E. G. (1984). *The discourse of medicine: Dialectics of medical interviews*. Norwood, NJ: Ablex.
Monzoni, C. M., & Drew, P. (2009). Inter-interactional contexts of story-interventions by non-knowledgeable story recipients in (Italian) multi-person interaction. *Journal of Pragmatics, 41*(2), 197–218.
Niemants, N. (2013). L'interprétation de dialogue en milieu médical: Entre profession et formation. In M. De Gioia, & M. Vittoz (Eds.), *Cahiers de recherche de l'école doctorale en linguistique française* (pp. 123–135). Padova: CLEUP.
Norrik, N. R. (2012). Listening practices in English conversation: The responses responses elicit. *Journal of Pragmatics, 44*, 566–576.
Pittarello, S. (2009). Interpreter mediated medical encounters in North Italy: Expectations, perceptions and practice. *The Interpreters' Newsletter, 14*, 59–90.
Pöchhacker, F. (2022). *Introducing Interpreting Studies*. London: Routledge.
Pomerantz, A. (1984). Pursuing a response. In Heritage, & M. J. Atkinson (Eds.), *Structures of Social Action* (pp. 152–163). Cambridge: Cambridge University Press.
Pope, E. (2019). Continuers in research interviews. A closer look at the construction of rapport in talk about interfaith dialogue. In K. Roulston (Ed.), *Interactional Studies of Qualitative Research Interviews* (pp. 219–238). Amsterdam: John Benjamins.
Robinson, J. D., & Heritage, J. (2005). The structure of patients' presenting concerns: the completion relevance of current symptoms. *Social Science and Medicine, 61*, 481–493.
Sacks, H., Schegloff, E. A., & Jefferson, G. (1974). A simplest systematics for the organization of turn-taking for conversation. *Language, 50*, 696–735.
Schegloff, E. A. (1980). Preliminaries to preliminaries: 'Can I ask you a question?'. *Sociological Inquiry, 50*(3-4), 104–152.
Schegloff, E. A. (2006). *Sequence organization in interaction: A primer in conversation analysis*. Cambridge: Cambridge University Press,.
Theys, L., Krystallidou, D., Salaets, H., Wermuth, C., & Pype, P. (2020). Emotion work in interpreter-mediated consultations: A systematic literature review. *Patient Education and Counseling, 103*(1), 33–43.
Theys, L., Wermuth, C., Hsieh, E., Krystallidou, D., Pype, P., & Salaets, H. (2022). Doctors, patients, and interpreters' views on the co-construction of empathic communication in interpreter-mediated consultations: A qualitative content analysis of video stimulated recall interviews. *Qualitative Health Research, 32*(12), 1843–1857.
van Braak, M., Schaepkens, S. P. C., van Dolder, E., Dral, L. K., van der Horst, Z., Houben, D. B., & Mees, E. E. (2023). What affects you? A conversation analysis of exploring emotions during reflection sessions in Dutch general practitioner training. *Frontiers in Psychology, 14*. https://doi.org/10.3389/fpsyg.2023.1198208
Verrept, H. (2012). Notes on the employment of intercultural mediator and interpreters in health care. In D. Ingleby, A. Chiarenza, W. Devillé, & J. Kotsioni (Eds.), *Inequalities in Health Care for Migrants and Ethnic Minorities* (pp. 115–127). Antwerpen: Garant.
Wadensjö, C. (1998). *Interpreting as interaction*. London: Longman.
Zandbelt, L., Smets, E., Oort, F. J., et al. (2006). Determinants of doctor's patient-centred behaviour in the medical specialist encounter. *Social Science and Medicine, 63*, 899–910.