Empathy in healthcare interpreting: going beyond the notion of role

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Abstract

The paper investigates empathy in healthcare interpreting by suggesting a theoretical framework through which some of the rigidities and ambiguities of traditional role categories may be overcome. Methodologically, a trifocal model has been designed entailing: a close-up view at locally produced interactional moves in mediated professional-patient encounters recorded at family planning clinics; an intermediate view focusing on the mediators' responses to a situational questionnaire; and a distance view of their tested individual dispositions. The interest of the analysis lies in the presentation of an innovative research model built on the core construct of empathy, and in the working hypotheses that may be derived from the interplay between its three in-built perspectives, rather than in the findings themselves which are hardly generalizable given the limited set of data under scrutiny.

Introduction

This paper stems from a preliminary reflection on some of the rigidities of the notion of "role", a notion which has been at the very core of investigations into dialogue interpreting since the very beginning (Pöchhacker 2004: 147-151), becoming over time one of its most prominent topics (see Valero-Garcés/Martin

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*   Although this paper is the outcome of a joint project, sections 3.2 and 3.3 were written by Gatti, and the others by Merlini.

2008). Though it has undoubtedly served many purposes – first among them the much-needed professionalisation of community interpreting – the schematic classification into typologies of behaviour proves to be rather ill-suited to an in-depth theoretical analysis of real-life interpreting practice. Pre-existing to talk as sets of normative behavioural expectations, roles are generally construed as rigid and formal conversational alignments that shape the interaction; in the sense that the participants' contributions are in some ways dictated by them. In a study of mediated encounters with asylum-seekers (Merlini 2009), Davies and Harré's (1990) socio-psychological construct of "positioning" was used as a more flexible and dynamic interpretative framework to account for the multiple and shifting identities that interlocutors construct and negotiate in conversation. Whereas, in that study, the two conceptual tools of roles and positions complemented each other, here we are moving a step farther, abandoning the notion of role altogether to present a more comprehensive analysis of the interpreter's capacity to adopt a primary speaker's perspective through what is known as "empathic behaviour".

1.   Empathy as perspective taking

The term "empathy" was coined by Titchener (1909) from two Greek words, the prefix ἐν meaning "inside" and πάθεια meaning "feeling, emotion". Originally, the notion of empathy, which translated the German "Einfühlung", developed within the field of German aesthetics and referred to the subject's self-projection into the objects of perception; in Titchener's definition the process is one of "feeling ourselves into them" (1924: 417). In the first half of last century, theories of empathy in psychology were predominantly influenced by this affective view foregrounding the subject's *vicarious emotional response*; with a few notable exceptions: Kohler (1929), Piaget (1932) and Mead (1934), for instance, held that empathy was more an *understanding* of the other's feelings than a *sharing* of them.

Despite the multiple theoretical and disciplinary perspectives from which the concept has been studied since then,[1] there seems to be general consensus among researchers on at least three points:

1. empathy entails, at a very basic level, a sort of awareness of another's experience;
2. empathy is not only an intrapersonal phenomenon that exists inside the empathizer, but is also an interpersonal activity, where the empathizer shows and communicates empathy to a receiver;
3. empathy correlates with beneficial effects for the receiver; in other words people are more likely to help others and less likely to harm them when they feel empathy towards them.

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1   For a comprehensive and detailed overview of the history of empathy research see Håkansson (2003).

In the remainder of this section, we shall briefly look at each of these statements.

If *awareness of the other's experience* represents a minimum common denominator (Håkansson 2003: 2), more fine-grained and often conflicting definitions of empathy have proliferated. One factor leading to this extreme diversification is the classic distinction between the emotional dimension and the cognitive one. Quoting from Adam Smith's (1759) *Theory of Moral Sentiments*, Davis (1980: 3) describes the two forms of empathy respectively as *instinctive*, in which case empathy can be described as a "quick, involuntary, seemingly emotional reaction to the experiences of others"; and *intellectualized*, described as the "recognition of the emotional experiences of others without any vicarious experiencing of the state". Given the relevance of this latter dimension of empathy for the present study, let us quote from the seminal works of Carl Rogers, the father of contemporary research on empathy, who brought the notion centre-stage in psycho-therapy and gave it its present popularity. Of his definitions of empathy, which remain among the clearest and most complete to date, the following two excerpts are worth considering:

> the state of empathy, or being empathic, is to perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person, but *without ever losing the "as if" condition*. Thus it means to sense the hurt or the pleasure of another as he senses it and to perceive the causes thereof as he perceives them, but without ever losing the recognition that it is as if I were hurt or pleased and so forth. *If this "as if" quality is lost, then the state is one of identification* (Rogers 1959: 210-211; italics added).

Construing empathy, in a later definition, as a "process" rather than a "state", Rogers (1975: 4) wrote:

> to be with another in [an empathic] way means that for the time being you lay aside the views and values you hold for yourself in order to enter another world without prejudice. In some sense it means that you lay aside your self and this can only be done by a person who is secure enough in himself that he knows he will not get lost [...] and can comfortably return to his own world when he wishes.

Though reference here is specifically to the psychotherapist-patient relationship, some aspects have much more general significance. First among them is Rogers' differentiation between empathy – characterised by the "as if" condition – and identification with the other. Secondly, the cognitive orientation integrates an emotional component, but keeps this firmly anchored to an unfaltering awareness of one's own self. Lastly, only "security in oneself" makes it possible to move back and forth between one's own world and that of the other in a non-judgemental manner. This way of being empathic is so complex and delicate that, as Rogers himself notes, it "is rarely seen in full bloom in a relationship" (1975: 2). Significantly, the title of his 1975 paper is "Empathic: an unappreciated way of being".

Whilst some authors have used the term empathy to refer to either an exclusively cognitive phenomenon or an exclusively emotional one, others have opted for two separate terms, drawing a clear-cut theoretical distinction between "empathy" and "sympathy" (see for instance Wispé 1986, 1991). Empathy is thus

viewed as understanding and perceiving the other's emotional state, but without acquiring it; the maintenance of a dual perspective remains fundamental even when a degree of emotional resonance is envisaged. Sympathy, on the other hand, always entails emotional identification – i.e. sharing the other's experience and sensations.

Reuniting these diverse conceptualizations within a single theoretical framework – the most inclusive one in contemporary literature – Davis treats empathy as a multidimensional phenomenon; in his own words, a "set of constructs, related in that they all concern responsivity to others but [which] are also clearly discriminable from each other" (1983: 113). He identifies four such constructs: 1) fantasy, i.e. the tendency to imaginatively transpose yourself into the feelings of fictitious characters in books and movies; 2) perspective-taking capability, i.e. the tendency to spontaneously adopt the psychological view of others in real everyday life; 3) empathic concern, i.e. the tendency to experience other-oriented feelings of warmth, compassion and concern for unfortunate others; 4) personal distress, i.e. the tendency to experience self-oriented feelings of apprehension and discomfort at witnessing the distress in others. Highly significant are the correlations Davis establishes between the constructs. In particular, he demonstrates that a greater perspective-taking capability is associated with more concern for the others and with less distress in the face of others' negative experiences. In other words, the more able we are to cognitively apprehend another person's perspective, the less self-centredly distressed and the more other-oriented concerned we are.

Coming thus to the second point of consensus, namely that empathy is an *interpersonal* as well as an intrapersonal phenomenon (Håkansson/Montgomery 2002, 2003), the current trend is to conceive of it not merely as a general organizing principle of social interaction, nor as a set of communicative acts practised unidirectionally by the empathizer on a passive recipient, but rather as a joint activity in which the empathic experience is co-constructed by interlocutors (Broome 1991; Della Noce 1999). In the specific field of medical communication, Ruusuvuori (2005, 2007) explores empathy and sympathy as two distinct processes of talk-in-interaction. Drawing on "empathy in action" studies by Branch/Malik (1993), Suchman *et al.* (1997), Beach/Dixson (2001), and Beach/LeBaron (2002), and applying the conversation analytical method, Ruusuvuori analyses sequences of troubles telling by patients and their receptions by medical practitioners. The study shows that in those cases where affiliation is present – a minority of instances in the overall corpus – both physicians and patients orient towards a restriction of such displays, which rules out sympathetic moves of experience sharing. Conversely, empathic actions – through which the professional manifests understanding of the patient's troublesome situation and makes it relevant to the consultation – are deemed not only acceptable but even desirable, as they maintain the focus of talk on the patient's experience, thus preserving problem solving as the main activity of the consultation. Far from arguing the inappropriateness of empathic behaviour in the specific institutional environment, Ruusuvuori points out possible ways of showing compassion and relating humanely to the other, albeit within the limits imposed by the professional activity at hand.

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The existence of a close connection between empathy and altruism has long been posited by philosophers and psychologists alike (in the latter field, among contemporary studies see for instance Eisenberg/Miller 1987; Batson 1991; Davis 1996; Hoffman 2000; Batson *et al.* 2002); this takes us to the third consensual statement that *empathy is beneficial for social relations*. Experiments by Batson and his colleagues, in particular, have not only validated Davis' correlation between perspective taking and concern for the other, but have also demonstrated that empathic concern, in its turn, leads people to improve the other's well-being through altruistically motivated efforts. If this applies on principle to all kinds of interactions, in service encounters between professional and client, unlike ordinary conversations, improving the other's well-being may be seen as conflicting with manifesting empathy, given that the trouble reported by one of the parties is usually the problem to be solved by the other party, who is therefore called upon to provide an objective and focused task-related response. As we saw earlier on, this contradiction is resolved if empathic displays are seen and used precisely as a means of problem solving to complete the institutional task while, at the same time, responding to a human being "in search not only of a solution to their problem but also of understanding and compassion" (Ruusuvuori 2007: 598). In fact, Coulehan *et al.* (2001: 221) unhesitantly state that empathy – which they define as "the ability to understand the patient's situation, perspective, and feelings and to communicate that understanding to the patient" – lies at the very heart of medical practice. There is by now ample documentation that an effective use of empathy promotes diagnostic accuracy, therapeutic adherence, and both patient and physician satisfaction (see among others Bertakis *et al.* 1991; Nightingale *et al.* 1991; Suchman *et al.* 1993; Roter *et al.* 1997). Viewing thus empathy as a clinical tool, a number of medical educators (see Spiro 1992; Brock/Salinsky 1993; Coulehan *et al.* 2001) have started conceptualising it as a set of teachable and learnable communicative skills, which need practising to achieve adequate mastery.

To conclude, considering our focus on (linguistically mediated) healthcare interactions, for the purposes of the present study empathy is conceived of here as a perspective-taking capability, entailing: awareness of both self and the other (and of self as distinct from the other); understanding of the other's situation; and a degree of concern for the other, communicated through a range of carefully selected affective displays in compliance with the aims and overall objective of the specific institutional activity.

2.   "Empathic: an unappreciated way of...interpreting"?

In the last century, the earliest attempts at producing modern codes of ethics and standards of practice were made in the field of conference interpreting, where the process of professionalization has been relatively fast and unproblematic if compared to dialogue interpreting. Owing to the specific contexts of international cooperation in which conference interpreting is habitually performed, the most appropriate behaviour was thought to be self-effacement, implying, as corollaries, maximum objectivity, confidentiality, impartiality, and neutrality. The basic equation between professionality and emotional detachment resulted

in the stigmatisation of any form of interpreters' empathic involvement. This has been particularly true in Western countries, as Rudvin (2007) convincingly argues in "Professionalism and ethics in community interpreting". In particular, she points out that human and moral responsibility has been relegated to a place of secondary importance against the extensive dominance of professional responsibility. Provocatively, she raises the following question:

> can we and should we make an absolute distinction between our private and professional lives, private emotions and professional detachment? (*ibid.*: 55).

The idea that professional conduct and empathic behaviour are irreconcilable seeped into debates on professional ethics in community interpreting at a time when the best strategy to promote its professionalization seemed to be the adoption of the same principles and rules laid down in conference interpreting codes of practice – witness, as another eloquent example, the interpreting-in-1st person rule (Merlini/Favaron 2009). Gradually, not least thanks to the fora of discussion provided by Critical Link conferences, practitioners as well as researchers started documenting and exploring the significant differences between the two interpreting domains, and their implications for professional ethics. Taking stock of the evolution of community interpreting over the last two decades, Martin/Valero-Garcés (2008: 2) relevantly observe that, however professionalized this practice becomes, community interpreters will always find themselves in "circumstances in which it would be difficult for any human being to remain unperturbed". Emergency and often dramatic situations, power imbalances between participants, clients' conflicting expectations, and wide cultural gaps account for the multiple and mutable dilemmas with which practitioners are constantly faced. The polarisation between the "impartial" and "advocate" role models is a theoretical simplification with very limited value for actual community interpreting practice, given the virtually infinite range of situational and interactional variants.

Notwithstanding the difficulty of identifying solutions which may be applicable throughout even one single sector of activity, setting-specific guidelines have nonetheless been produced in countries where the professionalization of community interpreting is more advanced. Narrowing the focus down to healthcare interpreting, and coming back to the object of the present paper, in her comprehensive report *The Interpreter's World Tour. An Environmental Scan of Standards of Practice for Interpreters*, Bancroft (2005) observes that the concept of empathy is mentioned in several of the more recent codes. To provide just one example, let us quote from the first such code in the US, i.e. the *National Code of Ethics for Interpreters in Health Care*, a most influential document drawn up by the National Council on Interpreting in Health Care (NCIHC) in 2004:

> [impartiality] is a principle that is misunderstood and misinterpreted by many to mean that interpreters should be disinterested in or uncaring with regard to the patient. To the contrary [...] *one of the overarching values* of the health care interpreter's code of ethics, a value that is shared with other health care professionals, *is the well-being and welfare of the patient*. In upholding this value, interpreters fully recognize and

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accept the humanity and the human needs of the parties in the encounter. *Responding with empathy* to a patient who may need comfort and reassurance *is simply the response of a caring, human being* (NCIHC 2004: 16; italics added).

Here, not only is empathy acknowledged as a natural response to a patient's plight – the lack of it being implicitly viewed as tantamount to inhumaneness – but, even more importantly, the interpreter's empathic behaviour is linked and made instrumental to the achievement of the over-arching goal of medical practice, i.e. the well-being and welfare of the patient.

The notion of "humane medical care", as derived from Mishler (1984), was first applied to the study of interpreter-mediated healthcare interactions by Merlini/Favaron (2005). Their analysis of speech-therapy sessions showed the interpreter's "overall tendency to strengthen […] the healthcare practitioner's *empathic* model of communication" (*ibid.*: 295; italics added). Though implicitly running through the entire paper – the only explicit reference being the just-quoted one – empathy did not constitute the theoretical tool for analysis, which revolved instead around the discourse categories of "voice of medicine" and "voice of the lifeworld".

Subsequent investigations into healthcare interpreting by Baraldi/Gavioli (2007), Ciliberti (2009), Zorzi/Gavioli (2009) and Baraldi (2012) deal with the interpreter's management of participants' emotional utterances. While express, if cursory, mention of empathy is made in the latter three – with Zorzi/Gavioli's contribution also introducing, tangentially, the empathy vs. sympathy distinction – the discussion is built around such concepts as "emotional involvement", "affect", and "affiliation", which are empirically explored through the methodological lenses of Conversation Analysis. Admittedly, these concepts largely overlap with that of empathy; so much so that the findings of such research are of the utmost interest to any one scholar approaching the theme of interpreter-mediated emotional communication dynamics. Baraldi/Gavioli (2007), in particular, expose a two-fold behavioural pattern. Contrary to what is frequently observed in the literature, i.e. a loss of emotional expressions (see Bolden 2000; Davidson 2000), in their corpus interpreters are invariably found to challenge affective neutrality through affiliative responses which provide reassurance and support, and treat the patient's manifestation of feelings and worries as conversationally relevant. Yet, in some interactions, the patient's affective contribution is cut out of the rendition, which prevents the involvement of the doctor in the affective interactional sequence. In others, instead, interpreters first affiliate to encourage the patient to say more, and then formulate their understanding of previous talk for the doctor, conveying the emotional gist of the patient's utterances, to enable its topicalization and elaboration by the healthcare professional. An affective triadic interaction is thus achieved.

Seminal as they are, these works are predominantly concerned with the effects of the interpreter's behaviour on the interaction, and their broader professional, institutional, and social implications. No consideration is given to the interpreter's inner dispositions, seen as the precinct of psychology. The present study differs in that empathy is specifically used as the core theoretical concept, and as a construct which brings together both the objective (interactional) and the subjective (attitudinal) dimensions of empathic behaviour.

3.   A *trifocal model* for assessing empathy in healthcare interpreting

The model we propose is designed to enable a comprehensive assessment of empathy (or the lack of it) in real interpreting practice through a "trifocal" approach. This entails a close-up view at locally produced interactional moves; an intermediate view focusing on elicited situation-dependent responses; and a distance view of tested individual dispositions. The progressive shift in focuses is thus a function of the researcher's positioning along a cline which goes from empathy as the actualised object of the conversational process, to the interpreter as the subject of the empathic experience. More specifically, the analysis is carried out on a three-fold set of data:

1. audio-recorded real-life linguistically mediated consultations in Italian family planning clinics;
2. questionnaires assessing *situational* empathy, i.e. empathic responses to a specific situation;
3. questionnaires measuring *dispositional* empathy, i.e. empathy understood as a person's stable character trait.

Our contention is that a combination of these analytic focuses is likely to yield a higher-quality image of interpreters' empathic vs. non-empathic behavioural choices. While referring the reader to the literature on empathy-related assessment tools and methods (for a review see, among others, Zhou *et al.* 2003; Gerdes *et al.* 2010), the specific interest of this paper lies in the presentation of a research model and the potential interactions between its three in-built perspectives, more than in the findings of the analysis itself, which hold no value in terms of representativeness of interpreting trends, given the limited set of data under scrutiny.

3.1   The recorded interactions

Seven linguistically mediated consultations were recorded in 2011 in two Italian family planning clinics. Since permission was obtained only to audio- and not to video-record, detailed observation notes on contextual and non-verbal aspects were taken during the consultations. Originally, the corpus was used to investigate the roles played by linguistic and cultural mediators[2] (Gatti 2011); the limits of a role-based analytic approach came once again in view. For the purposes of this study, a new analysis was conducted on the encounters to find evidence of empathic communication cues in three broad areas:[3]

1. *attentive listening cues* – e.g. confirming understanding through feedback tokens (mhm, yes, right, etc.) to invite the speaker to continue;
2. *perspective-taking cues* – e.g. checking understanding through requests for

2   For an in-depth discussion of the differences between the figures of "linguistic and cultural mediator" and "community interpreter" see Merlini (2009: 57-62). Given that these differences are of no immediate relevance to the scope of the present paper, the term mediator will be used henceforth as synonymous with interpreter.
3   On this see also Myers (2000) and Burgoon *et al.* (1984, 1996).

clarification, reformulation of speaker's utterances, elicitation of listener's questions; expressing understanding/approval of the other's point of view, reassuring, encouraging, offering advice;

3. *non-verbal cues* – e.g. eye contact, facial pleasantness, smiling, laughing, head nods, frequent and open hand gestures, touching.

Following the analysis, three consultations have been selected, showing respectively high, low, and zero levels of communicated empathy on the part of three different mediators. A summary overview is supplied in Table 1.

	Interaction 1 (I1)	**Interaction 2 (I2)**	**Interaction 3 (I3)**
Place	F a m i l y p l a n n i n g c l i n i c		
Date	22 Nov. 2011	22 Nov. 2011	15 Nov. 2011
Duration	29′00″	15′15″	13′23″
Service-provider	Italian sociologist female 45-50 years old	Italian obstetrician female 45-50 years old	Italian gynaecologist female 40-45 years old
Service-user	Estonian patient female 25-30 years old	Chinese patient female 20-25 years old	Chinese patient female 25-30 years old
Mediators	Armenian mediator female 45-50 years old	Chinese mediator female 25-30 years old	Chinese mediator female 45-50 years old
Situation	Termination of pregnancy	Prenatal tests	Post-surgery check
Degree of empathy	HIGH	LOW	ZERO

Table 1. Summary overview of recorded interactions

In I1, a young woman from Estonia (P1) goes to the family planning clinic to ask for a voluntary termination of pregnancy, thinking it can be done then and there. The sociologist (S) who meets her explains that a longer procedure is required and starts enquiring about her personal circumstances (in particular the relationship with her boyfriend). This annoys P1, who does not understand why she is being questioned and closes up. After a few exchanges in which P1 produces minimal responses, in an attempt to overcome her mistrust S invites the Armenian mediator to shift from Italian – a language that P1 knows well enough to hold the conversation – to Russian. The sociologist, who does not understand Russian, thus entrusts the mediator with the task of getting (linguistically) closer to the patient. Excerpt [1] shows how M1 goes about this task.

39 S: allora vogliamo parlare in russo che magari lei mi si smolla un attimo (.) eh↑
        Now, shall we speak Russian so she will maybe relax a little bit?
40 M1: Ты хорошо говоришь по-итальянски
        You speak Italian well.
41 P1: mhm mhm
42 M1: Она говорит Хочешь по-русски будем говорить чтоб ты расслабилась и всё
        She says, do you like us to speak Russian so that you may relax? That's all.
43 P1: А вот это сейчас зачем вот эти вопросы↑ Надо это всё↑
        Now, why all these questions? Is all this necessary?
44 M1: no dice per cosa queste domande↑
        She's asking, what's the point of these questions?
45 S: no perché=
        Well, because
46 M1: =Это такой уголок где стараются женщине дать помощь поддержать
        This is a safe place where people try to give women help and support.
47 P1: Да я знаю Я думала я только приду меня только проверит врач Я вот
48   сделаю своё дело и уйду И всё Нет↑
        *Yes I know, I thought I'd come here, the doctor would simply examine me, I would do what I
        have to do, and go away. That's all, isn't it?*
49 M1: ah perché dice vedi è pragmatica [dice io   ] pensavo di venire
        Because, you see, she is pragmatic, she says I thought I'd come here
50 P1:   [((laughs))]
51 M1: a fare l– ((hesitates))=
        to have a–
52 S: =l'aborto=
        abortion
53 M1: =risolvere il mio problema e andare via
        to solve my problem and go away.
54 S: mhm e invece in Italia c'è una legge per: interrompere la gravida:nza
55   quando non capisci lo chiedi a lei eh↑
        *Yes, but in Italy on the other hand there's a law to terminate a pregnancy – when you
        don't understand you ask her okay? –*
56 P1: mhm sì sì

5   Line numbers refer to their place in the original transcript. Idiomatic translations
    into English appear in italics; the use of punctuation is meant to increase readability.
    In transcribing the original utterances, on the other hand, the following conventions
    have been adopted:
        [ ]   overlapping utterances
        =   latched utterances
        ↑   rising intonation
        °word°   decreased volume
        word–   abrupt cut-off in the flow of speech
        wo:rd   lengthened sound
        (.)   untimed pause
        (( ))   contextual information; characterisations of the talk and vocalisations
                    that cannot be spelled recognisably

57 S: ((clears her throat)) per interrompere la gravidanza che dà la possibilità alla donna
58   di avere un colloquio (.) con un operatore (.) per poter parlare di sé perché si è
59   disperate no↑ quando si è incinta e non si vuole portare avanti una °gravida–°
60   quindi non lo vedere come (.) uno che vuole venire da te e: e ti vuole (.) fare delle
61   domande e:: te ti difendi e dici no non li voglio no↑ [vedila invece] come=

to terminate a pregnancy that gives the woman a chance to speak with a service provider, to speak about herself, because one is in despair – right? – when they're pregnant and don't want to carry on the pregnan– so don't take it as if someone came to you to ask you questions, and you are on the defensive and say no, I don't want them, okay? See it instead as

62 P1:   [mhm mhm   ]
63 S: =una possibilità per poter piangere stare male ma anche vedere ((someone
64   knocks at the door and comes in)) quali sono le cose positive (.) i risvolti

an opportunity to cry, to let your pain out but also to see what is positive about it, the consequences.

65   ((S stops talking to attend to the person who's entered the room))
66 M1:   Ты поняла да↑

Did you understand, yes?

67 P1:   [Да всё поняла   ]

Yes, I understood everything.

68 M1:   [Это уголочек   ] где можно выболтаться сказать понимаешь

This is a safe little place where you can talk, pour everything out. Do you understand?

[…]

74 M1:   Просто стараемся понять твоё состояние психологическое

We are simply trying to understand your state of mind.

75 P1:   mhm mhm
76 M1:   okay (.) cerchiamo di capire la sua ehm sit– sit– situazione psicologica in che stato è p–=

Okay, we try to understand her psychological condition, the state she is in, t–

77 S: =per capire (.) °perché qualsiasi scelta tu faccia sia per te la scelta migliore°

to understand so that whatever choice you make may be the best for you.

To mitigate the face threat inherent in the language shift request made by S, M1 first compliments P1 on her Italian (40). She subsequently translates the patient's question (43-44) thus conveying to the service provider P1's emotional state of annoyance/apprehension. As S takes the floor to motivate her questioning (45), M1 butts in (46) feeling that, for the conversation to proceed smoothly, she needs to preliminarily reassure P1 that she has nothing to fear since all the professionals working at the family planning clinic are there to help. The alteration of the turn-taking sequence reallocates the floor to P1 enabling her to manifest her intention and expectations (47-48). These are once again translated into Italian for the benefit of S (49). Worthy of note is the humorous twist M1 gives to the rendition; most likely a way to ease P1's discomfort (see the latter's laughs 50). Further evidence of the mediator's delicacy towards P1's feelings is her reticence to utter the word "abortion" (51). Knowing that the woman speaks some Italian, M1 opts for a rendition ("to solve my problem" 53) that attempts to keep the indirectness of the original wording ("what I have to do" 47-48). Before illustrating the purpose of the counselling session (57-64), S invites P1 to ask the mediator in case she does not understand. Following her explanation, M1 checks P1's understanding (66); despite the latter's confirmation (67) the mediator reiterates her initial reassurance (46; 68) – note the use of the same word "уголок", "safe place", becoming "уголочек" through the addition of the suffix of endearment "чек" – and then proceeds to translate the service provider's turn into Russian

(omitted lines). Highly revealing of the empathic communication model is M1's concluding remark "we are simply trying to understand your state of mind" (74), which she translates back into Italian (76). S, who is thus involved again in the exchange, confirms the orientation towards the patient's well-being (77).

Throughout the encounter, over and above the cues of perspective taking exemplified in [1] (see also in the excerpt the high frequency of Italian and Russian words for understanding), the Armenian mediator gives advice on issues of bureaucracy, and even suggests helping P1 solve a number of serious practical problems – having no identity document, no NHS health card, and no money to pay for the medical services. Field notes record that the Armenian mediator smiled frequently, kept eye-contact with the patient, and even touched her now and then as an affective display. No evidence was found either of sympathetic moves of experience sharing or of emotional distress. In terms of outcome, as the encounter progressed the patient's initial mistrust turned into a more relaxed and cooperative attitude.

In I2, a pregnant Chinese woman (P2) goes to the clinic to have information about routine pre-natal scans. Learning that P2's husband has a genetic defect, the obstetrician (O) recommends seeing a medical geneticist. The patient refuses taking any such appointment. O then asks her whether she is at least willing to have a nuchal translucency scan, and provides a detailed description of this non-invasive diagnostic test. Following P2's reiterated refusal, the obstetrician enquires about amniocentesis. In excerpt [2], the Chinese mediator (M2) is seen conducting an autonomous line of questioning in an attempt to understand the reason behind P2's third flat refusal.

[2]   I2 (41-69)

41 O: è interessata invece all'amniocentesi↑ questa puntura nella pancia appunto
42   usata per vedere come sta il bambino però questo è un esame invasivo
43   rispetto all'altro per vedere esattamente i cromosomi quindi si va a fare
44   uno studio preciso sui cromosomi si chiama amniocentesi
            Is she interested instead in amniocentesis? An injection on the belly which is used to see how the
            baby is. But this is an invasive test compared to the other one to see precisely the chromosomes; it is
            an accurate test on chromosomes, it's called amniocentesis.

45 M2:   有另外– 种很精确的那个测验方法 就是那个羊水检查 有个 =
            There is another kind of diagnostic test which is accurate. It's the test of amniocentesis. There is a

46 P2:   = 那个啊我不做
            I'm not doing that one.

47 M2:   不做啊
            So you don't want to do it, do you?

48 P2:   嗯
            ((onomatopoeic sound that confirms previous statement))

49 M2:   già quest– ancora non ho finito di spiegarle già ha detto no [non] lo voglio fare
            She's alrea– I have not yet finished explaining she's already said, no I don't want to do it.
50 O: [no] ((writing on a
51   form)) perfetto (.) e::: allora facciamo firmare che lei rifiuta qualunque
52   tipo d'indagine eh prenatale e anche la consulenza col genetista
                                                            Fine, so we'll have her sign that
            she refuses doing any kind of prenatal tests and consulting with the geneticist.

53 M2: 那上面是说=

Now, what she wanted to say earlier on was

54 O: =potremmo anche trovare il modo di non farla pagare se questo è un problema economico

55 eh [puoi dirlo

We could find a way to dispense her from paying if the problem is an economic one. You can say this.

56 M2: [她说你现在不做是于出经济方面的原因考虑呢 还是说就是不想做

She says the reason why you do not want to do it, is it because you think of the economic aspect or you just don't want to do the test?

57 P2: 不想做

I don't want to do it.

58 M2: 是因为她刚说可能要付费↑ 她说付费有可能你找到的话有些免费的

Is it because she's just said that you may have to pay? But she says that, as for the payment, if you find it perhaps there may be something for free.

59 P2: 也不是因为那个

That's not the reason either.

60 M2: 是你觉得没必要还是别的

Is it because you think there's no need for it, or for any other reason?

61 P2: 因为我看她们很痛很辛苦

Because I see it hurt them and it's fatiguing.

62 M2: 很痛↑ 是什么很痛 ↑

It hurts? What hurts?

63 P2: 看那个 因为我也有个同事也做了羊水检查 我看她们好累哦 我受不了

It is because I have a colleague of mine who did amniocentesis too. It seems to me they are exhausted, I could not stand it.

64 M2: 是做了检查之后 感觉她

It's after the test and she seems to

65 P2: 嗯

((onomatopoeic sound that confirms previous statement))

66 M2: perché lei è stata un po' spaventata da una sua collega che: che è che è incinta ((enters

67 a nurse)) e ha fatto amniocentesi dopo eh sembra che fisicamente lei dice l'ha–

68 comincia a stancarsi molto e lei l'ha visto e dice ma   [questo mi spaventa

Because she was scared by a colleague of hers who is pregnant ((a nurse comes in)) and did amniocentesis, after which it seems that physically, she says, she started feeling very tired, and she saw this and says this scares me.

69 O: [come vuole lei come vuole lei

As she likes, as she likes.

M2's first timid perspective-taking move is a request for confirmation (47). P1's curt reply is conveyed to O (49), who accepts it as final and writes it down on the medical consent form (50-52). Immediately afterwards, however, O takes up the topic again to make sure that the reason behind P2's opposition to amniocentesis is not the high cost of the test (54-55) and thus, implicitly, her embarrassment to admit that she cannot afford it. Instructed to relay O's doubt to P2, the mediator initiates a dyadic sequence of exploratory questions (56-65) aimed at apprehending P2's psychological state and grasping her real motives. She finds out that the refusal is based on the experience of a female friend of P2 who told her that the test was painful and that she felt exhausted after having it. M2 does not

respond to P2's manifestation of concern; she neither reassures her nor invites her to check with O whether her fears are founded or not. She does, however, convey the content of P2's turn to O – albeit in a rather emotionally neutral manner – thus making it relevant to the conversation. The obstetrician does not act on this, and closes the topic without dealing with P2's fears (69). Overall, the interaction sees M2 attentively listening to P2, frequently asking for clarifications, and checking understanding. On the other hand, no cues of emotional concern were found. Non-verbal displays of empathy were rare, with M2's body-language exhibiting a preferential orientation to the service provider. One of the outcomes of the encounter was that the patient decided against the diagnostic test on the basis of hearsay and fear, and not out of a reasoned and informed decision.

I3, a post-surgery check, involved a rather mechanic series of routine questions on the condition of the Chinese patient (P3), along with therapeutic instructions. Despite a few instances in which the interaction might have called for some form of empathic expression (specifically sequences of trouble telling where P3 complained of intense abdominal pain), no empathic cues were found on the part of the Chinese mediator (M3) – or indeed the gynaecologist (G) – in any of the three categories.

3.2   The situational questionnaires

Several months after the interpreted sessions had taken place a questionnaire assessing *situational empathy* was submitted to each of the three mediators. The questionnaire contains three scenarios which were designed to mirror the real contexts – i.e. a voluntary termination of pregnancy (scenario 1), a consultation on pre-natal tests (scenario 2), and a routine medical check (scenario 3). Going from 1 to 3, the respondent is thus presented with decreasingly delicate situations. The introduction of this variable was meant to check whether the sensitivity of the topic being discussed influenced the degree of empathy expressed by the mediators. Each scenario includes three multiple-choice questions. Answers are built on empathic cues belonging to the three categories of attentive listening, perspective taking, and non-verbal language. For each question, the respondent is required to opt for one out of three possible behaviours. An open question is added on to each multiple-choice one asking to motivate the answer. For reasons of length, only scenario 2 is reproduced here by way of exemplification (see Appendix).

Two out of the three mediators accepted to respond to the questionnaire: the Armenian one (M1) and the elder of the two Chinese ones (M3). The younger Chinese mediator (M2) refused, despite assurances of anonymity, saying questions were far too personal. This is a relevant datum; besides being possibly culture-related, it shows how the private sphere is thought of as totally distinct from the professional one. Equally significant was the reaction of M3, who initially refused to respond – giving the same reason as her colleague – but subsequently changed her mind, when we explained more in detail to both of them the importance of such data for community interpreting research and the training of future practitioners.

The analysis of the two available questionnaires confirms M1's preference for empathic behaviours, as against M3's predominant selection of the non-empath-

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ic alternatives. M3's responses were found to be mostly context-independent: in all three of the suggested scenarios, she opted for the same communicative modality. Interesting findings were yielded by her answers to the open questions. Her principal concern, as she herself states, is to translate as accurately as possible, make sure the patient has understood, and, if necessary, provide information of an institutional and administrative nature. Indicative of her priorities is the following statement: "It is very important to let the patient know about her rights, how to exercise them and what services she is entitled to". Referring to the situation in scenario 3, in which the patient feels embarrassed at answering sex-related questions, M3 chose the option: "I would help her overcome her discomfort by completing her sentences"; in motivating her choice she wrote: "[Chinese] women are quite introverted. Intercultural mediators usually have the skills to help them get over this embarrassment", which points more towards a functional rather than an empathic approach.

M1's behaviour, on the other hand, was found to be more dependent on the specific interactional context. Even though in the majority of cases she opted for empathy-marked answers, in scenario 2 (the one on pre-natal diagnostic tests), she displayed a preference for a less empathic attitude as her principal concern was that complete and correct information be conveyed to the patient. Her comments also indicate a preoccupation with not influencing the patient on such delicate and personal decisions. This raises the fundamental issue that empathic behaviour is thought of as potentially contrasting with professional neutrality and objectivity – it should be noted that none of the empathic options included in the questionnaire entail a trespassing of professional boundaries. Evidence of the perception of this contrast is forthcoming also in the other two scenarios, where M1 first followed her instinct and selected the most empathic behaviours, and then in the open questions felt the need to stress the importance of being neutral and not influencing the patient's decision making in medical matters.

The following are some of M1's most telling statements: "depending on the person I am mediating for, I am able to understand what the patient needs"; "I can feel it under my skin what a person is feeling and then I act accordingly"; "I would be willing to tell the patient about my personal experience to show that I understand what the patient is going through. Back in the 90s many people fled Russia, they fled severe depression and poverty, and they arrived in Italy hoping to find better living conditions. I myself lived that same experience, so I know what immigrants must undergo when they arrive in a new country"; "my role is that of being neutral and therefore I cannot be judgemental, but I may give my opinion and act in a more confidential manner especially if I have known the patient for quite a long time". These extracts taken from her abundant and lengthy comments reveal a highly empathic disposition, which would even incline M1 towards performing sympathetic moves of experience sharing. At the same time she prescriptively defines her role in terms of neutrality, which is however qualified as implying a non-judgmental rather than a disaffiliative behaviour. The contrast she perceives between professional ethics and a caring attitude is most likely resolved through the awareness that "my ultimate aim is to help these women".

3.3 The IRI questionnaires

Together with the situational one, a questionnaire measuring dispositional empathy was also submitted to the three interpreters. Again only M1 and M3 agreed to being tested. The measurement tool is Davis' (1980, 1983) Interpersonal Reactivity Index (IRI), which is to this day one of the most widely used tests of dispositional empathy. The IRI questionnaire consists of 28 questions divided equally among 4 distinct subscales, reflecting the above-mentioned components of fantasy, perspective-taking, empathic concern, and personal distress. These are answered on a 5-point scale ranging from "does not describe me well" to "describes me very well". M1's and M3's scores are shown in Table 2.

SCALES	M1	M3
FANTASY	13	9
PERSPECTIVE TAKING	20	10
EMPATHIC CONCERN	26	19
PERSONAL DISTRESS	12	9

Table 2. IRI scores

Scores reveal a marked difference between the two mediators. M1 scores especially high in the two central scales of perspective taking and empathic concern, 20 and 26 out of a maximum per scale of 28. Corresponding scores for M3 are significantly lower (10 and 19), yet with a narrower divide in the empathic concern scale. M3's score is in fact not as low as might have been expected in light of the preceding analyses. As for the personal distress scale – which we recall implies self-centred identification with the other person's distress – and the fantasy scale, scores are low for both mediators, with irrelevant marginal differences between them.

Findings for interactional, situational and dispositional empathy were thus found to coincide, with the only deviation of a relatively high empathic concern score for M3.

4. Some initial conclusions

For the purposes of the present study empathy was defined as a cognitive perspective-taking capability, entailing an understanding of the other's situation, along with a degree of other-oriented concern communicated through carefully selected affective displays. These do not include sympathetic moves of experience sharing which, in the institutional context under study, would shift the focus away from both the recipient of medical care and the problem-solving task. As for the personal distress component of Davis' empathy model, it bears limited relevance here, and only in so far as its manifestations are deemed incompatible not only with medical but also with interpreting practice. Thus qualified, empathy is seen as beneficial for professional relations in healthcare encounters, as it

contributes to the achievement of their ultimate goal, namely the well-being of the patient. On this premise, we will attempt to draw some conclusions from the findings yielded by the three analytic perspectives.

M1 was found to exhibit a markedly empathic behaviour in real-life interaction. This is in line with her scoring particularly high on the IRI scales of perspective taking and empathic concern. The situational questionnaire confirmed M1's attitudinal preference; yet, it also gave evidence of her perception of (and preoccupation with) a conflict between empathy and professional ethics. M2, who interactionally performed mildly empathic moves, refused to respond to the questionnaires, drawing a clear-cut divide between her private and professional selves. Despite the lack of precious data, this negative response of hers was thought to be quite significant in itself. As for M3, her initial selfsame reluctance would point to the possible culture-relatedness of such a view. The availability, in this latter case, of the three sets of data allows, however, for a more interesting hypothesis. While M3's responses to the situational questionnaire mirror her adoption of a strictly non-empathic interactional conduct, her relatively high score in the empathic concern scale reveals a different inner disposition. A feasible explanation is that empathy is again considered to be inappropriate in professional practice, and thus deliberately inhibited.

Evidently, a much wider corpus of data would be needed to verify these suppositions; the same holds true, at a more general level, for the outcomes of the three interactions, which would appear to confirm the favourable effects of an empathic communication model and, conversely, the detrimental ones of the lack of it. While the findings of this study cannot in any way be generalised, they indicate the kind of issues that may be explored through our trifocal model. Central among them is the persisting bias against an empathic interpreting conduct. Hopefully, this paper has exemplified how empathy can be fruitfully used as a theoretical construct to highlight the complex interplay between the interpreters' inner dispositions, perceptions of situationally suitable behaviours, concrete interactional moves, and their effects on real-life conversations. In our view, such an approach may help avoid the strictures and ambiguities of an external and essentially prescriptive point of view as is implied in the notion of role, with such categories as "advocate", "culture broker", and the highly equivocal "detached" and "involved translator". Precisely because of its awareness-raising potential, the current analysis could have a major part to play also in training, where empathy can be shown not to clash with professionality, and the tenets of neutrality and impartiality not to be one and the same thing as emotional detachment. Provocatively, it may even be suggested that would-be healthcare interpreters should test for empathy.

The model presented here is anything but definitive. Not only have many factors been left out which may substantially influence the adoption of an empathic vs. non-empathic behaviour (e.g. age, gender and professional experience of the participants in the interaction, or the primary parties' preferred communicative models), but further dimensions of the empathic relation could also be added; first among these the reception and perceptions of the target, i.e. the addressee of the empathiser's actions. Finally, more refined and accurate analyses could be carried out through multidisciplinary team work, particularly in terms of design of assessment tools and processing of larger quantities of psychometric data.

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Appendix: Situational questionnaire - Scenario 2

A young non-EU pregnant woman with a regular permit of temporary residence in Italy is at the family planning clinic for the first pre-natal checks. The obstetrician asks whether any of her family members have suffered from genetic defects. In light of the woman's positive reply, the obstetrician suggests she might want to do some specific tests, such as amniocentesis.

1. The woman is quite reluctant and scared to do such tests as she heard from a colleague of hers that they are painful.

   □   You facially express disapproval.
   □   You smile at her in a caring manner.
   □   You simply look at her.

Motivate your choice ....

2. As the interview goes on, the woman mentions a genetic defect affecting some of her husband's family members. While she speaks,

   □   you ask for more details.
   □   you listen and try to memorize the most important details.
   □   you listen attentively to her confirming understanding and showing interest.

Motivate your choice ....

3. The service provider explains the usefulness of genetic tests. The woman says she does not want to do them.

   □   You check again with her and then report her decision to the obstetrician.
   □   You tell her that you understand how difficult and delicate such decisions are and then report her decision to the obstetrician.
   □   You report her decision to the obstetrician without making any comments or enquiring further.

Motivate your choice ....