Dialogue interpreting in Psychological Medicine: an exploration of rapport management practices

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ABSTRACT

This thesis explores how the relational dimension of language use (Brown and Yule, 1983) is discursively co-constructed and perceived by the interlocutors that took part in a series of interpreter-mediated medical consultations. The interpreter-mediated encounters (IMEs) under scrutiny took place in an outpatient mental healthcare (MHC) clinic in Scotland called Psychological Medicine. This study is of an exploratory and qualitative nature, underpinned by a social constructivist epistemology. Also, it was empirically enabled through two datasets gathered using methods of data collection inspired by ethnographic approaches. Dataset 1 consists of transcriptions of three audio-recorded IMEs between an English-speaking consultant psychiatrist, a Spanish-speaking patient and three professional interpreters. Dataset 2 consists of retrospective interviews conducted with participants that took part in the consultations under scrutiny. The analysis was conducted in two stages. Discursive behaviours of interest were firstly traced in dataset 1 and then triangulated with the information gathered through dataset 2.

Relational dynamics are operationalised in this thesis following Spencer-Oatey's (2008) rapport management (RM) theory, grounded in the field of interactional pragmatics. By applying the principles of RM to the analysis of the two datasets, I shed light onto participants' RM practices and resulting relational outcomes in the analysed IMEs. To do that, I present analytical descriptions of a selection of excerpts where occurrences of rapport-sensitive speech acts (RSSAs) are reported, the reasons for their occurrence, and the ways in which they are managed by all participants. Ultimately, the findings provide insights into how interlocutors create and negotiate interpersonal meanings both triadically and dyadically; the role that contextual factors play in this process; and, finally, how all participants, including interpreters, are actively engaged in efforts to manage the interactional balance by discursively handling face sensitivities, behavioural expectations and interactional goals.

DEDICATION

To Christine, for lighting this spark.

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DECLARATION STATEMENT

Research Thesis Submission

Name*:*	Natalia Rodríguez Vicente		
School:	School of Social Sciences		
Version:	Final	Degree Sought:	Doctor of Philosophy

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In accordance with the appropriate regulations I hereby submit my thesis and I declare that:

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List of acronyms

APA – American Psychological Association

ASLIA – Australian Sign Language Interpreters Association

BAME – Black and minority ethnic (populations)

BSL – British sign language

CA – Conversation analysis

CDA – Critical discourse analysis

CI – Community interpreting

CIOL – Chartered Institute of Linguists

DA – Discourse analysis

DBS - Disclosure and Barring Service

DI – Dialogue interpreting

DPSI – Diploma in Public Service Interpreting

DSM-5 - Diagnostic and Statistical Manual of Mental Disorders

ENPSIT - European Network for Public Service Interpreting and Translation

FFA – Face flattering act

FTA – Face threatening act

GIMHS – Guidelines for Interpreting in Mental Health Settings

IME – Interpreter mediated encounter

IP – Interactional pragmatics

IRAS - Integrated Research Approval System

LACD – Linguistically and culturally diverse (patients)

MH – Mental health

MHA – Mental health act

MHC – Mental healthcare

MHI – Mental health interpreting

NHS – (UK) National Health Service

NRPSI – (UK) National Register of Public Service Interpreters

PSI – Public service interpreting

PTSD – Post-traumatic stress disorder

REC – Research ethics committee

RM – Rapport management

RSSA – Rapport sensitive speech act

RTA – Rapport threatening act

SA – Speech act

S. – Segment

SIP – Socio-interactional principle

Author's preface

"What unites the concepts of 'migration' and 'mental health' is stress:
Stress about the unknown and stress for what was left behind."

Dr. Joseba Achotegui-Loizate. March 2020[1]

My first community interpreting assignment did not last longer than 30 minutes, but it left such an impression on me that I still occasionally revisit it years later. Equipped with my masters-level interpreting skills and having interpreted simultaneously at a few conferences where my technical vocabulary was challenged, I confidently accepted an assignment concerned with support for homeless people. Once preliminary formalities were out of the way and the claimant was asked to provide an account on why he would qualify for supported accommodation, my confidence started to shake. The young venezuelan man described how he had migrated to the UK hoping for a better future, but his limited spoken English skills and lack of contacts in this country were obstacles to his ability to adapt. As his account unfolded he became increasingly upset, and I felt that my English rendition of his spoken Spanish could not fully represent the pain and distress that I could hear in his voice. I knew virtually nothing about mood disorders at the time, but I was aware that what this man was going through was something greater than ordinary pain.

After a few appointments, this man's caseworker issued a recommendation for him to get support at a mental healthcare clinic. I never saw this young man again, but when reflecting on the encounter I still consider what I, as an interpreter, could have done to fully render his distress, and how my performance might have affected his diagnosis should I have interpreted for him during a clinical mental health assessment. As a fellow human being, I wondered how many people might have been in a similar situation to that of this man, vulnerable, isolated and far from a home that did not fully feel like home. My reflections led me to pursue this thesis on the uniqueness of language mediation in mental health settings.

[1] Opening plenary lecture of the 7th International Conference on Public Service Interpreting and Translation: 'Mourning for the language and culture in immigrants with Ulysses syndrome' by Prof. Joseba Achotegui Loizate. Universidad de Alcalá de Henares. 26-27 March, 2020.

Chapter 1 – Introduction

Interpreting is a highly complex activity that requires the interpreter to immediately comprehend, analyse and convert a source message into the target language. The focus on the cognitive demands that this activity places on the interpreter has resulted in the view that the interpreting profession is a mainly technical one (Dean and Pollard, 2005). This notion is predicated on the supposition that source-to-target language skills and cultural knowledge are sufficient for successful interpreting competence in diverse interpreting situations and settings (*ibid.*). Whereas it is undeniable that competent interpreting requires the learning and application of technical aptitudes, it must also be considered that the interpreter's linguistic and intercultural skills are in many cases applied in a "dynamic, interactive and social context" (Dean and Pollard, 2011: 156). This is particularly salient in the case of interpreting in community-based settings, such as healthcare (Pöchhacker, 2004), the situational context that concerns this thesis. Applying technical skills in a social context means that interpreters' performance may be, at least in part, influenced by the interactional demands of the communicative encounter (Dean and Pollard, 2005).

The overall quality of an interpreter's performance in a community setting has been determined on the basis of a range of typically observed parameters, for example: the interpreter's terminological expertise and general command of the working languages involved; the degree of accuracy in the interpreter's renditions; and the interpreter's observance of principles established in codes of professional conduct, such as neutrality or impartiality. These are, indeed, essential pre-requisites for successful interpreting performance given that, ultimately, interpreters' main function is to facilitate communication between two parties that do not share a language. The evidence base of interpreting studies is considerably advanced in relation to interpreters' information-transfer and discursive-coordination tasks (Cambridge, 2012). This knowledge makes it possible to effectively anticipate challenges and optimise training tools to safeguard the quality of interpreters' job performance in relation to their information-transfer functions (*ibid.*). However, there are other aspects of triadic communication that are part of the reality of discourse and that interpreters must learn to handle effectively, such as the interpersonal dimension of talk (Major, 2013). There seems to be much to be learnt about interpersonal dynamics in interpreter-mediated talk, as will be further explained in section 2.3 of this thesis.

To determine whether an interpreter is good or bad at facilitating communication between primary speakers, we first need to determine what an interpreter should be 'good for', and what exactly the notions of 'communication' or 'language use' encompass. In this regard, this thesis is built on the core assumption that language use has two functions: transactional and interpersonal (Brown and Yule, 1983), two dimensions that holistically make up the act of communicating. The transactional component of language use refers to the goal of transferring information or performing certain tasks that fall outside the realm of the communicative activity itself. Complementarily, the interpersonal dimension of language use refers to the proactive handling of social relations through communicative means (*ibid*.). In this thesis I also assume that the transactional and interpersonal dimensions of language use are not distinct components but two intrinsically intertwined sides of communication (Spencer-Oatey, 2008). Drawing on the assumption that the interpersonal function of language is intrinsic to the very act of communicating, I conjecture that it is vital that interpreters are mindful of two factors to guarantee an all-encompassing successful performance: firstly, primary speakers' relational efforts and; secondly, their own involvement in direct interpersonal dynamics with primary speakers. Drawing on these ideas, in this thesis I seek to elucidate how the interpersonal, or relational, dimension of language use is negotiated in interpreter-mediated talk both triadically, that is, between primary speakers through an interpreter; and dyadically, which means directly between the different combinations (dyads) of participants involved in the triad.

The relational dimension of language use is operationalised in this thesis within the conceptual framework of Spencer-Oatey's (2008) rapport management (RM) theory. RM theory has been chosen as a theoretical tool to provide a scholarly basis to this inquiry because it embodies the latest developments in the field of interactional pragmatics (IP). More specifically, RM theory is a broadened framework that overcomes the limitations of Brown and Levinson's (1987) influential model of politeness. The central argument of RM theory is that a theory of speakers' relationally-oriented communicative practices should not only account for considerations of face. Instead, Spencer-Oatey (2008) proposes that it is also necessary to consider two other types of interpersonal needs and wants when analysing speakers' relational practices: 'behavioural expectations', grounded on perceptions of sociality rights and obligations; and 'interactional goals', which may be either transactional or interpersonal in focus.

The three bases together (face sensitivities, behavioural expectations and interactional goals) make up the notion of 'rapport', and so 'rapport management' refers to the discursive handling of the three bases in interaction. Depending on the success of RM efforts, interaction might unfold in different directions, conceptualised in RM theory as four different 'rapport outcomes': enhancing, maintaining, threatening or neglecting rapport. A rapport outcome results from the combination between a speaker's RM practices and the way in which such practices are perceived by the intended interlocutor. Thus in this thesis, the term 'rapport dynamics' jointly encompasses the notions of RM-related practices and perceptions. Depending on the cumulative effect of rapport dynamics in interaction, the interactional balance (also known as 'harmony' or 'positive rapport') in an interaction might be maintained or altered in different ways, as discussed in greater detail in section 4.2.3. Drawing on all these ideas, this thesis seeks to shed light onto interpreters' handling of primary speakers' pragmatic markers leading to the discursive handling of the three rapport bases, as well as interpreters' involvement in direct rapport dynamics with primary participants. Ultimately, this thesis aims to elucidate how rapport dynamics in interaction and the resulting interactional balance might be shaped by the process of language mediation.

Questioning the ways in which interpreters' job performance might contribute to maintaining or altering the interactional balance in an interpreter-mediated encounter (IME) necessarily entails the presupposition that interpreters might, in fact, influence the tenor or wider direction of talk. This leads me to discuss another core assumption underpinning this thesis: the idea that interpreters are fully-fledged agents in discourse who are actively involved in the co-construction of meaning in the communicative encounter (Wadensjö, 1998). This view of interpreters as active participants in meaning-making processes necessarily presupposes a 'dialogic' view of language and communication (Bakhtin, 1981); that is, the idea that all parties involved in a communicative exchange are co-authors of meaning as it unfolds along with a collective process of sense-making (*ibid.*). Adopting a dialogic view of interpreter-mediated communication positions this thesis within the tenets of the "dialogic discourse-based interaction paradigm" (Pöchhacker 2004: 79), a highly influential research strand within the field of dialogue interpreting studies. Following the core principles of this paradigm, the inquiry in this thesis recognises interpreters as standing at the centre of meaning co-construction: a process that encompasses the negotiation of both transactional and relationally-oriented meanings.

Drawing on these notions, this thesis is built on the hypothesis that, because interpreters may be active participants in the negotiation of relational meanings, they might through their agency reinforce, maintain, weaken or otherwise affect the quality of participants' RM practices and the resulting interactional balance in a communicative encounter; either consciously or non-consciously. Ultimately, because interpreters are seen as fully-fledged visible participants, another hypothesis that underpins this thesis is that interpreters are unavoidably drawn into dyadic rapport dynamics with primary participants. Drawing on all these ideas, uncovering the inner processes of interpreters' involvement in both triadic and triadic RM dynamics from a dialogical standpoint becomes one of the main objectives of this thesis.

In order to empirically enable this exploration, and in line with the analytical protocols promoted by the dialogic-discourse based paradigm, I adopt in this thesis a discourse-analytical approach to the study of actual instances of relational practices in naturally-ocurring interpreter-mediated talk. Namely, I adopt a multi-method approach underpinned by a case-study research design wherein the findings from the qualitative analysis of two datasets are assembled and triangulated, following Yin's (2018) guidelines for case study research design. The core dataset, dataset 1, consists of fieldnotes and transcriptions of three interpreter-mediated mental healthcare consultations that I observed and audio-recorded following a non-participant approach to the collection of data. These consultations feature an English-speaking psychiatry specialist, a Spanish-speaking patient and three interpreters, a different one per consultation. Dataset 1 is divided into 1,824 segments that represent speakers' turns. Dataset 2 is a supplementary dataset consisting of the transcriptions of retrospective interviews conducted with the psychiatrist and two of the interpreters featuring in dataset 1. By triangulating relevant material taken from the two datasets, I was able to investigate RM practices following a two-staged analytical protocol. Firstly, I identified RM practices as they discursively unfolded during the consultations, tracing instances of rapport-sensitive speech acts (RSSAs): the unit of discourse analysis. Secondly, I discussed a selection of RSSAs with the three participants mentioned above, following a preliminary discourse analysis of dataset 1. This qualitative study is underpinned by the epistemological stance of social constructivism, as explained in 5.1.3.

The unit of data collection was bound and defined by the clinical case of the Spanish-speaking patient featuring in dataset 1, referred to in this thesis by the pseudonym 'Irene'. The psychiatrist in charge of Irene's case, also a constant figure in the three consultations in dataset 1, is referred to by the pseudonym 'Dr. Sharpe'. The three consultations under scrutiny in this thesis feature a series of discussions held between Irene and Dr. Sharpe in an outpatient mental healthcare (MHC) clinic, called 'Psychological Medicine', located in a large general hospital in Scotland. In this medical ward, a range of healthcare specialists provide joint medical and psychological support for patients who suffer from interrelated physiological and psychological co-morbidities. Irene was referred to Psychological Medicine because she suffered from chronic kidney failure as well as depression and cognitive difficulties. The three audio-recorded consultations in dataset 1 show how Dr. Sharpe jointly addresses the biomedical and psychosocial needs of Irene as she faces the terminal stage of her illness. Dataset 1 shows how the intricacy of the complex and sensitive conversations that Irene's multifaceted clinical case involves poses unique challenges for interpreters. I consider these challenges worth describing and analysing not only from the linguistic and clinical angles, but also from the relational point of view, hence the focus of this thesis.

Irene's case, unfolding in a clinical MHC setting, was chosen as the situational background for this exploration on interpreter-mediated RM practices because the importance of relational dynamics is heightened in the field of MHC. In mental health work, the development of a positive relationship between MHC practitioner and patient is recognised as key for the formation of a 'working alliance': a term that refers to the positive interpersonal bond that encourages the patient and the therapist to work together with the common aim of achieving clinical goals and facilitating processes such as diagnosis and treatment (Casella, 2015). Thus, because a therapeutic alliance is essential to the fulfilment of clinical outcomes, and due to the importance of positive MHC practitioner-patient relational dynamics to foster such an alliance, I suggest that it is worth exploring how RM dynamics unfold in encounters where practitioner and patient do not share a language, particularly when considering that language use is a core component of relational work (Major, 2013).

Different MHC environments have bridged the language gap between MHC practitioners and linguistically and culturally diverse (LACD) patients differently. The

strategies that different organisations may adopt to effectively address the special needs of LACD populations when accessing MHC services where the vehicular language is the dominant language of the hosting society may depend on different factors, such as the nature of each organisation's remit and the potential and their potential to develop relevant resources. For example, the former UK-based organisation 'Mothertongue' (recently integrated into a mainstream healthcare service), was a culturally and linguistically sensitive professional counselling service for people from black and minority ethnic communities. To help these communities, Mothertongue employed multilingual counsellors as well as in-house interpreters trained to work in MHC. A similar example is 'Freedom from torture', an organisation that provides medical care, psychological support and rehabilitation therapies to survivors of torture residing in the UK. Freedom from Torture has a unique model of working with interpreters who are specially trained in the Human Rights-focused values of the organisation. The explicit remit of these organisations is to support members of minority ethnic populations (among which LACD patients might be found), which allows them to narrow down their focus and develop specific resources that cater for the particular needs of these groups. For example, both organisations employ multilingual therapists that can offer linguistic and cultural concordance with a given patient. In fact, it has been proposed that the gold standard for mental healthcare provision to LACD patients is matching such patients with a MHC practitioner that speakers their language (Mucic and Hilty, 2020). However, ensuring linguistic and cultural concordance between MHC practitioner and patient entails multiple logistical challenges. This is particularly the case in relation to public healthcare services that are offered to mainstream society as they might not be able to specialise in any specific population group. Additionally, another difficulty is that LACD patients may be speakers of a language of lesser diffusion, which makes it even more difficult to ensure language concordance between MHC practitioner and patient (Tribe and Raval, 2003). In light of these difficulties, the provision of interpreting services becomes a practical alternative to facilitate the access of LACD patients to specialised MHC settings. It is precisely the provision of interpreting services that has become the model predominantly adopted by mainstream public healthcare services in the UK. Irene's clinical case, the case study that articulates the inquiry in this thesis, provides an illustrative example of how this model of service provision works in practice.

While the provision of interpreting services might solve the immediate problem posed by the linguistic gap hindering access, this action by itself does not necessarily mean that equality of care has been ensured for the LACD patient involved. In line with the tennets of Hsieh's (2016) Bilingual Health Communication model, 'equality of care' is understood in this thesis as a situation whereby the linguistic and wider sociocultural differences of LACD populations have been actively considered, placing a positive value on those differences in an attempt to make sure that the standard of care offered to LACD patients is as equal as possible to that received by majority populations. Drawing on these ideas, this thesis is built on the assumption that ensuring equality of care for LACD patients entails safeguarding the mechanisms by which these populations benefit from positive relational dynamics with MHC providers, as well as from the ulterior therapeutic alliance that such dynamics might lead to. In other words, LACD patients should benefit from the same positive relational dynamics with their MHC providers that a monolingual patient would, despite linguistic and cultural differences.

Exploring the notion of equality of care for LACD populations by paying special attention to the quality of relational dynamics between LACD patients and MHC practitioners is not just a matter of academic interest but of societal value too. This is because it has been documented that the psychosocial wellbeing of migrant populations (the population group within which LACD patients may be categorised) is at increased risk when compared with the prevalence of mental illness among members of majority populations (Alegría et al., 2018). This increased risk of developing a mental health condition along with the wider difficulties that LACD users might face when trying to access MHC services in the hosting society puts them in a situation of double vulnerability (Mental Health Foundation, 2019). This situation stresses the need for studies that attempt to increase the visibility of the specific needs of this population group and enrich debates on how to best address them.

Before proceeding any further, it must be clarified that this thesis is aligned with the definition that the World Health Organisation (2018: 1) provides for mental health, that is: "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community". Absence of such wellbeing might lead to develop a mental illness, a condition that may interfere with an individual's daily functioning and may manifest through "forms of behaviour, physical symptoms or use

of language" (Hlavac, 2017: 7). Mental health difficulties may arise due to factors that are either intrinsic to the person, such as genetic predispositions; or extrinsic, such as environmental demands that exceed the person's inner resources to cope with adverse circumstances (Corey, 2013). Consequently, anyone is susceptible to developing a mental health difficulty at some point in their life regardless of background. However, as hinted at above, there is a set of migration-related stressors that contribute to the increased risk of some migrants developing mental health difficulties.

Migrating to a different country offers benefits such as access to new opportunities and exposure to other ways of life, but it can also be a source of difficulty. When sources of tension, or 'stressors', exceed an individual's inner resources to cope, a number of adverse psychological symptoms might arise as an adaptative response (Malm et al., 2020). Researchers in the fields of transcultural psychology and psychiatry have identified a number of stressors largely associated with the migration process, which fall under the overarching notion of 'migratory stress' (*ibid*.). For example, a source of distress for a migrant may be the loss of connection with aspects of the country of origin, such as the sense of belonging to a community, or familiarity with customs, values or landscape. Whilst this sense of loss may be a common experience among migrants and is a natural response to an adaptative process, excessive mourning when coping with the grief of the loss might result in psychopathology (Achotegui-Loizate, 2019). Stressors can also result from the migrant's attempts to navigate life in the hosting country. It must be mentioned here that this is not a uniform experience, and the impact on the migrant depends on variables such as socioeconomic status; the financial, social and human capital of the migrant; the individual's capacity to adapt to the 'acculturative stress'; the reasons for the migration; the sources of support found in the hosting society; and the migrant's knowledge of the majority language of the hosting country (*ibid*.). Adverse circumstances potentially found in the hosting society may include limited prospects for career advancement, poor access to housing or a lack of social support networks. Finally, complications when adapting to life in a hosting country may also be exacerbated if the migrant experiences issues of prejudice and discrimination motivated on the basis of race (so called 'hate crimes'). Such factors may remove the sense of security, cause a fear of discrimination and ghettoization, increase the risk of poverty, create vulnerability to homelessness and possible extradition, all of which might generate further levels of psychological distress. Achotegui-Loizate (2019), a specialist in transcultural psychiatry, amalgamated all these aspects into one

overarching ailment that he coined 'Ulysses syndrome'. The terminology of this umbrella term, which encompasses a range of symptoms, is inspired by the perilous journey of the main character of Homer's *Odyssey*.

All in all, it may be concluded that a range of social, cultural, political, economic or further environmental factors may shape a person's physical and mental health and, if the migration provides a challenge in terms of these factors, then a person might be at increased risk of compromised psychosocial wellbeing. This does not mean that every person who endures migration-related hardship will go on to develop such symptoms. And for those who do, the effect of the symptoms will not necessarily be incapacitating. In fact, migrants' resilience and capacity to adapt to adverse circumstances and to endure adaptative stress has been widely acknowledged (Achotegui-Loizate, 2019). However, when the intensity of the adaptative response compromises the individual's ability to function in everyday life, a migrant might need professional MHC support. If such migrant does not speak the language well enough to cope with the linguistic demands of a MHC session, then interpreters may make it possible for these patients to get the specialist help and support they need. Irene's case, at the centre of the case study presented in this thesis, is a true-to-life example of many of the abovementioned issues: Irene is an elderly woman that permanently migrated to Scotland from a Latin-American country because her daughter, her primary caregiver, had settled there. As Irene tries to adapt to her life in Scotland, she faces difficulties coping with her chronic illness as well as dealing with the isolation that is in part brought about by her inability to speak English. Facing both medical and psychological issues, she is referred to the department of Psychological Medicine by her primary physician, a place where she has three interpreter-mediated consultations with Dr. Sharpe, a psychiatry specialist. The sensitive nature of the discussions held between Irene and Dr. Sharpe make it worth hypothesising that relational dynamics are important in facilitating these conversations. As explained above, I was able to observe, audio-record and transcribe these three consultations, and I was also able to interview Dr. Sharpe and two of the three interpreters involved in these sessions. These two sets of data were brought together following a case-study research design (Yin, 2018), analysed through a converging line of inquiry inspired by RM theory (Spencer-Oatey, 2008) and articulated around the following research questions:

1. How do rapport management practices unfold, either triadically or dyadically, among participants involved in interpreter-mediated encounters in mental healthcare?

2. To what extent do contextual factors influence participants' rapport management practices?

3. Considering that medical encounters are a goal-oriented speech event and that the handling of interactional goals is a key component of rapport management theory, how are rapport-sensitive interactional goals discursively negotiated in interpreter mediated encounters in mental healthcare?

The exploration of these three research questions is underpinned in this thesis by five core assumptions, hinted at throughout this introduction. Firstly, that there is a relational component inherent to all language use (Brown and Yule, 1983); that interpreters inevitably get involved in the co-construction of that component due to the dialogic nature of communication (Wadensjö, 1998); that RM theory (Spencer-Oatey, 2008) is a useful way of operationalising relational dynamics; that a case study featuring a LACD patient in need of MHC services is a pertinent situational background for this exploration and, finally and most importantly; that ensuring that a LACD patient benefits from positive relational dynamics with a MHC practitioner despite language and cultural differences is key to ensuring equality of care.

In order to articulate this inquiry, this thesis will be divided into a series of chapters. Following this introduction (chapter 1), three literature review chapters will follow, which will address the gap in the literature on three fronts. In chapter 2, I will discuss theoretical notions of the field of dialogue interpreting that are key to frame this thesis. Namely, the dialogic discourse-based paradigm, the growing thematic scope and methodological complexity observable in current DI research trends, and the increasing use of triangulation in DI research. I also review some ideas around interpreters' involvement in interaction by approaching this concept through the following lenses: ethical views on interpreters' performance; and interpreters' role and positioning. Drawing on the notion of interpreters' involvement in interaction, I proceed to review studies on interpersonal dynamics in interpreted talk. In chapter 3, I draw attention to the situational context that frames the interpreter-mediated encounters under scrutiny in this thesis: mental healthcare. More specifically, I review the unique features of interpreter-mediated mental health encounters as a speech event, and how such features have been addressed in dialogue interpreting research. The overall aim of chapter 3 is to

contextualise the case study data gathered for the purposes of this thesis and to draw attention to the research potential of mental health interpreting as a field of study. Chapter 4 focuses on the Interactional Pragmatics (IP) angle of this thesis. More specifically, it explains some fundamental components of the conceptual framework that provides the scholarly basis for this study. Key aspects discussed in this chapter include the notion of meaning-making from an IP perspective, the idea of language use as social action and main theories on talk as relational action, including RM theory (Spencer-Oatey, 2008).

In Chapter 5, I discuss the methodological steps that I followed to conduct this empirical study. I firstly explain the methodological foundations and research design adopted for the research and after that, I discuss the practical realisation of such design by describing the processes of data collection and analysis.

Chapters 6 and 7 provide analytical descriptions of a series of selected excerpts extracted from dataset 1, some of them triangulated with quotes from dataset 2. The excerpts selected for discussion were chosen because they feature rapport-sensitive speech acts that elucidate aspects around how the interpersonal dimension of talk is negotiated in interpreter-mediated talk. Chapters 6 and 7 are approached from different angles; namely, chapter 6 focuses on the interplay of contextual factors and participants' rapport management dynamics; and chapter 7 is about the co-fulfilment of interactional goals by participants involved in the case study of this thesis.

Finally, in Chapter 8 I provide a summary of this thesis and its findings, I discuss the methodological advances of this work to the field of dialogue interpreting; its theoretical contribution and its practical applications. Finally, I offer recommendations for further research based on the learnings from this thesis.

In this introductory chapter, I have set out the academic and sociological background of this study and, drawing on that information, I have laid out the research questions being pursued through this work, as well as the structure of this thesis. Having established these foundations, the next chapter proceeds to review relevant literature to help frame this inquiry within the wider academic debate on dialogue interpreting.

Chapter 2 – Dialogue interpreting research and triadic interpersonal dynamics

In this chapter, I firstly introduce the notion of dialogue interpreting (DI) and outline some aspects of DI research that are necessary to frame this thesis. Namely, the dialogic discourse-based paradigm, the growing thematic scope and methodological complexity observable in current DI research trends, and the increasing use of triangulation in DI research. Secondly, I review some ideas around interpreters' involvement in interaction by approaching this concept through the following lenses: ethical views on interpreters' performance, and interpreters' role and positioning. Drawing on the notion of interpreters' involvement in interaction, I proceed to review studies on interpersonal dynamics in interpreted talk.

2.1 Dialogue interpreting research

In this section I define the notion of DI and outline some key terms associated with it. Later on, I discuss the paradigm of DI research within which this thesis is located and explain how the diversification of DI research trends reflects the increasing thematic and methodological refinement in the field of DI studies field. Finally, I focus on how the use of triangulation by DI scholars has contributed to the advancement of DI research, as this methodological approach is adopted in this thesis.

2.1.1 Dialogue interpreting

Dialogue interpreting comprises a broad range of language transfer activities that may unfold in a variety of dialogic events, including "medical consultations, welfare and police interviews, immigration hearings, courtroom trials, parent-teacher meetings, business and diplomatic encounters" (Merlini, 2015: 102). As diverse as these encounters might seem, they all share a unifying factor: their discourse format, or the fact that communication unfolds through a series of interventions exchanged by participants. In this communicative modality, talk results from a collective process of meaning negotiation that evolves "in and through interaction" (Monteoliva-García, 2017: 13). Nonetheless, not only are meanings jointly negotiated by interactants in the dialogic format, but also their "mutual alignments, roles and identities" (Merlini, 2015:

103). The ‘dialogic’ format is what sets DI encounters apart from events featuring conference interpreting, where participants’ interventions are mostly of a ‘monologic’ nature (Hale, 2007). That is, they are lecture-like, as the process of meaning transfer involved is mainly channelled in one direction and therefore, not easily subject to meaning negotiation.

Different categorisations of DI activities have been proposed, taking as primary reference the societal context of the communicative event in which the interpreting activity takes place. Settings-based categorisations of DI events reflect the constraints imposed by the different social, political and economic contexts of interpreter-mediated encounters; in terms of language register, simultaneity, power imbalance and organisational expectations (Downie, 2020). Terms that reflect this type of categorisation include healthcare/medical interpreting, legal/courtroom/judicial interpreting, police interpreting, and church/religious interpreting. Because the encounters cited above typically happen in intra-societal contexts, also known as community settings, DI is occasionally referred to as ‘interpreting in the community’, or ‘community interpreting’ (CI) (Pöchhacker, 2004). Among the terms CI and DI, the preferred term in this thesis will be ‘dialogue interpreting’ due to the strong focus of this study on the dialogic format of the events under scrutiny. However, the term CI will be occasionally used, particularly in sections where the focus is placed on the setting, rather than on the communicative format of the interaction.

Categories of DI events are not only determined by the setting in which the interpreting takes place. If attention is paid to the medium that enables the language-transfer activity, DI events might be categorised as telephone interpreting, face-to-face interpreting or video-remote interpreting. Similarly, if attention is paid to the modality of the languages involved in an interpreter-mediated encounter (IME), DI might be labelled as spoken language interpreting, whose main feature is its fully oral-auditory language modality; or sign language interpreting, whose modality is both spoken and also visual, one in each direction within the interaction. DI events can also be established by the professional status and level of skill and expertise of the interpreters involved in an IME, thus resulting in the terms professional interpreting and non-professional interpreting, also referred to as lay interpreting, ad-hoc interpreting, language brokering or natural interpreting (Antonini, 2015). In the context of this thesis, professional interpreters are regarded as skilled language professionals who have been

trained to a professional standard, have been accredited by a professional organisation and enable communication for the benefit of 'clients' or 'users', thus obtaining remuneration for their activity (*ibid*.). By contrast, non-professional interpreting alludes to a range of linguistic mediation activities performed by untrained bilinguals who are not remunerated for their work as interpreters (*ibid*.).

This section has provided a classification of some interpreting types which have been arranged by setting, medium, language modality and professional status. Drawing on the resulting categories and considering the features of the case study in this thesis, this work can be classified as follow: a study on mental health interpreting that offers an analysis of medical consultations featuring professional interpreters who work face-to-face as they mediate linguistically between speakers of two spoken languages. Having laid out the main features of the professional domain examined in this thesis, the remaining sections in this chapter frame this work from a more theoretical perspective. Namely, from the point of view of DI studies.

2.1.2 The dialogic discourse-based interaction paradigm

The research aims and analysis protocols adopted in this thesis are positioned within the tenets of the "dialogic discourse-based interaction paradigm" of interpreting studies (Pöchhacker 2004: 79). In this section, I review how this paradigm provided the groundwork for subsequent studies on DI in the community and also inspires current research, including this thesis.

The foundations of the dialogic discourse-based interaction paradigm started with the work of early DI scholars such as Roy (1989). This scholar, inspired by the work of sociolinguist Deborah Tannen, explored the turn-taking actions employed by a student using sign language student and an English-speaking university lecturer. Later on, Wadensjö (1998), inspired by communication frameworks proposed by Goffman (1967, 1981), explored a range of Russian-Swedish immigration and medical interviews. Both Roy (1989) and Wadensjö (1998) used conversation analysis and discourse analysis (explained below) respectively in their studies. In doing so, they became pioneers in providing a socially grounded account of interpreter-mediated talk. Regarding the analysis of interpreter-mediated talk, Wadensjö (1998) made a significant contribution to dialogue interpreting studies by providing her taxonomy of different types of

interpreters' renditions. This taxonomy is explained in section 5.3.2, as part of a discussion on the protocol for triadic discourse analysis followed in this study.

The work of Roy and Wadensjö provided a conceptual approach to dialogue interpreting that Pöchhacker would, later on, label as the "dialogic discourse-based interaction paradigm" (2004: 79). This paradigm was consolidated thanks to the work of scholars such as Metzger (1999), Tebble (1999), Bolden (2000), Mason (1999), Angelelli (2004a), Bot (2005), among others. More recent DI research studies that can be located within this paradigm and have also contributed to further refine it include the work of Baraldi and Gavioli (2015), Cambridge (2012), Merlini (2013), Martínez-Gómez (2016), Monteoliva-García (2017) or Angelelli (2020), among others. The unifying factor among these studies is that they integrate the two main principles of the dialogic discourse-based interaction paradigm of interpreting studies. On the one hand, the dialogic view of language and communication (Bakhtin, 1981). On the other hand, the application of discourse analytical techniques to the study of interpreter-mediated talk. These two principles are also fully adopted in this thesis and, therefore, are unpacked below.

Firstly, the dialogic view of language and communication, also known as 'dialogism', is the language philosophy described by Bakhtin (1981) that posits that meaning is not intrinsic to the lexical items that a speaker chooses to communicate but the result of a context-bound discursive negotiation between speakers, who assign sense to utterances as interaction unfolds. Drawing on Bakhtin's (1981) theory of dialogism, Wadensjö (1998) insisted on the 'triadic' nature of meaning negotiation in interpreted talk and on the active role that interpreters perform in the exchange of meanings and progression of talk. In the dialogic discourse-based interaction paradigm, the conceptual tenets of dialogism are supported methodologically by the use of discourse analytical approaches to the study of interpreted talk. Broadly conceived, discourse analytical approaches are those linguistic inquiries into how speakers use language to communicate for a given purpose, within the bounds of a particular context (Brown and Yule, 1983). There are different types of discourse-analytical approaches to the study of language use, for example discourse analysis (DA), conversation analysis (CA) and critical discourse analysis (CDA). Among these terms, DA is the most relevant in the context of this thesis, as it is the analysis tool adopted to examine the data gathered for the purposes of this study. DA is also referred to as 'ethnography of communication'. The aim of this approach is to examine the product of language use (text, talk) as evidence of the

process (discourse) and of interactants' decision-making processes when choosing communicative strategies (Mason, 2015). It aims to do so by examining the micro-level of talk while actively considering how the socioinstitutional dimension framing the encounter might influence participants' communicative practices (*ibid*.). This view presupposes a multi-layered architecture of processes to be scrutinised. Namely, participants' discursive outputs and higher-order processes affecting interaction. Merlini (2015: 103) discusses this multi-layered analytical aim of DA in relation to the study of interpreted talk, by positing the following:

> "whatever is attained in communication is a collective activity requiring the efforts of all participants; interlocutors' turn-by-turn contributions to the exchange need close scrutiny at a micro-analytical level through recording and transcription; and the interpersonal and socio-institutional dimensions also require investigation at a macro-analytical level."

Thus, Merlini's quote helps elucidate the twofold aim of DA when studying DI talk: firstly, the study of the local instances of interpreter-mediated talk exchanges; and, secondly, the macro-social forces that shape or determine speakers' decision-making by all participants, including interpreters, when uttering their interventions. Ultimately, this two-fold aim presupposes a conception of interpreted talk "a social practice embedded in a complex macro structural network that places further functional and pragmatic constraints on the possibility of rendering a source text into a target text in a reasonably similar form and function" (Rudvin, 2006: 31). Therefore, uncovering the interplay between such constraints and interpreting performance is one of the aims pursued when applying DA to interpreted talk. As will be further explained in chapter 5, this thesis adopts this aim and, therefore, will draw on a DA-based protocol, guided by Rapport-Management theory (Spencer-Oatey, 2008), to uncover discursive processes of participants involved in the interactions under scrutiny.

The work of scholars whose work may be framed within the dialogic discourse-based interaction paradigm (see list of authors at the beginning of this section) has substantially shaped the advancement of DI studies as a field of research in its own right. Their work has contributed to a shift in focus from the view of interpreting as a product of linguistic equivalence, to considering interpreting as a process of meaning co-construction. Accordingly, the focus of much DI research is now on different sociological, or wider contextual factors that may contribute to such process (Mason,

2015). The aim of the following section is to illustrate how DI research is becoming increasingly refined as it expands its thematic scope and methodological boundaries.

2.1.3 Expanding boundaries

The consolidation of the dialogic discourse-based interaction paradigm defined one of the directions in which DI research has evolved, as explained above. However, the field of DI research has also advanced in other directions. This development has been enabled thanks to dissemination channels dedicated to promoting knowledge exchange between scholars interested in DI events taking place in community settings. Among these channels can be found conferences series such as Critical Link[2], InDialog[3], organised by members of the European Network for Public Service Interpreting (ENPSIT); and the International Conferences on Public Service Interpreting and Translation[4], hosted at the University of Alcalá de Henares. There are also a number of peer reviewed journals that showcase up-to-date research studies and advancements in the field, such as *Interpreting: The International Journal of Research and Practice in Interpreting, Linguistica Antverpiensia* and *Translation and Interpreting Studies.* These channels have helped to turn the relatively recent field of DI studies into a fully-fledged and flourishing discipline that keeps developing in terms of thematic scope and methodological complexity. The aim of this section is to outline three directions in which DI research is expanding its boundaries, and to show how this thesis aims to make a contribution to the field by following them.

Firstly, it is worth mentioning that the field has become increasingly refined thanks to the work of scholars who have applied theoretical frameworks from other disciplines to the study of interpreter-mediated talk. Some disciplines that interpreting scholars have resorted to in an attempt to produce more fine-grained explorations into interpreted talk include sociology (Inghilleri, 2014), linguistics (Turner, 1995; Mapson, 2015), psychology (Costa, Lázaro-Gutiérrez and Rausch, 2020) or healthcare/clinical communication (Krystallidou et al., 2020; Rodríguez-Vicente, Napier and De Pedro, forthcoming). In importing theoretical frameworks from more established disciplines, these scholars have contributed to turn the young field of DI studies into a vibrant, versatile and prolific inter-discipline (Aguilar-Solano, 2020).

[2] https://criticallink.org/
[3] https://www.indialog-conference.com/

Its widening of thematic scope is another direction in which the discipline is expanding. The field of DI studies is becoming more diverse as an increasing number of studies seek to explore interpreting dynamics in previously unexplored community settings; for example, prisons (Baixauli-Olmos, 2013; Martínez-Gómez, 2016), questioning of minors (Salaets and Balogh, 2019) and conflict zones (Ruiz and Persaud, 2016). More relevant to this thesis, healthcare interpreting research studies can now be arranged by medical specialty; for example, oncology (Krystallidou et al., 2020), the emergency department (Cox and Lázaro-Gutiérrez, 2014) or speech pathology (Merlini and Favaron, 2005; Roger and Code, 2020). Even more specifically, within the specific field of mental health interpreting can now be found studies on interpreting in psychotherapy (Cambridge, 2012; Boyles and Talbot, 2017; Sander et al., 2018), psychiatric consultations (Smith et al., 2013; Sander et al., 2019) or neuropsychological testing (Casas et al., 2011). By focusing on community settings that had not been explored before, the outlined studies can shed light into the unique challenges that interpreters need to face in different settings, as well as on solutions required to overcome them.

Finally, the expansion of DI research is not only cross-disciplinary or thematic but also methodological. Evidence of the increasing use of innovative research methods in the study of interpreter-mediated talk can be found in the special issue on research methods in interpreting studies, edited by De Pedro-Ricoy and Napier (2017), the book on research methods on interpreting (Hale and Napier, 2013) or the latest issue of the FITISPos International Journal on research methods in public service interpreting and translation (Monzó-Nebot and Wallace, 2020). These sources provide examples of how studies on interpreted talk currently adopt increasingly sophisticated methods for data collection and stronger analytical protocols. Among these protocols can be found the use of triangulation, which is a core component in this thesis.

To sum up, this section has outlined three directions in which the field of DI research is advancing; namely, in terms of cross-disciplinary approaches, thematic scope and methodological innovation. As mentioned above, this thesis aims to make a contribution to the field by following these three directions. Firstly, this thesis fully integrates rapport-management theory (Spencer-Oatey, 2008), a theoretical framework rooted in the field of pragmatics, to provide scholarly basis to this study. Secondly, the case study analysed in this thesis is set in a highly specialised medical setting previously

[4] http://www3.uah.es/traduccion/en/psit-conference-2020/

unexplored in the field of DI studies, called Psychological Medicine. Thirdly, this thesis adopts the use of triangulation as an analytical tool. For this reason, the following section provides an account on the use of triangulation by DI scholars.

2.1.4 Triangulation

Research involving multiple methods is an integrative form of inquiry in which the researcher collects and analyses data by adopting several techniques in a single study, with the aim of either corroborating or enriching the resulting findings (Tashakkori and Creswell 2007). Although relatively new in interpreting studies, the number of DI research publications reporting the use of multiple methods is on the rise (Aguilar-Solano, 2020). Among these studies, two approaches may be differentiated. Firstly, mixed-method research, which integrates quantitative and qualitative techniques for data collection and/or analysis within the same study (Creswell and Creswell, 2017). Secondly, triangulation, or the combined use of qualitative methods (*ibid*). This section provides an overview of DI research studies that have drawn on triangulation as a tool to study interpreter-mediated talk, as this is also the approach followed in this thesis. Before proceeding to scrutinise such studies, two dimensions of triangulation must be considered: the type of triangulation adopted and its intended purpose.

Regarding triangulation types, four major categories have been distinguished in the literature (Denzin, 1978). Firstly, ‘data triangulation’, involving multiple data sources, even if collected through a single method. Secondly, ‘methods triangulation’, in which various data collection techniques are used. Thirdly, ‘investigator triangulation’, in which more than one researcher analyses the same data. Finally, ‘theory triangulation’, in which divergent theories are used to examine a phenomenon. See Vargas-Urpi (2017) for a revision of these types in relation to DI. Additionally, triangulation approaches may be differentiated by purpose, as this technique may be used to either to validity-check findings or to add depth to the discussion of findings. The former purpose is aligned with the positivist view that there a single reality and, therefore, corroborating findings through multiple approaches will help in confirming that the most accurate explanation has been provided (Fielding and Fielding, 1986). By contrast, the latter purpose pursues ‘completeness’ as an alternative to ‘confirmation’ in triangulation. This way, it is more aligned with the social-constructivist view that it is useful to capture different dimensions of an area of interest, especially when the phenomenon at hand is a

social reality (Breitmayer, Ayres and Knafl, 1993). By drawing on these concepts, it may be established that this thesis draws on triangulation of methods and data, with the purpose of achieving completeness in the analytical discussions provided, as this thesis is naturally aligned with a social-constructivist epistemology (see 5.1.3). This study is not a pioneer in following this approach, as per below.

There are different healthcare interpreting studies that have adopted triangulation techniques to yield a fuller picture of the object of study at hand, with the most predominant theme under investigation being the interpreter's role. For example, Angelelli (2004a) combined audio-recorded interaction, observations and interviews to examine the tension between prescribed ethics around the interpreter role and actual performance in healthcare interpreting. Leanza (2005) triangulated two data sources (participants and the interpreted interaction) and two methods (interviews and observations) to capture different views on the roles of community interpreters in paediatrics as seen by interpreters, physicians and researchers. In a similar vein, Aguilar-Solano (2012) conducted a study in which she triangulated participant observation, focus groups and audio-recorded interaction when examining the role and positioning of volunteer interpreters in a series of hospitals in the Andalusian region in Spain. In a similar vein, Kaczmarek (2016) used triangulation of interviews with service providers, service users and interpreters to gain a comprehensive understanding of the interpreter's role. These four studies establish different categories of interpreters' roles and provide full discussions on the functions that these encompass, thus proving triangulation to be a beneficial tool for the advancement of DI studies, as synthesised by Aguilar-Solano (2020: 47):

> "Engaging in multiple methods of [qualitative] data collection in interpreting research can lead to a thorough understanding of how interpreting scenarios are socially constructed, what dynamics are at play between different agents of the triadic event, and how these shape the role of the interpreter."

The notion of the interpreter's role is the main topic of interest among scholars using triangulation to explore the multi-dimensional nature of healthcare interpreters' functions. This may well be seen as a limitation in terms of thematic scope. As discussed in 2.2.2 below, discussions on the interpreter's 'positioning' are gaining ground in the academic debate over discussions over the interpreter's 'role'; understanding the notion of positioning as interpreters' dynamic adaptation of their role functions to fulfil communicative needs (Biagini et al., 2017). Having identified this gap

in the literature, this thesis attempts to use triangulation to shed light onto participants' relational positioning in a series of interpreted events, in an attempt to take a step beyond discussions on the interpreter's role.

2.2 Interpreters' active involvement in triadic talk

One of the foundational notions of DI research reviewed in section 2.2 was that of interpreters being fully-fledged participants who exert an influence over the co-construction of meaning in triadic talk, a view sustained by the tenets of dialogism (Bakhtin, 1981). In other words, interpreters are actively involved in the talk exchange (Mason, 1999). In this section, a special focus is placed on the idea of interpreters' 'active involvement' in triadic talk, understood as the degree to which interpreters actively engage with primary participants' discursive practices (Wadensjö, 1998). Firstly, I provide an account of ethics-oriented debates on interpreters' involvement. Secondly, I review the work of DI scholars who have proposed different taxonomies of interpreters' roles and descriptions of their positioning, in an attempt to elucidate how different degrees of interpreters' involvement may be expressed in practice.

2.2.1 Ethical views on interpreters' involvement

In the field of DI research, the academic debate over the appropriateness of different degrees of interpreters' active participation in triadic talk has developed in parallel with ethically oriented discussions concerning interpreters' behaviour (Setton and Prunč, 2015). Professional ethics are expressed in deontological codes, which aim at outlining the principles that underpin what counts as desired behaviour among the members of a professional group (Dean and Pollard, 2011). By determining what constitutes good practice, codes of professional ethics aim to provide a frame of reference that supports professionals in their decision-making processes. This is particularly relevant in the face of professional dilemmas occasionally encountered in community interpreting settings (Hale, 2007). Ethical views on interpreters' behaviours are also important for DI research, as different positionings around ethics will result in either *prescriptive* judgements or purely descriptive analyses of observed interpreters' behaviours (Hsieh, 2016). As will be explained below, this thesis adopts a descriptive approach to the analysis of interpreters' behaviour.

In early DI research, the notion of ethics was limited to "a few general principles deemed capable of straightforward application" (Setton and Prunč, 2015: 145): namely

truthfulness, impartiality, neutrality and professionalism. Furthermore these are the principles that have been expressed in the majority of interpreting codes of practice to date (see for example NRPSI, 2016). These four principles are underpinned by the same standpoint on interpreters' function: enabling communication while attempting to minimise the potential impact that the interpreting process might have on the interaction. In other words, say what the primary speakers say as they say it (accuracy), without taking any sides (impartiality), without getting personally involved with the subject matter being discussed (neutrality) and avoiding conduct that might pose a risk to your own professional status, for example, breaching confidentiality (professionalism) (Setton and Prunč, 2015). The universal applicability of these principles to the regulation of interpreters' professional performance has been problematised by a number of scholars. For example, as early as 1995/1999, Metzger provided evidence to suggest that the idea of interpreters' neutrality is a myth. This argument was further elaborated in the field of healthcare by Angelelli (2004b) who discusses the notion of the 'blind transfer' or the automatic application of principles originally rooted in the field of conference interpreting to the regulation of interpreter behaviour in community situations. More specifically, Angelelli proposes that the usefulness of rigid ethical values may be limited when applied to dialogic events that require a greater degree of behavioural flexibility, such as medical interpreting events. She defended this argument by triangulating interview data and observational data. More particularly, she juxtaposed users' reporting of conceptualisations and expectations of the interpreter's role with actual interpreters' role performance; and concluded that a degree of dissonance exists between prescription (ideas about what interpreters should do) and description (what actually happens in the field). Building on this tension and attempting to transcend the limitations of prescriptive views, Angelelli proposes a view of interpreters as fully-fledged participants endowed with a substantial capacity for 'agency' in interaction, a capacity to freely make choices that might influence the development of talk. Subsequent scholars have also aligned with this position and have pointed out that views on interpreters' behaviour guided by prescriptive ethical views tend to constrain interpreters' complex functions to that of information processors resembling translation machines (Bot, 2005). It would seem then that avoiding prescriptive approaches to interpreters' behaviour and engaging in non-judgemental observation of their performance would be a good methodological alternative that might more fully account for the intricacies of interpreter-mediated talk (Mason, 2014). This position is based on the recognition that professionalism should be

associated with the adoption of critical thinking models for appraising codes of ethics, carefully considering the contextual factors surrounding the communicative encounter. A range of DI scholars have articulated their studies around this view and have offered nuanced discussions on the complexity of the interpreters' functions (Dean and Pollard, 2011). Among these discussions, "the most complex and widely debated aspects of ethics in interpreting concern the interrelated issues of the nature, boundaries and flexibility of the interpreter's role", as pointed out by Setton and Prunç (2015: 47). A discussion on research studies around interpreters' role (and positioning, a derivative of the notion of role) is provided in 2.2.2 below.

Drawing on the concepts discussed in this section, it may be established that this thesis adopts a view on interpreters' behaviours based on a descriptive-ethics positioning. That is, this thesis aims to report on interpreters' behaviours as situated responses to contextual needs which might or might not correspond with prescriptive expectations associated with static views of interpreters' accuracy, impartiality neutrality and professionalism outlined above. Rather than focusing on how aligned interpreters' behaviours are with prescriptive expectations, the focus of this thesis is to provide analytical descriptions on the impact of those behaviours on wider participants' dynamics and the progression of talk.

2.2.2 Interpreters' role(s) and positioning

Different degrees of interpreters' involvement in triadic interaction have been documented in the literature and classified through role taxonomies. Interpreters' roles oscillate on a continuum that ranges between non-involvement and different degrees of interpreters' enactment of their agency (Bot, 2005). Narrower role constructs view interpreters as mechanistic translation machines, that perform in a neutral and invisible manner. However, after the myth of the interpreter's invisibility was deconstructed (Metzger, 1995/1999), different role conceptualisations have proposed broader role constructs that see interpreters as fully-fledged participants in interaction. For example, interpreters have been portrayed as intercultural mediators (De-Souza, 2016), facilitators of service provider-user relationships (Angelelli, 2004b), or institutional gatekeepers (Davidson, 2000). Leanza (2005: 186) proposed that healthcare interpreters may play the roles of system agent, community agent, integration agent or linguistic agent; according to their relation to cultural difference. Aguilar-Solano (2012) identified

the roles of patient advocate, co-provider or patient navigator. In a similar vein, Cambridge (2012) reviews a range of interpreters' role categories more frequently mentioned in the literature and proposes that interpreters' roles might fit into the impartial model, linguistic model, community model, advocacy model, or link-worker model. Grouping different functions that interpreters may perform into role categories has been helpful to elicit knowledge about the complex nature of the interpreter's task and as such, have helped the DI field move forward. However, DI inquiries into this topic seem to have reached a saturation point due to the limitations associated with the static notion of interpreters playing a discrete set of roles (Mason, 2009). In an attempt to overcome this limited view, one strand of DI research questions whether the role demarcations and taxonomies proposed truly "reflect the constantly evolving nature of interaction among participants in interpreter-mediated encounters" (Mason, 2009: 52). As a result, the concern with the identification and further classification of discrete categories for interpreters' global activity roles seems to have been gradually replaced by a new interest in exploring how interpreters 'shift along' a continuum of interactional involvement, made up of different functions. This shifting phenomenon is referred to as interpreters' positioning (Mason, 2009, 2014; Skinner, 2020) or role fluidity (Major and Napier, 2019). The new prominence of the notion of role fluidity follows an increase of scholarly interest in the ever-evolving nature of discourse (see Biagini et al., 2017). Within this strand of research, DI scholars propose that interpreter's roles and functions should not be seen as a fixed stance, but flexible and responsive to a set of dynamics imposed by the nature of the interpreter-mediated encounter (IME) (Hsieh, 2016). Through this approach, DI scholars do not seek to identify 'one' or 'a set' of overarching role categories that encompass a range of behaviours. Instead, the emphasis is turned to breaking down roles into the specific tasks that interpreters might play in interaction, in response to the contextual needs of the event. By adopting this approach, light can be shed on the interrelationship between situatedness and role performance within and across sections (Gordon, 2015; Wadensjö, 2015). Additionally, by exploring how interpreters adapt their performance to the contextual needs of the session, it is possible to study interpreting performance in relation to the communicative event or area of specialty within which interpreting takes place. That is exactly what Bot and Verrept (2013) do, as they establish a taxonomy of functions that interpreters might take on when working in the specific field of mental health interpreting; and introduce the idea of the 'interactive interpreter', which consist of interpreters shifting along the proposed taxonomy. By paying attention to the evolving nature of interaction, new

avenues for DI research open up as this debate makes it possible to explore the link between interpreters' adaptative response and the dynamism and features of the communicative event itself. This thesis is aligned with this approach to the study of interpreters' performance due to its research potential. More specifically, this thesis will focus on how interpreters position themselves in relation to the relational needs of the triadic event. For this reason, section 2.3 below reviews previous studies on DI research focused on triadic interpersonal dynamics in interpreted talk.

2.3 Interpersonal dynamics in interpreted talk

In the preceeding sub-section, I discussed how interpreters' involvement in interaction can oscillate on a continuum between a mechanistic attitude to meaning transfer and higher degrees of active participation (Bot, 2005). I also discussed how different scholars have attempted to organise different degrees of involvement by role categorisations and descriptions of interpreters' positioning. Because the range of interpreters' functions is multidimensional, there are different ways of approaching the study of interpreters' degree of participation in triadic discourse, one of them being focusing on the interpersonal dimension of interaction. In the rest of this section, I provide a review of DI studies that have focused on the relational dimension of interpreter-mediated talk, given that relational practices are the main focus of interest in this thesis, operationalised as rapport management practices (Spencer-Oatey, 2008).

A number of interpreting scholars have set out to study interpreters' involvement in interaction, as well as the interactional consequences of such involvement. Studies on interpersonal dynamics in interpreted talk have followed multiple approaches. This is because the notion of 'interpersonal dynamics' is considerably broad and thus, may be approached from different angles. For example, different interpreting scholars have conceptualised the relational dimension of talk differently and have centred their studies around notions of 'rapport' (Tebble, 1999; Mikkelson, 2008; Gallai, 2013; to name a few); 'trust' (Edwards et al., 2004; Robb and Greenhalgh 2006; Hsieh 2009; Tipton and Furmanek, 2016; among others) or 'relational practices' (Major, 2013), among others. While some scholars have exclusively focused on one concept, other scholars have referred to different interpersonal constructs within the same study. For example, Cambridge (2012: 26) posits in her study of interpreter-mediated psychotherapy that "rapport must be established quickly and then built upon over time, creating a

professional trust within ongoing consultations"; thus using both terms to define two complementary realities. In any case, despite disparities in approaches and conceptualisations; the common feature among relationally oriented studies of interpreted talk is their shared interest in examining the nature of interpersonal dynamics that run in parallel with discursive meaning-making. Whilst the studies cited immediately above have contributed to increase knowledge on triadic interpersonal dynamics in interpreted-talk, their scholarly basis is limited. With the exception of Tebble (1999); who talks about rapport against the wider theoretical framework of Systemic Functional Linguistics; the studies cited below study notions of trust and rapport as separate realities from wider linguistic-behavioural dynamics in interaction. This is due to the fact that they do not sustain their inquiries by a coherent theoretical framework that agglutinates the linguistic and relational aspects of interpreted talk. There is a number of DI studies that have focused on relational dynamics in triadic talk by drawing on theoretical frameworks rooted in the field of interactional pragmatics. Because of the highly specific nature of these studies and their theoretical grounding, they are reviewed separately in section 4.3 within a chapter on interactional pragmatics and dialogue interpreting.

Going back to DI studies on relational dynamics, differences in approach may be found depending on whether they study relational dynamics as a dyadic or triadic phenomenon. Some studies focus on how the interpreter affects the quality of the relationship that might be established between the primary parties through their performance. That is, they mainly look at 'triadic rapport dynamics' (Cambridge, 2012; Mapson, 2015). Other studies also pay attention to the interpersonal relationships that might be established between interpreters and service users themselves. That is, 'dyadic rapport dynamics' (Major, 2013). Among these studies, the most predominant research strand is that concerned with the effect of the interpreter on the development of triadic rapport, in other words the degree to which interpreters become involved in interaction as facilitators of interpersonal dynamics between primary participants and themselves (Angelelli, 2004). In order to explore interpreters' involvement in triadic interpersonal dynamics, different scholars have paid attention to diverse behavioural indicators of subjacent interpersonal dynamics between participants in interpreter-mediated talk. To assist in this query, many of these scholars have employed discourse analytical approaches to trace discursive behaviours indicating interpersonal dynamics. For example, Tebble discusses how the interpersonal metafunction of language is realised

through interpreters' relays of doctors' vectors of affect such as intonation or downtoning bad news. Krystallidou et al. (2018) explored the quality of relationships in medical interactions by exploring interpreters' relay of doctor's expressions of empathy. Cambridge (2012) examines verbal gift-giving and small talk. Major (2013) connects the idea of relational dynamics in healthcare interpreting with indicators of humour, positive reinforcement and small talk. Considering all these studies, it may be claimed that this thesis is aligned with the later research strand, that of studies looking into relational dynamics in interpreted talk conceived as a triadic phenomenon.

Two research outcomes are discernible among studies looking at interpreter-mediated interpersonal dynamics. The first strand of research includes studies that have found that interpersonally oriented strategies are not prioritised by interpreters and, thus, frequently omitted (Tebble, 1999, 2003; Bolden, 2000; Davidson, 2000; Leanza, 2005; Bot, 2005; Dysart-Gale, 2005; Aranguri et al., 2006; Cambridge, 2012). Some of the scholars who found this have tried to elucidate the reasons why interpreters tend not to engage in interpersonal behaviours. Several reasons have been proposed. For example, Dysart-Gale (2005: 401) proposed that interpreters are not trained to foster an interpersonal rapport between or across the primary speakers. In contrast, Iglesias-Fernández (2010) proposes that interpreters might not feel like engaging in interpersonal dynamics with primary speakers as it might compromise their professionalism. Regardless of the ethics around the appropriateness of interpreters' involvement, a common perception is that when interpreters fail to convey relationally oriented strategies initiated by primary speakers, they hamper, whether intentionally or unintentionally, the development of the creation of a positive rapport between the parties (Tebble, 1999). In other words, because interpreters are a gateway between users and providers and the institution, it is important that they reflect relational behaviours, or otherwise interpersonal tension might be created.

In contrast to these studies, a second strand of research encompasses a number of studies that suggest that interpreters are actively engaged in the promotion of positive interpersonal dynamics and rapport building behaviours among primary speakers. For example, Major (2013: 258) provides empirical evidence to show how healthcare interpreters are "aware of the importance of relational work at a global level and do not ignore it in favour of more health-focused talk". This finding led the author (*ibid*.: 272) to conclude "that interpreters are powerful agents when it comes to making decisions

about how to present participants through talk, and in facilitating and maintaining good relationships between patients and primary care practitioners, and also between themselves and other participants". In a similar vein, Mapson (2015) proposes that interpreters are actively engaged in the discursive negotiation of politeness strategies and the management of rapport. A contextual factor that has been identified as an enabler for interpreters' facilitation of interpersonal relationships is the continuity of allocation between a service user. In other words, fosters positive interpersonal dynamics in IMEs (Perez and Wilson, 2006; Hsieh et al., 2012; Schofield and Mapson, 2014; Bristoll, 2009; Major, 2013; Mapson, 2015).The juxtaposition of ideas outlined above has fostered the following debate: while some authors encourage interpreters to be cautious when engaging in rapport-building efforts in interaction in order to avoid stepping out of role (Cambridge, 2012), others propose that a degree of professional rapport does not equate to friendship and, therefore, it does not compromise professionalism or impartiality (Mikkelson, 2008; Hsieh, 2016, 2017; Monteoliva-García, 2017). This thesis aligns with the latter view.

2.4 Concluding remarks

In this section, I review some theoretical notions that are key to frame this thesis within relevant literature on DI research. Firstly, this thesis is aligned with the tenets of the dialogic discourse-based interaction paradigm, so it conceives interpreter-mediated interaction as a collective endeavour of meaning co-construction; a process where interpreters have agency to influence both the progression of talk and relational dynamics among primary participants. Secondly, this thesis is a reflection of how DI research is becoming more refined due to its widened thematic scope (settings-wise, in particular) and the increasingly complex methodological approaches adopted by DI scholars; for the following reasons: on the one hand, this thesis is concerned with interpreting as it unfolds in a highly specialised medical specialty (see 5.2.4), which poses unique challenges for interpreters on several fronts, including the relational area. On the other hand, this thesis adopts an analytical approach based on the triangulation of methods and data, in an attempt to enrich the analytical descriptions on participants' relational dynamics provided in chapters 6 and 7. At the end of the chapter, I review the work of DI scholars who have proposed taxonomies of interpreters' roles and positioning, thus contributing to label different degrees of interpreters' involvement in triadic talk; and finally, I narrow down the search onto studies about interpreters'

involvement with a particular focus on interpersonal dynamics. Reviewing these research studies is crucial to frame the work conducted in this thesis, which is all about how interpreters shift across a continuum of interactional involvement while they perform their language mediation functions, and the implications of their decisions upon wider relational dynamics established between all participants.

Chapter 3 – Interpreting in mental healthcare settings

In the previous chapter, I introduced the notion of interpreting as situated practice, which means that contextual factors surrounding an interpreter-mediated encounter (IME) may influence participants' way of communicating (Angelelli, 2004a). The idea of situatedness is key in Dialogue Interpreting (DI) research, as it is widely acknowledged that IMEs re-enact expectations associated with the larger communicative event within which the interpreting activity develops (Hsieh, 2016). Among other aspects, situatedness may influence the extent to which interpreters' engagement in relational practices in an IME is perceived as appropriate (Hsieh, Pitaloka and Johnson, 2013). Because the idea of situatedness is a foundational notion in this thesis, I draw attention in this chapter to the medical setting that frames the IMEs under scrutiny: a mental healthcare (MHC) outpatient clinic. More specifically, I review the unique features of interpreter-mediated MHC as a speech event, and how such features have been addressed in DI research. The overall aim of this chapter is to contextualise the case study data gathered for the purposes of this thesis and to draw attention to the research potential of mental health interpreting (MHI) as a field of study.

3.1 Overview of mental healthcare settings

The mental health (MH) field is broad and differentiated (Bot, 2005), and this breadth is reflected in MHI research. Empirical studies on MHI feature different MHC settings, professionals and encounter types, as shown in 3.3. In this section, I review some aspects of the MHC field that are relevant in this thesis with a twofold aim: firstly, facilitating understanding of the disciplinary background against which the MHI studies reviewed in 3.3 are set; and secondly, providing real-world context for the case study that provides an empirical basis to this study. With these aims in mind, I provide in this section an overview of MHC professionals (3.1.1) and MHC settings most commonly featured in MHI studies (3.1.2).

3.1.1 Mental healthcare work and professionals

This thesis understands the notion of mental health as the individual's successful performance of mental functions in terms of thought and mood, and their associated behavioural expression (Aguilar, 2019). When an individual's cognitive capacities are impaired, or a person's pattern of thought and/or behaviour interferes with their functioning on a social or developmental level, that person may be diagnosed with a mental illness (*ibid*.). One of the most influential reference manuals for mental health workers is the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (APA, 2013). The DSM-5 provides descriptions for a large range of mental disorders, classifiable into: anxiety disorders, affective disorders, personality disorders, psychotic disorders and dementias. The symptoms associated with illnesses classified into each of these categories are claimed to be universally experienced, even though they might be culturally expressed (Achotegui-Loizate, 2019). See section 3.2.1 for a more in-depth discussion on MH and cultural relativism.

The quality of life of a person who is affected by a MH ailment may be improved with appropriate professional support, therapy and prescribed medication to manage symptoms if needed (Aguilar, 2019). The nature and intensity of a patient's symptoms may call for the skillset of a particular healthcare professional, whose education and specialisation will determine their professional competencies in terms of role and engagement in particular MHC situations (*ibid*.). Psychiatrists and psychologists are the MHC providers most commonly mentioned in MHI literature, so their professional remits are summarised below.

Firstly, a psychiatrist is a medical doctor who has spent their residency specialising in MHC and has built (or aims to build) a career within this work domain. Since they are medical doctors, they are allowed to write prescriptions for medicine and predominantly adopt a biomedical approach to patients' care. This means that psychiatrists focus on what is most 'medical' about the patient's care, which may include the management of physical symptoms of mental illness and medication reviews (Pollard, 1998). The encounters analysed for the purpose of this thesis were conducted by a consultant psychiatrist. For this reason, medical topics are recurrent throughout the conversational segments shown and discussed in chapters 6 and 7 below. Apart from this thesis, other MHI studies that have explored interpreter-mediated talk in psychiatry include Price

(1975); Marcos (1979); Drennan and Swartz (2002); Bischoff et al. (2003); Farooq and Fear (2003) and Van Vaerenbergh (2020).

Along with psychiatrists, the professionals that most frequently feature in MHI studies are psychologists conduct psychotherapeutic work with linguistically and culturally diverse (LACD) patients. Psychologists are also MH specialists, but they are not involved with a patient's medical care as they cannot prescribe medication because they have not received medical training. Psychology is itself a broad field and offers multiple specialisations. Psychologists who proceed to specialise in the healthcare field pursue a specialisation called 'clinical psychology', which might be pursued at master's or doctoral level. Clinical psychologists adopt a psychosocial approach to the patient's care, which means that they focus on eliciting a full picture of the patient's emotional, social, spiritual and wider mental dimensions of an individual's mental health, in an attempt to address those aspects that might interfere with the patient's development or social functioning (Rohlof, 2020). Thus, their main remit is to perform MH evaluations and conducting psychotherapeutic treatment or counselling tasks with patients in order to help them manage unhealthy patterns of thought and behaviour (Pollard, 1998). Several scholars have explored interpreter-mediated talk in counselling or psychotherapeutic settings involving psychologists. Examples include the articles in Tribe and Raval's compilation on mental health interpreting (2003); Tribe and Lane (2009); Dabić (2010); Cambridge (2012); Leanza et al. (2014); Costa (2016, 2017); Boyles and Talbot (2017), and Hlavac, Surla and Zucchi (2020).

Other professional profiles may also be involved in MHC work such as social workers, primary healthcare practitioners, psychiatric nurses, etc. However, because these professions do not feature as frequently in MHI research and due to space constraints, they will not be reviewed in this section.

3.1.2 Inpatient and outpatient care

MHC professionals may provide their services in a variety of settings run within the public, private or third sector (Hlavac, 2017). Among these three groups, interpreters are more likely to be called in to work in the public sector (Pollard, 1998). For this reason, in this section I provide an outline of two public healthcare settings where MHC

services may be provided and that have also featured in MHI research: inpatient units and outpatient clinics.

Firstly, inpatient care refers to hospital-based settings where patients stay overnight or longer in order to ensure their and other's safety. The duration of admission might vary and depends on the patient's conditions. Patients might be admitted voluntarily, but there are also laws (for example, the Mental Health Act, 2003) that allow health authorities to admit a patient to inpatient treatment even if the patient is uncooperative ('sectioned' patients). Inpatient care facilitates patients to take part in group activities, education programmes and psychotherapy sessions (Pollard, 1998). Several types of MH specialists might be seen in an inpatient unit, including psychologists, psychiatric nurses who are in charge of the daily running of the unit, and psychiatrists who will often visit the patient once a day ('ward round'). As patients' respective conditions improve, they can get ready for discharge. Some MHI studies have been set in an inpatient MHC unit. For example, Hagan et al. (2013) examined the competency of ad hoc interpreters in interpreting psychiatric teams in a South African psychiatric hospital.

However, most of the MHI literature is set in outpatient MHC treatment centres or clinics. This is because the majority of patients are not admitted to hospital and, instead, they attend outpatient clinics. In fact, Pollard (1998: 75) establishes that "the vast majority of patients in the mental health service system see clinicians once per week or less" (Pollard, 1998: 75). Different services may be offered in outpatient MHC clinics; for example psychotherapy, psychoeducational groups, substance abuse recovery treatments, child and adolescent MHC services, occupational health services or stress management groups[5]. The setting for the case study under scrutiny in this thesis is also an example of an outpatient MHC clinic. It is called Department of Psychological Medicine, located within a large public hospital in Scotland. The remit of this clinic is discussed at greater length in 5.2.4.

[5] https://www.nhs.uk/service-search/other services/Outpatient%20mental%20health%20services/LocationSearch/573

3.2 Transcultural psychiatry and psychology

Public MHC is delivered through mainstream services designed to serve the population at large. Therefore, they might not necessarily have the resources to cater for the needs of a particular sub-population (Pollard, 1998). Consequently, when members of a subset of a population, such as ethnic minorities, access mainstream services some adjustments might be needed to accommodate for particular challenges in access. The fields of transcultural psychiatry and psychology (hereafter jointly referred to as 'transcultural MHC') look into these challenges, with the aim of ultimately enhancing the cultural sensitivity needed on the part of healthcare practitioners and organisations when assisting these populations (Qureshi, 2020). Among members of ethnic minority populations in need of MHC, some might have a command of the language used by the hosting society that allows them to access health services without language mediation. In this case they are 'only' culturally diverse, and communication difficulties might originate in the mismatch of backgrounds, and potentially the resulting mismatched expectations, between provider and patient (Schouler-Ocak, 2020). But ethnic minority patients might also be both culturally *and* linguistically diverse (LACD). When LACD patients access MHC services, interpreters are needed to facilitate interaction between patient and healthcare practitioner. In the following sections, I provide an account of the implications of providing MHC services to LACD populations, with the aim of stressing the difficulty of the task facing interpreters working in MHC settings. To do this, I firstly address the interplay between culture and mental health. Later, I focus on the challenges of intercultural MHC assessment, treatment and the establishment of a therapeutic alliance between MHC practitioner and patient when they do not share a language.

3.2.1 Culture, language and mental health

There is a number of MHC work and research strands that address the interrelationship between language, culture and mental health, for example the disciplines of transcultural psychiatry and intercultural psychotherapy. These two fields are concerned with addressing the sociocultural context of mental illness and attempt to develop culturally appropriate interventions based on that knowledge (*ibid*.). Some assumptions rooted in the field of ethnopsychology underpin the work of disciplines looking into the link between culture and mental health (Belsiyal, 2016). Ethnopsychology establishes

that all human beings are born with equal cognitive abilities; however, collective variations in thinking might result from the influence of the cultural milieu in which members of a certain group are acculturated from a young age (*ibid*.). That is, there is close interplay between an individual's mental profile (including motivation, cognition, emotion, perception and also mental health) and the wider cultural and social environment surrounding that individual (Achotegui-Loizate, 2019). The tenets of ethnopsychology are consistent with Foucault's (1965) relativist view of mental illness, which posits that psychiatric practice cannot be understood in isolation from other societal institutions. Drawing on this argument, he questions the universal validity of dominant MHC epistemic models of psychopathology, diagnosis and treatment (*ibid*.).

Related work in cognitive linguistics also looks at the relationship between language and thought (for example Wierzbicka, 1999). Much of this work is based on the Sapir-Whorf hypothesis of linguistic relativity, which claims that the structure of a language affects its speakers' worldview and cognition and therefore people's perceptions are influenced by categories in their language(s). From the point of view of linguistic relativity, the fact that every language contains its own picture of the world, inclusive of the ethnopsychology of its speakers, impacts on its speakers' mental processes. As a result, emotional concepts, metaphors and values do not have direct equivalents in all languages. For example, words like 'depression' (Reali, Soriano and Rodríguez, 2016), 'soul' (Wierzbicka, 1989) or 'distress' (Westermeyer, 1990) may have different meanings or values associated with it, depending on the culture in which they are located. This interrelationship between culture, language and mental health has implications for interpreter-mediated MHC events, as will be discussed in the next three sub-sections.

3.2.2 Transcultural evaluation and diagnosis

MHC practitioners might encounter challenges when trying to reach a MH diagnosis for a LACD individual because in MHC settings, language itself becomes "the principal investigative and therapeutic tool" (Farooq and Fear, 2003: 104). This is because symptoms of mental illness are not always associated with directly observable signs of morbidity and, therefore, they are elicited mainly through self-report of the patient's interpretation of bodily and mental sensations (Bauer and Alegria, 2010). Drawing on this idea, linguistic and cultural differences might affect a MHC practitioner's

interpretation of the patient's self-report of symptoms, even when there is an interpreter present (Tribe and Raval, 2003).

A number of scholars have examined the specific ways in which language barriers may interfere with the goals of a mental status examination. More specifically, they have suggested that one of the main difficulties of cross-linguistic diagnosis is the MHC professional's lack of direct access to the following features of language: disorders of speech (aphasias, mumbling, rapid speech and neologisms), thought processes (such as flight of ideas, disorganisation, tangentiality), thought content (grandiosity, delusions, obsessions, magical thinking), register (idiolect, cursing), perceptions (hallucinations) and the language chosen for emotional outbursts (Bauer and Alegria, 2010; Cambridge, 2012; Resera, Tribe and Lane, 2015).

Cultural differences may also pose a challenge for MHC practitioners when diagnosing LACD patients. This is because, as Helman (2007: 128) puts it, "each culture (and to some extent each gender, social class or even region) has its own 'language of distress', which bridges the gap between subjective experiences of impaired wellbeing and social acknowledgement of them". As a result, cultural factors might determine which symptoms or signs are perceived as non-normal. For an in-depth exploration of the notion of normalisation, see Foucault (1977).

Drawing on the idea that the appropriateness of certain behaviours may be perceived differently across different ethnic groups, it has been suggested that a clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behaviour, beliefs or experience that are particular to the individual's culture (Turner, 1995). Due to cultural differences, clinicians might fail to recognise or understand culture-bound idioms of distress if they are not sufficiently familiarised with the ways in which members of a certain socio-cultural group convey affliction (Nichter, 2010). Cultural manifestations of mental illness have been acknowledged in the most recent edition of the DSM-V (2013).

Some authors have suggested that interpreters might be a valuable resource when addressing the cultural gap between MHC practitioner and patient, by brokering the

nature of culture-bound syndromes/idioms of distress should they come up in an interpreter-mediated session. For example, Van-De-Geuchte and Van-Vaerenbergh (2017) talk about the benefits of professionally trained interpreters working as intercultural mediators in psychiatry. However, this is contested; it has also been suggested that there is currently no reference framework in place that permits interpreters to educate themselves in matters related to cultural relativism and mental health (Aguilar, 2019).

3.2.3 Three-person psychology

Language and cultural differences also become salient within the context of psychotherapeutic treatment, occasionally referred to as 'talking therapies' due to the dialectal nature of the work (Cambridge, 2012). In psychotherapy, the MHC professional addresses the patient's moods, feelings, thoughts and behaviours with the aims of increasing their awareness, self-compassion and acceptance of themselves and of providing them with the tools to accept or work towards changing the problematic aspects that brought the patient to therapy in the first place (Kluge, 2020). Bot (2001: 29) stresses that words, embedded in the relationship between patient and therapist, form the basis for psychotherapeutic treatment. In the same line of thinking, Messent (2003: 138) stresses the value of words in fostering healing by positing the following:

> "rather than searching for words that truly match an experience or an idea, we are looking more often for words, images or metaphors that will reflect some aspect of an experience in a way that will be both true to the client´s experience, and move the client on, by helping him or her to view the experience in a new way."

Through this quote, Messent appeals to the process of meaning co-construction that takes place during the psychotherapeutic process, whereby the therapist attempts to help the patient reframe their experiences under a more constructive light in order to encourage change. The relational view of psychotherapy that resonates in Bot's and Messent's quotations corresponds with the predominant view of modern psychotherapeutic thinking. This was not always the case, however. Instead, in classical psychoanalytical and psychodynamic theories, based on Freud's principles, the psychotherapist analyses the psyche of the subject without becoming personally involved. This approach is known as 'one-person psychology', which Bot (2005) connects with the monological view of language (see 2.1.2 for an explanation of

monologism and dialogism). Later developments in the field of psychotherapy built on the criticism that one-person psychology was unrealistic, and the notion of 'two-person' psychology arose from these criticisms. The two-person psychology view is built on the assumption that "the therapist plays a role in the construction of a therapeutic reality, which is created in the interaction between therapist and patient and is based on the patient's and the therapist's subjective experiences" (Bot, 2001: 29). Bot (2005) proposes that the two-person psychology view fits in well with Bakhtin's dialogical view of language and communication; that is, the view that meaning is partly determined by interaction itself. Drawing on the dialogical view of psychotherapeutic dialectical processes and Wadensjö's (1998) descriptions of interpreter-mediated conversation as triadic communication in its own right, Bot (2001: 29) proposes the term 'three-person psychology' when referring to interpreter-mediated psychotherapy. Three-person psychology refers to the idea that an interpreter is not only an active participant in the negotiation of discursive meaning but also "an integral part of a therapeutic reality constructed through the interactions and subjective experiences of the three interlocutors" (Bot, 2001: 30). This idea has been developed further by later scholars (see Tribe and Raval, 2003; Costa, 2016; Kluge, 2020, to name but a few) who see interpreters as bridges across languages but also emotions, narratives and witnesses to the primary participants' attempts to reframe experiences.

3.2.4 Therapeutic alliance in triadic encounters

Another key aspect of MHC work that may change due to the language mediation process is the establishment of the so-called therapeutic alliance between the MHC provider and the patient. As Bot (2005) establishes, in MHC the development of a positive relationship between the therapist and the patient is necessary for the formation of a working alliance, which is strategically used to facilitate processes such as diagnosis and treatment. A working alliance refers to a positive bond that encourages therapist and patient to work together with the common aim of achieving positive clinical outcomes for the patient (Casella, 2015). Helpful consequences resulting from a positive therapeutic alliance may include a reduction in the patient's anxiety levels (Di Matteo and Tranta, 1979), and enhanced levels of patient's trust for the practitioner (Tribe and Raval, 2003), enhanced self-disclosure during consultations (Bauer and Alegría, 2010) and compliance with treatment and medication (Hsieh and Hong, 2010).

A number of authors have explored interpreters' involvement in the establishment of a therapeutic alliance between the healthcare practitioner and the patient (Haenal, 1997; Miller et al., 2005; Tribe and Thompson, 2009; among others). This issue is relevant from a language mediation perspective because "where the mental health professional and the person with a mental illness do not have a common language, the work of the interpreter in building the relationship is critical" (Hlavac, 2017: 1). Interpreters become actively involved in facilitating the establishment of a therapeutic alliance between healthcare practitioners and are also drawn into a process of alliance formation with primary participants (Costa, 2016). This involvement is the research focus for Tribe and Thompson (2009), who explore the different dynamics in the triangular relationship between therapist, client and interpreter, emphasising the different patterns of alliances that may occur. In their study, they observe that interpreters become actively involved in transference and countertransference dynamics (that is, the projection of feelings from patient to therapist and vice versa). Drawing on this finding, they conclude that the management of this involvement will result in different alliance patterns, also referred to as 'pairings'.

Once it is recognised that interpreters play an active role in the establishment of emotional and relational dynamics in triadic talk, the next step is to explore the factors that determine interpersonal outcomes (Resera, Tribe and Lane, 2015). A number of scholars have looked into the different outcomes that might result from the management of interpreters' involvement in relational dynamics in triadic talk. For example, Cornes and Napier (2005: 405) point out that the construction of a positive working alliance between interpreter and healthcare practitioner in mental health is the single most important predictor of therapeutic success or failure in interpreted interactions. Similarly, Bot (2005) establishes that, for healthy therapeutic alliances to thrive in interpreter-mediated talk, it is crucial for the therapist to be aware of the patient's emotional reliance on the interpreter.

A number of scholars have also looked at elements that might negatively affect the establishment of a therapeutic alliance between healthcare practitioner and patient in interpreter-mediated talk. For example, Yahyaoui (1988) established that the presence of interpreters might be too disruptive in the course of psychotherapeutic treatment for the formation of a therapeutic alliance. Cox (1977) and Owan (1985) establish that

patients might feel embarrassment or shame when disclosing sensitive issues in the presence of an interpreter.

Conversely, a number of scholars take a more affirming stance towards the use of interpreters in therapeutic settings, positing that interpreters provide a positive contribution to relational dynamics in interaction if these forces are handled appropriately. Scholars in this line of thinking do not focus on the additional challenges that interpreter-mediated practice might pose, but on the potential ways to work with interpreters in partnership to mitigate disruptions and enhance the effectiveness of interpreter-mediated MHC work (see Bot, 2005; Zimányi, 2009; Resera, Tribe and Lane, 2015; Boyles and Talbot, 2017).

3.3 Main thematic orientations in mental health interpreting research

In this chapter so far, I have reviewed some key features of the communicative event within which MHI unfolds: cross-linguistic and cross-cultural mental healthcare. Having clarified the background of MHI studies, the purpose of this section is to review the main thematic orientations in MHI research. As explained in previous sections, the mental health field is very broad, and encompasses encounters as diverse as 'psychiatric assessments, medication reviews, psychometric tests, as well as family, couple and individual psychotherapy' (Tribe and Lane, 2015: 254). Nonetheless, some research themes are dominant, despite and across this diversity. These are outlined below.

3.3.1 Equivalence

A large number of research studies into MHI have been conducted by MHC professionals driven by their concerns about how using interpreters may influence their practice. The earliest studies following this approach date back to the 1970s, are rooted in the field of psychiatry, and mainly focus on adverse events attributed to inadequate interpreting. The methodology employed by these studies was eminently quantitative and largely attempted to enumerate and classify non-professional interpreters' error rates as registered in audio and videotaped encounters (Sabin, 1975; Price, 1975; Launer, 1978; Marcos, 1979; Farooq, Fear and Oyebode, 1997, Farooq and Fear, 2003). Some conclusions reported through these studies is that interpreters may not be familiar

with specialised terminology used in mental health practice (Cornes and Wiltshire, 1999). Another finding reported was that, when interpreters translate into the therapist's language, they soften the emotional impact of how the client expresses what they are experiencing (Sabin, 1975). In a similar vein, Price (1975) highlighted the ways in which interpreters trained as therapists might twist the translation towards their own preconceptions on how the therapy should proceed. Similarly, the works of Marcos (1979), Farooq, Fear and Oyebode (1997) and Farooq and Fear (2003) highlight occurrences of interpreters' omissions, additions and/or distortions of meaning in interpreted interviews where the interpreters were not experienced in psychiatric work. These observations become particularly relevant when studies feature patients who have language disfluencies, which occur when patients have mental health issues or distortions in their thought processes that cause them to make statements that do not make sense to others. Some scholars have provided evidence of the ways in which interpreters may attempt to make sense of what is said before passing it on, rather than rendering what was said and how (Pollard, 1998; Farooq and Fear, 2003; Crump and Glickman, 2011). Farooq and Fear (2003) refer to this type of interpreter's action as 'normalisation'. A common feature, and main shortcoming, of these research studies is that they are conducted unilaterally by MHC professionals. This means that the views expressed in these studies largely reflect the opinions of this professional group and largely neglect to report on the views of interpreters themselves, which could help to contextualise their decision-making.

3.3.2 Interpreters' role(s) in mental health

A number of studies have provided taxonomies of roles that interpreters may play when working in an MHC setting. The most commonly mentioned roles are outlined and synthesised below.

Conduit model of interpretation

An interpreter who follows a conduit approach to language mediation tries to interpret "as far as is linguistically possible on a word for word basis and adopts a neutral and detached stance" (Resera, Tribe and Lane, 2015: 255). This model of interpreting might be helpful in MH encounters where accuracy is particularly relevant for diagnostic or therapeutic processes, such as in the case of psychometric tests or structured therapies, or when the patient is language dysfluent and rendering such dysfluency is itself needed

for diagnostic purposes (Pollard, 1998). Several authors have identified in their studies that some MHC practitioners prefer interpreters to behave as conduits in order to avoid conflict. For example, Hsieh et al. (2013) reported the views of MHC professionals who stated that any input on the part of the interpreter might have therapeutic consequences in a MHC context. In any case, the validity of the conduit (translation-machine) model both in MHC has been strongly criticised for being both a myth and impractical, following a converging line of criticisms in other interpreting specialities (Bot, 2003; Bot and Verrept, 2013).

Interpreters as intercultural mediators

Some scholars have stressed the value of interpreters taking on more active and visible roles in MHC work compared to other medical specialties (Hlavac, Surla and Zucchi, 2020). More specifically, it has been proposed that when interpreters working in a MH setting act as culture brokers, they might help to clarify the nature of culture-bound syndromes or idioms of distress. For example, Aguilar (2019: 35) proposes the following:

> "an interpreter who educates himself regarding these issues [idioms of distress] becomes a valuable resource for the clinician to help identify and understand these cultural manifestations idioms and to determine whether the clients' signs and symptoms significantly impair their functioning within their cultural context and norms of acceptable behaviour which is the hallmark of mental illness."

However, several scholars have warned of the potential dangers of aiming to adopt this role if a critical stance is not taken. For example, Bot and Verrept (2013) have claimed that ethnic origin alone is not enough to fully understand a person's cultural but also individual values. Additionally, Bot (2005) mentions that the intercultural mediator role in MHC poses the risk of assuming that an interpreter has encyclopaedic knowledge of the culture, as well as the misidentification of the interpreter's own opinion as widely accepted cultural knowledge. Additionally, Blackwell (2005: 86) warns that "having admitted that the interpreter is a source of expertise it is easy for the therapist to allow the interpreter to take over and in some sense 'lead' the therapeutic process". The two views on interpreters acting as intercultural mediators in MHC can be conciliated by considering the following statement by Resera, Tribe and Lane (2015: 225):

"while interpreters can helpfully act as bicultural brokers, this requires experience on the part of both the interpreter and the clinician, to ensure that any information is treated appropriately within the mental health setting and for the ultimate benefit of the service user."

Advocacy model

In the role of advocate, the interpreter actively promotes the interests of the service users at the individual, group or community level, thus going beyond the interpreting function as such. A number of authors have stressed the value of interpreters taking on advocacy tasks when working in MHC. Through this role, interpreters represent the service users' interests, speak on behalf of the user, and perform tasks such as helping the user navigate the healthcare system (Patel, 2003). This role has been predominantly discussed in relation to users in need of such guidance, for example, recently arrived asylum seekers and refugees. However, this role has been strongly criticised as it steps out what is considered an interpreter's remit, at least in the UK.

Interpreters as co-therapists

Another role that has been mentioned in the MHI literature is that of interpreters as co-therapists. Through this role, interpreters might take on therapeutic tasks. For example, in the model that the organisation Mothertongue[6] used to follow, a number of bilingual clinicians and interpreters used to undergo MHC training work together in order to jointly pursue therapeutic outcomes. However, the co-therapist model has also been criticised, as some conditions need to be met for this model to work in practice. For example, Westermeyer (1990) criticises that this model poses the risk of clinicians assigning the status of junior clinician to interpreters, forcing them to work beyond their competency. Bot and Verrept (2013) criticise that the extent and cost of the special training required mean that it would be most cost-effective for interpreters with this training to work independently as bilingual therapists themselves. Additionally, Hanneke Bot (2015) also criticises the co-therapist role by arguing that the therapist is ultimately responsible for the outcomes of the session.

[6] Mothertongue used to be an organisation aimed at providing culturally and linguistically sensitive therapeutic support for people from black and minority ethnic communities. In 2000, this service and its therapy model became integrated into an NHS mental healthcare service.

The 'interactive interpreter' or 'role fluidity' in MHC

In section 2.2.2 above, I discussed how scholars' concern with proposing interpreters' role taxonomies is being gradually replaced by an interest in examining the dynamic positioning of interpreters as they shift along a continuum of interactional involvement in response to the interactional needs (Biagini, Davitti and Sandrelli, 2017). The notion of the 'interactive interpreter' in mental healthcare, proposed by Bot and Verrept (2013: 126) amalgamates the roles stated above and plots them along a continuum of interactional involvement:

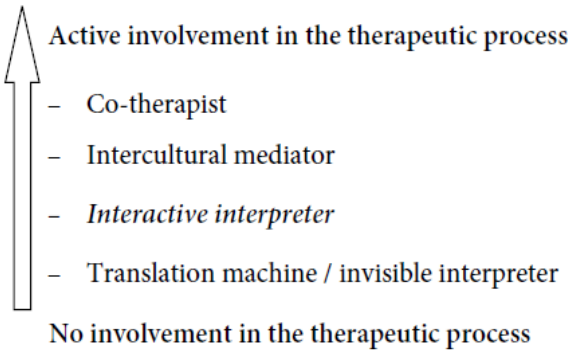


Figure 1 – Continuum of interpreters' involvement in mental healthcare encounters

This continuum is useful to promote a finer grained understanding of interpreters' shifting roles in relation to MHC encounters. This is particularly relevant if considering the different types of communicative events that might be encountered within the mental health field. In this regard, Bot (2015: 262) reflects upon the interplay between the diversity of mental health types of encounters and the need for interpreters to be flexible in the roles that they adopt when working in this setting. Thus, she posits that the conduit model might be more useful for structured sessions while freer roles might be more useful for cotherapeutic models; and she argues this by clarifying the following information:

> structured therapies usually use specific terms to instruct their patients, to phrase interventions and to measure progress. By contrast, counselling therapies emphasise the importance of the working relationship between therapist and patient and the importance of rewording experiences.

Finally, Bot (2015) establishes that, in order for an interpreter to be successful when shifting across roles, it is important for that interpreter to have knowledge of the

encounter's interactional purposes and the specific conversational techniques that will be used to meet this purpose.

3.3.3 Effect of mental health interpreting on interpreters' wellbeing

Research has also focused on the impact of MHI on interpreters themselves, on those from immigrant and refugee backgrounds (Doherty, MacIntyre and Wyne, 2010). Among these studies we can find Green, Sperlinger and Carswell (2012) writing about the UK context, Lipton et al. (2002) in the Australian context, Holmgren, Søndergaard and Elklit (2003) in the Danish context, and Dean and Pollard (2011) and Harvey (2001, 2003) on sign language interpreters in the United States. The risk of interpreter's experiencing burnout or the reactivation of trauma, as well as the potential for their own psychological health to impact on interaction between patient and clinician, is highlighted as is the issue of adaptability to so-called host communication competences (Zimanyi, 2012), as is the risk for interpreters to over-empathise with clients (Harvey 2003). For this reason, it has been suggested that interpreters who work in MH settings should have peer support (Costa, 2016; Hlavac, 2017).

3.3.4 Inter-professional collaboration

One of the main aims of MHI research is to elucidate the complexities of this type of practice in order to identify best practices (Tribe and Thompson, 2009). One of the most recurrent features cited as best practice in interpreter-mediated MHC work is the promotion of joint working practices between the MHC practitioner and the interpreter. A number of articles have proposed that a positive working relationship between practitioner and interpreter stems from collaborating before, during and after the triadic event.

Some scholars have concluded that one of the ways in which collaboration outside the session is best achieved is through briefings. During this preparation time, some authors suggest that it is helpful for interpreters are to be informed about the specific role that is expected of them, in accordance with the therapeutic goals that will be pursued in the upcoming encounter (Kluge, 2020). During the session, it has been established that MCH practitioners and interpreters are better able to develop a positive working

relationship if they work towards achieving the same goals (Hsieh et al., 2010). Other suggestions include the observation that collaboration during the session is best achieved by following a previously agreed protocol consisting of behavioural and linguistic rules, such as that MHC practitioners use complete sentences with an appropriate length for interpreters to relay the utterances (Boyles and Talbot, 2017).

Leanza et al., (2014) suggest that post-session de-briefings are important so that MHC practitioners might offer interpreters support and supervision, and to provide the opportunity for interpreters to make suggestions and/or provide culture-related information to MHC practitioners. Another commonly mentioned theme is the impact of MHC work on interpreters' wellbeing (Bancroft, 2017), due to the intensity of the content discussed, the symptoms of the patient's MH condition (Miller et al., 2005), and the potential resonance between the patient and the interpreter's lifeworld due to their occasionally common origin (Resera, Tribe and Lane, 2015). These factors might lead interpreters to develop vicarious trauma (Roberts, 2015). Vicarious trauma is normally understood as "a transformation in the self that results from a professional helper's empathic engagement with survivors of traumatic experiences" (Schlesinger, 2015: 434). It has been documented that interpreters are at increased risk of vicarious traumatisation when working in MHC settings (Miller et al., 2005). If left unaddressed, negative dynamics might arise in the session, for example, based on the interpreter's emotional reactions. This is particularly problematic if an interpreter overidentifies with a patient and might manifest an emotional response. The consequences of the potential impact on interpreters' wellbeing may surface and manifest not only after but also during the session. Some studies have shown that interpreters' distress during MHC sessions impacts negatively on their performance (Roberts, 2015). It has been suggested that this negative impact could be mitigated through appropriate professional support mechanisms, such as briefings for interpreters regarding what to expect in the session, and support and supervision after the session (Gallagher et. al., 2017).

3.4 Concluding remarks

This thesis sheds light onto the relational dynamics of interpreter-mediated talk by drawing on the analysis of a series of IMEs that were led by a psychiatrist in an outpatient MHC clinic called 'Psychological Medicine'. Acknowledging the particularities of the setting where the examined consultations took place is an

important part of this study. This is because this work aims is to promote a better understanding of the social, institutional and medical context where it is set; and the interplay between such context and participants' relational dynamics. To facilitate this understanding and to ground further discussions, I review in this chapter relevant features of transcultural mental healthcare, the larger communicative activity that frames the case study that provides the empirical basis for this thesis. I do so by firstly bringing attention to the vast and differentiated nature of MHC sub-contexts as this diversity is reflected on MHI research studies, which may refer to contexts as diverse as counselling therapies or psychometric tests. Having introduced this diversity, the case study presented in this thesis is contextualised within the medical field of psychiatry. This is important to clarify why chapters 6 and 7 provide discussions of interpreted sequences that include both psychosocial discussions and medication reviews. In this chapter I also make reference to the close connection between language, culture and mental health by discussing two themes that are relevant for this inquiry: on the one hand, the fact in the field of MHC language use may be itself a tool both for diagnosis and treatment. On the other hand, I make reference to the notions of ethnopsychology and Whorfianism to illustrate that there may be cross-cultural differences in the conceptualisation and expression of mental health distress. Reviewing these aspects evidences the heightened importance of the language and culture dimensions of MHC work, which make the work of interpreters in this field remarkably complex and worth examining. After having reviewed some relevant features of transcultural MHC communicative events, I proceed to review the main thematic orientations that are predominant in MHI research. Among the studies reviewed, this thesis is most closely aligned with works around interpreters' dynamic positioning in response to contextual demands arising in interaction, with a particular focus on relational factors.

Chapter 4 – Dialogue interpreting and interactional pragmatics

This chapter includes a discussion of Spencer-Oatey's (2008) rapport management (RM) theory, the theoretical framework that provides the scholarly basis for this thesis. RM theory is a complex framework, built upon a number of concepts grounded in the field of interactional pragmatics (IP). So, in order to facilitate an understanding of RM theory, I firstly discuss the underlying notions that make up its conceptual framework before proceeding to examine the theory itself. Finally, I review some empirical studies on Dialogue Interpreting (DI) that have turned to the IP concepts reviewed in this chapter to inform their analyses.

4.1 The pragmatics of interaction

In this section, I review some notions from the field of IP that RM theory integrates. More specifically, I firstly describe the notion of 'meaning as interaction' (4.1.1). Later on, I introduce the view of language as social action (4.1.2). Finally, I distinguish between the transactional and interactional dimensions of language use (4.1.3). These concepts are also key to the qualitative analysis of the data presented in chapters 6 and 7 in this thesis.

4.1.1 'Making' meaning

This thesis draws on the communication model proposed by Thomas (1995), who understands 'meaning' as a result of the interplay between factors (*a*) – (*c*) outlined below:

(*a*) the speaker's intended meaning when producing language. This first layer of meaning consists of two main components: firstly, the *utterance meaning*, which refers to the grammatical and semantic meaning of what is said; and, secondly, the *pragmatic force* (also referred to as 'illocutionary meaning' or 'illocutionary force'), which refers to the communicative *intention* of a speaker, expressed through their language use.
(*b*) the hearer's understanding and interpretation of the speaker's utterance meaning and pragmatic force.

(c) the social, cognitive and wider contextual factors that may shape the interlocutors' linguistic production and their mutual interpretation of each other's language use.

In other words, Thomas' (1995) communication model posits that meaning is not something inherent in words alone, nor is it produced by the speaker alone, nor by the hearer. Instead, meaning is made through the interplay between the three factors above as interaction unfolds. Drawing on this view of communication, Thomas (1995) defines interactional pragmatics as the discipline that approaches the study of human language use by examining the interaction between the different contributions of speaker, hearer and context to the meaning making process. Spencer-Oatey's (2008) RM theory is based on a view of communication that is aligned with Thomas's (1995) multi-layered conceptualisation of meaning-making. In turn, both theoretical standpoints are integrated into this thesis.

4.1.2 Speech acts: language use as social action

Pragmatics-oriented studies of communication practices, such as this thesis, are concerned with how utterances are used with a specific purpose in mind (Barron et al., 2017). This approach presupposes a view of language use as a goal-bound and contextually situated social action (*ibid*.). Understanding language use as social action means that communication practices are seen as a means to achieve an outcome. The notion of 'speech acts' is very convenient for studies on language use as the result of a motivated decision-making process. A speech act (SA) is an utterance marked by its speaker's intention to have a certain effect on the interlocutor. The theory of SAs was firstly introduced by Austin (1962) and further developed by Searle (1969). The theory of SAs sees utterances as performing three types of acts. Firstly, a locutionary acts consists in uttering meaningful sentences. Secondly, an illocutionary act refers to the communicative intention behind an utterance. Finally, a perlocutionary act refers to the desired effect of an utterance on its interlocutor. Among these three acts, the most predominantly used term in pragmatics studies is that of illocutionary act. In fact, Spencer-Oatey (2008: 336) establishes that "nowadays, the term 'speech acts' is often used to mean the same as 'illocutionary act'." Illocutionary acts can be sorted out into different categories depending on the communicative intention that they perform, for example, a 'greeting', an 'apology' or a 'rejection'. Empirical studies on language use that adopt SAs as their unit of analysis typically draw on recordings of naturally

occurring interaction as primary source of data (for example see Moeschler, 2010). Studies following this approach are aligned with the tenets of discourse-based analytical approaches to trace natural occurrences of SAs, which normally place an emphasis on the illocutionary act embedded in the utterances (*ibid*.). Because the management of interactional rapport may itself be a desired outcome embedded in language use, the use of SAs as an analytical unit is suitable for any study on rapport management (see 4.2.3 below). In fact, a special type of SA is proposed in RM theory: rapport-sensitive speech acts (RSSAs) (Spencer-Oatey, 2008: 19). The notion of RSSAs is further explained in 5.3.2 below, which discusses how RSSAs are used as the analytical unit for the analysis of dataset 1 within this thesis.

4.1.3 Dimensions of language use

Brown and Yule (1983) talk about two main functions of language use. On the one hand, the 'transactional' dimension of language use refers to processes related to the transmission of information and/or the achievement of one purpose external to the communication itself. On the other hand, the 'interactional' or interpersonal dimension of language use refers to the management of social relations through the use of language. Brown and Yule (1983) also suggest that talk within a specific communicative event may be either transactional or interactional in focus. For example, greetings and small talk are examples of language primarily interactional in focus, as their purpose is to develop and nurture good social relations. By contrast, the purpose of a history-taking phase within a medical consultation may be transactionally oriented towards the gathering of information. More recent developments within IP have suggested that the dimensions of language used proposed by Brown and Yule are not completely separate categories. It has been suggested that, contrarywise, the two dimensions are closely interconnected (Spencer-Oatey, 2008). This entails that the relational aspect of language use is constantly present in situated language use, although to different degrees, depending on the type of communicative activity (*ibid*.). Aligned with the latter standpoint, this thesis is built upon the view that the transactional-interactional duality is blurred, and that the relational dimension of language use (understood in this thesis as 'rapport management') is inherent to all situated communicative practices. This view shapes the analytical approach adopted in this thesis (see 5.3 below).

4.2 Theories on talk as relational action

In this section, I provide an account of three key theoretical notions which are rooted in the field of IP and shed light on the interpersonal dimension of language use: face (Goffman, 1959), politeness theory (Brown and Levinson, 1987) and RM theory (Spencer-Oatey, 2008). The theoretical notion of face as well as the theories of politeness and RM make up the conceptual framework of this thesis, so I discuss each of them in the following subsections.

4.2.1 Face

Face is an influential concept that was first introduced in 1955 by Goffman and is still widely upheld among IP academic works. According to Goffman, face is the positive image or social value that a person claims for themselves during an interactional event. Because this definition is somehow vague, but also versatile, different scholars have approached it differently and have contributed to its subsequent development. For example, some theorists taken an 'attribute' approach to face, and maintain that face is associated with the positively evaluated attributes that a person wishes to claim in interaction with others (for example, Spencer-Oatey, 2007). By contrast, others (Arundale, 1999, 2006, 2010) dispute this approach and conceptualise face as a purely relational phenomenon that is interactionally achieved through the dialectic negotiation that occurs in interaction. This latter group of scholars posit that face is purely relational rather than an individual concept, a phenomenon that only exists once active interaction between at least two people occurs (Arundale, 2010). This thesis is aligned with the attribute-based perspective on face proposed by the former group of scholars and explained by Spencer-Oatey (2008: 14) as follows:

> "face is closely related to a person's sense of identity or self-concept: self as an individual (individual identity), self as a group member (group or collective identity) and self in relationship with others (relational identity). In all three respects, people often regard themselves as having certain attributes or characteristics […]. People have a fundamental desire for others to evaluate them positively."

Acknowledgment of the interlocutor's positively sensitive attributes and its associated respect for their face are displayed through communicative behaviours. Drawing on this statement and considering that face is a sensitive construct, people tend to cooperatively attempt to promote both the other's and one's own sense of self-esteem, autonomy and solidarity in conversation (Merlini, 2013). Against this background, Goffman (1969: 216) labelled 'facework' as the actions taken to address the interlocutor's face needs. This idea was further developed by Brown and Levinson's theory of politeness (1987), described below.

4.2.2 Politeness theory

Politeness theory was proposed by Brown and Levinson (1987) as an attempt to explain human interaction by proposing that relational work revolves around being 'polite'. Their proposed notion of politeness should not be confused with the ordinary sense of 'politeness', that is, the adoption of courtesy manners in a given interaction. Instead, their theory on politeness draws on Goffman's concept of face but adds the notion that we have two faces: one positive and one negative face. Each of these faces is associated with different wants. Namely, 'positive' face is associated with the desire to be approved of whist 'negative' face, also referred to as 'autonomy' face, is associated with the desire to be unimpeded. A subsequent development of the construct of positive face (Tae-Seop and Bowers, 1991) is that face can be further divided into 'competence' face (being recognised through our professional aptitudes) and 'fellowship' face (being respected and being included). All of these face types will feature in the analytical descriptions of the excerpts shown in chapters 6 and 7 below.

Brown and Levinson (1987) propose that face is negotiated in interaction. This means that people tend to recognise each other's face and have a desire to have their face supported as well as the interlocutor's confirmation of acknowledgment of the identity traits claimed. 'Identity traits' as referred to as 'attributes' in this thesis, as discussed at the end of 4.2.1 above. When we interact, we seek confirmation of the self-conception (in terms of positive attributes) that we are trying to portray through our behaviour; and this is all done through facework efforts. However, Brown and Levinson (1987: 65) proposed in their theory on politeness that, sometimes, face needs are not respected. This is the case when 'face-threatening acts' (FTAs) happen. FTAs, "by their very nature run contrary to the face wants of the addressee and/or the speaker". More

specifically, they are interactional episodes where the face that a person is attempting to maintain is challenged or undermined in some way, whether deliberately or not. In this regard, Brown and Levinson (1987) postulate that certain communicative acts (for example, criticism, disagreement, apologies, or requests) inherently threaten the positive or negative face of the speaker and/or the hearer. From an attribute-oriented approach to face, FTAs could be seen as a mismatch between an attribute that they are claiming, and the attribute perceived to be ascribed by others (Spencer-Oatey, 2008). As a result, it could be claimed that politeness presupposes a constant potential for hostility inherent in certain acts between two potentially aggressive speakers, which such speakers seek to disarm to make communication possible (Hernández-López, 2008).

Brown and Levinson (1987) propose that FTAs provoke a loss of face that, in turn, triggers the need for redress behaviour to restore the interactional balance. This need for restoration is caused by the fact that FTAs might produce an emotional reaction based on feelings of embarrassment or agitation (Ting-Toomey and Cocroft, 1994). In contrast, if speakers share a cooperative approach, their tendency will be to mitigate such feelings or prevent them altogether by supporting their mutual faces (Hernández-López, 2008). The nature and degree of restoration needed when a FTA has taken place, in terms of what strategies might need to engage in facework to restore a person's face, depends on how threatening the FTA is. This is the main contribution of politeness theory: it is mostly interested in the rituals whereby speakers' present their faces and support each other's faces.

According to Brown and Levinson (1987), there are different factors that influence the degree of threat of an FTA, namely: the power differential between hearer and the speaker (that is, the degree of inequality); the distance–closeness between them; and the degree of imposition of the content of the utterance. As speakers weigh these factors, they will locate the degree of face threat higher or lower in the face risk scale. Additionally, as they attempt to minimise the threat posed by an FTA, they will engage in one of the following four behaviours. Firstly, not performing the FTA. Secondly, performing an FTA indirectly by going 'off-record', for instance through hints, understatements or irony. Thirdly, performing an FTA 'on-record', which means taking redressive action to offset the face loss. Redressive action means something differently depending on whether the FTA involves the positive or negative face of the affected party, which result in positive or negative politeness strategies respectively.

Broadly speaking, negative politeness uses mitigation strategies such as indirectness; questions and hedges; impersonal and passive constructions. Positive politeness entails explicitly acknowledging others wants, asserting reciprocity of wants and gift giving. The fourth behaviour that may be adopted to mitigate an FTA is to go 'bald on-record' which means not taking any form of redressive action. This action is the less ambiguous and more efficient. However, it ranks the highest in the face risk scale as it entails a higher risk of throwing the interactional equilibrium off balance (Hernández-López, 2008). As mentioned below, the choice of one strategy over another depends on the speaker's estimate of risk to face; this assessment is based on the advantages and disadvantages of each strategy, as well as on such contextually and culturally defined variables as social distance, relative power and ranking of impositions (Brown and Levinson, 1987).

All in all, as a model of strategic message construction, politeness has proved a useful theoretical tool for scholars to explore the patterns of social relationships in the context of real-life conversations (Merlini 2013). However, politeness theory has faced criticism on several grounds. One such is its excessive pessimism. As it rests mainly on the notion of FTAs, the theory suggests that social life consists solely of potential threats, which may at best be avoided or defused. To overcome this limitation, Kerbrat-Orecchioni (2005) grants an autonomous status to positive politeness, and proposes a category consisting of 'face-flattering acts', which refers to all acts that exclusively aim to acknowledge someone's positive face attributes. Another criticism of politeness theory alludes to its focus on the individual rather than on the relationship or society (Arundale, 1999) and its assumption that there is a universal procedure for managing interpersonal relations (for example, Eelen, 2001; Watts, 2003). Finally, one of the main criticisms of politeness in RM theory is that, far from being a tool for knowing how to manage relations, the classic model of politeness "is rather a descriptive theory of one aspect of communication – face" (Hernández-López, 2008: 59). This last criticism argument refers to a limitation of politeness theory that is overcome by rapport management theory, described below.

4.2.3 Rapport management theory

As mentioned at the end of 4.2.2 above, one of the main criticisms of Brown and Levinson's (1987) politeness theory is around its focus on face as main driver for people's politeness-oriented behaviour. However, face is just one aspect out of the multiple factors that might influence speakers' decision-making processes when using language for relational purposes. In an attempt to overcome the weaknesses of politeness theory, Spencer-Oatey (2000 and revisited in 2008) proposes her Rapport Management (RM) theory: a broadened framework that builds on the abovementioned notions of face and politeness.

RM shares a starting point with politeness theory: that a speaker, when formulating an utterance to contribute to an ongoing interaction, evaluates the hearer's face needs and wants and accordingly chooses certain forms of expression. Thus, the notion of face is adopted as the first component of rapport in RM theory. However, this theory goes a step beyond and proposes two more factors, labelled 'bases', as drivers of speakers' relational practices: sociality expectancies and behavioural expectations (see 4.2.3). Another novelty element of RM theory is that it draws attention to contextual factors that might influence participants' discursive management of the three bases. These two contributions of RM theory to the field of interactional pragmatics are integrated into the analytical framework of this thesis to examine interpreted talk, so both aspects are summarised below. However, RM theory was originally devised to better understand cross-cultural mismatches in handling rapport within interactions that are not necessarily interpreter-mediated. For this reason, the two sub-sections below include some reflections on the potential benefits and limitations associated with the applicability of RM theory to the analysis of interpreter-mediated talk.

4.2.3.1 The three bases of rapport

Spencer-Oatey (2008) conceptualises people's use of language to manage social relations through the notions of 'rapport' and 'rapport management'. These concepts replace previous notions of politeness. Rapport is defined in RM theory (2008: 35) as speakers' "subjective expressions of (dis)harmony, smoothness-turbulence and warmth-antagonism in interpersonal relations". And rapport management is understood as the

ways in which such (dis)harmony may be (mis)managed through language use (*ibid*.). The (mis)management of rapport depends on the handling of the three factors shown in Figure 1, referred to as the three 'bases' (figure taken from Spencer-Oatey, 2008: 14):

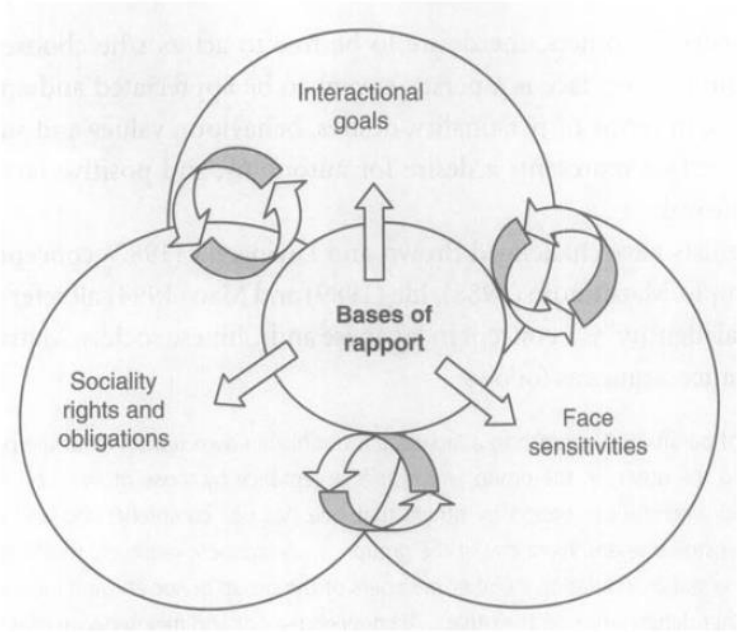


Figure 2 – The bases of rapport management

Face sensitivities

Similarly to politeness theory, RM theory draws on Goffman's (1969) notion of face. However, politeness theory sees face as a bi-dimensional construct consisting of positive and negative face. By contrast, in RM theory the notion of face is based on an 'identity attributes' approach; which stipulates that people claim certain identity attributes in their interactions with others, such as attributes related to status, competence, personality traits, etc. As a result, if an interlocutor perceives that there has been a mismatch between the identity attributes that they claim and the ones they perceive, this mismatch is perceived as face threatening (Spencer-Oatey, 2008). When such a mismatch arises, face sensitivities have been overlooked, and as a result, perceptions of interpersonal rapport may be affected. It has been suggested that speakers' faces are represented by and through interpreters' performance in IMEs (Merlini, 2013). Drawing on this statement, it might be posited that the negotiation of participants' face needs and wants in IMEs is partially dependent upon interpreters' awareness to accurately represent participants' discursive actions aimed at face management.

Sociality rights and expectations or 'social expectancies'

Spencer-Oatey (2008) explains how people typically form expectations as to the behaviour that may or should occur in a given context, based on the norms, conventions, principles, arrangements and protocols that they believe are associated with that context. As a result, people then go on to develop a sense of appropriateness (or lack thereof) associated with such behaviours. Consequently, people may start to feel that they have the 'right' to expect a certain behaviour and that others have the 'obligation' to perform it; in the same way that they have the obligation to display certain behaviours to others and that others have a right to expect such behaviour. This goes in line with the identities being at play in each interaction, for example, a professional or a personal setting. Ultimately, people might feel annoyed if the expected behaviour does not occur or has been infringed. Because failure to fulfil expectations may result in offence, Spencer-Oatey refers to this notion as the second base of rapport, labelled 'sociality rights and obligations' (2008); and later as 'social expectancies' (2009). The latter label is the preferred term in this thesis for readability purposes, even though specific reference will be made to 'sociality rights' or 'sociality obligations' in the discussion of the data when specifically referring to each of the two dimensions of social expectancies. The notion of social expectancies is key in the discussions of the data as the encounters under scrutiny take place in an interpreter-mediated institutional (healthcare) encounter where all participants; that is the clinician, patient and interpreters; are bound by a set of expectations associated with the role that they play in that particular communicative event. In this regard, Spencer-Oatey posits that social expectancies are particularly salient in professional environments, as job roles are typically associated with a set of expected rights and obligations. In this regard, what is interesting in terms of rapport is that "there are limits to the scope of the rights and obligations of any given role and so, if people go beyond that scope and assume rights that they are not entitled to or fail to uphold the rights and obligations that are perceived as within that role, then offence may occur" (2009: 106-107). This is particularly interesting for an analysis of relational dynamics in encounters mediated by interpreters, as what falls under the interpreter's role is still being queried in academic debates; and in professional practice, different stakeholders (service provider, service users or interpreters themselves) might also have diverging views of what counts as interpreters' functions. In the light of constant redefinitions of the interpreter's role, an analysis of

perceptions around interpreters' relational involvement in triadic interaction conducted from the lens of social expectancies seems particularly promising.

Upon further description of sociality expectancies, Spencer-Oatey (2008: 16) also proposes that there are two fundamental sociopragmatic interactional principles (SIPs) that underlie interaction and articulate social expectancies: equity and association. On the one hand, the socio-interactional principle of 'equity' is associated with people's fundamental belief of entitlement to personal consideration from others. This might encompass being treated fairly, not being unduly imposed upon, ordered about, taken advantage of, etc. Two core elements make up the notion of equity: firstly, the idea of 'cost–benefit' (the extent to which we are exploited or disadvantaged, and the belief that costs and benefits should be kept roughly in balance through the principle of reciprocity); and secondly, the continuum of 'autonomy– imposition', which is associated with the extent to which people control us or impose on us.

On the other hand, the socio-interactional principle of 'association' (*ibid*.) refers to the belief that we are entitled to a degree of social involvement with others, in keeping with the type of relationship that we have with them. Two continuums may be differentiated within the construct of 'association': firstly, the 'interactional involvement-detachment' continuum refers to the extent to which we associate with people or dissociate ourselves from them; and secondly, the 'affective involvement-detachment' continuum refers to the degree to which we share concerns, feelings and interests or some sort of affective space with interlocutors. These two continuums that result from different positionings around the equity and association SIPs are actively considered in the discussions presented in chapters 6 and 7 below.

Interactional goals

Spencer-Oatey (2008) posits that interactional goals are a third factor that can influence interpersonal rapport. In her description of RM theory, she explains that people often have specific goals when interacting with others (*ibid*.). Goals can be purely task-based (transactional) or relationally-oriented (Brown and Yule, 1983). Arranging an appointment is an example of a transactionally-oriented discursive activity whereas comforting a person in distress is an example of relationally-oriented talk. Both transactional and interactional goals may need to be fulfilled through discursive means. When this is the case, they are referred to as interactional goals, as they are fulfilled through interaction itself (Spencer-Oatey, 2008).

The discursive negotiation of interactional goals may have rapport-related outcomes. This is because every participant in a communicative event may have a set of goals in mind, with some of them needing to be interactionally negotiated. As a result, failure to fulfil such goals through interaction might result in offence or annoyance, thus disrupting the interactional balance, or 'harmony', of an encounter (*ibid*.). Drawing on these ideas it seems apt to assume that, when interactants rely on an interpreter to communicate, the negotiation of interactional goals may turn partially dependant on the interpreter's performance. For this reason, chapter 7 below is entirely dedicated to exploring how discursive goals are negotiated by participants involved in the interpreter-mediated encounters analysed in this thesis.

Managing the three bases: interactional balance and RM domains

In section 4.3.2 above I reviewed how the mitigation of face threatening acts is core to Brown and Levinson's politeness (1987) model of politeness. Drawing on this tenet of politeness theory and the broadened framework of rapport management, Spencer-Oatey (2008) establishes that a positive rapport (also referred to as 'harmony') between interlocutors may be threatened if one of the speakers engages in any of the following behaviours: overlooking face sensitivities, infringing social expectancies (either by threatening rights or through obligation-omission) or hampering interactional goals. As a result, rapport management behaviour may refer to any communicative behaviour aimed at redressing the potentially negative impact of rapport-threatening acts (RTAs), either by acknowledging face sensitivities, honouring social expectancies or enhancing the fulfilment of interactional goals. These three actions may be carried out through a range of RM strategies, which can be classified within the following list of RM domains:

- The 'illocutionary domain' refers to the rapport-enhancing or rapport-threatening implications of performing speech acts.
- The 'discourse domain' refers to the discourse content or discourse structure of an interchange, including topic choice, topic management and the organisation and sequencing of the information being discussed in the interaction.
- The 'participation domain' refers to the procedural aspects of an interchange, such as turn-taking, people's engagement with each other's answers and the inclusion/exclusion of people present.
- The 'stylistic domain' refers to the stylistic aspects of an interchange such as choice of genre-appropriate lexis, use of honorifics.

- The ‘non-verbal’ domain refers to the extra-linguistic aspects of interaction such as gestures, body movements, eye contact or proxemics.

All of these domains encompass a range of linguistic, paralinguistic, pragmatic and wider interactional parameters (e.g. turn-taking) that might be influenced in interpreted talk. This statement is particularly salient if we consider the notion of interpreters’ active involvement in triadic interaction (see 2.2). In section 4.3 below, I review a series of research studies on dialogue interpreting that have examined the interplay between interpreters’ performance and one, or several, of the five domains listed above. Because the five domains might take different forms in interpreted talk, they are explicitly considered in the analytical descriptions of the interpreted sequences provided in chapters 6 and 7.

4.2.3.2 Contextual factors influencing rapport management dynamics

Spencer-Oatey (2009) explains how RM practices do not occur in a social vacuum and for this reason, they might be perceived differently depending on the context. She illustrates this point by exemplifying how two people might perceive a same speech act differently; for example, a person might perceive it as a rapport-threatening act (RTA) while another person might not perceive a degree of threat associated with it. This difference in perspectives might result from the interplay of a result of contextual factors that may influence RM dynamics. From now onwards, ‘rapport management dynamics’ is the term that will be used to refer to both: participants’ rapport management practices, (or ‘behaviour’), and the outcomes of such practices. In turn, ‘RM outcomes’ are understood as participants’ perceptions of (dis)harmony in their interpersonal relationship with their interlocutor. (Dis)harmony is also referred to as ‘interactional balance’/‘positive rapport’, or lack thereof; in line with Spencer-Oatey’s (2008) terminology. The RM framework (*ibid.*) draws attention to a range of contextual factors that may influence participants’ RM dynamics. These factors will articulate the discussion offered in chapter 6 below, so they are summarised in this section.

Participant relations

One of the contextual aspects influencing interpersonal rapport is the type of relationship established between the interlocutors involved in an encounter. Drawing on previous work from the field of Pragmatics (Brown and Levinson, 1987), Spencer-

Oatey conceptualises participant relations in terms of two types of variables: vertical factors, which refer to notions of power or status' and horizontal factors, which refer to distance or solidarity. The combination of these two variables define different relational configurations. The assumption is that different relational configurations will be reflected through participants' choices regarding language use.

'Power' defines the position of interlocutors in interaction in terms of status (high/low). For example, drawing on French and Raven's (1959) taxonomy of power types, it could be argued that a doctor is an institutionally dominant position as s/he can exert 'expert' power that the patient seeks and needs; and 'reward' power, through which s/he has control over someone's outcomes, for example, by providing a prescription.

'Distance' refers to the expression of closeness, familiarity and relational intimacy between two people. Different authors have operationalised this construct differently; for example, it has been conceived in terms of social similarity/difference (Brown & Gilman, 1960); length of acquaintance (Slugoski & Turnbull, 1988); and positive/negative affect (Baxter, 1984).

Type of speech event

Spencer-Oatey (2008) explains how the display of rapport management behaviours among interlocutors may be subjugated to the conventions associated with the speech event within which the interaction develops. More particularly, Spencer-Oatey draws on Levinson's (1979) definition of 'activity type' as an interactional event where members are goal-defined, socially constituted, and bounded by the constraints imposed/required by the communicative event which defines participants' allowable contributions. An example of this would be expectations about speaking rights and turn taking (Spencer-Oatey, 2009). Other contextual aspects cited by Spencer-Oatey include conventions on speech act realisations, sociopragmatic interactional principles underlying communication, the number of participants who are present in a communicative event, and the social roles that participants adopt. Four overall rapport management dispositions or 'orientations' might develop, depending on the handling of the 'three bases' and on the influence that contextual factors exert upon the interactants (Spencer-Oatey, 2008):

- 'Rapport enhancement' orientation: a desire to strengthen or enhance harmonious relations between the interlocutors.;
- 'Rapport maintenance' orientation: a desire to maintain or protect harmonious relations between the interlocutors;

- ‘Rapport neglect’ orientation: a lack of concern or interest in the quality of relations between the interlocutors; and
- ‘Rapport challenge’ orientation: a desire to challenge or impair harmonious relations between the interlocutors.

To conclude this section, it must be acknowledged that there are several reasons why RM theory may be chosen as an adequate and up-to-date framework to articulate a study on relational practices either in monolingual or interpreter-mediated talk. Firstly, RM represents an expansion of the notions of face and politeness. RM theory represents an advancement in relation to these two theories because communication is no longer seen in terms of positive or negative politeness; or as a phenomenon utterly dependent on face concerns. Instead, interlocutors’ relational practices are understood in RM theory as a complex and dynamic phenomenon that can only be explained by accounting for a multiplicity of variables and factors. In RM theory, a range of interactional pragmatics concepts (‘the three bases’) and concepts from the sociology of language (‘contextual factors’) are integrated together along with a concern with participants’ perception of interpersonal rapport.

4.3 Dialogue interpreting and interactional pragmatics

Some research studies on dialogue interpreting (DI) have resorted to theories from the field of IP to enrich their findings. IP is useful in the study of DI for, at least, four reasons. Firstly, the literature on DI provides evidence to suggest that interpreters’ agency can have an impact not just on the negotiation of transactional meaning but also on interpersonally oriented meaning, which might be conceptualised through politeness or RM dynamics (Cambridge, 2012). Secondly, primary speakers’ faces are represented through interpreters’ talk (Merlini, 2013), which might also be applicable to RM-oriented communicative actions. Thirdly, in interpreter-mediated talk, the presence of an actively engaged and visible third party multiplies the values and potential effects of rapport-oriented strategies (Mapson, 2015). Finally, interpreters might find themselves directly engaged in dyadic relational dynamics with primary participants (Major, 2013). Below I provide a review of a number of DI research studies that have drawn on any of these four assumptions in their explorations of interpreter-mediated talk, as they share a high degree of scholarly basis with this thesis.

Firstly, Berk-Seligson is one of the scholars who first applied a theoretical framework from the field of pragmatics to study relational dynamics in IMEs. In her 1988/2002 studies, she presented mock jurors with two stylistically different versions of interpreted witness testimony. This means that her study is primarily concerned with the stylistic domain of RM. Berk-Seligson (1990) found that changes in politeness strategies in the interpreters' renditions could affect juror's impressions of a witness. In revealing this, she connected the appropriate management of politeness strategies with the management of relations among participants. Her findings led her to advocate for the inclusion of pragmatics in courtroom interpreting education programmes to raise awareness of the potential effect on juries of the translational choices that interpreters may make.

Hale (1997/2004) also applied pragmatic concepts to the study of relational dynamics in courtroom interpreting situations. In her work, Hale investigated shifts of register, finding that interpreters addressing the court tend to increase the formality of the witness's speech but translate speech addressed to witnesses more informally. Additionally, in her 2001 study, Hale investigated equivalence of illocutionary force in the translation of speech acts taking place in examination-in-chief and cross-examination. She found that the illocutionary force of coercive questions is sometimes lost, particularly due to the different forms of such questions in Spanish and English. Thus, Hale's work is concerned with the stylistic and illocutionary domains of RM. Another scholar who took an early interest in the interpersonal dynamics of IMEs was Tebble (1999). She focused on the notion of interpersonal metafunction of language, operating from a Systemic Functional Linguistics (Halliday, 1994) framework to analyse the discourse structure of medical interpreting encounters with a focus on interpersonal meaning and register shifts. This study is concerned with the stylistic domain of RM. In her 1999 study, Tebble presents a theoretical framework for analysing the interpersonal metafunction of language and claims that interpreters need such framework to read and convey the tenor of a physician's consulting style. Among other issues, Tebble concludes that interpreters occasionally omit the interpersonal metafunction of language and this might have negative implications for the establishment of rapport between primary participants. Another study worth mentioning is that of Mason and Stewart (2001), in which the authors look specifically at hedging, modality, register and off-record speech acts in interactions taking place in the courtroom and during immigration service interviews. This means that their study is

concerned with the illocutionary act of RM. Their findings suggest that FTAs in the speech inherently adversarial events under scrutiny are frequently modified in the act of translating, thus influencing the progression of talk.

Additionally, Merlini (2013) explores politeness dynamics through a qualitative analysis of three IMEs in the fields of healthcare, education and social services. Her theoretical framework is articulated around Brown and Levinson's classical model of politeness (1987), to which Merlini (2013) adds Kerbrat-Orecchioni's (2005) concept of 'face-flattering acts' (FFAs). By adding FFAs to her analytical framework, Merlini is able to analyse the mitigation of FTAs but also values FFAs for their productive rather than redressive action. Merlini (2013: 267) posits that interpreters' "face-work correlates with their understanding of the institutional goals being pursued during the interactions, their identification of power relations among participants, and their personal and professional status", even though she does not provide empirical evidence to fully back up this statement. In any case, the work of Merlini provides a contribution as it advocates for the importance of exploring facework in IMEs given that interpreters can be considered as fully-fledged participants in the interaction and consequently an additional image of self is at stake during the communicative event. Merlini's work is concerned with the illocutionary domain of RM.

In a similar manner, Cambridge (2012: 4) highlights the importance of the 'impartial' model when interpreting in a situation where participants' face may be threatened. More specifically, she explains how mental health interpreting requires an accurate, faithful and complete rendition of the original messages even if this sometimes implies transmitting emotional content such as insults or swearwords. In such cases, softening the original register may be against users' interests, which is why interpreters need to learn how to transmit both emotional content and pragmatic intention of the original messages even when they may feel their face is being threatened because of this. This study is concerned with the illocutionary and stylistic domains of RM. Similarly, in 2013, Major joined the academic debate by exploring relational work in IMEs and concludes that relational work is a fundamental aspect in community interpreting. More particularly, Major conducts an interactional sociolinguistic study for which the primary data comprised video recordings of two naturally-occurring interpreted general practice consultations, involving Auslan/English interpreters. The results from the discourse analysis of her data suggest that interpreters modify face-threats, facilitate social talk

and humour, in an attempt to facilitate relational work between primary participants. Her study is concerned with the verbal domain of RM and concludes that interpreters are aware of the importance of relational work and do not ignore this aspect of interaction, as had been suggested in previous works (for example, see Tebble, 1999). Another study worth mentioning is Cambridge (2012), who follows a discourse analytical approach to the analysis of interpreter-mediated psychotherapeutic sessions and concludes that interpreters tend to mitigate face threats. Similar findings were reported by Martínez-Gómez (2016), who examined an audio-recording of an interview between a prison psychologist and a foreign language-speaking inmate interpreted by another inmate. She found that the interpreter aims to protect and improve his fellow prisoner's face. Finally and, in a similar vein, Mapson (2015) looked at interpreting linguistic politeness from British Sign Language (BSL) to English. Mapson found that interpreters' knowledge about how politeness is used in BSL was important in ensuring that their strategies met their original relational intent. Both Major (2013) and Mapson (2015) integrate the RM framework in their respective studies when making reference to certain interpreters' behaviours.

To conclude, it must be acknowledged that all the studies reviewed in this section have drawn on concepts from the field of IP, mainly face and politeness, to shed light on participants' relational dynamics in IMEs. These studies make a contribution to the field of interpreting studies by importing concepts from IP to the analysis of DI data, and this thesis aims to follow this research strand. Nonetheless, the limitations of these studies point out at two important gaps in the literature. Firstly, these studies are mainly concerned with the notions of face and politeness, and very few make explicit reference to the broadened framework of RM. This means that there have been advancements in the field of IP that have not been reflected in DI studies. Secondly, each of these studies seems to be concerned with one or two isolated domains of RM, with none of the reviewed studies having attempted to conduct a holistic inquiry into interpreted data by making reference to all, or at least several, RM domains. The discussions provided in chapters 6 and 7 aim to address these two gaps in the literature. A third gap in the literature that might be identified after reviewing DI studies drawing on IP frameworks is related to the setting that these studies refer to. In this regard, it is worth mentioning that, except for Cambridge (2012), none of the reviewed studies focus on the mental health area. As a result, this thesis aims to address this gap in the literature by applying RM theory to the analysis of interpreter-mediated consultations in a psychiatry setting.

4.4 Concluding remarks

This chapter provides a discussion on three elements that make up the conceptual framework of this thesis: the notion of face (Goffman, 1959), politeness theory (Brown and Levinson, 1987) and RM theory (Spencer-Oatey, 2008); three theoretical elements rooted in the field of IP. Having reviewed these notions, it can be established that the broadened framework of RM theory seems to provide the most encompassing framework available in the field of IP to guide inquiries on participants' relational practices in both monolingual and multilingual encounters (Hernández-López, 2008). For this reason, RM theory was implemented as the theoretical frame to scholarly support the conceptualisation and methodological approach adopted in this thesis. After justifying this choice of theoretical framework, I proceed to review research studies on DI that have resorted to the concepts of face, politeness theory or RM theory to guide their inquiries and enrich their findings. After providing this review, I conclude that only a limited number of DI studies have resorted to the theoretical tools and coherent framework that RM theory provides. This means that there has been progress in the field of IP; namely, the theoretical contribution of RM theory; that has not been reflected in the field of interpreting studies. This gap in the literature is worth addressing because RM theory was originally devised to examine cross-cultural mismatches in the handling of politeness, not to elucidate inner relational dynamics underpinning interpreter-mediated talk. For this reason, it seems worth exploring the applicability of RM theory as a theoretical and analytical framework to study encounters mediated by interpreters, with the aim of identifying both its research potential and limitations when used for this purpose. With this aim in mind, in this thesis I draw on RM theory to examine RM practices and perceptions among participants that took part in a series of IMEs that took place in a clinical mental healthcare setting. The hypothesis underlying this exploration is that a study of DI based on RM will not only shed light into the suitability of RM theory as a framework to study interpreter-mediated talk. Instead, I also hypothesise that drawing on the three bases and five domains of RM will also help to provide an IP-based discussion on interpreters' active involvement in triadic discourse (see 2.2), and how interpreters' agency might affect the progression of talk at the relational level. This is all particularly relevant when it comes to IMEs taking place in a mental health setting, due to the importance of relational dynamics in achieving therapeutic outcomes in this domain (see 3.2.4).

Having laid out the literature background and theoretical framework underpinning this thesis through three literature review chapters (2, 3 and 4), I proceed to describe the datasets and methodological approach adopted to empirically enable this study in chapter 5 below. Later on, in chapters 6 and 7 I provide a discussion of the findings resulting from the qualitative analysis of the data. Finally, these findings will be synthesised in chapter 8 against the studies reviewed so far in the three literature review chapters.

Chapter 5 – Methodology, methods and data

In this chapter, I discuss the methodological steps that I followed to conduct this empirical study. I firstly explain the methodological foundations and research design adopted for the research. Subsequently, I discuss the practical realisation of such design by describing the processes of data collection and analysis.

5.1 Methodology

In this section, I operationalise the object of study of this thesis (5.1.1) and I discuss how such operationalisation motivated the choice of a case study research design (5.1.2) as well as the adoption of constructivism as the epistemological stance for this research (5.1.3).

5.1.1 Object of study

The object of study of this thesis is two-fold: rapport-related perceptions and rapport management (RM) practices. In alignment with Spencer-Oatey's RM theory (2009: 102), described in 4.2.3, this thesis understands 'rapport' as "people's subjective perceptions of (dis)harmony, smoothness-turbulence and warmth-antagonism in interpersonal relations". Drawing on this definition, 'rapport management' is conceived as "the ways in which this (dis)harmony is (mis)managed" (*ibid.).* Thus, the object of study of this thesis is twofold because there is a 'product' dimension to the notion of rapport, that is, as a subjective perception; and also a 'process' dimension, that is, the communicative moves leading to participants' perceptions of (dis)harmony in real interactions. The product and process dimensions of this object of study call for a multimethods approach, as two different types of data are needed, along with their corresponding data collection strategies.

Rapport perceptions

On the one hand, exploring rapport in its product dimension calls for the exploration of participants' views on relational rapport in a given interaction as well as the decision-making processes underpinning their own RM-related communicative practices. For this reason, conducting individual interviews with selected participants was chosen as the best method to directly access their views on rapport and RM. I decided that one-to-one in-depth interviews centred around the idea of rapport was an appropriate method to address the object of study because rapport, understood as the individual perception of

interactional harmony, belongs to the realm of the subjective, idiosyncratic and even of the semi-unconscious (Spencer-Oatey, 2008). For this reason, participants' views should be central when addressing this concept. Additionally, multiple contextual factors including environmental, interpersonal and intrapersonal aspects, may impact on what a person perceives as harmony or antagonism in their social relations (*ibid*.). The fact that all these factors may shape a person's subjective view of rapport, means that their perception is individual (what a person might perceive as a harmonious relationship might not be shared by their interlocutor) and unique in time (the same interactional occurrence might enthuse or bother a person differently under different circumstances). For these reasons, I determined that an exploration on rapport should be situated, that is, context-bound. Consequently, I decided that the best way to explore the interplay between contextual factors and participants' rapport perceptions was to ask them about their views on rapport in relation to a specific communicative encounter. That is, by conducting post-event interviews around what participants' views on rapport were for that specific interaction.

Rapport management practices

On the other hand, exploring rapport in its process dimension, that is, exploring the act of managing rapport, requires a different type of inquiry approach and data. Rapport perceptions are born out of the interplay between participants' interactional dispositions, also known as 'orientations', and the exchange of relational moves in interaction (Spencer-Oatey, 2008). Relational moves that seek to maintain or change the interactional balance of an encounter are referred to in this thesis as RM practices or RM behaviour. Rapport management practices may consist of linguistic, paralinguistic and non-verbal actions that may be traced in discourse. Because an inquiry into this dimension of rapport requires looking into the process of exchanging relational moves, the ideal data to capture this dimension would be video or audio recordings of speakers interacting in a real-life situation with the aim of tracing and describing authentic instances of rapport management practices.

Conclusion: two dimensions of research subject

In brief, two different types of data are required to conduct a comprehensive inquiry into the two dimensions of rapport: eliciting participants' views is necessary to shed light into rapport as a perception; and examining genuine instances of rapport management practices is necessary to gain insights into the process dimension of this

concept. As a result, a multi-method approach to data collection and analysis, sustained by a case-study research design was selected as the most appropriate method to effectively address the twofold dimension of rapport for the reasons discussed below.

5.1.2 Case study research design

Guided and prompted by the twofold operationalisation of its object of study, the mode of inquiry adopted in this thesis follows the principles for case study research design proposed by Yin (2018). Yin recognises that the validity of case studies as a formal research design has been repeteadly questioned in the past. So, in his 2018 work, he clarifies that the view of case studies as a non-rigorous enough research method is rooted in the confusion between non-research case studies, found as supplementary material in many sources; and case study research understood as a formal research method. Having clarified this difference, Yin goes on to explain that case studies, when conducted following systematic procedures, can be a promising research design with great potential to ensure rigour within qualitative approaches. However Yin (2018) also stresses that, to ensure that case study research is conducted in such a way that safeguards rigour, a set of guidelines must be methodically followed as case studies have their own logic. The main guidelines for case study research proposed by Yin (2018) are discussed below because they will be integrated and adopted in this thesis.

Firstly, Yin establishes that a case study must be concerned with the investigation of a real-life, contemporary and specific phenomenon within its real-world context (*ibid*.). Also, Yin establishes that such phenomenon must be investigated in depth. In Yin's view, depth can be achieved by accounting for as many contextual factors surrounding the phenomenon under scrutiny, as this will help build a more complete picture of how the phenomenon interacts with its real-world environment. In this regard, Yin proposes that accounting for as many contextual factors as possible can be achieved by relying on multiple sources of evidence, with data converging in a triangulating fashion (*ibid*.).

Following Yin's (2018) description of case study research design, the real-life phenomenon that this thesis aims to examine are RM practices between participants involved in a number of interpreter-mediated events, as well as their views on interactional rapport for those encounters. To enable this inquiry, this thesis draws on the triangulation of two datasets that feature two different types of qualitative data. Dataset 1 consists of transcriptions of three interpreter-mediated audio-recorded consultations between an English-speaking psychiatrist and a Spanish-speaking patient. Dataset 2 consists of retrospective interviews conducted with participants involved in

the consultations featured in dataset 1. In triangulating datasets 1 and 2, the goal is to fully understand their RM practices as well as how participants make meaning of such practices in retrospective. It is expected that true-to-life findings will be produced by exploring participants' spontaneous rapport management behaviours in natural clinical consultations. This inquiry will be enabled by providing analytical descriptions of excerpts extracted from the data, selected on the grounds of relevance. Below, I describe what the notions of 'analytical descriptions' and 'relevance' mean in this context.

Firstly, 'analytical descriptions' are understood as qualitative discussions that are contextually-grounded and empirically supported and framed by a suitable theoretical framework (Blaikie, 2000). Spencer-Oatey's RM theory (2008) is the theoretical framework of this study, and will thus help determine what excerpts are relevant enough to be analytically described. Drawing on RM theory, a given excerpt might qualify as relevant to be analytically described if it elicits some aspect of participants' RM behaviours or their understanding of rapport.

One of the reasons why RM theory and case-study research were selected as complementary pillars for this study is because RM theory promotes the study of how participants' rapport management behaviours are influenced by broader contextual factors. In turn, understanding how the object of inquiry interacts with its real-world contextual environment is one of the main aims of case study research design, given that understanding this interplay is a form of gaining depth of findings. In other words: a case study research design is useful to safeguard the analytical depth required by the study of an object of study as complex and contextually-bound as rapport management in interpreter-mediated talk.

Finally, it must be acknowledged that a reason why a case-study research design is useful to study RM practices and perceptions is because the multiplicity of methods embraced in case study research design. I posit that multi-methods can help counteract the biases potentially encountered in the interpretative inquiry involved in the exploration of a concept as subjective as rapport in interpreter-mediated talk. In this regard, an analytical approach based on triangulation, that is, the juxtaposition of several qualitative datasets can play an important role in counteracting these biases when approaching interpreter-mediated talk because:

> "triangulation can contribute to corroborate or refute findings by including the theoretical constructs that guide the description, analysis and interpretation of data in the triangle and identifying evidence for convergence patterns among datasets and provide an internally coherent pathway." (Aguilar-Solano, 2020: 38).

Section 5.3.4 below offers an in-depth discussion of how, following the line of Aguilar-Solano's (2020) thinking in her quote, triangulation is used to explore RM practices between participants in this study.

5.1.3 Epistemological stance

The ultimate aim of this thesis is to build a qualitative account as comprehensive as possible of how participants make collective sense of linguistically expressed meanings; more specifically of relationally-oriented talk, understood as rapport management. These meanings will be explored through different angles; thus, the collection of two complementary datasets offering discursive and interview data. Regarding the data from the interviews, it is accepted in this thesis that different participants may understand the same interactional episode under a different light, as their cognitive frame might be conditioned by a number of intrapersonal or sociological factors. Instead of assigning the status of valid or invalid to any of these opinions, all participants' views that provide a relevant viewpoint on the object of study will be equally considered, as they might contribute to build a fuller picture on the complexity of RM practices and perceptions. Accommodating a relativist perspective to the study of rapport is necessary because, as mentioned in 5.1.1, the notion of rapport belongs to the realm of the subjective. This is because, even if RM practices can be observed, described and even traced and quantified; rapport outcomes (rapport enhancing, threatening, maintaining or neglecting) ultimately depend on the interactant's perception (Spencer-Oatey, 2008). Consequently, there is not just one possible single answer when providing an account of relational practices in interpreted interaction. Instead, it is acknowledged in this thesis that multiple meanings of a same reality may be valid because even if different participants' views do not converge, they might be approaching the same phenomenon from different angles, expressed through different viewpoints.

All in all, due to the subjectivity that is intrinsic to the study of rapport, this thesis needs to accommodate a 'relativist' epistemological perspective, which naturally aligns this inquiry with the concerns of post-positivistic approaches to gaining knowledge from the social sciences, particularly with that of 'social constructivism'. Pöchhacker (2011: 13) proposes that "the fundamental assumption of constructivist epistemology is that there is no single reality; rather, reality exists only as represented by human thought, and all knowledge about it is necessarily a human construction". Thus, due to the qualitative nature of this inquiry as well as the multiple and potentially diverging ways that

different people might perceive the idea of interactional rapport, a relativist standpoint underpinned by a constructivist epistemological stance seem appropriate for this study. A constructivist epistemology is not only relevant to enable the accommodation of different participants' views, but also in relation to the relationship between the researcher and the object of study: describing and analysing rapport management practices is an observer-dependent undertaking, so caution must be exerted to minimise bias. Relevant to this idea is Aguilar-Solano's (2020: 36) paraphrasing of Taylor, Bogdan and DeVault (1998), whereby she discusses how:

> "constructivism suggests that reality is constructed through processes of social interaction, including the relationship between researchers and participants and, therefore, truth is a flawed notion that is relational and dependent on researcher's perspectives."

Precisely because the study of rapport is observer-dependant, it is acknowledged in this thesis that potential for researcher's bias must be proactively minimised whenever possible. Minimising researcher's bias will be one of the explicit uses of triangulation in this study.

In conclusion, this thesis features a qualitative inquiry that accommodates a relativist perspective of reality and a social constructivist approach to the study of rapport. Having laid out the epistemological foundations and research design that underpin the research conducted as part of this thesis, I proceed to discuss in the next section the procedures followed to gather datasets 1 and 2, the two components of this case study.

5.2 Data collection: building the case

In this section, I provide an account of the steps taken to gather the necessary data to build the case study presented in this thesis as well as a description of the case itself.

5.2.1 Contacting healthcare providers

As this study is aligned with the dialogic discourse-based paradigm of interpreting studies, which places an emphasis on exploring authentic data (see 2.1.2), my aim was to analyse authentic audio-recorded interpreter-mediated mental healthcare (MHC) consultations. However, I started my PhD having no contacts in the National Health

Service. For this reason, I decided to circulate an online questionnaire among MHC practitioners in Scotland where I sought their opinion about different aspects of mental health interpreting. The results of this inquiry will be published in Rodríguez-Vicente, Napier and De-Pedro (forthcoming). In this online questionnaire, I invited them to provide their e-mail address in case they were interested in participating in an observational study. One of the participants who completed the online questionnaire contacted me by-email and expressed his interest on this project. He was a consultant psychiatrist working in a public healthcare setting in Scotland, with previous experience providing his services through interpreters. I refer to him in this thesis as 'Dr. Sharpe', as that is the pseudonym assigned for him in the dataset 1 transcripts. Dr. Sharpe invited me to present the preliminary questionnaire data as part of a formative event for the MHC staff working at his hospital. My talk followed a group discussion, which raised awareness among the professionals on the value of conducting a study based on real cases as well as on their own role in facilitating access to these data. At the end of this event, I obtained the informal support of the MHC team at the hospital in question to observe authentic interpreter-mediated events (IMEs). However, because this research involved engagement with human participants, it could not be conducted without prior ethical approval granted by the NHS research authority as well as Heriot-Watt University. The process involved in obtaining ethical approval is detailed below.

5.2.2 Ethical approval

I submitted the application for ethical approval to the School of Languages and Intercultural Studies (LINCS) Ethics Officer at Heriot-Watt University on the first of May 2017. I received a favourable response on the eleventh of May that year. Regarding ethical approval granted by the UK National Health Service (NHS) research ethics authorities, I formally initiated the application process in May 2017, and I was granted final clearance to conduct the study a year after, in September 2018 (see formal letters of approval in appendix 1). Obtaining ethical approval by the relevant NHS Health Research Authorities entailed the following processes:

1. Obtaining a favourable opinion by an independent NHS Research Ethics Committee (REC) that can be located anywhere in the UK. See formal letter of ethical approval in Appendix 3, form 1. The REC allocated to my application was called 'Leicester Central'. In order to receive this approval, it is necessary to complete an Integrated

Research Application System (IRAS) request through their web-based portal[7]. The IRAS application requires the completion of multiple forms as well as the submission of supporting documentation such as a full protocol for the study, and consent forms and participant information sheets for the potential participants (see appendix 4, forms 1 and 2).

2. Obtaining approval by the relevant Information Governance Team (called 'Caldicott Guardian') at NHS Lothian[8], the health area within which the data collection for this thesis was conducted. The Caldicott Guardian is concerned with the handling of patient-identifiable data and compliance with relevant Data Protection legislation. See formal letter of approval by Caldicott Guardian in Appendix 3, form 2.

3. Obtaining an 'honorary research contract' through a Research Passport application. This application consists of three independent processes: Receiving an Enhanced DBS (Disclosure and Barring Service) criminal record check. Receiving an Occupational Health certificate which included data from my own health records including immunisations. This information had to be translated and sent by the Spanish Health Authority to the UK health service Showing proof of sponsorship granted by the Human Resources Department at my University. See honorary research contract letter in Appendix 3, form 3.

4. After completing the three steps outlined above, the Research and Development (R&D) team from NHS Lothian, made the final decision. To enable this decision, the R&D team required the completion of a final application demonstrating official proof of sponsorship by a healthcare practitioner from the NHS premises in which the study is taking place, as well as by a manager for such premise. See formal letter of approval in appendix 3, form 4.

5.2.3 Fieldwork and case selection

As soon as I was granted ethical approval by all the relevant research authorities, Dr. Sharpe invited me to observe some of his upcoming interpreter-mediated consultations.

Observing medical consultations

From August 2018 to May 2019, I was able to observe medical consultations involving English (Dr. Sharpe's language) and languages such as Polish, Spanish, Urdu, Italian, Chinese, Arabic, and Lithuanian. Dr. Sharpe always selected the consultations that

[7] https://www.myresearchproject.org.uk/
[8] https://www.accord.scot/research-access/go-study-mangement

would be appropriate for me to observe, mainly those involving patients with mental heatlh conditions that were not acute, to ensure patient's wellbeing. I always observed the sessions as a non-participant and only had personal contact with the patients briefly in the waiting room before the consultation started. Informed consent from interpreters and patients was elicited just before the beginning of the consultation, always in the presence of Dr. Sharpe. Interpreters helped in explaining the content of the participant information sheets and consent forms, originally in English, to the patients. An exception was regarding Spanish language, as I provided Spanish translations of all documents for all Spanish-speaking patients. While asking for informed consent, I asked participants whether I could observe and audio-record their consultations, but I made clear that they could refuse one of the two options or deny informed consent entirely either at the start of the consultation or once the session was initiated.

The observer's paradox

Once confirming that all participants (doctor, interpreters and patient) for each consultation provided informed consent to my observations, I would come into the consultation room along with the participants. Once inside the room, I would sit at the back, to avoid being part of participants' viewing angles in an attempt to minimise the 'observer paradox', documented by Labov (1972). Sociolinguist Labov (*ibid*.) described his frustrations at participants increasing their register when they knew that they were being observed as they became self-conscious of their speech; so I took action to minimise this phenomenon and capture rapport management practices that were as spontaneous and genuine as possible. Other actions taken to minimise the observer's paradox included using an audio-recorder of a small size that was always placed on the floor, just beside my chair, so that it would not become a distraction for participants. Also, I did not participate in the sessions in any personal capacity beyond that of observing and taking notes, thus following a non-participant observation approach (Hale and Napier, 2013). Once the consultation started, I took ethnographic notes of non-verbal communicative actions of participants and started the audio-recording of the session if I was granted permission for this purpose..

Selecting the case

Despite collecting data on many medical consultations involving different patients and language combinations, I decided for this thesis to exclusively use the recorded material of three consultations involving the clinical case of a Spanish-speaking patient from a

Latin American country. That means that this patient is the unit of data collection for the case study featured in this thesis. This patient is referred to by the pseudonym 'Irene' from now onwards. There were three reasons for the selection of this case. Firstly, Spanish is my first language so I would not need to rely on external help to transcribe the audio recordings. This would have been problematic due to questions of reliability, confidentiality and the sensitive nature of the data (Temple and Edwards, 2002). Secondly, I was able to observe three consultations involving Irene, instead of the one-off consultations where I saw other patients. This continuity made it possible for me to witness Irene's health journey as well as her growing relationship with Dr. Sharpe, with myself and the three different interpreters that worked in each of Irene's sessions. My language affinity with Irene enabled me to fully immerse myself in the case study in different ways. For example, I understood everything inside the consultation room (unlike in situations involving other languages); and I was also able to build my own rapport with Irene, her daughter (Laura) and the three interpreters involved. Additionally, Irene allowed me to audio-record every consultation, after my reassurances that the audio material would be kept private and confidential. My language affinity with Irene helped me access and audio-record the interactions, but I must acknowledge that such affinity might have been the reason why my presence might have partly influenced participants' behaviour, even if that was in subtle ways. I noted in my ethnographic notes that there were two occasions where the patient looked at me, while smiling, after making a joke. Also, I noted that there were three instances where the interpreters (two of them) looked at me when having difficulty coming up with an equivalent in Spanish of an original word in English.

5.2.4 The case

As mentioned in the preceding section, the case study presented in this thesis revolves around the clinical case of a Spanish-speaking female patient and an English-speaking psychiatry consultant that took place in a Department of Psychological Medicine within a large hospital in Scotland.

5.2.4.1 Psychological medicine

The Department of Psychological Medicine is a mental health outpatient clinic within a public hospital located in a health area managed by the NHS Lothian regional trust. In this clinic work a variety of mental health professionals, including psychiatry consultants, trainee doctors, psychiatric nurses and psychologists. The team delivers their service to approximately 12,000 patients per year, some of whom being linguistically and culturally diverse and therefore need interpreters to access this service. Patients referred to this clinic typically suffer from multiple ailments, normally with one physiological condition and another of a psychological nature. This type of multimorbidity may arise because mental and physical wellbeing exert a powerful influence over one another (McFarlane, 2010). Physical and psychological comorbidities might feed one another and, therefore, need to be treated jointly (*ibid*.). This means that, even though it is a mental health service, it is strongly linked with other medical specialties and thus, the name 'Psychological Medicine'.

5.2.4.2 Supplier of interpreting services

The Scottish National Health Service is divided into sub-organisational units serving a geographical area called health boards or trust. Each trust functions as an independent organisation and autonomously manages the services they offer including communication support, which encompasses interpreting services. The model of provision within NHS Lothian consists of their own interpretation and translation service which is centrally funded by the board. Hence clinical meetings including the ones featuring in this thesis are free of charge for patients. For the languages in most demand, the NHS Lothian interpreting and translation service has a pool of contracted interpreters who work for the board when required. For other languages, such as languages of lesser diffusion, interpreting services are outsourced to a private agency. The particular interpreters that feature in this thesis are all part of the pool of interpreters of the NHS Lothian interpreting service.

5.2.4.3 The participants

'Irene' is the pseudonym for a Spanish-speaking patient of Latin-American origin who accessed the Department of Psychological Medicine seeking help and advice on her comorbidities. Irene is an elderly woman with chronic kidney failure who depends on dialysis treatment to survive. Irene accessed the service because she was not only

struggling with the symptoms of her disease but also with depression and cognitive decline.

Irene's daughter, referred to in this thesis by the pseudonym 'Laura', attended all of the sessions that feature in dataset 1 of this thesis as her mother's companion. She is fully proficient in English and a native speaker of Spanish. Additionally, she works in a dialysis-related field, so she has good health-care literacy and knowledge of her mother's condition in English and Spanish. In accordance to the service policy, she is not allowed to interpret for her mother and interpreters are called into the sessions. Her role in the sessions is normally that of a by-stander.

'Dr. Sharpe' is the pseudonym for the mental health specialist who took on Irene's mental health care and treatment. He is a doctor with previous experience in the field. His experience includes providing his service through a number of interpreters and language combinations including English and Spanish.

As mentioned in the preceeding section, the three interpreters that feature in this study are freelances that are also part of the pool of the NHS Lothian interpreting service. The table below shows some basic information about the three interpreters (with pseudonyms).

Table 1 – The three interpreters

	Interpreter #1 Elisa	**Interpreter #2 Julia**	**Interpreter #3 Maya**
Occupation	PhD student + freelance translator and PSI interpreter	Full time freelance translator and interpreter (conference + PSI)	Full time freelance translator and PSI interpreter
Interpreter education	MA interpreting and translation	MA Interpreting	DPSI Law
PSI experience	8 years	Over 30 years	Over 15 years

Elisa and Julia were previously acquainted with both Irene and her daughter. Firstly, the NHS Lothian interpreting service always employs the same interpreters as they belong to their own internal pool of contracted interpreters. This increases the chance of

patients seeing interpreters multiple times. Secondly, Irene suffers from a chronic condition, which means that she has constant contact with different health services, which also increases the chances to see different interpreters for every hospital visit.

5.2.4.4 The consultations

I observed and audio-recorded three consultations featuring Irene, Dr. Sharpe and three different interpreters that took place between December 2018 and May 2019. I cannot provide the exact dates for confidentiality reasons (see Appendix 3).

While general details about the three recorded encounters are schematically outlined in tables 2, 3 and 4 below; more specific situational, sociological and interactional information on each of the consultations will be provided in chapter 6 and 7.

Consultation # 1

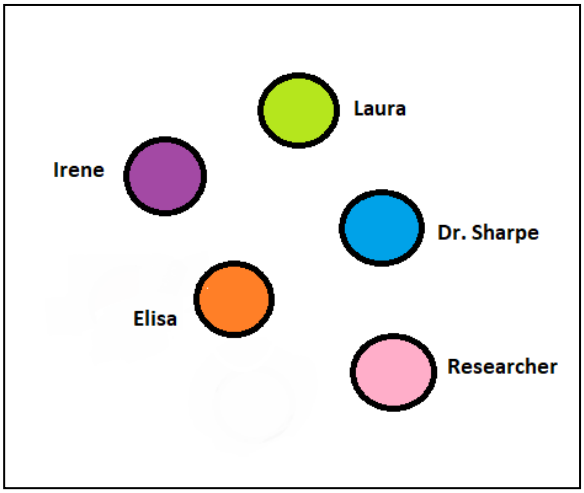
Irene's primary physician has referred her to Psychological Medicine, concerned by her extremely low mood. The reasons for her mood are explored in consultation #1; namely, the negative effects that Irene's burdensome treatment (haemodialysis) is having on her life and relationships; the distress that Irene's cognitive decline is causing her and her daughter; and Irene's reported feelings of isolation living in Scotland. All of these issues are explored in this session by Dr. Sharpe. An argument takes place between Irene and her daughter during the consultation, which leads Dr. Sharpe to decide to separate them in the first stages of consultations #2 and #3. In consultation #1, solutions to her medical problems are discussed, including a change of dialysis treatment and the possibility of a kidney transplantation. The possibility of prescribing antidepressant medication for Irene is also explored at the end of the session.

Table 2 – Consultation #1

Consultation #1 (1h)	
Phase 1: Introduction	Greetings
	Contextualising session within patient's healthcare journey
	Determining reasons for session: • Extreme sadness and desire to die due to health condition and personal circumstances • Side effects of medication • Recent change in dialysis treatment • Memory problems and cognitive decline
Phase 2:	Change in dialysis treatment • Self-reliance to manage treatment and assistance required • Comparison between previous and current treatment • Views on treatment by patient and her daughter
	Medication

Medical discussion	• Link between memory problems and pressure to take medication • Side-effects
	Possibility of transplantation • Obtaining patient's and relative's views • Requirements to qualify for transplantation
Phase 3: Psychosocial discussion	Personal reasons for sadness • Difficult relationships with relatives • Limitations of kidney disease on daily routine • Negative experience with healthcare system in home country • Difficulties associated with experience of migration
Phase 2.1.: Medical discussion	Antidepressants prescription
	Addressing cognitive decline: suggesting undertaking a memory test
Phase 4: Closing	Invites patient to ask questions • Living on dialysis • Interrupting treatment and end of life
	Farewell

Figure 3 – Seating arrangement in consultation #1



Consultation #2

Four months after the first appointment, Irene goes back to the department of Psychological Medicine as her new treatment (peritoneal dialysis) is not being as effective as expected. Dr. Sharpe decides to see Irene and Laura separately first and together at the end. He discusses potential prognosis outcomes that could result from a range of treatments including blood transfusions, which the patient refuses on religious grounds. The patient's fears caused by the progression of her illness and cognitive decline are addressed. At the end of the consultation, Dr Sharpe initiates a discussion on terminal care.

Table 3 – Consultation #2

Consultation #2 [1h]	
Part I: Doctor, patient and interpreter meet privately [26m]	
Phase 1: Introduction	Greetings
	Determining purpose of session: Failure of dialysis therapy
	Contextualising session within patient's healthcare journey
Phase 2: Medical discussion	Determining whether patient is hopeful for improvement
	Finding out whether patient's stance on treatment has changed • Whether to shift back to haemodialysis • Whether to interrupt treatment • Whether patient has discussed possibilities with anyone
	Determining whether patient still passes urine
	Explaining prognosis after interrupting dialysis treatment (death)
	Discussing memory loss
	Determining patient's understanding of her condition and prognosis
Phase 3: Psychosocial discussion	Addressing patient's fear about prognosis
	Discussing patient's social support
	Discussing patient's involvement with religious group
	Ascertaining whether patient has religious views on treatment
Part II: Doctor and family member meet privately [12 mins]	
Part III: Doctor – interpreter – patient – family member [22m]	
Phase 4: Providing view of current state and prognosis	Disclosure of current status, prognosis and further steps • We can only control your symptoms • We do not have a cure • Discloses prognosis: dialysis will become more difficult/patient disoriented • We need to start end-of-life discussions now: future treatments that the patient would like to receive/refuse such as resuscitation/blood transfusion/haemodialysis • Encourages patient to communicate her decision and provides advice on this • We need decisions in writing (they can be translated by NHS service)
Phase 5: Closing	Dr. Sharpe encourages patient to ask questions
	Dr. Sharpe arranges the next appointment. Farewell.

Figure 4 – Seating arrangement in consultation #2 [Part I]

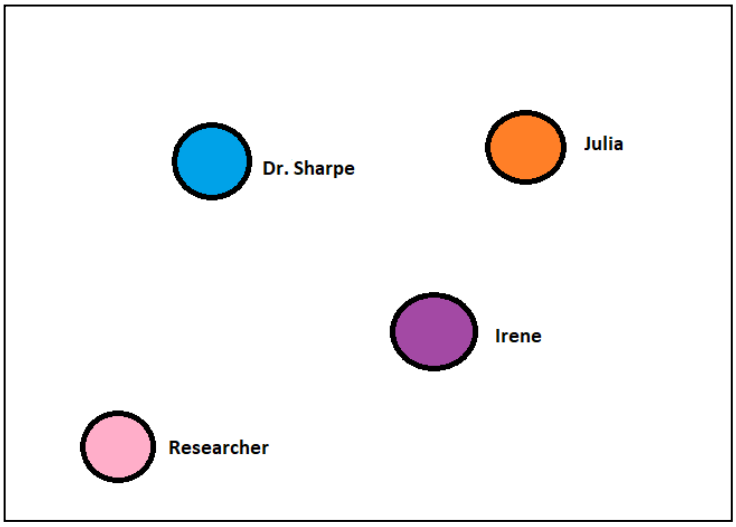
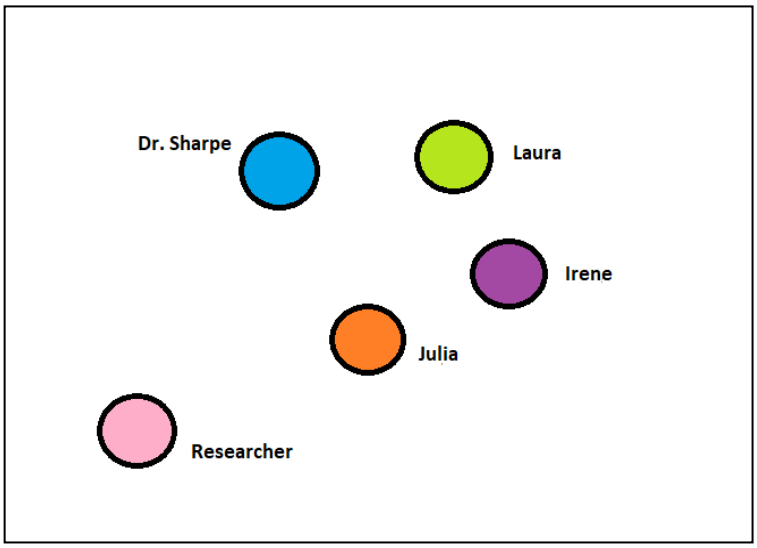


Figure 5 – Seating arrangement in consultation #2 [Part II]



Consultation #3

Irene's illness worsens and the peritoneal dialysis continues not to work. In the light of these adverse events, Dr Sharpe initiates a conversation on the treatments that Irene would and would not like to receive once the end of her life is nearer, including resuscitation. The consultant's reason to pursue this conversation is to seek consent on treatment provision before the patient's cognitive abilities decline to the point of hampering Irene's ability to genuinely provide informed consent. Additional medical issues such as memory loss are also discussed. Unaddressed family issues and end-of-life goals are explored, as well as Irene's daily routines that may be impacting her depression.

Table 4 – Consultation #3

Consultation #3 [1h 3m]	
Part I: Doctor, patient and interpreter meet privately [21m]	
Phase 1: Introduction	Greetings
	Contextualising session within patient's healthcare journey
	Determining reason for session
Phase 2: Medical discussion	Problems with new dialysis treatment
	Future treatments in place
	Potential modification of treatment • Considering failure of current treatment, discussing possibility of shifting back to previous treatment • Ascertaining that patient fully understands the consequences of her choice • Explaining to patient that she will not be forced to have treatment
	Potential interruption of treatment • Logistics involved in communicating her choice • Do Not Resuscitate plan • Reassure patient about continuity of receipt of health care after deciding to interrupt treatment (keeping symptoms under control)
Phase 3: Psychosocial discussion	Personal circumstances • Leaving the house • Social support: asking patient about involvement with religious community
Part II: Doctor ad family member meet privately (13 minutes)	
Part III: Doctor – interpreter – patient – family member (29 minutes)	
Phase 4: prognosis	• Summing up: reassuring patient and relative about involvement of healthcare team despite unpromising prognosis
Phase 5: Closing	Invites patient to ask questions
	Arranging next appointment and farewell

Figure 6 – Seating arrangement in consultation #3 [part I]

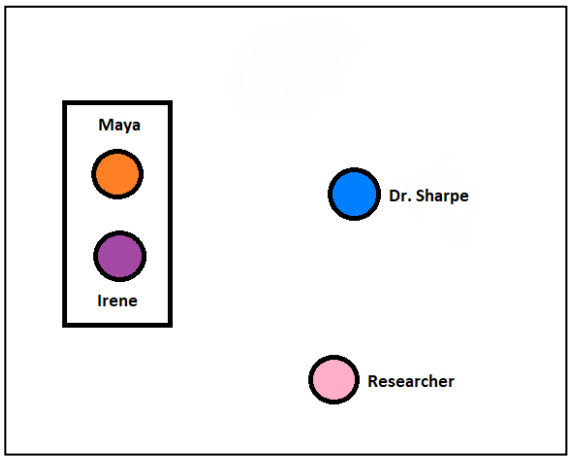
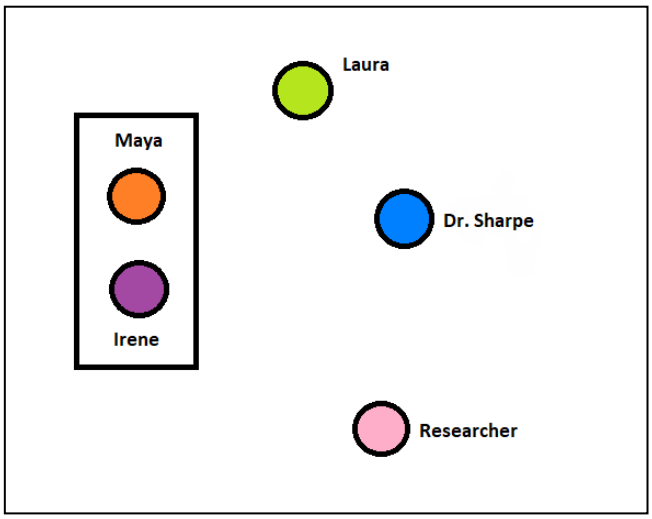


Figure 7 – Seating arrangement in consultation #3 [Part II]



5.2.5 Retrospective interviews

The interview with Dr. Sharpe was arranged directly between the clinician and myself, using e-mail correspondence, after I was informed that the patient's clinical case was over which meant that there would not be any subsequent sessions to observe. This interview took place two weeks after the last consultation that I observed (May, 2019), in Dr. Sharpe's office at the hospital. This interview lasted for 1 hour.

The interviews with interpreters Elisa and Julia were arranged thanks to the manager of the interpreting service at the hospital, who sent them the invitation attached in appendix 5, as an e-mail. Elisa and Julia contacted me directly using the e-mail address

provided in this invitation and we arranged two separate interviews. Both interviews took place in the Comely Bank Centre, a building where the interpreting service of NHS Lothian is coordinated. This building has meeting rooms that interpreters can use via prior request. The interview with Elisa took place on 12th April 2019 and lasted for 1 hour. The interview with Julia took place on 27th April 2019 and lasted for 2 hours. Dataset 2 was collected following a preliminary analysis of dataset 1, which followed the analytical protocol set out in the next section.

5.3 Data handling, analysis and reporting of findings

In this section I discuss the protocol that I followed to handle the transcriptions of dataset 1, to analyse datasets 1 and 2 and to report on the findings resulting from triangulating them.

5.3.1 Transcription and segmentation of dataset 1

The transcriptions of the audio-recorded consultations were made manually using Microsoft Word, following the horizontal transcription model that Gallez (2014) used for her study of interpreted talk in a legal setting. In Gallez's (2014) transcription model, each of the participants is represented within a column. The columns become the referential basis for the rest of the transcript as each of the participant's turns is placed in a row in the corresponding column. In this thesis, each of these rows, representing a single turn of a participant, is called a segment (S.). The series of rows expands downwards as the interaction unfolds. As this model provides a backbone for the interaction, the audio-recorded material was directly typed into a pre-designed table template in Word that followed the format shown in Table 5.

Table 5 – Horizontal transcription

	Column 1	**Column 2**	**Column 3**	**Column 4**
S.	**Clinician (Dr. Sharpe)**	**Interpreter (Elisa/Julia/ Maya)**	**Patient (Irene)**	**Patient's daughter (Laura)**
1	Primary utterance 1 in English			
		Rendition of		

2		primary utterance 1 in Spanish		
3			Primary utterance 2 in Spanish	
4		Rendition of primary utterance 2 in English		
5	Primary utterance 3 in English			(Contributes very few interventions)

Following this model, the full propositional content of the English and Spanish utterances was transcribed and included into the corresponding column and cell, divided by participants and segments respectively as shown in the table. As I was transcribing the audio-recorded material, I also included side notes on RM-oriented non-verbal behaviours that I wrote down in my fieldwork notes during my observations. Similarly, only the paralinguistic elements that seemed relevant from a RM perspective were annotated in the transcripts and selected for inclusion in the reporting of findings. Appendix 1 includes a list of transcription conventions adopted in the interactional excerpts from dataset 1 shown in chapters 6 and 7. All in all, consultation #1 consisted of 631 segments; consultation #2 was made up of 681 segments and consultation #3 included 512 segments, thus summing a total of 1824 segmetns to be analysed. After the transcriptions were completed in Microsoft Word, they were imported as files into the qualitative data analysis software NVivo for further annotation, description and analysis, as further described in section 5.3.3.

The allocation of participants to each of the columns is supported by the following rationale. Firstly, Dr. Sharpe occupies column 1 on the left because he is the participant that holds the institutional power (see 6.2.1). This means that he is the participant that manages how the consultation unfolds by selecting or discarding topics, directing the topic transitions through the formulation of the relevant questions, and making the transitions between the different consultation phases (Tipton and Furmanek, 2016). For

this reason, it is useful to have the doctor (institutional representative) on the first left column. This allows to easily trace the stages of the consultation. Regarding the interpreters, they have been placed in the middle column of the table, between Dr. Sharpe and Irene, because of the role that they play as linguistic mediators. This positioning provides a quick visual representation of how the utterances are bridged through the interpreters' renditions. Finally, the patient has been placed in the third column, and her daughter is placed in the fourth column as she barely intervenes.

5.3.2 From speakers' turns to RSSAs

Following the audio-transcriptions of the medical consultations, the next step consisted in identifying the unit of (discourse) analysis in the transcripts. The unit of analysis are rapport-sensitive speech acts (RSSAs). RSSAs will be explained later on in this section as a few steps are required before RSSAs can be identified. Namely, the consideration of the following three-fold multi-layered division of participants' speech output:

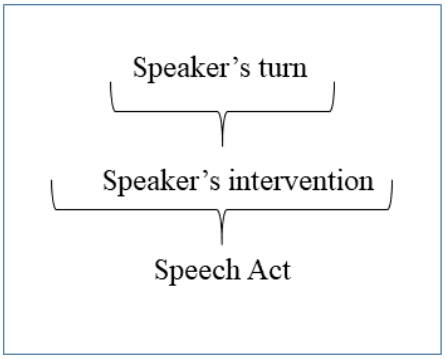


Figure 8 – Architecture of speakers' discursive output

Speakers' turns are the most basic layer in the architecture of participants' speech output. They are the minimal unit for transcription. As explained above, each of the speaker's turns is represented in a single row, or a segment (S.) in the transcriptions. Segment are not a reliable unit of analysis as they are not comparable either in formal nature or communicative function. Nonetheless, the division of the audio-recording into speakers' turns through the segments provided a baseline for further analysis.

The second level of transcript analysis is that of speakers' interventions, which may coincide with speakers' turns or not. Table 6 below shows an example from consultation #3 of a speaker's intervention (highlighted in red) that does not coincide

with a turn as well as a turn (highlighted in blue). By providing table 6, I seek to illustrate that one turn may be split over several interventions

Table 6 – Turns and interventions

S.	Dr. Sharpe	Maya	Irene
338	I get the impression that, although your health problems continue		
339		Tengo la impresión de que aunque continúen tus problemas de salud *I get the impression that even though your health problems continue*	
340	You are rather more accepting of them		
341		Ahora mismo parece aceptarlos mejor *Now you seem to accept them better*	
342			Sí *Yes*

Primary participants' interventions can be composed of a single or several turns. This happens when a sentence/an idea made up of several sentences is interrupted to enable the interpreter's rendition of smaller but still meaningful chunks. Even though interventions brings us a step closer to an analytical unit for discourse analysis, they are still not relevant enough from the point of view of pragmatics as a speaker's intervention does not equate to speaker's intention (illocutionary force). Once participants' interventions have been identified, a basis can be established for the following layer of analysis: the identification of speech acts and RSSAs.

As explained in section 4.1.2, a speech act is a meaningful unit of a participant's speech production through which he or she tries to perform an action. The intention of a speech act is conveyed by its illocutionary force. Thus, a speech act is identified by trying to identify the intended illocutionary force of the primary participant as well as by locating its perlocutionary effect (the reaction that it causes on the hearer). A speech act may coincide with an intervention (or even a turn), but also, the illocutionary force of an SA

can be distributed throughout a series of interventions produced by a speaker. For example, the speech act in excerpt 18 analysed in section 7.1.1.1 below is an example of what Van Dijk (1997: 99) refers to as "macro speech act" in which the illocutionary force is distributed across multiple turns. Once identified the speech acts (either micro or macro types) in the transcripts, an analytical basis is established to conduct the following step in the analysis: the identification of rapport-sensitive speech acts (RSSAs).

As mentioned above, the unit of analysis are RSSAs, which are speech acts (see 4.1.2) that bear rapport-management implications, that is, they seek to either maintain the interactional status or cause a change in the interactional balance of the encounter either by enhancing, threatening or neglecting rapport (Spencer-Oatey, 2008). Tracking RSSAs in transcribed discourse requires that the following conceptual layers be considered:

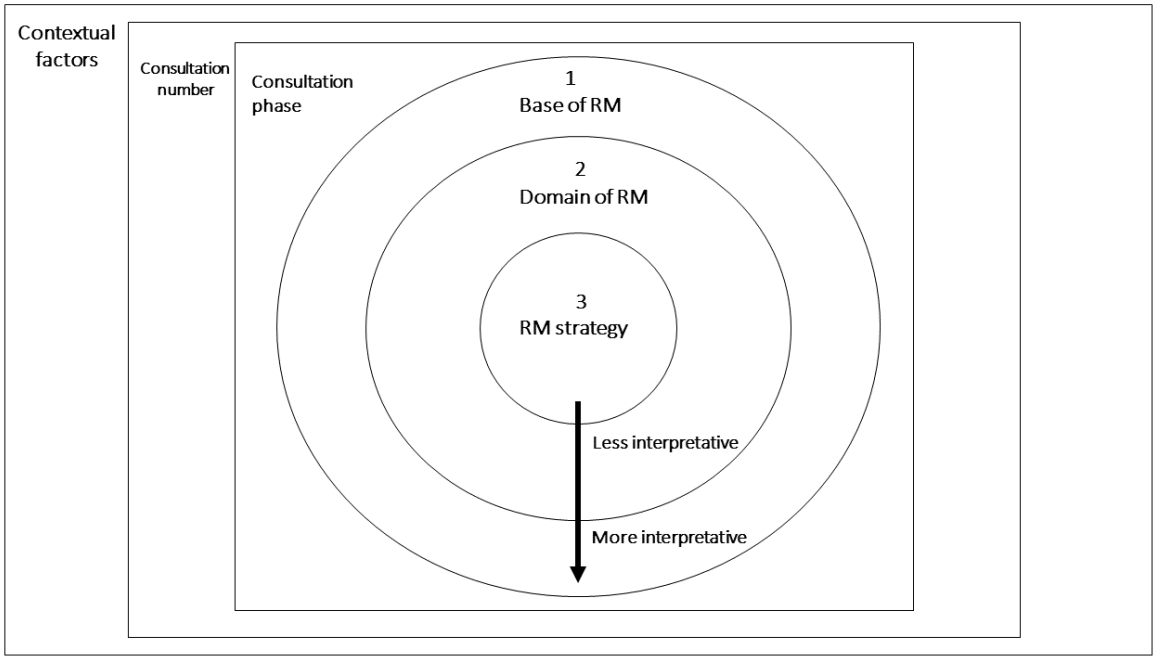


Figure 9 – Conceptual layers for analysis

A systematic approach to the analysis of RSSAs entails making a distinction between three dimensions of RSSAs. Figure 9 above graphically shows such dimensions by displaying them in three concentric circles (levels) that increase in level of abstraction as they move away from the core.

Identifying RSSAs

RSSAs can be identified by following a top-down (from level 1 to 3) or a bottom-up approach (From level 3 to 1) analysis of the levels described below.

Level 1: As discussed in section 4.3.3.1, interactional rapport may be affected by the management of three main factors, the 'bases' of rapport, represented in circle 1 of figure 9. The three bases are face sensitivities, sociality rights and obligations and interactional goals. A speech act whereby any of the three bases has potentially been affected signals a localised interactional imbalance (positive or negative) and may then be regarded an RSSA. Drawing on contextual factors is essential to determine whether a participants' face has been enhanced or threatened, whether someone has shown (un)fulfilment of a perceived sociality role or whether there is a match or mismatch in interactional goals. An RSSA can be initiated by any of the speakers involved in an IME, including the primary speakers and the interpreter. This level of analysis (the one that requires the most abstraction and interpretative effort) is not only used for the identification of RSSAs but also for the categorisation, coding and presentation of findings.

Level 2: Once an RSSA has been identified, the next analytical step is to decrease one level (circle 2) in abstraction and determine the domain within which the identified RSSA could be classified. As discussed in section 4.2.3.1, the five domains of RM management are illocutionary, discourse, participation, stylistic and non-verbal. Each of the domains is of a very different linguistic nature and has its own repertoire of strategies (level 3).

Level 3 refers to the verbal (linguistic), paralinguistic or non-verbal materialisation of the identified RSSA, which signals relational work. This level refers to directly observable communicative behaviour, so it requires less interpretative effort.

Describing and analysing RSSAs

Once an RSSA has been identified, as well as the domain of rapport management to which it belongs and the strategy through which it has been materialised, it can be described and analysed in terms of success in its reception by the intended hearer (perlocutionary effect). The following questions guided the description of RSSAs:

Table 7 – Identifying and describing RSSAs

Topic	Questions
Identifying RSSA	• What is the RSSA? • What base of RM has been affected? • What domain does it belong to? • What is the function of this RSSA?
Speakers involved	• Who initiates the RSSA? • Who is the intended/unintended hearer?
Interpreter's rendition	• How is the RSSA rendered by the interpreter? • Is the illocutionary force of the original enhanced/mitigated/neutral in the interpreter's rendition?
Perlocutionary act	• What is the effect of this utterance on its intended interlocutor?
RSSA and context	• What is the context of this RSSA? • How does the RSSA relate to the context that surrounds it?

Comparing RSSAs in original and interpreted utterances

One of the assumptions underpinning the analytical approach in this thesis is that interpreters might render the pragmatic markers within original RSSAs in different ways which might, in turn, lead to differerent rapport management outcomes. From this point of view, it is important to compare the semantic content of original and rendered utterances. To support this undertaking, I adopt Wadensjö's (1998: 107-108) taxonomy of interpreters' renditions:

- A 'close' rendition happens when the propositional content and style in the rendered utterance substantially matches that of the original.
- An 'expanded' rendition refers to a situation where there is more explicitly expressed information in the rendition than the original.
- A 'reduced' rendition happens when the interpreter's turn contains less explicitly expressed information than the original.
- A 'substituted' rendition is a combination between expanded and reduced.
- A 'multi-part' rendition happens when two interpreted utterances correspond to one original, which is split into parts by another original.
- A 'summarised' rendition is text that corresponds to two or more prior originals.
- A 'non' rendition is a rendition actively initiated and owned by the interpreter.
- A 'zero' rendition is an original utterance left untranslated by the interpreter.

5.3.3 Annotation and coding

As mentioned earlier, word files with the transcriptions of each of the three sessions were imported into NVivo for subsequent annotation and coding. The annotation feature within NVivo was used to link the handwritten ethnographic fieldnotes with the segments that they referred to, and to note new memos aimed at describing the data and linking it with previous interactional pragmatics theories, as shown in chapters 6 and 7.

The process of annotation was useful to answer the question "who is doing what?", that is, what types of RSSAs tend to correspond to which speaker. For example, RSSAs associated with the doctor tend to reassure, provide information, or elicit information from the patient. As for coding, a taxonomy of Nodes was set up in NVivo in order to classify the RSSAs in the files imported, as the figure below shows:

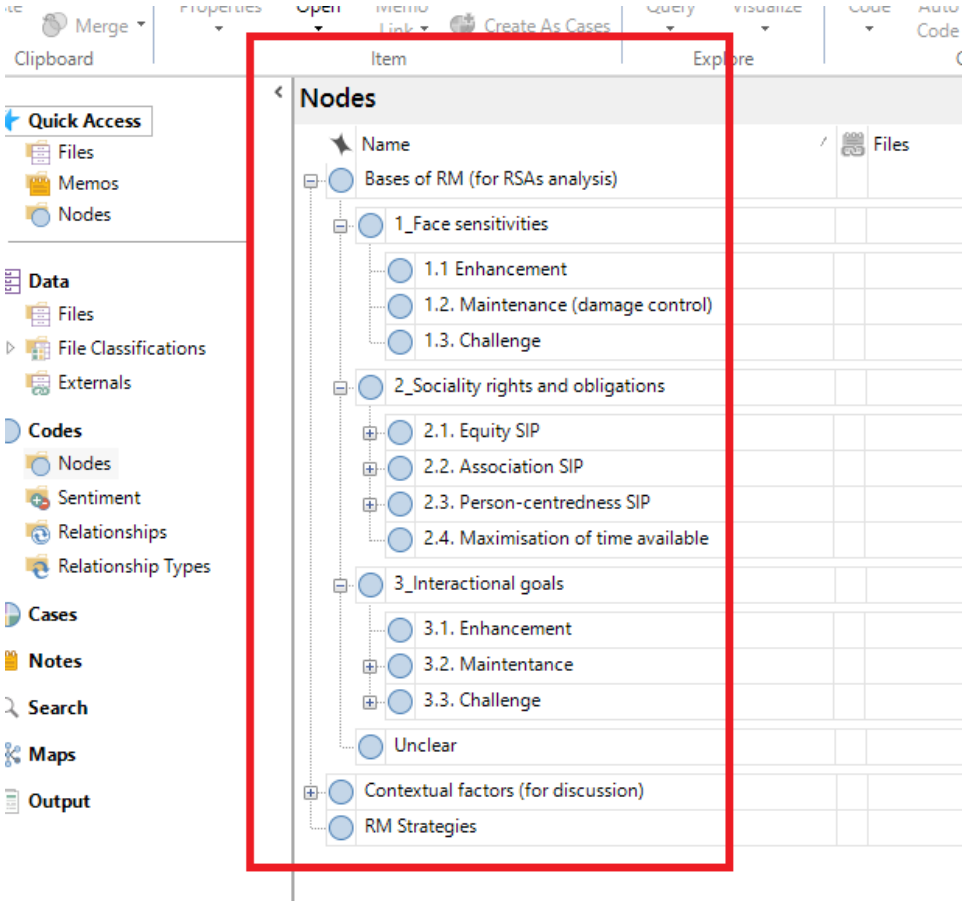


Figure 10 – Coding template

The codes refer to each of the 'bases of rapport' as defined by Spencer-Oatey (2008) and, within each of the codes, sub-codes were added to further clarify whether the selected RSSA is aimed at rapport enhancement (positive rapport), maintenance (threat mitigation) or challenge (negative rapport) and to trace interactional patterns. For example, discovering the category of RSSA that is the most prominent would help to

establish whether the sessions have an overall rapport enhancement, maintenance or challenge orientation.

5.3.4 Triangulation and reporting of findings

A qualitative approach was selected as the most appropriate means to scrutinise and report the findings from the discourse analysis of dataset 1. The aim was to illustrate theoretical arguments through the analytical description of a selection of RSSAs. The following list offers an outline of the criteria that was developed throughout the data analysis stage to determine what makes an RSSA worth providing with an analytical description and therefore, candidate to be shown as part of the findings chapter in this thesis:

- A participant (this term includes primary speakers and interpreters) has deliberately/unintendedly initiated an RSSA that has the potential to:
    - Enhance/threaten (with or without mitigation) another participant's face
    - Enhance/Infringe another participant's sociality rights/obligations (behavioural expectations)
    - Enhance/Hamper another participant's interactional goals
- The illocutionary force of the original utterance (marked/unmarked) has been considerably enhanced/diminished in the interpreter's performance, thus making it marked.

If an RSSA under scrutiny fulfilled the requisites above and also helped illustrate in any way how rapport management dynamics are negotiated, I provided an analytical description for the excerpt containing such RSSA. For those RSSAs that I discussed with participants as part of the interviews, I integrated relevant participants' quotes into their analytical descriptions, triangulating both datasets. Chapters 6 and 7 are the result of this process. In these chapters, I provide a selection of the most relevant excerpts containing RSSAs, some of them being triangulated with quotes from dataset 2.

5.4 Concluding remarks

The initial assumption for this thesis was that, in order to build a holistic explanation of participants' rapport management practices, it is necessary to consider a wide perspective of communication whereby a variety of elements are integrated; namely, pragma-linguistic descriptions of participants' discursive practices as well as interlocutors' perceptions of and attitudes towards interactional rapport. In this chapter, I have discussed how the multi-methods methodological approach to data collection and

analysis within this thesis responds to such requirement. Namely, by adopting a case-study research design wherein two datasets, containing discursive practices and participants' perceptions are assembled and triangulated. I also discussed in this chapter how this inquiry is underpinned by the epistemological stance of social constructivism.

The methodological approach makes it possible to move away from a text-centered interpreted-oriented analysis to one that focuses on how higher-order layers of meaning (see the three circles in 5.3.2) are co-constructed by all participants. The results from this methodological inquiry are shown in chapters 6 and 7 below.

Chapter 6 – Interplay of contextual factors and rapport management dynamics

Rapport management (RM) theory proposes that speakers' RM practices and the resulting outcomes in terms of interlocutors' perceptions of (dis)harmony do not happen in a social vacuum (Spencer-Oatey, 2008). Instead, participants' RM dynamics (a concept that encompasses both RM practices and perceptions on rapport) are influenced by a range of contextual factors (*ibid*.). In this chapter, I examine the interplay between rapport perceptions and RM practices adopted by the participants featured in this case study and a set of selected contextual factors framing the analysed encounters. A discussion on such interplay is provided along with a qualitative analysis of a selection of excerpts extracted from datasets 1 and 2. The four sections in this chapter are named after the contextual factor that shapes participants' RM practices and perceptions shown in the excerpts included within each section. The contextual factors selected for discussion are the following: participant relations in terms of power (6.1) and distance (6.2), behavioural expectations stemming from views on sociality rights and obligations (6.3) and features of the speech event framing the examined encounters (6.4).

6.1 Participant relations (I): power

Building on previous work rooted in the field of interactional pragmatics (IP), Spencer-Oatey (2008) proposes that the type of relational configuration established between participants involved in a communicative encounter may have an influence on their RM dynamics. Relational configurations can be understood in terms of power and distance, as explained in section 4.2.3. In an attempt to explore how rapport management dynamics between participants featured in my case study are connected to the type of relationships established between them, I focus on the notion of power in this section, and distance will be discussed later on in section 6.2. In turn, this section on power is divided in two parts. In 6.1.1, I provide an analytical description of two excerpts in which Dr. Sharpe and Elisa[9] face some tension between them as they share a degree of interactional power. In 6.1.2, I provide an account of another power-related relational issue, this time between the same interpreter and Laura, the patient's daughter.

[9] Dr. Sharpe is the consultant psychiatrist leading the consultations featured in the case study described in section 5.4. Elisa is interpreter #1 in this case study. See 5.4.3 for a full list of case study participants.

6.1.1 Power tensions between doctor and interpreter

Interpreter-mediated medical encounters re-enact relational configurations associated with the larger communicative event within which the interpreting activity takes place (Hsieh, 2016). The medical encounters in dataset 1, for example, are an example of an institutional event that carries an in-built asymmetry of power in which the doctor is the participant with the highest interactional status (Cordella, 2004). The power differential in a medical consultation is legitimised by the expert knowledge of the clinician, which the patient benefits from (French and Raven, 1959). In the encounters featured in dataset 1 Irene, the patient, accesses Dr. Sharpe's expert knowledge about her clinical needs and prognosis, as well as his professional opinion on treatment options available to her. The transcripts from dataset 1 show how Dr. Sharpe's footing as a high-status participant in the interaction becomes discernible in several ways. For instance, he initiates, directs and changes conversation topics to fulfil his medical agenda. In response, Irene listens and complies with the conversational direction that Dr. Sharpe proposes. By determining the purpose and scope of the sessions and employing strategies for topic control, Dr. Sharpe enacts his "institutional power" (Mason and Ren, 2012: 119) over the interaction. Nonetheless, Dr. Sharpe's institutional power is not sufficient to wield full control over the interaction. The language difference between Dr. Sharpe and Irene unavoidably leads the doctor to transfer a degree of power over the interactional management to the respective interpreters. The power exerted by the interpreters as they handle discourse dynamics, expressed for example through turn-taking, was labelled by Mason and Ren (2012: 119) as "interactional power". Ideally, the doctor's enactment of institutional power in an interpreter-mediated event (IME) would complement the interpreter's enactment of interactional power in an orderly and symbiotic manner. Whilst this symbiosis seems to be the standard across all sections in dataset 1, two localised episodes in consultation #1 are worth highlighting because the joint handling of turn-takings evidence a tension inherent in the shared enactment of interactional power between doctor and interpreter.

Excerpt 1. Consultation #1 – Ss. 91 - 93

Segment (S.) 92 in excerpt #1 below shows the clinician's first attempt to explicitly manage turn-taking dynamics in consultation #1. His action is prompted by the length of the patient's utterance in S. 91.

Table 8 – Excerpt 1

S.	Dr. Sharpe	Elisa	Irene
91[10]			Pero por eso yo digo que es un milagro *{enthusiastically}* porque yo creo en Dios yo participo en la iglesia y todo y pedí a Dios que me ayude y les decía me voy a morir, me voy a morir y de repente cambió todo totalmente y estaba comiendo no tengo ningún problema no me cansaba porque antes me agobiaba, me levantaba a las ocho de la mañana a las doce me tenía que acostar *[interrupted]* *That is why I am saying that it is a miracle {enthusiastically} because I believe in God I participate in church and everything and I asked God to help me and I told them I am going to die I am going to die and suddenly everything changed totally and I was eating I do not have any problem I was not tired because before I would get anxious I would wake up at eight in the morning and at twelve I had to go back to bed* *[interrupted]*
92	*[interrupts]* **I think probably we need to translate small amounts at a time**		
93		*{rushed}* For me it was a big change, it was like a miracle and I believe in God and I asked him to help me with that because I was feeling really tired I used to get up at 8 really exhausted and now I don't feel like that	

[10] Line numbers refer to their place in the original transcripts. Features of interest in the excerpts are shown in bold. Back translations are displayed in grey italics below the original utterances. See Appendix 1 for a full list of transcription conventions adopted in the excerpts.

S. 91 shows the patient's enthusiasm about her primary physician's decision to stop her medications. Apparently, this change made her feel so healthy and relieved that she refers to the doctor's decision as a God-sent miracle ("*un milagro*", S. 91). Her intervention is lengthy, due perhaps to her excitement and/or her lack of awareness of the need to pause to allow for interpretation, as no instructions on the interpreting process were provided at the onset of the consultation. The patient's utterance [S. 91] extends until Dr. Sharpe interrupts the patient [S. 92]. In doing so, Dr. Sharpe's utterance includes three mitigation strategies, which suggest a deliberate attempt to redress the potentially rapport-threatening force of his interruption. The hedges "I think" and "probably", as well as the use of the plural pronoun "we", infuse the utterance with a level of indirectness that shows Dr. Sharpe's will to take redressive action.

Dr. Sharpe's illocutionary goal in S. 92 is seemingly obvious: he would like to receive the translation in smaller chunks. However, the pragmatic force of the utterance is not so clear, as it can be interpreted in different ways. One possibility is that Dr. Sharpe is signalling that he would like the interpreter to interrupt the patient earlier, so as to enable the translation of smaller chunks. An equally valid interpretation is that Dr. Sharpe would like the patient to finish her turns earlier to allow the interpreter to intervene more frequently, thus providing shorter renditions. Due to the ambiguity of the pragmatic force of the utterance, it is for to the interpreter, Elisa, to decide whether S. 92 constitutes a request for the patient to speak in smaller chunks or an implied instruction for herself to be more proactive in interrupting the patient. The perlocutionary act of S. 92 becomes evident in S. 93, as it displays that Elisa understood the latter to be Dr. Sharpe's intent. This can be inferred because, instead of relaying S. 92 into Spanish, Elisa provides a rushed interpretation into English of what she remembers from S. 91.

The interpreter's lack of proactiveness in interrupting the patient could be explained by considering the real-time immediacy inherent in the logistics of the interpreting process: S. 91 might seem like an incoherent string of words at first encounter, due to the abrupt topic transition from the patient's views on spirituality to her physical symptoms. If this apparent incoherence is considered, it could be suggested that the interpreter was trying to make sense of the patient's interventions in S. 91 prior to proceeding to translate the utterance.

A complementary explanation adopts a RM theory-informed analysis of this excerpt. From a relational perspective, it would make sense that the interpreter proactively

decided not to interrupt the patient earlier in an attempt to respect the patient's 'equity right'[11] to freely express herself without feeling constrained by the interpretation process. Avoiding interrupting a patient's flow of thinking and expression, particularly in relation to emotionally charged accounts, has been highlighted as crucial in mental health interpreting elsewhere (Pollard, 1998; Boyles et al., 2015; Aguilar, 2019). If this were the case in excerpt 1, I would argue that the interpreter was complying with the notion of social expectancies, the second base of RM theory, by actively preserving the patient's sociality rights, in relation to the equity dimension.

Drawing on RM theory, I would also propose that Dr. Sharpe's interruption was triggered by the perception that his right to get a complete and accurate interpretation of the patient's statement was being infringed upon, whether by the patient who spoke for too long or by the interpreter who did not interrupt earlier.

A final feature of interest in excerpt 1 is the perlocutionary effect of S. 92. The pragmatic ambivalence in Dr. Sharpe's utterance is understood by the interpreter as a 'request' illocutionary act for her to be more proactive in interrupting the patient, and not as an 'instruction' act for the patient to be more mindful of the interpreting process. It is remarkable how not only is S. 92 perceived as a request, but the 'request' is itself legitimised by the interpreter, who behaves according to what she believes the clinician is expecting her to do, that is, to provide more timely renditions of the patients' intervention.

From a politeness theory standpoint (Brown and Levinson, 1987), requests illocutionary acts such as the interpreter's understanding of Dr. Sharpe's S. 91 are inherently threatening to the negative face of the interlocutor, as they negatively affect their freedom from imposition. For example, in this case, the interpreter's sense of professional autonomy (an identity attribute) seems to be affected by what she perceives to be a doctor's directive. The face-threatening nature of S. 92 also explains Dr. Sharpe's decision to use multiple hedges to redress the potential impact of his request.

As explained in 4.2.3, RM theory incorporates the notion of face as understood in politeness theory, but it also goes a step beyond and sees perceptions of face as dependent on contextual factors surrounding the speech act. In this respect, RM theory proposes that, while orders and requests are rapport-sensitive speech acts (RSSAs) and therefore need to be worded carefully, that does not mean that they automatically threaten face or infringe upon sociality rights. Instead, perceptions depend on a range of

[11] In rapport management theory (Spencer-Oatey, 2008), the right to 'equity' is one of the sociopragmatic interactional principles (SIPs) that rule interaction, along with the SIP of 'association' (see 4.2.3)

contextual factors. For instance, the power differential existing between speakers in an interaction might define whether or not a request is perceived as rapport-threatening. Applying this theoretical positioning to the particular case of S. 93, we see that the interpreter quickly legitimises and acts on the clinician's request with due diligence and without signalling annoyance or offence. Quite the opposite, in fact: she dutifully tries to relay as much information as she remembers from S. 91. Elisa, the interpreter, does so despite having the legitimate interactional power to coordinate turns herself, a power intrinsic to her role as expert in both languages (Mason, 2015). Dr. Sharpe's powerful position as institutional representative means that the interpreter has not seen her equity rights affected, as she has internalised the doctor's high-status position in the interaction. As a result, she seems to have understood the directive as being within the scope of her obligations to comply with institutional norms. This would explain why the pragmatic imposition inherent in Dr. Sharpe's request is seen as legitimate, and therefore Elisa willingly and positively acts on it.

To conclude the analysis of this excerpt, it is worth digging a bit further into the interpreter's rendition of Dr. Sharpe's pragmatic ambivalence. S. 92 could have been accurately interpreted as an instruction for the patient to break her contributions into smaller chunks. However, the interpreter takes on full responsibility for her performance and also for the patient's actions. Thus, she rushes to provide as full a rendition of what she remembers from S. 91. This is problematic, as the interpreter's room for manoeuvre is clearly limited by the lack of cooperation on the part of the patient. Drawing on this, I posit that this excerpt shows that an interpreters' successful performance may depend on primary speakers' cooperation. In this case in particular, I believe that S. 91 shows that by prioritising her own interactional goals; that is, getting her narrative across over the need to pause for interpretation; the patient infringes on the interpreter's sociality right to expect such cooperation from primary speakers. Because there was no briefing at the onset of this consultation and potentially due to the patient's cognitive difficulties, it is likely that the patient was unintentionally doing so. Against this background, if the doctor intended his request to be understood as an attempt to correct the patient's behaviour, then this was misunderstood by the interpreter.

Excerpt 2. Consultation #1 – Ss. 266 – 270

The description of excerpt 1 is applicable to excerpt 2, which also contains an example of the clinician's call for the patient to provide shorter chunks for translation. However,

excerpt 2 adds a novelty aspect, as the patient's daughter gets involved in the power dynamics being negotiated between Dr. Sharpe and Elisa, the interpreter.

Table 9 – Excerpt 2

S.	Dr. Sharpe	Elisa	Irene	Laura
266	*[Interrupts]*		*{Addressing Laura}* a mí me parece que estás confundida. La primera vez que él me dijo y se quedó callado, así como 10 minutos y yo decía algo estará pensando él y yo pensé en qué me irá a decir y entonces me dijo bueno vamos a pensar en el transplante y a mí me dio una cosa: *[interrupted]* *{Addressing Laura}* *It seems to me that you are confused. The first time that he told me, and he went quiet like this for about ten minutes and I said he must be thinking something he and I thought what will he tell me? and then he said well let's think about a transplant and I was shocked:* *[Interrupted]*	
267	*{Addresses patient}* **Remember that we need to translate just smaller amounts at a time otherwise I don't follow what you are saying**			
268 **269**		*{rushed}* the first time that she		*[Overlapping]*

		[Laura overlaps] {looks at Laura, slightly frowns} (1.5)		**Muy bien** *Very good*
270		***{Looks as though she has lost train of thought}*** e:: e:: <yes> the first time she went back to the doctor and the doctor was listening to her after ten minutes he kept quiet and I started to wonder, and he kept quiet and then he started talking about a transplant		

Again, Dr. Sharpe calls for the translation of shorter chunks following a series of lengthy utterances. As Dr. Sharpe's first call for shorter chunks was not translated into Spanish (see excerpt 1), it is not surprising that Irene kept producing lengthy interventions. The lack of translation of the instruction at the time it was made seems to have perpetuated the problem.

Whilst Dr. Sharpe's first attempt to manage turns [S. 92 in excerpt 1] was pragmatically ambivalent in that it was not clear whether he referred to the interpreter or to the patient, his second attempt [S. 267] reveals the actual intent of his utterance. The disambiguation takes place through Dr. Sharpe's direct gaze at the patient along with the wording of his request: "Remember that we need to translate smaller amounts at a time, otherwise I don't follow what you are saying". The phatic token "remember that", addressed to the patient (which is largely meaningless as S. 92 was never translated into Spanish so the patient could not remember what she had not been told), along with the use of the second person reinforced by the clinician's gaze direction reveals that he was in fact trying to instruct the patient to speak in shorter chunks. Examining S. 267 in this light suggests that the clinician's use of the plural pronoun could signal an attempt to mitigate the potential face threat by building a sense of team camaraderie (we need to translate, implying that 'we are all responsible' for producing translatable chunks).

In spite of the contextual cues that signal disambiguation, the interpreter continues to take the clinician's attempt to educate the patient as a reminder for herself to provide more timely translations. Again, Elisa opts to provide a zero rendition (see 5.3.2 for a

full type of interpreters' rendition types) of Dr. Sharpe's request and rushes a rendition in Spanish of S. 266.

It seems that Laura, the patient's daughter, also understands Dr. Sharpe's S. 267 as a prompt for the interpreter, evidenced by her utterance in Spanish *"*muy bien*"*. This literally means "very good" but probably in this context was intended to mean "well done". Laura's supporting move is worth noting if analysed considering the participation domain of rapport management; that is, the domain concerned with the procedural aspects of an interchange which includes the inclusion/exclusion of people present. From a participation viewpoint, Laura is clearly supporting Dr. Sharpe's action (interpreted as a request for Elisa to be more diligent in managing turns), but she does so in Spanish, a language which the clinician cannot understand. This means that the person who is actually being ratified as interlocutor must necessarily be another person in the room who knows both languages: that can only be Elisa, the interpreter. Laura's utterance has a clearly visible effect on Elisa. S. 268 is produced right after Dr. Sharpe's utterance and at the same time as Elisa starts providing a translation of S.266. This causes the interpreter to direct an annoyed look at Laura and also get distracted, evidenced by her losing her train of thought for a few seconds until she is able to resume her rendition [S. 270].

From a RM viewpoint, it seems that S. 268 reflects Laura's rapport neglect orientation towards the interpreter. There is little of value that S. 268 could contribute to the consultation beyond that of urging the interpreter to be more proactive in managing the patient's turns. RM theory would suggest that there could be different explanations for Laura's reprimand; for example, if Laura is noticing that Elisa is not being proactive enough to effectively manage turns, she could perceive that Elisa is not respecting her mother's right to a competently performing interpreter.

Elisa's reaction to Laura's reprimand is worth analysing from a RM viewpoint. Elisa willingly complies with what she understands to be Dr. Sharpe's request for her to perform differently, without showing any negative reaction. However, she *does* show a negative reaction to Laura's explicit endorsement of the clinician's request. As discussed above, power differences between speakers might contribute to a recalibration of the value of the dichotomy benefit-imposition (see 4.2.3.2). If a speaker perceives that an order/request comes from a source holding a legitimately powerful position, the balance gravitates towards the benefit end of the continuum. For example, segment 1 above showed how the interpreter was happy to comply with the doctor's directive, possibly because she seems him as an authoritative figure who has a right to perform

directives, so the interpreter does not react negatively. However, segment 2 shows how the interpreter does respond negatively to Laura's verbally explicit support for Dr. Sharpe's directive. This is probably because, in the interpreter's yes, the order comes from an non-legitimate source, as Laura does not have a position of power in the interaction. This disrupts the interactional balance in that it generates disharmony between the interpreter and the patient's daughter. Elisa reacts by actively showing that she may have felt unduly imposed upon; that is, that the patient's daughter has affected the interpreter's sense of equity rights by infringing upon her sociality right to professional autonomy.

Joint handling of institutional and interactional power: concluding remarks

Excerpts 1 and 2 show that the clinician's pragmatically ambivalent requests for shorter translated chunks are understood by both the interpreter and the patient's daughter as an appeal to the interpreter to manage turns more effectively. I believe this needs to be problematised: there was little room for manoeuvre for the interpreter in the face of the patient's lengthy interventions, apart from interrupting the session to explicitly instruct her to speak in smaller chunks. This is problematic as this encounter happened in a mental health setting, a context where letting the patient express herself freely without feeling constrained by the interpretation is of major importance (Aguilar, 2019).

By presenting excerpts 1 and 2, I argue that Dr. Sharpe was, in fact, not questioning the interpreter's agency to coordinate turns nor overstepping the interpreter's interactional power whatsoever. Instead, he was exerting his institutional power over the patient, instructing her to speak in shorter and more manageable turns to facilitate the interpreter's task and preserve the interactional equilibrium. Excerpts 1 and 2 also show that there is not an intrinsically threatening value to rapport-sensitive speech acts (RSSAs) such as requests. This is because, even if their illocutionary force might seem potentially threatening (requests might compromise freedom from imposition) and therefore might need to be worded carefully (through redressive strategies), their perception is dependent upon contextual factors such as power. The interpreter in excerpts 1 and 2 responds well to the doctor's request, but that is not the case in relation to Laura's explicit endorsement of such a request. This might be because the interpreter perceived the request as legitimate if originating from a speaker holding a high-status position in the interaction as an institutional representative, whereas the patient's relative does not hold such position. This interpretation would support the argument that

rapport-management communicative behaviours and perceptions are strongly dependent on the relational configurations resulting from power relations between participants.

6.1.2 Power tensions between interpreter and patient's family member

This section illustrates how the presence of a patient's family member in the consultation room can strongly disrupt interactional dynamics. Excerpts 3 – 5 described below took place in consultation 1# (see 5.2.4 for outlines of the three consultations). Consultation #1 is the only session in which the patient (Irene) and her daughter (Laura) are simultaneously present throughout the whole session, for the reasons explained in 5.2.4. Also, in order to contextualise excerpts 3 – 5, it must be mentioned that Irene and Dr. Sharpe had not seen each other for two years prior to consultation #1. For this reason, Dr. Sharpe's goal during consultation #1 is to find out what the patient's medical and personal journey has been for the past two years in order to better understand her current physiological and psychological status. It becomes apparent during the consultation that the patient's physical and mental health have deteriorated, and this has not only had a negative effect on Irene's quality of life but also on that of the patient's daughter, Laura: her primary caregiver. Irene does not speak more than a few words of English, so she needs full interpretation. By contrast, Laura is fully proficient in English as well as a native speaker of Spanish and also has a great deal of health literacy[12] in both languages because she is a healthcare worker. During consultation #1, both Irene and Laura provide different narratives of what has happened over the past two years, which evidences their conflicting perspectives on Irene's health journey and current capacity to manage her own treatment. The difference in the speakers' capacities to express themselves, the tension inherent in the power dynamics established between Laura and the interpreter as well as the emotionally charged nature of the situation combine to create a breeding ground for disharmony that heavily disrupts the interactional balance, as evidenced by excerpts 3-5 below.

Excerpt 3. Consultation #1 - Ss. 151 - 154

Immediately before this excerpt, Dr. Sharpe asked Irene whether she has been managing well the self-administration of her dialysis treatment or whether, by contrast, she has been missing any of her dialysis sessions. The patient replies that she has been doing fine, although she also admits to occasionally forgetting to dialyse on time and delaying

[12] 'Health literacy' is understood in this context as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." (Institute of Medicine, 2004).

some of her sessions. Laura had been mostly silent throughout the consultation until this moment. S. 152 shows how Laura abruptly interrupts her mother in order to provide her version of the facts.

Table 10 – Excerpt 3

S.	Dr. Sharpe	Elisa	Irene	Laura
151			**[151]** No perdía sesiones, las atrasaba ***[interrupted]*** porque (.) *I didn't miss sessions, I delayed them* ***[interrupted]*** *because (.)*	
152				**[152]** ***[Interrupts]*** <That's her opinion about how she was doing with the dialysis>
153	*{Redirects gaze from Irene to Laura}* *{Nods}* Yes			
154				and the real situation has not been like that, so she's been missing sessions, she's been picking mixed treatments, she was not clear on what she was using, I could check that in the bag. The same happened with the medication so she's grown really deteriorated and even got a peritonitis *(3)* *{Laura addresses interpreter and points at Irene}* *{crossly}* **<Could you translate that for her please?>**

Segments 151-152 show how Laura abruptly interrupts Irene by addressing the doctor directly in English to express her disagreement with her mother's account. In terms of participation framework (Goffman, 1981), the doctor ratifies Laura's intervention by redirecting his gaze onto her, confirmed by his nodding and the verbal utterance "yes". Following this ratification, the patient and interpreter stay silent while Laura carries on and suggests that Irene was so incapable of properly managing her treatment that she ended up falling ill with peritonitis as a result. Because this dyadic exchange between Laura and Dr. Sharpe [Ss. 152-153-154] happened in English, the patient cannot understand it. Additionally, Elisa does not relay this dyadic exchange into Spanish; so this leaves the patient out of what seems to have been a side-interaction and also prevents the patient from taking part in it. This changes when Laura explicitly asks the interpreter: "could you translate that for her, please?" in English.

Looking at this excerpt through the lens of RM theory would suggest that several RSSAs have disrupted the interactional harmony in this exchange. To begin with, Laura has interrupted Irene to provide her own, and very different, version of events [S. 152]. This means that the patient's equity right to not be unduly imposed upon has been infringed. It is also worth mentioning that S. 152 seems to have been prompted by a previous RSSA: by not entirely telling the truth, Irene was hampering Laura's interactional goal of providing the doctor with a truthful account of what Irene's health journey had truly been, which could hamper the fulfilment of a proper assessment of Irene's ability to manage her own treatment. This is relevant in terms of Laura's interactional goals as her mother's illness is also impacting her own quality of life.

Ss. 152 and 154 include two face-threatening acts (FTA). Firstly, the pragmatic implicature inherent in Laura's refuting account is that Irene has not been telling the truth, which challenges the patient's identity claim of honesty, understood in this context in terms of mental aptitude of accurately remembering and telling the truth. Secondly, Laura claims that Irene's health deterioration is a direct result of her being incapable of managing her own treatment, which clashes with Irene's identity claim of autonomy. These FTAs, produced bald on-record (see 4.2.2 for a list of FTA types), as well as the fact of the utterance having been relayed in English, evidence that Irene was been actively left out throughout these sequences. This can at least partially explain why the interpreter stays silent even three seconds after S. 154 is produced. It is only when Laura explicit requests that the interpreter translate her utterance that two aspects becomes evident: firstly, Laura wants to make Irene aware of her frustration at her

incapability to comply with treatment instructions; and secondly, that Laura is frustrated with the interpreter's non-rendition.

A RM theory-informed interpretation could suggest two complementary explanations for Laura's frustration with the interpreter's zero rendition of S. 154. Firstly, the function of Laura's RSSAs aimed at her mother could not be ultimately fulfilled without translation into Spanish, which hampers Laura's interactional goal to make her mother aware of her frustration. Secondly, Laura may have perceived that, by not relaying her English utterances to Irene, Elisa was not complying with the interpreter's sociality obligation (behavioural expectation) to translate all that is discussed during a session, including a family member's comments.

Excerpt 4. Consultation #1. Ss. 260-269

The discussion provided under excerpt 3 is partially applicable to the analysis of excerpt 4 below. Excerpt 4 shows how the tension between Laura, the patient's daughter and Elisa, the interpreter, intensifies at a later moment in consultation #1.

Table 11 – Excerpt 4

S	Dr. Sharpe	Elisa	Irene	Laura
260	And so: Dr. Bloom said that you told him **that you (.) wish to die ↓**			
261		Dr. Bloom dice que tú le habías dicho a él que: (.) **querías morirte ↓** *Dr. Bloom says that you had told him that: (.) you wanted to die ↓*		
262			No precisamente así, pero me dijo algo de un transplante y claro: *Not exactly like that but he told me something about a transplant and of course:*	
263		Not exactly but he talked to me about		

		a transplant		
264			<No no no no> pero fue solo ESA vez *<No no no no> but it was just THAT ONE time*	
265				*{Addressing Irene}* I don't agree because you have constantly been saying I wanna die for the last year. {*Addressing Dr. Sharpe}* She's been saying constant I wanna die {***Tutting, addressing interpreter, pointing at Irene}*** <**Elisa could you just>**
266	Sí *Yes*			
267				**[267]** So she's not been keen to do many things with us either *[overlapping]* when she was feeling a bit better
268 **269**		**[268]** Ella dice que *[overlapping]* tu hija dice que tú fuiste diciendo que tú quieres morir *[overlapping]* y no has querido hacer muchas cosas con la familia *She says that* ***[overlapping with Laura]*** *your daughter says that you said that you want to die* ***[overlapping with Irene]*** *and that you did not want to do many things with the family*	**[269]** *[Overlapping] {addressing Laura}* A mí me parece que estás confundida *It seems to me that you are confused*	

Three interactional moves are particularly salient in excerpt 4. These are explained in the three sub-sections below.

Ss. 260-264

S. 260 displays a speech act consisting of Dr. Sharpe's attempt to verify whether Irene feels any desire to end her life, as reported by Dr. Bloom: Irene's primary physician. This speech act is intrinsically threatening to Irene's face, given that it explicitly questions the patient's willingness to stay alive and, by extension, implicitly questions Irene's appreciation of, and willingness to comply with, the healthcare team's instructions, medication and treatment. As a result, it becomes an RSSA in relation to Irene's face sensitivities. The face-threatening potential of this interactional move might account for Dr. Sharpe's downfall intonation as he says, "you wish to die", as well as for the brief pause immediately preceeding this clause. This prosodic shift could be seen as an attempt to mitigate the face threatening potential intrinsic to the speech act. The prosodic modulation in Dr. Sharpe's formulation, and even the brief pause, seems to be picked up by Elisa, who reproduces "que querías morirte" ("that you wanted to die") with a downfall intonation, thus infusing her Spanish rendition with a layer of affect present in the original. That is, the interpreter makes use of paralinguistic features to convey in Spanish the mitigation of the threatening illocutionary force of S. 260, as intended by the original speaker. In fact, the face threatening potential of S. 260 is evidenced by its perlocutionary effect: through Ss. 162 and 164, Irene claims that she only expressed her desire once, as an involuntary reaction to the overwhelming suggestion that she should consider a transplant; that is, she denies Dr. Bloom's account of her words.

Ss. 265-266

Irene's denial of Dr. Bloom's account seems to prompt a very similar interactional dynamic to the one displayed by Ss. 151 and 152, described above. Laura expresses her disagreement and denies her mother's account, which threatens her mother's positive face by challenging her identity claim of honesty. The rise in volume of Laura's voice indicates a heightened sense of discontentment, and even frustration at her mother's account.

The way in which Laura addresses the interpreter is particularly noticeable in S. 265. Firstly, she begins her utterance by addressing Irene in the first person ("I don't agree with you because you have been saying constant I wanna die…"). Laura's tutting, the sudden direction of her gaze onto the interpreter while pointing at her mother and her

explicit directive for the interpreter to translate ("Elisa, could you just…?!") suggests that Laura was expecting Elisa to provide a simultaneous rendition of her utterance. This is further evidenced by her repetition of the first sentence ("you have been saying I wanna die constantly for the last year. She's been saying constant I wanna die…"), prior to the directive. So, from a RM viewpoint it could be claimed that Laura's RSSA (i.e. her directive for the interpreter to translate) was triggered by the unfulfilled behavioural expectation of the interpreter's sociality obligation to provide a simultaneous rendition. The expectation of a simultaneous rendition is worth highlighting, particularly when considering that the interpreter had been providing consecutive renditions up until the moment of Laura's interjection. For this reason, it could be argued that Laura is not respecting the interpreter's sociality right of receiving original utterances in translatable chunks to enable a consecutive interpretation. Additionally, Laura's use of the interpreter's first name while performing her explicit directive seems to make it more personally critical. This could be interpreted as a challenge to the interpreter's identity claim of professional competency, thus threatening her professional face. In any case, the interpreter ratifies and accepts Laura's directive by saying "yes" and providing a simultaneous rendition. Remarkably, none of the paralinguistic features of Laura's speech indicating anger and frustration are relayed by Elisa, who provides her rendition in a calm and soothing tone.

S. 267- 269

Both Laura and Irene's desire to get their conflicting narratives across places the interpreter in a difficult situation, personally and interactionally speaking. While Laura is providing her account and Elisa is trying to provide a simultaneous rendition into Spanish for the patient, Irene interrupts Elisa's rendition to deny Laura's account, as evidenced by S. 269. This means that, at this point in the interaction, the patient, the interpreter and the patient's daughter are all speaking at the same time. This makes it literally unfeasible for the interpreter to comply with the behavioural expectations of all parties, including Dr. Sharpe's expectation of getting a full account of what patient and relative are saying.

Excerpt 4 shows how the rapport bases of all the speakers involved in the interaction are affected, in some way or another, partly due to the emotionally heightened nature of the sequence.

Excerpt 5. Consultation #1 - S. 320

As the consultation unfolds, Laura seems to grow increasingly annoyed at the interpreter's performance, which is evidenced by her use of code-switching.Excerpt 5 shows an example where Laura uses English and Spanish within the same segment:

Table 12 – Excerpt 5

"No, she hasn't been referred. Mamá, no te ha referido porque la primera vez que
Mum, he did not refer you because the first time that
hablamos de ello I was the first person to say NO because you tú estabas muy confundida
we talked about it *you were very confused*
and that is a big complication with the transplant"

Laura's nervousness seems to increase when the topic of a transplant arises later on in the session. Just before S. 320 was uttered, Dr. Sharpe had asked the patient whether she had been referred for a kidney transplant. Laura replies to this immediately, before her mother utters a word. It is probably the sensitive nature of the discussion that leads Laura to speak both languages intermittently within the same segment as she addresses both Dr. Sharpe and her mother within the same intervention. It seems that, by taking on the responsibility to communicate with the two parties simultaneously and in different languages, Laura is trying to ensure that no piece of information is left uncommunicated; thus evidencing her suspicion of the interpreter's competency. All speakers are silent while Laura utters S. 320, including the interpreter, who leaves it completely unaddressed. S. 297 seems to be a chaotic information-transfer exercise attempting to communicate with both parties and probably produced out of frustration.

Excerpt 6. Consultation #1 – Ss. 545 - 550

Excerpt 6, below, shows a different, more functional, code-switching modality.

Table 13 – Excerpt 6

S.	Dr. Sharpe	Elisa	Irene	Laura
545				Because we have been talking about the in the case it doesn't work any more
546	**Yes**			
547				Cuando no funcione más la máquina, tú tendrías que volver a la hemo *When the machine does not work any longer, you would have to go back to the haemo*
548			**Ah**	
549				She would need to go back to the haemo
550	**Yes**			

This excerpt shows how Laura addresses Dr. Sharpe and Irene in their own language through Ss. 545, 547 and 549, and each of the speakers ratifies Laura's utterances through Ss. 546, 548 and 550 in their corresponding language. Laura's use of both languages completely excludes Elisa from the interaction; so the interpreter opts to stay silent and not engage throughout the whole sequence, thus staying in 'stand-by mode' (Monteoliva-García, 2017). As such, a RM-informed interpretation would posit that this behaviour constitutes a blatant threat to the interpreter's professional face by challenging Elisa's identity claim to interpreting competence. The lack of mitigation strategies, which results in the apparent disregard for the interpreter's face sensitivities, seems to evidence Laura's lack of concern for, or interest in, the quality of relationship established between herself and the interpreter. This behaviour is aligned with the relational disposition that Spencer-Oatey (2008: 32) labels "rapport neglect orientation".

Power dynamics between interpreters and family members: participants' perceptions

Excerpts 5-6 confirm Spencer-Oatey's (2008) claim that the number of participants that take part in an interaction is a contextual factor that necessarily affects rapport-management dynamics. In particular, the material presented has shown specific ways in which the presence of a relative in a medical consultation where the patient needs full interpretation multiplies the potential for RSSAs. The excerpts have also evidenced how some of these RSSAs might arise due to conflict between the interpreter and the family member with regard to which of them holds the interactional power. According to the evidence presented, it seems that RSSAs are the materialisation of speaker's perceptions and that, if such perceptions are negative (such as an unfulfilled expectation) and left unaddressed, subsequent RSSAs are to be expected as the interaction unfolds. The data also show that the effect of RSSAs seem to be cumulative (Thomas, 1995), as the speakers appear to use a decreased amount of mitigation with every RSSA. This is evidenced by Laura's displays of mistrust towards the interpreter's skill. The interpreter's perceived non-compliance with the relative's expectation seemed to trigger the relative's decision to adopt a code-switching strategy in an attempt to fulfil her own interactional goals, resulting in a blatant threat to the interpreter's professional face. All in all, due to the clear connection between the presence of Laura in session 1, the tense power dynamics established between Elisa and Laura, and the negative implications of this situation on interactional rapport, I decided to ask Elisa and Dr. Sharpe about this issue in the retrospective interviews. Firstly, I asked Dr. Sharpe whether the presence of family members in the consultation room is common, to which he replied the following:

"Yes, it is common, and there is a reason. Dialysis is a very burdensome treatment and often family members are expected to help with it, so they come to the consultations. If it becomes clear that their mutual presence causes friction, I try to see a patient and a family member separately and then see them together."

Dr. Sharpe's comment suggests that the relational tensions between Irene and Laura that can be identified through excerpts 3-6 are an example of what regularly happens with patients who endure complex health conditions, regardless of language differences. It also seems that, when a linguistically and culturally diverse patient accesses a health service, the potential for delicate ethical issues arising in the session multiplies when family members become involved. For example, according to Dr. Sharpe, when Irene started accessing Psychological Medicine, her daughter always initially interpreted for her. However, Laura's concerns about her mother discontinuing treatment caused a

tension that became unsurmountable and led the clinician to start requesting the provision of professional interpreters in his practice.

In my interview with Elisa, I had a chance to ask her about own experiences with, and impressions of, family members when they are present in the consulting room. Upon discussion of this issue, Elisa recounted the following.

[1] [13] "Many times, I have walked to an appointment and I have been told by a family member to go home as they would interpret for the patient. That is not a great start, is it? Those attitudes undermine my work. But I know it is not personal, they just don't want interpreters to interfere in very intimate family issues and so they feel uncomfortable with an external presence. But I always feel that if they interpret that puts the patient at risk because they bring their own baggage and might not interpret well."

After establishing her views about this issue in general, I asked her how she felt specifically about Laura's presence in the session that I observed, to which she replied the following.

[2] "I was aware that the daughter knew English and Spanish and I felt that she was scrutinising my work to check if I was missing information. And she was judging my work."

Final remarks

The distribution of interactional power between the participants involved in an IME seems to be a highly sensitive factor for rapport management dynamics, as it could be seen as the discursive materialisation of underlying perceptions of power. Preserving the interactional balance is a multi-party undertaking that depends on the cooperation of *all* participants, including the interpreter. Section 6.2 shows two instances in which this balance was disrupted across two dyads: firstly, the clinician-interpreter dyad (6.1.1); and secondly, the family member-interpreter dyad (6.1.2). Both cases show that the deterioration of rapport is not voluntary but prompted by specific circumstances; for example, a mis-inference of pragmatic ambivalence in 6.1.1; or the difficult personal history between the family member and the patient in 6.1.2. The complex interplay of circumstances that surround an IME, particularly in a context as sensitive as a clinical mental health setting, means that it is not realistic to see interpreters as the ultimate bearers of interactional power. To perform well, interpreters are heavily reliant on the

[13] Interpreters' quotations shown in chapters 6 and 7 are my own translations, as the interviews conducted with the interpreters took place entirely in Spanish. The original quotations in Spanish can be found as a list in annex 2, identified by the number tags provided in the main text.

primary speakers' communicative behaviours, and this goes beyond their bilingual competence, professional role or personal agency to manage turns.

6.2 Participant relations (II): distance

The interactional distance-closeness continuum (see 4.2.3), from now onwards jointly referred to as 'distance', is another feature of the situational context that might substantially contribute to shape people's language use for relational purposes (Spencer-Oatey, 2008). In this section, 'distance' is explored by examining participants' views on this notion and ways in which it becomes discursively manifest between doctor and patient (6.2.1) and between patient and interpreters (6.2.2).

6.2.1 Doctor-patient distance

This section discusses two behaviours that illustrate how distance between doctor and patient is discursively co-constructed in interpreter-mediated talk. The notion of distance will be explored in relation to doctor and patient's efforts to directly speak to each other (6.2.1.1) and participants' use of the second person pronoun (6.3.1.2).

6.2.1.1 Direct communication

There are several instances across dataset 1 where both the doctor and the patient proactively try to use each other's primary language. This enables direct communication between them, as no mediation by the interpreter is required in these occurrences. It could be posited that this behaviour does not serve much purpose beyond its relational nature, as it simply evidences the primary speakers' desire to communicate directly. This behaviour breaches the normative expectation that each primary participant will use their own language for the interpreter to provide a rendition. Precisely because it is not a normative behaviour, there is no consistency in interpreters' responses towards this behaviour and several types of reactions will be discussed below. Due to the rapport management implications of these reactions, I provide below an analysis of excerpts 7-9 as they show a range of three different positionings adopted by interpreters in response to the doctor and patient's attempts to communicate directly.

Excerpt 7. Consultation #1 - Ss. 1 - 4

Table 14 – Excerpt 7

S.	Dr. Sharpe	Elisa	Irene
1	Hello, nice to see you again		
2		Buenas tardes,	

		estoy muy contento de verla otra vez *Good afternoon, I am very happy to see you again*	
3			e: the same
4		It's a pleasure for me, I am very pleased to see you	

Excerpt 7 presents the first four segments of consultation #1. 'Greeting' is the speech act that Dr. Sharpe and Irene are engaged in through this sequence. When Dr. Sharpe utters a courtesy greeting, Irene replies in English. Elisa, the interpreter, seems to notice the patient's desire to make a connection with Dr. Sharpe by engaging with him directly. In response, Elisa performs the initially intended speech act (reciprocating the greeting) and enhances the illocutionary force of S. 3 by saying: "it's a pleasure for me", reinforced by "I am *very* pleased to meet you". Elisa's enhanced rendition evidences the interpreter's attunement with the relational aim underlying Irene's utterance.

Excerpt 8. Consultation #1 – Ss. 604-610
Table 15 – Excerpt 8

S.	Dr. Sharpe	Elisa	Irene
604			Es muy kainet usted *You are very kainet*
605		Kainet? <ah> You are very kind	
606	How do I say happy Christmas in Spanish?		
607		<Feliz navidad> *<Merry christmas>* *{laughs}*	
608	Feliz navidad *[with strong English accent]* *Merry Christmas*		
609		*{Looks at patient, smiles}* feliz navidad te ha dicho *Happy Christmas, he told you*	
610			Ah: me:: <merry merry christmas>

This sequence is located at the end of consultation #1. In this excerpt we can see how the patient attempts to call the doctor kind, trying to use the word in English within a sentence in Spanish. However, the patient is unable to properly pronounce the word in

English and utters the phonetic equivalent of [*kainet*]. The interpreter asks the patient what she meant by the word 'kainet' by repeating it, but as soon as she realises that Irene meant 'kind', she re-directs her rendition towards Dr. Sharpe and provide a correct English version of what the patient was trying to say. Dr. Sharpe seems to have realised the patient's attempt and responds by asking the interpreter for the Spanish equivalent of 'Happy Christmas'. Upon hearing the response of the interpreter, Dr. Sharpe utters "Feliz navidad", thus reciprocating the patient's desire to communicate directly. Perhaps prompted by a desire to ensure that the patient recognises Dr. Sharpe's will to communicate directly with her, the interpreter exercises her agency to clarify the clinician's action. The interpreter's clarification is successful, evidenced by the fact that the patient responds by saying Happy Christmas in English.

Excerpt 9. Consultation #3 – Ss. 50 – 55

Table 16 – Excerpt 9

S.	Dr. Sharpe	Maya	Irene
50	Have things gotten better or worse since I last saw you?		
51		En general desde que la he visto, en este mes, ¿están las cosas mejor o peor? *In general, since I last saw you, are things better or worse?*	
52			Mejor *Better*
53		Better	
54	How much better, **a bit, poco?**		
		¿Cómo de mejor, **un poquitito mejor?** *How much better, **a little bit better?***	
55			Bastante *Quite a lot*

Excerpt 9 shows Dr. Sharpe's attempt to reinforce a question that he poses in English by adding a repetition of the last word in Spanish. The interpreter seems to pick up on what Dr. Sharpe is trying to do – that is, attempting to come across as caring and approachable to the patient by speaking her language (Major and Napier, 2019). The interpreter's reaction is to translate the whole utterance; however, she modifies the 'a

bit' (*poco*) and changes it for the diminutive equivalent a 'little bit' (un *poquito*). The use of diminutives has typically been understood as a pragmatic marker aiming to reaffirm solidarity if compared to its neutral equivalent (Sifianou, 1992). As a result, it could be claimed that the interpreter is aware of and aligned with the clinician's relational attempt of coming across as approachable to the patient.

Concluding remarks: different ways of dealing with primary speakers' direct talk

Excerpts 7 - 9 evidence Dr. Sharpe and Irene's attempts to communicate directly by using each other's respective primary language. These actions challenge the interpreters' normative positioning and leave it up to the interpreters to decide on the best course of action for dealing with these interactional moves. In the three excerpts, we can see three different strategies:

- Excerpt 7 shows a rapport enhancement move enabled through translation, in relation to the original utterance;
- Excerpt 8 shows how the original utterance is not translated but meta-linguistically explained;
- Excerpt 9 shows the interpreter providing a translation including a diminutive form of an originally neutral term.

The commonality across these three strategies seems to be the interpreters' attunement to the relational aims of the primary participants and wanting to help facilitate their interpersonal relationship without disrupting their efforts to communicate directly. Similar findings on this matter have been discussed by Wadensjö (1998), Major (2013) and Major and Napier (2019). These authors found that enabling direct communication is an important strategy in the development of relationships between participants as it reduces their mutually perceived social distance imposed by the language discordance.

To conclude this section, it is worth including the following quote by Wadensjö (1998, 122): "a kind of joyful relief can sometimes be observed when primary parties suddenly find themselves understanding one another directly.".

6.2.1.2 Use of second singular pronoun

This sub-section discusses how doctor-patient distance is discursively represented through the use of second person singular pronouns. Terms and manners of address belong to the stylistic domain of rapport management (see end of 4.2.3.1). More specifically, RM theory establishes that stylistic features such as manners of address need to be effectively managed if participants are willing to create or maintain a

harmonious relationship (Spencer-Oatey, 2008). This is due to the connection between terms of address and associated perception of status (*ibid*.). In Castilian Spanish, there are two terms of address in the second person singular which are associated with higher (*usted*) and lower (*tú*) perceptions of the hearer's interactional status. Cultural and individual variations, as well as the formality of the setting, account for different choices regarding the use of the formal or informal term of address (Schwenter and Morgan, 2015). The choice of pronouns can thus affect the linguistic representation of relational/social distance between speakers which might, in turn, motivate different rapport management behaviours. For this reason, I decided to look at manners of address adopted by participants in my case study, in an attempt to shed light onto the interplay between usage of second-singular pronouns and representations of distance. To enable this enquiry, I counted all instances whereby the three interpreters, Irene and Dr. Sharpe used the second person singular when addressing each other. Before proceeding to discuss the results of this enquiry, it must be stressed that the difference in formality of pronouns does not exist in the second person singular pronoun in English. This means that the T/V issue only becomes relevant in relation to two aspects: firstly, the interpreters' renditions of the instances in which the doctor addresses the patient by using the second person singular pronoun; and secondly, the patient's terms of address when addressing the doctor.

Consultation #1

Table 17 – Participants' use of second-person singular pronoun in consultation #1

# times that Dr. Sharpe directly addresses Irene by 'you'	75	
# times Elisa (interpreter #1) directly addresses patient	**Tú**	72
	Usted	9[14]
# times Irene directly addresses Dr. Sharpe	**Tú**	3
	Usted	0

Consultation #2

Table 18 – Participants' use of second-person singular pronoun in consultation #2

# times that Dr. Sharpe directly addresses Irene by 'you'	93	
# times Julia (interpreter #2) directly addresses patient	**Tú**	0
	Usted	86
# times Irene directly addresses Dr. Sharpe	**Tú**	0
	Usted	6

[14] The interpreter and the doctor use a different total number of personal pronouns because of the different ways in which the interpreter might re-phrase the doctor's interventions.

Consultation #3

Table 19 – Participants' use of second-person singular pronoun in consultation #3

# times that Dr. Sharpe directly addresses Irene by 'you'	54	
# times Maya (interpreter #3) directly addresses patient	**Tú**	10
	Usted	48
# times Irene directly addresses Dr. Sharpe	**Tú**	0
	Usted	4

The tables show that Dr. Sharpe uses the word 'you' to address the patient 72 times in consultation #1, 93 times in consultation #2, and 54 times in consultation #3. Conversely, Irene does not address Dr. Sharpe directly as frequently: only 3 times in consultation #1, 6 times in consultation #2 and 4 times in consultation #3. This is because, as discussed in 6.1.1, Dr. Sharpe is the participant with the highest interactional status in these encounters as he is the one holding the institutional power due to his expert role. Consequently, he leads the consultations by adopting several discursive devices, including asking questions to Irene as well as addressing her directly for other purposes, such as providing guidelines on how she should administer her treatment. These discursive devices require of the use of the second-person singular pronoun. By contrast, Irene follows the conversational direction that Dr. Sharpe sets, and answers questions by employing the first-person singular pronoun.

As mentioned above, terms of address are not relevant in relation to Dr. Sharpe's use of 'you'. What is interesting from an interactional pragmatics perspective are the following aspects: firstly, the interpreters' rendition of Dr. Sharpe's use of 'you' as '*tú*' (informal) or '*usted*' (formal) when addressing Irene; and, secondly, Irene's use of *tú* or *usted* when addressing Dr. Sharpe, as both forms are pragmatic markers that discursively convey different degrees of formality/distance between Dr. Sharpe and Irene.

Looking at the interpreters' use of *tú/usted,* we can see how each of them behaves differently. Elisa, interpreter #1, comes from a country where the T/V difference is present. She uses 9 instances of the formal 'you' (*usted*) in the first phase of the interview, then shifts to the informal (*tú*) in the subsequent instances. Julia, interpreter #2, comes from a region where they use the informal second-person singular pronoun *'vos'* and the formal equivalent (*'usted'*);; and employs *usted* entirely throughout the session. Maya, interpreter #3, comes from a country where the T/V is also present. She uses *tú* 10 times, but the predominant pronoun throughout the rest of the consultation is *usted,* with 48 occurrences.

In the retrospective interviews conducted with Elisa and Julia, the interpreters working in consultations #1 and #2 respectively, we explored the reasons for their preferences regarding the use of pronouns in general. In this regard, Elisa provided the following account:

[3] "I think that whether I use *tú* or *usted* is only going to make a difference to the patient as the doctor is not going to perceive the difference anyway. So, I make a decision on the basis of the patient's needs or how the session is going. But I admit that in general I prefer to use *tú*. It just makes everything easier for me and maybe that even makes the patient see the doctor as less distant, who knows."

From an interactional pragmatics perspective, I would highlight from Elisa's account the idea of choosing pronoun on the basis of what (she perceives to be) the patient's needs. It would have been useful to explore this issue further and find out what such needs might encompass. In any case, what can be distilled through Elisa's account is that she has an overarching preference for the informal pronoun when addressing the patient because that might transmit an idea of the doctor as a less distant figure. She also acknowledges that using tú facilitates her work, maybe because she is more prone to use it in her everyday life, even though this theme was not pursued in the interview. Conversely, Julia's response to the question of pronouns was as follows:

[4] "Healthcare is a formal setting so I use *usted* [formal], that's it. But that is a personal value of mine. I would never address a doctor using *vos* [informal] just like I would not do that when talking to the headmaster of my children's school."

Julia's account evidences that she is more prone to use the formal pronoun when addressing interactants that she perceives as having a higher interactional status in general. This is interesting considering that in her original Spanish dialect, there is only one second-person singular pronoun: *vos*. If we jointly consider quotes **[2]** and **[3]**, it could be argued that different interpreters might have different preferences and motivations underpinning their use of second-person singular pronoun, depending on overarching perceptions of speakers' status as well as how different degress of distance-closeness should or should not be discursively conveyed. This is relevant as there are rapport management implications. Namely, different perceptions of distance-closeness might drive a preference for cordiality/neutrality or rapport enhancing predispositions.

Having discussed interpreters' use of the second-singular personal pronoun, it is also worth analysing Irene's use of *tú* and *usted*, which is inconsistent across different consultations as shown in the tables. More specifically, she only uses *tú* in consultation #1, *usted* in consultation #2 and *usted* in consultation #3. In other words: the term of

address adopted by the patient corresponds with the term of address most predominantly used by each of the three interpreters. The point I make in reviewing the patient's behaviour regarding pronoun usage is that she seems to adapt to the interpreter's form of address. My interpretation of the patient's behaviour is that, by accomodating to the interpreter's pronoun usage, the patient is adapting to each interpreter's socio-psychological and linguistic representation of Dr. Sharpe. This behaviour can be explained by referring to Communication Accommodation Theory (Ylanne, 2008), which states that "speakers are motivated to reduce linguistic or communicative differences between themselves and their speaking partners under specifiable circumstances, principally when they want to be approved of and when they want their communication to be more effective" (Ylänne, 2008: 164). In line with this theory, I argue that Irene's linguistic accommodation behaviour suggests that she was internalising Dr. Sharpe's linguistic portrayal of having decreased (consultation #1) and increased (consultations #2 and #3) social distance from her, and showing cooperation by adapting to each interpreter's choice of pronouns. Because we can see how Irene adapts to the interpreter's linguistic representation of Dr. Sharpe as more or less distant, we can conclude that there is flexibility in the co-construction of people's identities particularly in relation to social distance. By adapting different linguistic behaviours, Irene's actions demonstrate that people's identities are not fixed but subject to constant re-definition by speakers. Taking this interpretation a step further, I propose that interpreters' choices when translating might influence speakers' perceptions. More specifically, interpreters are central to the process of on-going discursive redefinitions of social distance between speakers, as their choice of stylistic/further discursive devices in their renditions might modify in different ways the pragmatic markers included in the source utterances.

6.2.2 Interpreter-patient distance

This section is divided into two parts: in 6.2.2.1, I examine an instance whereby Julia, interpreter #2, shows a verbal display of personal closeness towards Irene; followed by an account of Julia's and Dr. Sharpe's views on this occurrence. Later on, in 6.2.2.2, I talk about continuity of interpreter provision, as this aspect considerably influences perceptions of distance between patient and interpreter.

6.2.2.1 Stepping out of role to display closeness

Excerpt 11 illustrates how Julia proactively initiates a verbal display of closeness towards Irene in consultation #2. Before proceeding to the main discussion, excerpt 10 below provides background information needed to understand excerpt 11.

Excerpt 10. Consultation #2 – Ss. 559 - 572

Prior to excerpt 10, Dr. Sharpe had disclosed Irene's poor prognosis and explained that she will need to rely on haemodialysis to survive for the rest of her life. He also explained that haemodialysis is a burdensome treatment that will considerably impact her quality of life. The parties involved in this discussion proceed to talk about the plausibility of an scenario whereby Irene might want to stop receiving haemodialysis, which would lead to the end of her life. In excerpt 10, Dr. Sharpe explains to Irene that, should she make that decision, she would be supported by a range of professionals.

Table 20 – Excerpt 10

S.	Dr. Sharpe	Julia	Irene
559	If you thought you have had enough of dialysis, who would you tell?		
560		Si usted pensara, está bien, basta de diálisis, ¿a quién se lo diría? *If you thought that's enough, enough dialysis, who would you tell?*	
561			E::
562	Would you tell me?		
563		**¿Me diría a mí?** ***Would you tell me?*** ***{Points out at Dr.}* O sea, al médico** ***{Smiles}*** ***I mean, to the doctor {Smiles}***	***{Looks confused at the interpreter}*** ***{Smiles}***
564			Sí *Yes*
565	Would you tell Dr. Bloom?		
566		¿Le diría al Dr. Bloom? *Would you tell Dr. Bloom?*	

567			Yo creo que sí *I think so*
568		I think so	
569	Would you tell any of the community dialysis nurses?		
570		¿Le diría a alguna de las enfermeras de diálisis de la comunidad? *Would you tell any of the community dialysis nurses?*	
571			Probablemente *Probably*
572	Probably, ok, so it wouldn't be just you telling your daughter it would be you telling the doctors and the nurses that are involved		

In excerpt 10, Dr. Sharpe is letting Irene know that she could talk to a range of professionals whenever she decided to interrupt treatment, should she decide to do so. The doctor communicates this idea by breaking his intervention into small segments and mentioning one member of the healthcare team at a time. A misunderstanding happens during this interchange [S. 563], as the patient is not sure whether the interpreter is interpreting for the doctor in the first person or whether Julia is referring to herself. The misunderstanding is quickly resolved through Julia's clarification in the second part of S. 563, which is underpinned by a smile shared between the interpreter and the patient, manifesting their rapport maintenance orientation, characterised by conflict avoidance.

Excerpt 11. Consultation #2 – Ss. 641 – 643

By the time that excerpt 10 is produced, consultation #2 is nearly over, and Dr. Sharpe reaches for his diary to schedule the next follow-up appointment with Irene. The patient is very quiet and looks somewhat appalled, directing a blank stare at the floor. This is probably due to the intensity of the discussion on terminal care that she had just had with the doctor. Laura, the patient's daughter is also visibly upset.

Table 21 – Excerpt 11

S.	Dr. Sharpe	Julia	Irene	Laura
641	Yeah, sure. Let me get my diary			
		Silence for 4.5 seconds		
642	***{Checks diary}***	***{Looks at patient}*** **¿Y a MÍ no me lo diría, Irene?** ***{smiles}*** ***And you wouldn't tell ME, Irene? {smiles}***	***{Gazes at floor}*** ***{Quiet laughter}*** ***{Sheds a tear}***	***{Smiles}***
		(4.5)		
643	*{Looks up}* Next month? Is Friday afternoon OK for you?			

Excerpt 11 shows that the interpreter breaks the silence of 4.5 seconds that occurs while Dr. Sharpe silently checks his diary. S. 642 shows that Julia looks at the patient and utters the Spanish equivalent of: "And you wouldn't tell ME, Irene?". As there is no immediately preceding segment that might explain the interpreter's action, it seems that the interpreter is referring back to the sequence shown in excerpt 10. It could even be hypothesised that the interpreter is jokingly referring to the misunderstanding that took place in S. 563, in particular.

In spite of the seriousness of the subject matter, it is evident that Julia's comment in S. 642 is intended as a joke. We can infer this from her mocking frown as she pretends to be offended while simultaneously looking directly at the patient with a smile. Understanding Julia's joke involves a two-fold inference: firstly, that Julia is somehow part of the healthcare team, so would have a right to be informed of Irene's decision; and/or, secondly, that Julia deserves to be aware of Irene's decisions on the grounds of personal closeness. Judging by the perlocutionary act of S. 642, that is, Irene's reaction in S.643, it seems that the patient was able to accurately infer the intended meaning.

Irene laughs quietly, although she does not meet the interpreter's gaze nor verbally responds. In any case, Laura, the patient's daughter smiles at the interpreter's comment. The tense atmosphere surrounding the silent participants waiting for Dr. Sharpe to schedule the next visit seems to be somehow lessened by the interpreters' joke, as well as by Irene's and Laura's reactions.

S. 643 evidences that Dr. Sharpe does not call explicit attention to this side-exchange while he checks his diary. Instead, he resumes the conversation that was paused at S. 641. The interpreter does not make him aware of the content of the dyadic exchange either, even if it is clear that the doctor has heard it. A reading of this behaviour through the lens of prescriptive ethics (see 2.2.1) would suggest that, in being excluded from this exchange, Dr. Sharpe's right to know everything that is discussed in the session is infringed. Moving away from prescription, a descriptive counterargument would suggest that nobody made Dr. Sharpe aware of the content of this interaction due to the low clinical significance of the comment in relation to the encounter in general, or to Dr. Sharpe's future actions. Indeed, there is little that S. 642 contributes to the conversation beyond its purely relational purpose. A RM theory-informed reading of the excerpt would suggest that the interpreter was performing a rapport-enhancement action by acknowledging the association rights of the patient, a sub-set of the second base of rapport: 'sociality rights'; in particular, the right to affective involvement, expressed through small talk.

Julia's action is not only salient due to its relational aim but also because she breached a normative behaviour by stepping out of the prescribed interpreter's role and engaging with the patient on a personal footing. Whilst ethically questionable from a prescriptive stance, this action does not seem to pose a problem for the clinician. In fact, the clinician shows his satisfaction with Julia at the very end of the session by asking her the following question: "what is the best way of increasing the chances that you will come back to interpret for her in our next session?

Witnessing Julia's action caused me to wonder about Julia's decision-making processes underpinning S. 642 and whether she would have done the same with any patient. If that were the case, I wondered what conditions would make Julia feel confident to perform a similar action in a different case; and whether she was aware about the potential rapport management implications of S. 642. With these questions in mind, I raised these issues in my retrospective interview with her, and she offered the following view:

[5] "Let's say I did not mean to become Irene's friend with that comment. It was more about handling a tense situation in such a way that it becomes less uncomfortable for everyone, melting the ice […]. I felt morally compelled to make the situation as bearable as possible for her […]. You are not going to change anyone's life with silly comments like that, but you might make it easier for a person to get through a difficult moment. That is the thing, she is not just a patient, she is a person, in the same that I am not just an interpreter, I am a person. Whether you want it or not, you get involved."

Julia's comment confirms that S. 642 was serving a relational purpose. Despite the well-intended nature of this action, it cannot be denied that Julia engaged in a side-exchange with the patient, which naturally excluded the clinician. Guided by the literature warning that interpreter-patient alliances risk being unhelpful to clinicians (Tribe and Thompson, 2009), I decided to enquire with Dr. Sharpe about S.642, to which he offered the following view:

"So long as it is clear that it is small talk between them I do not mind it. I would rather have that than an awkward silence because awkward silence takes away from rapport and small talk helps build it."

I followed up on this answer by asking whether he would then expect an interpreter to fill the silence while he was performing other tasks such as checking his diary, to which he responded:

"Would I expect it? Probably not. Would I welcome it? Yes. If the interpreter feels OK or rather able to fill that void, then why not. Rather than having the interpreter and the patient sitting there thinking 'we are not meant to talk', and all of that while I am trying to sort out the next appointment? that just feels artificial, tense and undermining of the discussions that might have happened before that. If the interpreter was feeling able to engage in small talk that just feels more natural to me. At the end of the day, it was a tough discussion for everyone and that includes the interpreter. I see that the purpose of the interpreting is to make the interaction as natural as if everybody in the room shared a language. So, if the interpreter felt able and thought that it was natural to break the silence, then why not?"

It is noticeable that Dr. Sharpe used the word "able" three times in this account. In this regard, Dr. Sharpe's comment suggests that he has a high level of trust in Julia's ability to manage small talk, which resonates with previous studies suggesting that clinician-interpreter trust is key to promoting a positive working/professional alliance between them which, by extension, might benefit the patient due to improved working dynamics (Costa, 2017). It also seems to corroborate that effective professional alliances can counteract clinician's feelings of suspicion whenever an interpreter and patient engage in side-exchanges (Hsieh, 2017). Overall, it seems that excerpt 11 is an example of a

well-balanced compromise on the part of the interpreter between breaching behavioural expectations and engaging in rapport enhancement behaviour through small talk: a behaviour that is also supported by the clinician due to its low clinical risk nature.

Going back to the idea of 'ability' to intervente, the idea that the interpreter needs to feel able or somewhat 'allowed' to take an action that might defy normative expectations also came up in my interview with Julia. In this regard, when I asked her whether she would have performed a similar action to S. 642 in a consultation featuring a different patient, she replied "of course not. At least not by default. But I was *familiar* with Irene and her case". By saying 'familiar', Julia referred to the knowledge of a person/clinical case acquired through repeated interactions. Julia's remark on familiarity opened a new line of enquiry, which elicited further findings on an aspect that is key to fully understand percpetions of distance between a patient and an interpreter: repeated contact between them across several encounters, discussed separately below.

6.2.2.2 Repeated contact between patient and interpreter

Slugoski and Turnbull (1988) establish that repeated contact over time is likely to result in familiarity between interactants, which might lead to perceptions of reduced social distance, or 'closeness', between them. Such perceptions of relational closeness might, in turn, shape RM dynamics (Spencer-Oatey, 2008). In this section I talk about repeated contact between interpreters and patients, as this aspect might drive perceptions of distance-closeness between them. To begin this discussion, it must be mentioned that Dr. Sharpe explained in his interview the reasons why a certain familiarity may be established between some patients and interpreters in an outpatient mental health department, by stating the following:

"Many mental health conditions are chronic and the supply of interpreters speaking a certain language is quite small so sometimes the interpreters when they arrive in the ward will know the patient and may have seen them during previous relapses."

That is, the long-standing nature of some mental health conditions may cause an affected patient to recurrently attend a mental health clinic, thus increasing the likelihood that such patient sees a given interpreter several times, particularly when it comes to languages of lesser diffusion. But this is not the only reason that an interpreter and a patient suffering from a chronic mental health illness might be familiar with each other: both interpreters #1 and #2 admitted during their interviews having met Irene in the past, particularly in social services and in physiological health consultations. This

might be because NHS Lothian covers a population of approximately 800,000 inhabitants distributed across the city of Edinburgh and the Lothian areas. The relatively limited geographical area covered by this health service may be an idiosyncrasy that facilitates repeated encounters between service users and interpreters using a particular language across difference services. So, considering Dr. Sharpe's and the interpreters' accounts, two aspects might cause interpreters and patients to be familiar with each other: the chronic nature of certain illness and the relatively small size of their place of residence. It must be noted that we are dealing with 'accidental' repeated contact, not deliberate continuity of interpreter provision promoted by the relevant interpreting service, as continued interpreter allocation is not ensured by the interpreting service featured in this case study.

From a theoretical standpoint, it could be claimed that the type of relationship established between patients and interpreters who know each other from previous encounters fits with what Watts (2003: 153) calls a 'latent network' as opposed to an 'emergent network'. This means that interactional meaning is built upon information shared and identities negotiated in previous encounters. Spencer-Oatey (2008) states that when a relationship is of a latent nature, the overall RM predisposition established between interactants is likely to be that of 'rapport maintenance': that is, the concern with preserving a previously established cordiality. In an attempt to shed light on what this means in practice, I conducted a qualitative analysis of datasets 1 and 2 which led me to identify two consequences of repeated contact between a patient and a given interpreter: relational closeness and increased efficiency in lexical retrieval, two aspects that carry rapport management implications.

Relational closeness

A few minutes before consultation #2 started, I was in the waiting room of the Psychological Medicine ward along with Irene and Laura. As we were waiting for consultation #2 to start, Julia (interpreter #2) arrived in the waiting room. As soon as Laura saw this interpreter, she stood up and hugged her. I noted down in my ethnographic journal how remarkable Laura's emotional reaction was, especially having witnessed the minutes prior to consultation #1, in which only cordial greetings were exchanged with interpreter #1. Witnessing this moment led me to ask Julia about this occurrence in our retrospective interview, to which she replied:

[6] "You can tell what seeing you in different sessions means for some people with complex physical or mental health issues. A lot of the content discussed in these sessions is very sensitive and can bring them shame, so I can see why some of them might not feel comfortable talking about some of these issues in front of a different interpreter every time. Who the interpreter is *does* matter."

Applying this general statement to the specific case of Irene, Julia said:

> **[7]** "If the interpreting service manager offered me an interpreting job right next to my home and another one two hours away but the patient was Irene, I would have prioritised taking on Irene's session because I know what my presence means to her. We have known each other for several years. The interpretation does not change, but I believe that the overall experience for the patient does."

When I asked Julia to elaborate further on this matter, she sought to illustrate the nature of her interpersonal relationship with Irene by telling me about the first time that they met. In this encounter, Irene and Julia found out their common Latin-American origin. More particularly, Julia recounted how Irene recognised her Argentinian accent as soon as she introduced herself, which she habitually does in the waiting room with every patient. In turn, when Julia found out that Irene was Chilean, she hummed a verse from the song *Las Dos Puntas*[15] in an attempt to establish common ground between them. Julia recounted that Irene recognised the song and that the episode was followed by further small talk, which enabled the relationship to start on a positive footing that was sustained in subsequent encounters.

The participants' behaviour and perspectives here are aligned with previous studies on trust between interpreters and minority language users. This has been been identified as a major theme in the healthcare interpreting literature (Brisset, Leanza and Laforest, 2013), as well as in community interpreting generally (Edwards et al., 2005) including sign language interpreting (Napier, 2011 and Napier et. al, 2019). It has been advocated that continuity of interpreter provision facilitates interpreter-client trust (Perez and Wilson, 2006). In reference to these studies and based on the participants' behaviours within my own datasets, I propose that trust dynamics between interpreter and patient are key to a positive perception of the health service in the eyes of the patient, and that continuity of interpreter allocation substantially enhances the development of this

[15] What Julia specifically sang was: *"Cuando pa' Chile me voy cruzando la cordillera, late un corazón contento porque una Chilena me espera…"* (When I am on my way to Chile, crossing the range, my heart beats happily because a Chilean woman is waiting for me…). *Las Dos Puntas* is a traditional Argentinian folk song, also well known in Chile, and connects both countries through the symbolic idea of a pilgrim who travels between two endpoints (*dos puntas*) situated one in each country.

relational relational closeness, which creates the conditions for enhanced trust dynamics.

Enhanced lexical retrieval

Both Elisa and Julia mentioned in their interviews that continued contact with a given patient helps them to build an understanding of their condition. According to these two interpreters, continued contact with a patient's clinical case facilitates the activation of a linguistic repertoire linked to that case; for example, in relation to the nature of the illness, treatment and medication. Elisa stressed that activating a familiar linguistic repertoire helps her to perform more efficiently. This aspect had already been raised by Mapson (2015), who provides evidence to suggest that a connection exists between repeated contact between interpreter and service user, and a more 'focused' interpreting performance, resulting from an enhanced lexical retrieval in the translation process. According to Mapson, the increase in an interpreter's focus resulting from repeated contact is due to a reduction in cognitive load, resulting from increased familiarity with the linguistic repertoire around a user's case. Mapson also proposed that a reduced cognitive load releases mental space for interpreters to pay attention to relational aspects such as the rendition of rapport-building strategies, which otherwise might have been dismissed in the face of more 'pressing' tasks, such as ensuring accuracy. Building on these notions, an analysis of dataset 1 suggests that there is a further reason for repeated contact between interpreter and patient having a positive influence on RM dynamics. This reason is illustrated through the analysis of excerpt 12 below.

Excerpt 12. Consultation # - Ss. 131-148

Excerpt 12 can be found in the initial stage of consultation #3, the last session of dataset 1. To understand excerpt 12 and why it is related to the notion of increased familiarity between interpreter and patient resulting from repeated contact, it is important to consider two aspects: firstly, that the medical themes and technical lexicon used across consultations #1, #2 and #3 in dataset 1 are consistent. This is because the three consultations are about the management of Irene's illness; and secondly, that there is a different interpreter allocated to work in each of the three consultations.

In consultations #1, #2 and #3, Dr. Sharpe and Irene discuss about the fact that the patient is not willing to undergo haemodialysis, a very taxing (but effective) treatment that Irene has tried in the past. Instead, she is only willing to undergo peritoneal dialysis, a less burdensome but also less effective form of treatment. Against this

background, at the beginning of consultation #3, Dr. Sharpe recaps the conversations that previously took place in consultations #1 and #2 and seeks Irene's explicit confirmation that she would not like to undergo haemodialysis treatment again. Maya, interpreter #3, is in charge of interpreting in this consultation, but she is unfamiliar with Irene's clinical case.

Table 22 – Excerpt 12

S.	Dr. Sharpe	Maya	Irene
131	In the last session, you said that you do not want to continue receiving dialysis. Is this still the case?		
132		¿En la última sesión dijo que no quería seguir con la diálisis? *In the last session you said that you do not want to continue with dialysis?*	
133			No, era:: {*hesitant*}. <ay> ¿cómo se llamaba? Esa otra diálisis, la de volver al hospital **<esa de la que hablamos en la última cita>** *No, it wa::s [hesitant] <ay> what was the name? the other one, the one for which I come back to the hospital <**the one we talked about in our last appointment**>*
134		She does not want to come back to the hospital for the dialysis, she can't remember the name	
135	I am not sure I understand that		
136		No entiende *He doesn't understand*	
137			(2) e:: a ver, la peritoneal sí, pero la otra no, **{*directly***

			addressing interpreter*} ¿cómo se llamaba la otra?** *Eeee peritoneal yes but not the other one,* ***[directly addressing interpreter] what was the name of the other one?
138		*{Addressing clinician}* Yes for the peritoneal but not the other one, **what is the name of the other one?**	***{frowns}***
139	**Does she mean the haemodialysis?**		
140		***{Leans towards doctor}*** **Sorry, the what?**	
141	**Haemodialysis**		
142		*{Addressing patient}* ¿La hemodiálisis no? *Not the haemodialysis?*	
143			**<ESA decía>** no, esa no, pero la otra sí *<**THAT IS THE ONE I said**> no, not that one, but yes for the other one*
144		Not haemodialysis but the other one	
145	But she does want peritoneal		
146		Pero usté sí quiere la peritoneal	
147			Sí, esa sí esa *Yes that one yes that one*
148		That one, yes	

The miscommunication that occurs across Ss. 133 and 148 is caused by the patient's inability to remember the word haemodialysis, a word that had been mentioned a considerable number of times both in consultations #1 and #2. The interpreter competently renders the patient's hesitations [S. 134], but Dr. Sharpe does not understand the reason for such hesitations [S. 135]. As the patient becomes frustrated with her inability to recall the name of the treatment, she explicitly asks for the interpreter's assistance to help her remember [S. 137]. However, the interpreter, Maya, had never interpreted for Irene before; so she keeps relaying the hesitation to Dr. Sharpe

[S. 138]. Irene frowns immediately following Maya's lack of direct response to her question. It would be interesting to find out whether Irene asked the interpreter on impulse due to frustration or whether she did not remember that Maya was not the interpreter in the previous sessions. Given the rapid cognitive decline, memory loss and overall confusion that Irene was experiencing, either of these two reasons are equally plausible. Eventually, the responsibility to clarify the issue falls on Dr. Sharpe, who is able to detect the source of the hesitations and introduces the word haemodialysis [S. 139]. The communication is interrupted again in S. 140 because Maya does not understand the word, as it is the first time that this term has come up in consultation #3. Dr. Sharpe repeats the word haemodialysis [S. 141] upon Maya's request to do so. Finally, the communication flow is restored once the name of the treatment is understood by all three participants after an exchange of fifteen turns.

A RM-theory informed reading of this excerpt 12 helps to identify how at least one rapport base has been affected for all three participants. Firstly, the patient's frowning at Maya's lack of answer to her direct question [S. 137] evidences Irene's frustration either with Maya's behaviour or with the situation in general. This would partly depend on whether or not Irene addressed the interpreter due to a frustration reflex. This would mean that Irene was not actually addressing Maya personally but instead verbally expressing her own doubts out loud. However, as mentioned above, it is equally plausible that Irene could not actually remember whether Maya was the interpreter in the previous sessions, due to her severely impaired memory; similarly, the patient could not remember me at the time of the third session, even though I had observed the two previous sessions with her. If in fact Irene could not remember that Maya was not the interpreter in the previous sessions, I would posit that Irene became frustrated at the interpreter's lack of immediate answer, given that the word haemodialysis had been constantly present in previous sessions. From a RM-theory perspective, this would mean that the patient was frustrated at the interpreter's lack of fulfilment of her professional obligations (second base of rapport: sociality expectancies). Yet it would have been hard for the interpreter to meet the patient's expectation as she was not present either in consultation #1 or #2. What is more, the interpreter's own sociality right to equity was negatively affected, as the patient did not respect the contractual arrangement intrinsic to IMEs whereby primary participants refrain from engaging directly with the interpreter. Finally, it could be argued that, even though Dr. Sharpe may have felt frustration at the misunderstanding, particularly considering that the word haemodialysis was a core concept within Irene's clinical case.

I connect excerpt 12 with the importance of sustaining continuity of patient-interpreter allocation as a way to preserve positive RM dynamics. This is because I hypothesise that the interruption of the communication flow described above would have not happened if the same interpreter had been allocated throughout Irene's consultations with Dr. Sharpe. It has been well-documented elsewhere that when community interpreters are well-prepared and familiar with a topic, they are better able to make efficient lexical choices (Schofield and Mapson, 2014), to better anticipate the content to be discussed (Liontou, 2015), and to disambiguate and more efficiently draw on contextual assumptions when performing translating functions (Mason, 2006). If we apply this rationale to interpreter-mediated physical or mental healthcare for patients suffering from a chronic condition, I believe that interpreters would benefit from being repeatedly exposed to the terminological repertoire associated with a clinical case. Taking this a step further and applying it to the analysis of excerpt 12, I posit that if the same interpreter had been consistently allocated to Irene's case, s/he would have been familiar with the term 'haemodialysis'. If that had been the case, the interpreter might have been better equipped to use her agency to directly address Irene's question [S. 137]. All in all, excerpt 12 is an illustration of how an interpreter's lack of familiarity with the subject matter can interfere with the linguistic and relational dynamics of an interpreter-mediated session. All in all, I believe that having a consistent interpreter in place would have decreased the chances of communication breakdowns such as those in excerpt 12, as well as the RSSAs associated with them. To clarify, I am not arguing that interpreters should be expected to become experts on the specific case of each patient that they see, as that is clearly beyond their professional responsibilities. But I do posit that the findings from the analysis of excerpt 12 suggest that, when it comes to the care of chronic patients and particularly in the field of mental health, there are certainly benefits associated with continuity such as familiarity with a linguistic repertoire. Additionally, in terms of rapport management dynamics, continuity of interpreter provision might not only increase the potential for rapport enhancing behaviours but also reduce the chances of rapport-threatening occurrences taking place, such as the misunderstanding described in excerpt 12 caused by unfamiliarity.

6.3 Behavioural expectations

Spencer-Oatey and Franklin (2009) explain that when speakers interact with each other, they often adopt certain roles. For example, within the context of this study, Dr. Sharpe interacts with Irene in his capacity as consultant psychiatrist; Irene listens to and

complies with the doctor's guidelines; and the three interpreters take care of the linguistic mediation aspect of the consultations. There are behavioural expectations for the figures of 'doctor', 'patient', 'interpreter' and 'patient's family member' in terms of sociality rights and obligations, which are shaped by pre-existing institutional expectations (Cordella, 2004). On the basis of this logic, this section is built on the following premise: if the four types of participants cited above comply with the behavioural expectations associated with their role, and all interactants have matching expectations, rapport between them will be in equilibrium. Conversely, if any of the participants assumes rights that they are not entitled to or fail to uphold a certain obligation that a participant expects from them, the interactional balance might be affected due to mismatching expectations (Spencer-Oatey and Franklin, 2009). This issue is particularly relevant in relation to the functions expected of interpreters, as the extent of their role is still subject to ongoing debate (see 2.2.2), so this issue is part of the discussion offered in this section.

This section will be articulated around two sociopragmatic interactional principles (SIPs) described in RM theory: 'equity' and 'association' (see 4.2.3). 6.3.1 deals with the SIP of equity by exploring shared decision-making between Dr. Sharpe and Irene, and 6.3.2 revolves around the SIP of association by exploring interpreter-patient interactions in the waiting room, prior to the beginning of the medical consultations.

6.3.1 Equity and shared decision-making

In this section, an interactional incident caused by mismatching behavioural expectations takes place between Irene and Dr. Sharpe. This incident begins as Dr. Sharpe adopts a person-centred care (PCC) approach to healthcare delivery and communication[16]: an approach that places great emphasis on shared decision-making between patient and healthcare practitioner. Irene is not familiar with PCC models of decision making, so she is a bit confused when Dr. Sharpe asks her about her views on taking antidepressants.

[16] PCC refers to "mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values, and which demonstrates compassion, continuity, clear communication and shared decision-making" (Scottish Government, 2019: 1)

Excerpt 13. Consultation #1 – Ss. 447 – 451

Table 23 – Excerpt 13

S.	Dr. Sharpe	Elisa	Irene
447	Do you feel that you need antidepressants now?		
448		¿Tú crees que necesitas esas pastillas contra la depresión ahora? *Do you think you need those pills against depression now?*	
449			Yo creo que no porque he comido muy bien he dormido bien ***{shrugs shoulders}*** **pero él es el experto no yo** *I do not think so because I have eaten well I have slept well* ***[shrugs shoulders] but he is the expert not me***
450		I do not think so because I have eaten well I have slept well **but maybe it is best if you decide**	
451	Right, OK *{addressing Laura}* is there a difference of view here?		

Prior to S. 447, Dr. Sharpe had had a discussion with Irene and her daughter, Laura, regarding Irene's depressive symptoms and the possibility that Dr. Sharpe could issue a prescription for antidepressants. However, because Irene's symptoms had improved recently due to a change in treatment, Dr. Sharpe questions the current suitability of prescribing the medicine particularly considering the high risk of side effects for Irene. Instead of clearly indicating his professional reluctance to prescribe antidepressants, Dr. Sharpe initiates a process of shared decision-making with Irene by asking her directly whether she believes that she actually needs the antidepressants despite the change of circumstances. A reading of this action based on RM theory could suggest that Dr. Sharpe is actively trying to preserve Irene's right to the equity SIP. In this case, this would mean preserving the view that Irene is an autonomous agent fully capable to making treatment-related decisions for herself, in line with the PCC-inspired view that

patients are experts of their own condition[17]. Nonetheless, Dr. Sharpe's action does not seem to have its desired outcome. This is because, upon being asked, Irene [S. 449] provides her opinion but also expresses that she prefers to delegate the decision to Dr. Sharpe. She expresses her preference by saying: "he is the expert, not me" [S. 449] while shrugging her shoulders, thus evidencing her view that the decision to take antidepressants or not should be Dr. Sharpe's professional statement, not her personal choice.

Drawing on this statement, I argue that Irene's reaction might be linked to her expectations of a more doctor-centric approach to decisions being made with regards to her healthcare. Because Dr. Sharpe fails to uphold Irene's behavioural expectations associated with a doctor-centric approach, she expresses confusion, if not dissatisfaction, in S. 449. As a result, what started as an open invitation to engage in shared decision-making [S.447] ends up looking like the doctor's unwillingness to make a decision [S.449], or the clinician's failure to uphold a professional obligation associated with his expert role.

The interpreter's action in S. 450 becomes particularly relevant from a RM-theory viewpoint. Instead of conveying the rapport-threatening nuance of Irene's words indicating dissatisfaction [S. 448], the interpreter opts for a more neutral way of conveying the original pragmatic force: "maybe it is best if you decide". By providing a less loaded rendition, the interpreter is able to convey the semantic substance of Irene's utterance ('I prefer you to make the decision for me') without making it explicit that Irene is questioning Dr. Sharpe's upholding of his expert role. Thus, the interpreter's conciliatory rendition contributed to the mitigation of a potentially threatening RSSA. The rapport-neutral nature of the perlocutionary act of S. 450 evidences the success of the interpreter's attempt to mitigate the risk of confrontation: Dr. Sharpe accepts Irene's remark without questioning the issue further or displaying any relationally-relevant reaction. What is more, he addresses the patient's daughter to get further input on her views on the suitability of the prescription, in what seems to be an effort to keep engaging in a PCC-based shared decision-making process [Ss. 449 – 450].

Spencer-Oatey (2008) suggests that the SIP of equity is a belief that shapes people's value-laden behavioural expectations, based on their perceived sociality rights and obligations. This means that, if a person perceives that s/he has been treated as an equal, rapport is preserved. Interestingly, the behaviours described through excerpt 13

[17] http://tvscn.nhs.uk/networks/long-term-conditions/care-planning-patients-experts-managing-conditions/

demonstrate that it was precisely being treated as an equal that caused Irene's confusion or dissatisfaction. This would suggest that when participants uphold roles that are intrinsically unequal, such as in a doctor-patient interaction, efforts on the part of the powerful participant to treat the hearer as an equal might be perceived with suspicion or confusion, as Irene's behaviour demonstrates. This is particularly the case when a relationship between unequal roles is based on the expert power of one of the parties (such as Dr. Sharpe's expertise on Irene's condition). If the powerful participant attempts to delegate authority to the less powerful, this might be perceived as neglect, and therefore might negatively affect interactional rapport between the parties. The interpreter's action described in excerpt 12 contributed to the mitigation of Irene's RSSA in the eyes of Dr. Sharpe. But it must not be forgotten that, as a result of the interpreter's mitigation, Irene's interactional goal of showing discomfort in the role of decision-maker was left unaddressed. The conclusion from this discussion is that RSSAs may play a role in the fulfilment of interactional goals even if they are potentially threatening to someone's sensitivities. For this reason, I would argue that an interpreter's effort to mitigate the perceived threat may not always be an inherently helpful action, evidenced by the fact that Irene's interactional goal was lost in the translation process.

6.3.2 Association in unsupervised interpreter-patient interactions

The socio-interactional principle of association refers to the belief that we are entitled to a degree of social involvement with others, in keeping with the type of relationship that we have with them (Spencer-Oatey, 2008). For example, depending on what we expect our relationship to be with a certain person, we might expect different degrees of small talk with them, understanding small talk as social chitchat or casual/light conversation that does not fulfil a transactional purpose (Major, 2013). Appropriately handling small talk is a balancing act as different people might have different thresholds of what counts as an appropriate amount of this communicative practice. This uncertainty becomes relevant in relation to situations where an interpreter and a patient are sitting close to each other in the waiting room of a ward where a consultation with a doctor is going to take place. Arriving early, the interpreter might find themselves sitting next to the patient prior to the consultation, raising the question of whether they should engage in conversation with a patient or not; as this is a situation where professional boundaries and relational rules, including the suitability of small-talk, are not clear.

Many healthcare interpreting guidelines suggest that interpreters should not be left alone with patients (Hlavac, 2017). However, it has been reported that this is common practice in actuality (Hsieh, 2016). Interpreters have reported experiencing difficulty in balancing their relationship with patients and ensuring neutrality with them in situations where they interact with them directly (Fatahi et al., 2009). I witnessed this issue during my fieldwork, as I observed how interpreters #1, #2 and #3 engaged in small talk with Irene and her daughter prior to consultations #1, #2 and #3 respectively. Thus, it could be posited that the three interpreters shared a physical and a private interactional space with Irene prior to the medical consultation led by Dr. Sharpe. To contextualise these occurrences, it is worth mentioning that the physical features of the waiting room at the Psychological Medicine ward may make it difficult for interpreters and patients *not* to interact with patients. To illustrate this, below is a photograph of the waiting area.

Figure 11 – Waiting area of the Psychological Medicine ward

Figure 10 shows the limited dimensions of the waiting room, as well as the small number of chairs, all of which are placed close to each other. The Psychological Medicine department is a small clinic with only a limited number of patients attending at a time, so the size of the waiting room is designed according to its purpose. This small space means that physical proximity makes interactional dynamics more salient.

Drawing on this statement, I posit that the enforced physical proximity may prompt interpreters and patients to engage directly, particularly in cases where interpreter and patient know each other from previous encounters; as is the case of Irene and interpreters #1 (Elisa) and #2 (Julia).

The gap between theoretical prescriptions and reality in practice around unsupervised interactions between interpreter and patient may be bridged in multiple ways depending on the interpreter. During my fieldwork (see 5.2.3), I saw a range of different behaviours, with some interpreters sustaining small talk with patients whereas other interpreters refrained entirely from interacting with the patient prior to entering the consultation room. When discussing this issue in the retrospective interview with Julia, interpreter #2, she admitted finding it too uncomfortable for everyone if she does not break the silence and introduce herself to the person she believes that she has identified as the patient. Additionally, she admitted that engaging in small talk with the patient prior to a consultation may be instrumental as she might find out the reason for the consultation, a helpful piece of information that is rarely provided in the assignment brief.

On a different note, from the point of view of some patients, engaging in a degree of interactional involvement with interpreters prior to the consultation might be a positive action. In this regard, Elisa explained in her restrospective interview that, in her experience, some patients become excited about the possibility of speaking their home language with her prior to the consultation. Upon discussion of this theme, she explained:

[8] "It is like they cling to you because a language is part of your subjectivity, your psychology, your most intimate being […] especially in a foreign country if they feel isolated or unprotected. So they speak to you, they see that you listen and it seems that just holding a conversation with them is a relief for them."

Elisa's words seem to refer to a reaction towards what Achotegui-Loizate (2019) describes as distress caused by the migrant's separation with the primary language, one of the losses faced as part of the 'Ulysses syndrome', or migratory stress/grieving. In this sense, while it is undeniable that small talk between interpreters and patients might be of value on the basis of Elisa's account, caution must be exercised in relation to this matter. Hsieh (2016: 222) found that mental healthcare providers are more likely than clinicians from other specialties to believe that interpreters should refrain from chitchatting with patients because any interaction with them may have "serious clinical and therapeutic consequences" due to their heightened state of vulnerability. As a matter of fact, interpreters engaging in unsupervised conversations with patients may be seen

as contravening interpreting code of ethics (ASLIA, 2011). There is a reason behind this, as it has been suggested that private conversations between interpreters and patients may pose a risk due to the increased likelihood of patients disclosing information that should be best disclosed during the medical consultation (Hlavac, 2017). This aspect resonates with my own findings: in my interview with Julia, she provided an account of a time when she had had a conversation with a patient in the waiting room; and, once inside the consultation room and the doctor asked the patient what was wrong, the patient addressed the interpreter directly and said the equivalent of 'what I told you earlier'. This episode illustrates what the ASLIA Guidelines for interpreting in mental health settings (GIMHS) refers to as 'overdisclosure'. Regarding this, the ASLIA GIMHS (2011: 4) recommend that an interpreter working in a mental health setting should refrain from interacting with the patient prior to the formal consultation, as this might increase the risk of the following:

"the patient bonding with the interpreter rather than the clinician; the patient disclosing information to the interpreter that would be best disclosed to the clinician; the possibility of the interpreter unknowingly undermining work done by the clinician".

This statement suggests that unsupervised interactions between patient and interpreter may cause feelings of mistrust in the healthcare professional towards the interpreter involved. When discussing patients' potential disclosure of information prior to the consultation, Dr. Sharpe offered a more conciliatory view in his retrospective interview:

"I am aware that some of my colleagues feel wary when they feel that patient and interpreter are already close before you even meet the patient as that might impinge on our own relationship with the patient. But being realistic, I think that there is no point in opposing that. If they are sitting in the waiting room, not interacting is in itself a form of interacting, an odd dynamic. There could be important discussions between them that should be part of the clinical encounter. If Irene had said to the translator something that appeared relevant then both should feel able, even encouraged, to let that be part of the discussion in the session with me, not ruled out. There should be an ability on my part to say: "did anything emerge from your discussions while I was talking to your daughter?" That would be a nice compromise."

It can be distilled through Dr. Sharpe's account that he has a more cooperative-based view of the adequateness of unsupervised interactions between interpreters and patients. Instead of dismissing the potential value/risk of such interactions altogether, he focuses on the positive aspects of interpreter-patient bonding. Thus, if we draw Dr. Sharpe's view as well as Elisa's and Julia's perspectives together, it can be claimed that all of them had matching expectations regarding the sociality rights of interpreters and

patients to engage directly outside of the triadic encounter. Thus, cordiality was preserved between them. Nonetheless, it must also be acknowledged that there is not a single valid perspective on this complex issue, which means that there is also potential for disharmony resulting from mistaching expectations on the adequateness of interpreter-patient small talk sustained in the waiting room; both between interpreters and patients, and between healthcare practitioners and interpreters.

6.4 Type of speech event

Spencer-Oatey (2008) establishes that the type of activity in which participants are involved influences rapport management dynamics between them. The author of RM theory draws on Levinson's (1979: 368) definition of 'activity type' to make this statement: "a fuzzy category whose focal members are goal-defined, socially constituted, bounded, events with constraints on participants, setting, and so on". Thus, the type of activity or 'speech event' that frames the consultations featured in dataset 1 is a cross-cultural and cross-linguistic clinical mental healthcare speech event (see sections 3.1 and 3.2 for a discussion of this type of encounters). Drawing on these notions, sections 6.4.1 – 6.4.3 below provide descriptions of three interactional incidents in which there is a connection between RM dynamics between participants and a certain feature of the speech event. More specifically, the type of condition that the patient is suffering (6.4.1 and 6.4.2) and the concern with maximising the use of time, so prevalent in healthcare encounters (6.4.3).

6.4.1 Conflicting versions on the patient's treatment adherence

Excerpt 14 below shows a tension between Dr. Sharpe's and Irene's version of the patient's adherence to the instructions that she received regarding the administration of dialysis.

Excerpt 14. Consultation #2 – Ss. 20 – 32

Table 24 – Excerpt 14

S.	Dr. Sharpe	Julia	Irene
20	Have there been occasions when it has become detached, the connection between you and the machine?		
21		¿Alguna vez se desconectó la conexión entre usted y la máquina? *Have you ever disconnected from the*	

		machine?	
22			*Silence*
23		¿Ha pasado? *Has it happened?*	
24			No: *[downward intonation]*
25	**I heard from Dr. Bloom that there had been ↓**		
26		**Me dijo el Dr. Bloom que sí (*0.5*) ha sucedido ↓** *Dr. Bloom told me that it has happened*	
27			NO NO
28	Is it possible that it has happened but you don't remember?		
29		¿Es posible que haya sucedido y que usted no se acuerde? *Is it possible that it has happened but you do not remember?*	
30			*(3)* No: ↓
31		No	
32	Ok *{writes notes}* *(2)* Are things better or worse or the same for you now than they were in December?		

Before this excerpt took place, Dr. Sharpe had been informed by Irene's primary physician, Dr. Bloom, on the quick deterioration of cognitive abilities that Irene was experiencing. He had also informed Dr. Sharpe that Irene has been detaching herself from the dialysis machine, whether consciously or accidentally. Despite having this knowledge prior to the session, Dr. Sharpe actively seeks Irene's version [S. 20]. Upon hearing the interpreter's rendition of the doctor's question [S. 21], Irene refuses to respond. Interestingly, the interpreter takes a proactive role and repeats Dr. Sharpe's question [S. 23], to which Irene responds very hesitantly by saying no [S. 24]. After hearing Irene's answer, Dr. Sharpe contradicts the patient's version by stating that Irene's primary physician had reported that she had indeed been disconnected from the machine [S. 26], a version of events denied by the patient [S. 27]. Dr. Sharpe enquires further and asks the patient whether she might not remember the actual events [S. 28],

which the patient continues to deny [S. 30]. At the end of this sequence, Dr. Sharpe decides to drop the issue and move onto a different subject.

I posit that two RSSAs take place throughout this sequence. The first RSSA is initiated (most likely unintentionally) by Irene in S. 24, where she contradicts the official version of Dr. Bloom. A first reading of this RSSA would suggest that she is hampering the interactional goals of Dr. Sharpe: he is trying to verify a factual piece of information, and the patient is not being cooperative. However, a second reading of the sequence would suggest that something else was happening. Dr. Sharpe stated in his retrospective interview that, while he sustained the conversation with Irene, he was also assessing her cognitive ability to react as well as to process and recall information. Therefore, if we consider that Dr. Sharpe, by aiming to verify with the patient information that he already knows [S. 20], is actually checking whether she remembered, then we could conclude that Irene's negative answer is not actually hampering his goals.

The second RSSA that could be identified in this sequence is Dr. Sharpe's contradiction of Irene's statement in S. 25. I would argue that, by opposing her view while providing further evidence (Dr. Bloom's report), he is challenging the patient's face sensitivities. When considering face sensitivities, Spencer-Oatey (2008) establishes that each of us has a fundamental desire for others to evaluate us for our positive attributes, instead of acknowledging our faults. I would argue that Dr. Sharpe's action in S. 25 implies that Irene is not telling the truth, which is certainly not an acknowledgment of a positive quality but a subtle threat to Irene's positive face. Spencer-Oatey also suggests that attributes only become face sensitive (positive or negative) when a value is associated with them, and this depends on the person affected and the context in which the FTA is taking place. In this particular case, the notion that Irene is not telling the truth is highly sensitive because: (a) lying is not seen as a positive quality, particularly in a cooperative setting like healthcare; and (b) she might not be telling the truth because she does not remember. Throughout consultations #1, #2 and #3, Irene's fading memory was a particularly sensitive topic, as Irene was slowly becoming aware of her own deterioration and struggling to acknowledge what was happening to her. For all these reasons, I would argue that Dr. Sharpe's action in S. 25 is of a highly threatening nature to Irene's positive face.

The data shows that Dr. Sharpe was aware of this, as he employs a mitigating strategy through paralinguistic means: he actively modulates his intonation. Dr. Sharpe adopts a downfall intonation when opposing the patient's view [S. 25], which is competently replicated by Julia in excerpt 13 when providing a Spanish rendition for Irene [S. 26].

By replicating Dr. Sharpe's RM-oriented use of intonation, Julia demonstrates that she is attuned with the doctor's relational disposition.

The conclusion that could be drawn from the analysis of excerpt 14 is that, in an MHC context, the production of RSSAs might be unintentional, as people's linguistic or behavioural actions might be heavily conditioned by their impairment or condition. For example, in this case Irene opposed Dr. Sharpe's version of events by claiming that the failure to dialyse had not happened at all. This does not correspond with her physician's version, based on Irene's health. It is likely that Irene was either not telling the truth due to a reason such as embarrassment, or she could perhaps not remember the truth. These aspects, and the resulting lack of cooperativeness on the part of Irene, could be due to Irene's mental condition. For that reason, it could be argued that behavioural expectations should be calibrated in accordance with the speech event that speakers are involved in. Taking the notion of intentionality of non-normative rapport management behaviour in a cooperative setting a bit further, it is worth acknowledging the following quotation by Dr. Sharpe in his interview: "many patients that come here do not want to be here and they do not want to see us". Drawing on this statement, it could be hypothesised that, if a patient is unwilling to attend a session, they might not adopt a 'rapport maintenance orientation'. This additional fact reinforces the notion that behavioural expectations in relation to rapport management must be calibrated according to the institutional and interactional features of each activity type.

6.4.2 Dealing with emotion-invoking subjects

As explained in section 5.5, this case study features a patient who is entering the terminal stage of her renal disease. As a result, an important aspect that is present throughout the examined consultations is Dr. Sharpe's willingness to help Irene come to terms with her circumstances. During one of these acceptance-focused discussions, the emotional intensity of the conversation is so heightened that the patient bursts into tears, prompting a response in the interpreter worth remarking on from the relational standpoint.

Excerpt 15. Consultation #3 – Ss. 301 – 310

Table 25 – Excerpt 15

S.	Dr. Sharpe	Maya	Irene
	Are you more accepting now of spending the rest of your days in Scotland?		

301			
302		¿Entonces ha aceptado que va a pasar el final de su vida aquí en Escocia? *So, you have accepted that you are going to spend the rest of your life here in Scotland?*	
303			Sí, ya qué voy a hacer en Chile *Yes, I have nothing to do in Chile*
304		Yes, because there is nothing left for me to do in Chile	
305			Si yo sé que mi hija hizo bien en traerme aquí *I know that my daughter did a good thing by bringing me here*
306		I think it was a good idea that my daughter brought me here	
307		***{Looks at patient}*** ***{Nods}***	*{Addressing interpreter}* Porque *Because* ***{Voice breaks. Cries}*** sabes *you know,* ***{Cries. Looks down}*** ***(2)*** ella es mi hija única *she is my only daughter*
308		***{Swiftly addresses doctor, looks back at patient and sustains gaze onto her}*** Because she is my only daughter	***{Looks down}***
309		***Keeps looking at patient*** ***Nods***	Y quiere lo mejor pa mí {*continues crying}* *So, she wants whatever is best for me*
310	*{Takes notes}*	*{Addresses doctor}* so she wants the best for me	

The physical configuration of participants' positioning in consultation #3 is worth noting to contextualise the communicative actions shown in excerpt 15. As visually displayed in section 5.2.4, Irene and Maya are sat closely next to each other on a sofa,

facing Dr. Sharpe. Therefore, when S. 307 is uttered by Irene, the close physical proximity between the patient and the interpreter seems to add to the sense of affective involvement between the two: the patient expresses her sadness while directly addressing the interpreter, who keeps her gaze fixed on the patient while nodding. Maya quickly translates for Dr. Sharpe in S. 308. Maya's body language while uttering S. 308 is worth remarking: she gazes at the doctor at the start of her rendition but halfway through her intervention, she turns her gaze back to the patient despite the patient being silent and looking down. It would be difficult to explain the purpose of this movement without taking into account the interpreter's potential desire to visually display a sense of emotional presence for the patient, reinforced by the physical proximity shared between them. This behaviour resonates with the findings of Aguilar (2019: 45), who suggests that the sensitive nature of topics discussed in MH work might have an influence on how communicative dynamics unfold, explaining that:

> "sometimes the client will speak directly to the interpreter especially if talking about an uncomfortable or sensitive topic. If the client becomes emotional or begins to talk without interruption about a personally emotion invoking subject, perhaps it would not be the time or therapeutically indicated to immediately stop the client and inform her about the proper use of the interpreter."

The interpreter's communicative behaviour displayed through excerpt 15 complements Aguilar's discussion by suggesting that it is not only patients who 'breach' normative expectations of non-verbal behaviours typically associated with turn-taking. Instead, interpreters may also want to slightly tweak the pattern of communicative practices that they would normally engage in, prompted by the distinct demands of the interactional event – such as when responding to a patient's outburst of emotion linked to the discussion of a sensitive topic, common in MHC work. From a RM-theory standpoint, it could also be argued that Maya was honouring Irene's right to interactional, and even affective, involvement on her part, prompted by the heightened emotionality of this occurrence.

6.4.3 'Saving time' and rapport implications

Excerpts 16 and 17 below show how Elisa, interpreter #1 shows through her renditions her concern with maximising the use of time in the consultation as well as the rapport implications of her actions.

Excerpt 16. Consultation # 1 - Ss. 286 – 288

Excerpt 16 shows how Elisa omits parts of Irene's account that refer to the patient's spirituality.

Table 26 – Excerpt 16

S.	Dr. Sharpe	Elisa	Irene
286			Al principio yo me negaba rotundamente porque me daba miedo que me obligasen a tener un transplante, pero luego **un día cambió todo porque escuché a dios. Dios me dijo que quería que yo viviera más tiempo, que me quedaban cosas por hacer en vida.** Entonces ahora me siento más positiva con esa idea del transplante porque si me lo está usté ofreciendo es por algo. De todas formas, **Dios dirá hasta donde vivo.** *At first I totally refused [a transplant] because I was scared I might be forced to have it but then **one day everything changed because I listened to God. God told me that He wanted me to live longer, [and] that I still had things to do in life.** So now I feel more positive about the idea of a transplant because there must be a reason why you are offering it to me. **In any case, God will decide how long I will live.***
287		At the beginning I refused because I was scared that they will force me to have a transplant but **one day all changed when I listened to God's voice and I think I can live longer to do more things while I live so now I am more open to the idea of the transplant.** There	

		must be a reason why you are offering it to me.	
288	**First of all you can rest assured that you CANNOT be forced to have a transplant. There is no medical way, no legal way to do that**		

Excerpt 16 shows how the patient tells the clinician about the aspects that influenced her decision-making processes when considering receiving a transplant [S. 286]. The patient directly connects her motivation to accept it with God's mandate to live longer. The final sentence in S. 286 evidences the patient's belief that the clinician's offer of a transplant must be a sign of God's will. The patient's feelings of gratitude towards what she perceives to be a God-sent signal drives her decision to accept the transplant. However, the spiritual dimension of the patient's utterance does not seem to come across clearly enough in the interpreter's rendition [S. 287]. There is no clear link in S. 287 between the patient hearing God's voice and her motivation to accept the transplant. The final sentence of S. 286 is also fully omitted in the interpreter's utterance. For these reasons, S. 287 can be classified as a reduced rendition, adopting Wadensjö's (1998) taxonomy. More particularly, the interpreter reduces the weight of the spiritual motive that drove Irene's change in attitude [S. 287]. This action was addressed in my retrospective interview with Elisa. Speaking about the reasons that led her to filter out part of the patient's speech talk around spirituality, Elisa noted:

[10] "as an interpreter, sometimes you need to gear the patient's answer towards what the doctor needs to hear because sometimes patients answer in a way that is not relevant, and everybody wastes time when that happens. Patients sometimes just respond to their own anxieties and preoccupations not to the actual doctor's questions."

Elisa's statement suggests that she occasionally prioritises clinically-relevant talk over what she perceives to be non-clinically-relevant aspects of the patient's discourse, depending on how relevant she perceives the patient's interventions to be in relation to the healthcare provider's goals. This view resonates with Bolden's findings (2000), that the interpreter's goal-orientedness may lead to the filtering of patients' accounts to exclude the parts of the patients' utterances that are not perceived as clinically relevant.

Leaving the interpreter's action aside, Dr. Sharpe's response [S. 288] to the patient's account is worth noting from the standpoint of RM theory: because of the significance of Irene's fear of being forced to have a transplant or maybe because he does not perceive Irene's emphasis on spirituality, he addresses the medico-legal dimension of receiving a transplant, after having perceived this to be Irene's main fear. However, it could be hypothesised that Irene could have seen her sociality right to have her faith considered by the doctor somehow infringed, as her whole narrative on God's will influencing her choice to receive a transplant has been completely dismissed. It could also be argued that the lack of any kind of reference to Irene's spirituality might have portrayed the doctor as uncaring or insensitive in the patient's eyes, thus threatening perceptions of interactional rapport between them.

In my retrospective interview with Dr. Sharpe, I enquired about the interpreter's reduced rendition in S. 287 and he acknowledged that it would have been useful for him to grasp the importance that the patient attributed to religion. Upon further discussion, Dr. Sharpe explained that he normally finds it useful to invite patients' narratives on faith, particularly when terminal patients are involved. He added that he could have used this information to enhance his attempts to elicit answers from the patient regarding future treatments and end-of-life plans while also integrating the patient's lifeworld into his medical talk. He cited the following examples: "Do you think God has a plan for you? Do you agree with that plan? Do you think God would like you to live longer?" Through this pattern, two different ways of conceiving health, illness and treatment would co-exist and also support each other. This mutual support happens because both biomedical goals (eliciting medical information) and interactional goals (making the patient feel like that doctor has taken an interest in her narrative) complement each other. The rapport management implications of Elisa's action in excerpt 16 are not necessarily direct and immediately observable. Instead, I propose that the rapport-related consequences of this reduced rendition are indirect, in the sense that the interpreter's reduced rendition of the spiritual content in Irene's utterance prevented the doctor from showing appreciation for the spiritual narrative underpinning her understanding of her illness. All in all, excerpt 16 may well be seen as a missed opportunity for further rapport-enhancement actions, caused by the interpreter's reduced rendition in which the patient's spiritual component was partially omitted due to the interpreter's perceptive judgement on the relevance of such component.

Excerpt 17. Consultation #1 – Ss. 127 - 132

Excerpt 17 shows how Elisa proactively aims to manage the progression of talk.

Table 27 – Excerpt 17

S.	Dr. Sharpe	Elisa	Irene
127	Does that mean that you miss some dialysis exchanges, or you do them late?		
128		¿Las sesiones del tratamiento las haces más tarde o completamente nunca? *Do you do the treatment sessions later on or completely never?*	
129			**[129]** A ver sí bueno yo miraba el reloj y me decía uy se me pasó la hora, no entendía por qué me pasaba y ***[Interrupted]*** *Let's see well yes I looked at the watch and said to myself whoops the timing went past I did not understand why that happened to me and*
130		**[130]** ***[Interrupts]*** ¿las hacía atrasadas? *You did them delayed?*	
131			Sí *Yes*
132		I did them later I mean delayed	

Through S. 127, Dr. Sharpe aims to find out the ways in which Irene has not been following the treatment administration guidelines. Before this exchange, the patient had explained that her progressive memory loss had been preventing her from meeting her treatment schedule. When the patient is asked whether she misses the dialysis exchanges or just delays the sessions, she does not provide a straightforward answer [S. 129]. Instead, she provides a circumlocution around how she reacts and feels when she realises that she has forgotten to dialyse. Her answer [S. 129] is interrupted by the interpreter [S. 130], who re-directs the conversation flow by encouraging the patient to provide a more to-the-point answer so that she addresses directly what the clinician asked. The patient responds by providing a precise answer/affirmation of the

interpreters concise suggestion [S. 131] which is then relayed by the interpreter. I cannot account for whether the doctor realised or not. But if he did, he did not act upon this interpreter's move. Elisa's discursive move matches the notion of the interpreter as an 'institutional goalkeeper'. This concept was firstly proposed by Davidson (2000: 40), who found that some interpreters aim to proactively keep the medical interview 'on track' and the physician on schedule. Similarly, Hsieh (2016) proposed that interpreters may occasionally internalise the goals of the medical institution, such as the time-keeping goal. These two views could help frame S. 130. What is more, Elisa's view on the interpreter's role in relation to the time factor in healthcare (See quote **[10]** in 6.4.3) confirms that she has, indeed, internalised the institutional principle of maximising the use of time and that helps to explain S. 130. Elisa's will to function as a timekeeper could theoretically indicate that she is 'transactionally aligned' with the institutional goals of the setting at large as well as with what she perceives to be the intention behind S. 127. However, I would suggest that Elisa is also 'relationally misaligned' when it comes to the rapport expected to be established between the patient and the doctor-interpreter acting as representatives of the health service. More particularly, I believe that the interpreter's interruption threatens the patient's equity right to be listened to, given that the narrative that she is trying to get across to the doctor is dismissed as irrelevant. In fact, it is remarkable that the patient's narrative could have actually been relevant for the sake of a consultation in the Department of Psychological Medicine, given that the patient was expressing how puzzled she was at becoming aware of her memory loss. Considering the double aim of Psychological Medicine (see 5.2.4), a discussion on the interrelationship between cognitive impairment and the administration of a physical treatment could have been extremely relevant which questions the value of the interpreter's transactional alignment.

6.5 Concluding remarks

In Chapter 6, I have provided analytical descriptions of interactional episodes selected for discussion because they illustrate in some way how participants' RM actions and perceptions should not be understood in isolation from the contextual factors surrounding a given encounter. This interplay between RM dynamics and context has several implications, synthesised as part of a discussion on the two core findings of this chapter, provided below.

Core finding 1 - Contextual factors shape participants' perceptions of RSSAs

One of the main findings discussed in this chapter is that RSSAs are not inherently rapport-threatening or rapport-enhancing to the addressee; instead, rapport outcomes depend on participants' preconceptions of a number of factors. For instance, power has been identified as a highly-sensitive factor influencing RM dynamics between participants featured in my case study. Power-related tensions were identified between the doctor and an interpreter when jointly handling turn-taking as well as between that interpreter and the patient's family member over what interpreting modality should be adopted. Interestingly, power tensions between the doctor and the interpreter cause less disharmony than tensions between the interpreter and the patient's family member, probably due to the difference in interactional status between the doctor and the patient's relative. This evidences that participants' ways of handling of RM dynamics prompted by interactional incidents uncover pre-existing hierarchies for a given interaction. For example, healthcare events such as the ones analysed in this thesis are asymmetrical due to the doctor's expert power, and this is reflected on RM actions and perceptions between participants. By providing these discussions, I aimed to illustrate that interpreters become an active part of pre-existing relational configurations by assuming a unique status within them which, in turn, conditions their engagement in RM dynamics. Behavioural expectations also seem to be a crucial aspect determining participants' RM perceptions. If participants, including interpreters, have matching expectations in relation to the sociality rights and obligations expected from them, harmony will be preserved. However, if there is a mismatch of expectations, the interactional balance will be affected. This becomes particularly relevant when describing the effect of Dr. Sharpe's attempts to engage in shared decision-making with Irene (6.3.1), or the different opinions around unsupervised interactions between interpreters and patient in the waiting room (6.3.2). Finally, the type of speech event will require a recalibration of RM dynamics. Uncooperativeness on the part of the patient might be due to a mental health problem, thus re-interpreting RSSAs as the result of confusion/cognitive decline/reactiveness towards the health service or fear. Additionally, increased emotionally might prompt rapport enhancing behaviours that would not happen otherwise. All in all, perceptions of RSSAs might also depend on expectations associated with each speech event.

Core finding 2 – Contextual factors shape participants' initiation of RSSAs

Another core finding discussed in chapter 6 is that some contextual factors might drive participants' motivation, or lack thereof, to initiate RSSAs towards a certain speaker. For example, in 6.2.2.1 I discuss how an interpreter challenges the normative notion of impartiality to display a gesture of personal support for the patient. However, this interpreter admitted not doing this regularly and; instead, explains how her action was particularly prompted by her familiarity with the patient involved due to repeated contact between them, as well as by the emotional intensity of the subject matter in that specific consultation. Thus, perceptions of 'closeness' and the difficult subject matter typically associated with the types of conversations held in the psychiatry setting within which it took place, are contextual factors that drive this interpreter's breaching of normative expectations regarding non-involvement. This means that different contextual aspects might determine what RM behaviours are acceptable or not for a given interaction. This statement is relevant from the point of view of interpreting studies as, drawing on it, it could be suggested that interpreters should develop a contextual awareness to understand and accommodate to people's use of language for language use under different conditions. It becomes clear that interpreters may influence the portrayal of RM-related pragmatic markers. Therefore, it seems crucial that they develop the capacity to assess contextual variables and adapt their positioning accordingly.

Research implications

In this chapter I have discussed how the relational configuration between participants (in terms of power and distance), their behavioural expectations and the nature of the speech event are factors that may shape participants' RM-oriented communicative behaviours and perceptions of the interactional balance. This means that examining participants' relational behaviours and perceptions in any given interaction should not be done in isolation from a consideration of the context framing a given encounter. In this regard, RM theory may well be seen as a solid tool to explain relational dynamics between participants as the multiplicity of contextual variables in any encounter including interpreter-mediated events.

Finally, it must be acknowledged that, even though this chapter has elicited interesting findings in relation to how context influences RM dynamics between participants, not enough attention has been paid to the fact that interpersonal dynamics in a goal-oriented speech even such as a medical setting are, at least partly, instrumental to the achievement of ulterior aims: in the case of consultations examined in this study, this

ulterior purpose is the fulfilment of a medical agenda. Drawing on this idea and, in order to complement the data and analysis presented in this chapter, chapter 7 will provide an in-depth discussion of the co-construction and co-fulfilment of the participants' goals, with a particular focus on the alignment/misalignment of goals between interpreters and primary speakers as well as its rapport management implications.

Chapter 7 – Interpreter mediated negotiation of interactional goals

This chapter offers analytical descriptions of sequences from datasets 1 and 2 that focus on participants' discursive negotiation of interactional goals, and the effect of such negotiation on their perceptions of interpersonal (dis)harmony. As discussed in 4.2.3, interactional goals are the third base of rapport management (RM) and may be of a transactional or interactional nature. The reason why I pay special attention to the third base of RM in this chapter is because the interpreter-mediated events (IMEs) featured in this study take place in a medical setting, which is a goal-oriented speech event (Brisset et al., 2013). Medical encounters are goal-oriented because their raison d'être is to fulfil an agenda aimed at improving the patient's health and quality of life. In turn, such an agenda consists of a set of objectives that need to be achieved to fulfil that purpose (Cordella, 2004). Thus, because this thesis is concerned with medical consultations, this chapter draws on the assumption that the successful negotiation of interactional goals is a matter of heightened importance for all participants featured in my case study. A second assumption sustaining this chapter is that, because the examined consultations are interpreter-mediated, the success of the discursive negotiation of interactional goals between primary participants may be reliant upon the interpreter's performance, at least to a certain extent. In this chapter, interpreters' attunement with primary speakers' interactional goals is referred to as 'alignment'; and the reverse is termed 'misalignment', in line with Hsieh's (2016) Bilingual Health Communication model. In summary, the purpose of this chapter is to shed light onto how relationally-oriented interactional goals are discursively co-fulfilled between participants featured in this thesis. This exploration is articulated by paying attention to the alignment and misalignment of goals between Dr. Sharpe and the three interpreters (section 7.1) and between the interpreters and Irene (7.2).

7.1 Clinician-interpreter (mis)alignment of goals

In this section, I report on the findings from my qualitative inquiry into a series of interactional episodes found in dataset 1 that illustrate the notion of alignment and misalignment of goals pursued through the doctor and the interpreters' communicative actions. (Mis)alignment of goals in the doctor-interpreter dyad is examined in relation to the four occurrences that seem to bear substantial rapport management implications: reassuring the patient (7.1.1), discussing the patient's religious views on treatment

(7.1.2), sequencing discourse (7.1.3) and the clinician's refusal to prescribe antidepressants (7.1.4).

7.1.1 Reassuring the patient

7.1.1.1 On interrupting treatment (I): doctor-interpreter misalignment

Excerpt 18 below was extracted from consultation #3. In this consultation, Dr. Sharpe explains that Irene's peritoneal dialysis is failing. Consequently, shifting to haemodialysis becomes the only treatment that can keep her alive. However, Irene is not willing to undergo haemodialysis. As a result, an end-of-life scenario becomes increasingly plausible, so Dr. Sharpe initiates a discussion on end-of-life care. End-of-life communication protocols for clinicians stress the importance of offering reassurance to patients when having these discussions (Woo, Maytal and Stern, 2006). According to these protocols, it is of vital importance to tell patients what to expect from the dying process, while promising that the medical team will not abandon them at the end (*ibid*.). That is exactly the communicative goal that Dr. Sharpe is trying to accomplish in excerpt 18.

Excerpt 18. Consultation #3 – Ss. 235 – 249

Table 28 – Excerpt 18

S.	Dr. Sharpe	Maya	Irene
235	If you **decided** to stop peritoneal dialysis		
236		Si **decide** parar la diálisis peritoneal *If you **decide** to stop peritoneal dialysis*	
237	We **would not stop** seeing you		
238		**No vamos a dejar** de verla *We **are not going to stop** seeing you*	
239	Our nurses **would be visiting** you to make sure that you are not in pain or otherwise ill		
		Nuestras enfermeras **van a seguir visitándola** para asegurarnos de que no	

240		está sufriendo dolor ni está enferma *Our nurses **are going to keep visiting you** so that we make sure that you are not in pain or ill*	
241			Ya, de acuerdo *I see, OK*
242		Ok	
243	And if you **needed** to be admitted to a hospital to control your symptoms, we could do that		
244		Y si **necesitamos** ingresarla en el hospital para controlar sus síntomas, eso también se puede hacer *And if we **need** to admit you to a hospital to control your symptoms, that could be done*	
245			**Doctor habla usté como si fuera muy próximo esto. Todavía no he decidido nada y ya están pensando que me va a pasar to' esto** ***Doctor you speak as if this would all be immediate. I have not decided anything yet and you [pl.] are thinking that all this will happen to me***
246		Doctor you are speaking as this is very near. I didn't decide anything and you are already thinking that this will happen to me	
247	**I apologise. I was talking in hypothetical terms as this is one possibility of many. I did not**		

	mean to make you feel uncertain or worried		
248		Disculpe, estaba hablando de un caso hipotético dentro de las varias situaciones que podrían darse. No quería que se preocupase *I apologise, I was talking about a hypothetical case within the various situations that could arise. I did not want to worry you*	
249			**Vale doctor, me da gusto oír eso** ***Ok, doctor, I am glad to hear that***

Throughout segments 235 to 243, Dr. Sharpe attempts to reassure Irene about the potential outcomes of her hypothetical decision to interrupt treatment. These Ss. appropriately illustrate what Van Dijk defines as a "macro speech act" (1997: 99): a communicative action where the intended illocutionary force is distributed across a sequence of utterances. In this case, 'reassuring' is the illocutionary act that Dr. Sharpe pursues throughout this sequence. More specifically, the clinician aims to comfort Irene by making explicit that the hospital staff would not just be willing to accept her decision to interrupt treatment should she decide to do so, but also that they will be committed to ensuring her wellbeing following her decision, by providing palliative care.

Through a RM theory lens, Dr. Sharpe's speech act reflects an attempt to honour the Socio Interactional Principle (SIP) of 'equity' between Irene and the hospital staff. By explicitly confirming that Irene will be well cared for even if she decides to put an end to her treatment and therefore to her life, reassurance is provided around Irene's full autonomy to decide. In doing so, Dr. Sharpe openly acknowledges that it is an 'obligation' for the hospital staff to honour Irene's 'right' to decide and act accordingly. Because behaving according to behavioural expectations, fostered around pre-conceptions of rights and obligations is key to ensure interactional rapport, I argue that the act of reassurance shown through excerpt 18 fulfils the criteria to be considered an RSSA in relation to the second base of rapport.

Having clarified the goal that Dr. Sharpe is trying to fulfil, it is worth discussing how he proceeds to achieve it. In this regard, it is worth pointing out his use of the conditional

tense throughout Ss. 235 to 243. The Cambridge handout on Medical English for Health professionals (Faya-Ornia and Hernández-Lázaro, 2017) encourages the use of second conditional constructions when referring to hypothetical scenarios rather than actual situations. This recommendation, which Dr. Sharpe follows, is key to reassuring Irene about her autonomy to freely make a decision. That is because, by speaking in hypothetical terms, the end-of-life scenario becomes a potential situation resulting from a choice which is yet to be made, rather than an unescapable fate. For example, by wording his statements as: "if you needed to be admitted to a hospital to control your symptoms, we could do that". Nonetheless, despite Dr. Sharpe following this protocol, attempting to reassure Irene about her decision, the patient manifests distress around feeling cornered in an end-of-life scenario. This suggests that the perlocutionary effect seems to be opposite to what was intended by Dr. Sharpe's reassuring efforts. The mismatch between the intended meaning and Irene's sense-making could be attributed to several causes including cognitive factors biasing the patient's interpretation of Dr. Sharpe's utterances. No tangible evidence was found to prove a causal effect between any specific factor and the perlocutionary effect on Irene. However, there is textual and, more specifically, grammatical evidence to hypothesise that the interpreter's shift in the conditional tense employed might have, at least partly, influenced the meaning negotiation process, as explained below.

Both English and Spanish make a difference between the first and the second conditional structures. Both constructions have similar grammatical forms and equivalent functions across the two languages. More specifically, the first conditional is used to talk about situations that are likely assuming that a certain condition is met. For example: 'if you interrupt dialysis, your body will not survive'. By contrast, the second conditional adds a degree of uncertainty and is therefore used to talk about situations that involve a higher chance of unlikelihood. For example: 'if you decided to interrupt treatment, we would provide palliative care'.

Excerpt 17 shows how the interpreter uses the first conditional (Spanish equivalent of *if + present + future tense*) when translating Dr. Sharpe's interventions, which he expressed in the second conditional (*if + past simple + conditional tense*). By drawing on the grammatical difference between the two tenses in Spanish and English, I argue that Irene's understanding of Dr. Sharpe's intention might have been affected by the interpreter's shift in tense usage.

This is relevant from an interpreting studies viewpoint given that, whilst the transactional content expressed is the same (an interpreter's goal), a subtle shift in the

use of a grammatical device had the unintended consequence of conveying a higher sense of immediacy, which had an impact on the intended goal negotiation process ('comforting') and therefore influenced rapport-related outcomes.

There are, indeed, salient rapport management implications associated with this misunderstanding. S. 245 shows how Irene expresses her discomfort at feeling pressured into interrupting all types of dialysis ("I have not decided anything yet and you [pl.] are thinking that all this will happen to me"). This communicative action could be interpreted as a display of assertiveness in which Irene claims her right to autonomy to make treatment-related decisions for herself. Irene's move is rapport sensitive because of the implied notion that her right to decide is not being respected by the hospital, which by extension denotes an obligation-omission behaviour on the part of the healthcare staff. In other words, Irene's sociality expectancies (second base of rapport) are infringed and, as a result, her rapport perception is negatively affected, as expressed by S. 245. In an attempt to restore the interactional balance, Dr. Sharpe apologises for how his utterance came across [S. 247], which Irene positively reacts to [S. 249].

Following Dr. Sharpe's guarantee around the hypothetical nature of an end-of-life scenario [S. 247], it is clarified that Irene's right to decide will be respected at all times, and that it is the hospital staff's obligation to act accordingly. Irene's display of her understanding of Dr. Sharpe's clarification suggests that the interactional balance has been restored once the enactment of rights and obligations for both parties has been clarified.

All in all, the why, the how and the with what consequences the misunderstanding in excerpt 18 happens, suggests some ideas about the nature of doctor-interpreter alignment of goals. Namely, the interpreters' active participation had an unintended impact on how the message was understood. Such unintended impact was contrary to the goal that Dr. Sharpe was pursuing. More particularly, the excerpt shows that the interpreter was not fully aligned with Dr. Sharpe not because she was unaware of the doctor's goal but unmindful of the doctor's means to achieve it. Against this background, I argue that alignment between interpreters and primary speakers not only depends on the interpreters' perception of the speakers' goals, as Hsieh (2017) proposes. Instead, I propose that alignment is also dependent on the interpreters' capacity to identify and actively render the discursive mechanisms (grammatical, linguistic, paralinguistic or overall relational) through which an intended goal is expected to be fulfilled.

7.1.1.2 On interrupting treatment (II): doctor-interpreter alignment

Excerpt 19 below illustrates how interpreters can contribute to the achievement of a primary speaker's discursive goal. In particular, it shows how the interpreter takes additional action to complement Dr. Sharpe's efforts to reassure Irene about her prognosis.

Excerpt 19. Consultation #3 – Ss. 250 – 256

The first segment in excerpt 19 immediately follows the last segment of excerpt 18.

Table 29 – Excerpt 19

S.	Dr. Sharpe	Maya	Irene
250	What I am trying to help you understand is, if you said no more dialysis**, we wouldn't walk away**		
251		Lo que quiero que usté entienda, **¿vale?** (.) es que, si usted dice que no quiere más diálisis, nosotros **no la vamos a dejar sola. No nos vamos a retirar** *What I want you to understand,* ***ok?****, Is that if you do not want any more dialysis,* ***we are not going to leave you****. We are not going to vanish*	
252	Were you worried about that?		
253		¿Estaba usted preocupada por eso? *Were you worried about that?*	
254			No, en realidad no, pero ahora que lo menciona {*chuckles and shrugs shoulders}* *No, not really, but now that you mention it*
255		No, not really but maybe now that you mention it {*Smiles}*	
256	*{Smiles}* But right now you are willing to continue dialysis		

S. 250 shows how, after clarifying the misunderstanding described in excerpt 17, Dr. Sharpe attempts to clarify what his intention was when bringing up an end-of-life scenario: to inform Irene about the fact that she will always receive treatment, no matter what decision she makes eventually. An analysis of excerpt 18 based on speech act theory would suggest that Dr. Sharpe carries on trying to comfort Irene about her potentially future decisions, by providing reassurance about her prognosis. In order to do so, Dr. Sharpe does not explicitly say that Irene would be treated through palliative care provision if she interrupted treatment. Instead, he uses figurative language to express that the hospital staff will not stop being involved even if the situation becomes complicated: "we wouldn't *walk away*". I hypothesise that Dr. Sharpe's use of figurative language is adopted with hedging purposes, as he is using the term 'walking away' while denoting the idea of 'not providing terminal care', a substantially more loaded term.

The use of figurative language has been associated with enhanced clinician-patient communication in general (Casarett, et al., 2010), and has also been recommended as a linguistic tool for healthcare practitioners to comfort patients who are terminally ill (*ibid*.). All of this seems to suggest that Dr. Sharpe's use of 'walk away' was a deliberate move of central importance to communicate that Irene will always be supported despite her unfavourable prognosis. Maya, the interpreter, seems to recognise not only the reassuring function behind S. 250 but also identifies Dr. Sharpe's use of figurative language as a linguistic device through which he expects comforting to be achieved. Maya's rendition evidences her attunement with Dr. Sharpe's aims by using two pieces of figurative language; namely, the Spanish (nearly-) equivalents of: "we are not going to leave you" and "we are not going to vanish".

Whilst it could be argued that Maya's language choices do not express the exact same meaning, I propose that they fulfil the same reassuring function around Irene's prognosis. In doing this, Maya demonstrates having identified both the action that Dr. Sharpe was trying to fulfil as well as how he was proceeding to achieve it, thus evidencing how she internalises the doctor's goal.

All in all, I argue that Ss. 250-251 are a good example of a full and conscious alignment of goals between interpreter and healthcare provider. Because the alignment is achieved around an action that intrinsically pursued a relational function ('reassuring'), I posit that this instance of alignment contributes to the preservation of a positive interactional rapport between all participants. This is confirmed through Ss. 254-256: upon Dr. Sharpe's enquiry about whether the provision of palliative care was indeed among

Irene's concerns, Irene replies by jokingly saying that she only became concerned as the doctor raised the topic. Ultimately, it seems that all speakers are pursuing the preservation of a positive interactional balance, marked by the mitigation of rapport threatening acts.

7.1.2 Discussing religious views on treatment

Excerpt 20 shown below took place as part of a larger discussion on the medical treatments that Irene might need in the future, given that her health status is gradually deteriorating due to her terminal illness. In accordance with section 5 of the Adults with Incapacity (Scotland) Act (2000), it is important to have anticipatory discussions on treatment options if the patient's prognosis is poor. This is because discussing treatments in advance enables patients to express their preferences in a competent, and therefore informed, manner as their capacity to do so has not yet been compromised. Against this background, one of the medical treatments that Dr. Sharpe offers the patient is a blood transfusion, which she refuses on religious grounds, as shown below. The rapport implications of this tense interchange are discussed below.

Excerpt 20. Consultation #2 – Ss. 527 – 533

Table 30 – Excerpt 20

S.	Dr. Sharpe	Julia	Irene
527	Can I just check something you said earlier? You said that, as a Jehovah's witness, you will not like to have a blood transfusion. Did I understand that correctly?		
528		Para que me quede claro, como testigo de Jehová**, que usted ha comenzado a ser**, ¿es cierto que usted no aceptaría una transfusión de sangre **en caso de que fuera necesaria?** ¿Entendí eso correctamente? ¿**No la aceptaría, aunque le salvara la vida?** *Just so that I am clear. As a Jehovah's Witness**, which you recently became**, is it true that you would not accept a blood transfusion **in case it was necessary?** Did I understand*	

		that correctly? ***You would not accept it even if it saved your life?***	
529			No
530		No *No*	
531	And you are clear about that		
532		**¿Eso lo tiene claro?** *You are clear about that?*	
533			Sí *Yes*

S. 527 indicates how Dr. Sharpe recaps an immediately preceding discussion in which the patient disclosed that she is a member of a religious group whose doctrine does not approve of medical procedures involving blood products. In doing this, the doctor seeks the patient's explicit confirmation that she does not want to receive blood transfusions. This means that the clinician is seeking the patient's informed consent to not be treated, even in the potential case of acute need. In medical practice, the notion of informed consent is ancillary to a fundamental principle of biomedical ethics: respect for the patients' autonomy to decide upon their health issues (Entwistle, 2010). Drawing on these concepts, it can be established that Irene is enacting her right to autonomy by refusing to provide her consent to be treated with a blood transfusion in the future [S. 529].

In the field of biomedical ethics, there are two types of actions that healthcare practitioners can engage with in relation to a patient's right to autonomy and self-determination. Firstly, the principle of 'negative obligation' entails refraining from taking coercive action or actively trying to convince a patient to make a certain decision (Coggon and Miola, 2011). Secondly, 'positive obligation' refers to the actions that a medical practitioner may take in an attempt to compensate for any difficulties the patient faces in making decisions in a competent, and therefore autonomous, manner (*ibid*.). Excerpt 20 shows a scenario where the patient needs the practitioner to adopt a positive obligation stance because she suffers from several conditions that may compromise her capacity to make informed decisions: an affective disorder (depression), as well as difficulty processing and remembering information due to her cognitive impairment. Consequently, the healthcare practitioner's engagement with positive obligation behaviour is vital to increase this patient's capacity for exerting her right to autonomy and thus, safeguard her involvement in competent decision-making. In excerpt 20, the clinician's positive obligation stance is displayed through his attempts

to obtain the patient's explicit confirmation that she is unwilling to receive a blood transfusion, should she need one in the future [Ss. 527 and 531].

S. 528 shows how the interpreter seems to be aligned with the clinician's positive obligation stance through an expanded rendition in which she adds the Spanish equivalents of "in case it were necessary" and "you would not accept it even if it saved your life?". S. 528 also evidences how the interpreter actively retrieves information previously discussed in the encounter and incorporates it into this sequence. In doing so, she evidences her desire to remind the patient that her life might become dependent on a blood transfusion. Because the information about a blood transfusion being vital to keep the patient alive was mentioned earlier within consultation #2, the interpreter seems to be drawing on what Mason (2006) would call 'contextual assumptions' as she retrieves this information in excerpt 20. This is further confirmed by her addition: 'which you recently became'; a sentence that suggests further questioning of the patient's decision.

Approaching this excerpt from a relational viewpoint, I posit that the realisation of this doctor-interpreter instance of alignment becomes problematic. More specifically, I posit that, by adding the elements 'which you recently became' and 'even if it saved your life', there is an underlying persuasive element to the interpreter's contribution that was not present in the original, even if the interpreter is 'just' making the implicit explicit (Hsieh, 2017). The interpreter is aligned with the doctor in terms of transactional goals (enhancing patient's awareness) but changes the tenor by adding the extra dimension of persuasion, which is not present in the original utterance, because the doctor is only looking for a factual response. I posit that S. 528 entails a triple rapport-threat to the patient. Firstly, her face sensitivities are affected as her criteria to autonomously make decisions seems questioned. Secondly, her right to unimpededly exert autonomy over her treatment decisions also seems infringed upon. Finally, the patient's interactional goal of getting her opinion across seems hampered as there is some obstruction to the negotiation of goals between primary speakers. All in all, the interpreter's rendition may well be seen as an instance of transactional alignment with what she perceives to be the doctor's goal to ensure Irene's autonomy, but the practical realisation of such goal carries a full rapport threat only partially present in the original.

Furthermore, excerpt 20 shows how participants might discursively negotiate a divergence of views. The segments evidence a clash between a biomedical and a religious standpoint. On the one hand Dr. Sharpe, functioning as a representative of the medical institution, offers the possibility of a blood transfusion to Irene. On the other, Irene refuses Dr. Sharpe's offer so that she can honour her spiritual beliefs. It is evident

that this gap between the medical urge to preserve life and the patient's spiritual beliefs imposing constraints on the medical options available entails a disagreement. In the classical model of Politeness (Brown and Levinson, 1987), 'disagreeing' is seen as an intrinsically face threatening act due to its high potential for disrupting communication if the disagreeing act is mishandled (Maíz-Arévalo, 2014). This idea is worth applying to the analysis of excerpt 20, where the difference of opinion between speakers seems to entail a degree of interactional tension. Additionally, Spencer-Oatey (2008) mentions that when two people have a disagreement, there is a transactional aspect to their divergence as well as a relational aspect to their discrepancy. In this particular case, I contend that Irene's concern with having a treatment imposed on her makes excerpt 19 a particularly sensitive exchange, both from a relational viewpoint and from a biomedical ethics angle. If we approach this matter by referring to the second base of rapport, as described in RM theory, I posit that Irene's wish involves a re-assessment of the expected enactment of rights and obligations in a healthcare setting. More particularly, her refusal of a blood transfusion entails a deviation from established medical protocol (the obligation to preserve life). As a result, instead of pursuing their standard biomedical duty, the healthcare team involved in Irene's treatment must be flexible and cater for her needs; namely, the prioritisation of her autonomy. This approach prioritises Irene's inner peace stemming from spirituality during her terminal stage. Finding common ground when negotiating religious beliefs in crucial in a medical setting (Cordella, 2012). This means that, if Dr. Sharpe wants to preserve a positive rapport with Irene, he must be flexible in his approach to the enactment of the healthcare team's obligations in relation to Irene's rights. More specifically, he must recalibrate his normative obligation and commit *not* to administer treatment, in order to cater for Irene's spiritual needs.

All in all, extract 20 shows how both Dr. Sharpe and Irene maintain a cordial and non-confrontational discursive style to reach a consensus in the face of their differences. This mutually cooperative behaviour helps them to reach a peaceable agreement, which evidences the rapport-maintenance nature of the consultation at large.

Also, in this section, I wanted to illustrate that, whilst not administering treatment to a patient in need may be perceived as obligation-omission behaviour on the part of a healthcare team in a different context (naturally leading to a negative impact on rapport), in this case study, refraining from treating Irene becomes a recognition of her right to autonomously decide on the handling of her future treatments. The interpreter contributes to achieving this purpose by aligning her performance with Dr. Sharpe's

goal to engage in positive obligation behaviour and get Irene to a place of autonomous decision-making, even though this seems to happen at the expense of relational aims, as a persuasive (impositive) element not present in the original utterance is included into the exchange.

7.1.3 Discourse organisation and content

Most of the excerpt descriptions provided so far focus on the RM implications of performing certain speech acts, that is, the illocutionary domain of RM. However, the illocutionary domain is only one of the five domains of language use that can affect perceptions of interactional rapport (see section 4.2.3.1). This section deals with the *discourse* domain of RM, that is, the domain concerned with "the discourse content and discourse structure of an interchange" (Spencer-Oatey, 2008: 21). More specifically, in this section I account for how Dr. Sharpe attempts to handle transitions between consultations stages (7.1.3.1) and also how he pursues a highly sensitive topic (7.1.3.2). I also discuss interpreters' contribution and associated RM dynamics.

7.1.3.1 Managing transitions between consultation stages

This section shows how an interpreter's rendition changes the RM quality of Dr. Sharpe's original utterance, aimed at changing topics of conversation as well as transitioning between consultation phases.

Excerpt 21. Consultation #1 – Ss. 98 - 105

This excerpt was extracted from the transition between the first and second phases of consultation #1. Prior to S. 98, Dr. Sharpe had been enquiring about Irene's overall health for the past year. An exchange of questions and answers helps contextualise consultation #1 within the patient's overall health journey. After this introductory dialogue, Dr. Sharpe moves on to the second phase of the consultation: a medical discussion on the treatment that Irene needs due to her renal disease. The transition between phases is marked by S.100.

Table 31 – Excerpt 21

S.	Dr. Sharpe	Elisa	Irene
			Yo muchas veces lloré y nadie supo. Y muchas veces escribía, leía, y nadie supo pero ahora es

98			como que nací de nuevo me siento ta: n feliz *Many times I cried and nobody knew. And many times I wrote, read, and nobody knew but now it is like I was born again I feel so happy*
99		Many times I was sad and cried and nobody knew and I used to write and read also but now I feel like I have been born again. I feel so happy	
100	**Ok It is good to hear that you are feeling better but now let me ask you some questions to clarify this for myself**		
101		**Bueno pues ahora quiero hacerte algunas preguntas para poder estar claro de todo** ***Well so now I want to ask you some questions to be clear about everything***	
102			**Bueno** **(2)** **Vale {*shrugs shoulders}*** ***Ok*** ***(2)*** ***fine {shrugs shoulders}***
103		**SURE that's fine *{eagerly}***	
104	You were on dialysis at the hospital?		
105		¿Estabas con diálisis en el hospital? *Were you on dialysis at the hospital?*	

Through S. 98, Irene reports on the sadness that she has been feeling for the past year due to the side-effects of her previous medication . The repetitions of a parallel syntactic structure (many times I cried and nobody knew/many times I wrote, and nobody knew) seems to suggest her wish to heighten the discomfort that her previous medication had caused her. Halfway through the segment, Irene shifts her tone when referring to the change in her mood that followed her primary physician's decision to change her

medication, as that stopped the side effects. By doing this, she marks a stark contrast between the notions of discomfort and her recovered wellbeing after the medication change. This contrast becomes even more conspicuous when she uses a metaphor by which she compares the feeling healthier with being born again. For all these reasons, Irene suggests how excited she is for her improved wellbeing.

This is something that Dr. Sharpe seems to notice as he actively reacts to Irene's enthusiasm regarding her newly improved emotional state by responding "it is good to hear that you are feeling better…" [S. 100], which conveys recognition. By initiating his intervention on that note, he makes sure to explicitly acknowledge Irene's narrative before re-directing the discussion onto a different matter. Furthermore he marks the topic shift from Irene's overall health to the specifics of her medication by saying "…but now let me ask you some questions". In phrasing his intervention like this, the disjunctive conjunction 'but' acts as a contextualisation cue marking the transition from one to the second topic. This way of crafting the sentence probably represents an attempt to mitigate the triple rapport-threat that could have been posed to the patient if the clinician jumped straight into a discussion on dialysis as an immediate response to Irene's intimate disclosure about her emotional state. By saying 'triple threat' I mean that leaving S. 100 unmitigated (without the first clause, prior to 'but') would mean the following: firstly, threatening the patient's face as her regards would be dismissed as unimportant; secondly, infringing the upholoding of the association rights of the patient, as she has a right as a patient to be acknowledged when providing an account of her health status; and finally, hampering her interactional goals by not respecting her wish to allocate some time to the discussion of her discomfort. Nonetheless, the soothing element of S. 100 is unsuccessful, as it is not rendered by the interpreter. The perlocutionary act of S. 101, and particularly the pause in-between the words that make up the segment [Ok (2) fine] as well as her shrugging shoulders, suggests that Irene is somehow surprised at the clinician's answer. Drawing on this, I posit that a rapport-threatening act has taken place due to the interpreter's partial omission [S. 101]. It must also be mentioned that the patient's reaction cannot be noticed by Dr. Sharpe, as the interpreter transforms Irene's tone of dissatisfaction into a more eager response ["sure, that's fine"].

Excerpt 21 displays how the transactional aim of shifting topics to enable the progression of the consultation is achieved. I also posit that the interactional rapport is superficially preserved as the session progresses without noticeable conflict. Yet, the disappointment insinuated by Irene's response in S. 102, likely caused by what seems to

come across as an abrupt topic change leading to a triple threat, goes unnoticed and therefore remains unaddressed. Ultimately, I propose that the interpreter's omission in S. 101 may be seen as a case of the following: firstly, 'transactional alignment', because the interpreter helps Dr. Sharpe in bringing the consultation forward; but also 'relational misalignment' in relation to Dr. Sharpe's approach to the patient's face sensitivities, association rights and interactional goals, which means that the relational intent in S. 100 is entirely missed.

7.1.3.2 Pursuing a highly sensitive discussion topic

This section discusses the rapport management implications of Dr. Sharpe's attempt to discuss an end-of-life scenario with Irene.

Excerpt 22. Consultation #2 – Ss. 577 - 582

The discourse domain of RM also encompasses the inclusion of sensitive topics in a conversation (see 4.2.3). Spencer-Oatey (2008: 21) stresses the need to carefully handle sensitive topics in interaction "if harmonious relationships are to be preserved", due to the risk of potentially negative RM consequences associated with raising them. Several authors have also connected the discursive treatment of difficult subject matters, such as taboo conversation topics, with an enhanced need to mitigate the potential FTAs that potentially go along sensitive subjects (Ghounane, Serir-Mortad and Rabahi, 2017).

The consultations in dataset 1 provide examples of how the inclusion of delicate issues around patients' physical and mental wellbeing is at the heart of interactions in the Department of Psychological Medicine (see section 5.2.4). This is certainly the case in consultation #2, when Irene realises that an end-of-life scenario is more imminent than she had anticipated, causing her angst. Against this background, excerpt 22 shows how Dr. Sharpe actively seeks to pursue a conversational discussion that Irene seems to find remarkably difficult to engage with.

Table 32 – Excerpt 22

S.	Dr. Sharpe	Elisa	Irene
577	**Now might be the time to** start planning how much treatment you want us to give you if in the future you are delirious or disorientated and can't answer our questions		

	about what treatments you would like to have		
578		**Ahora es el momento** de que usted nos diga cuánto tratamiento quiere que le demos si en el futuro está delirante o desorientada y no puede responder a nuestras preguntas sobre qué tratamientos quiere *Now is the moment for you to tell us how much treatment you want us to give you if in the future you are delirious or disoriented and you cannot answer our questions about what treatments you want*	
579			**Bueno {voice breaks}** ***Well*** ***(3)*** **E:: {*cries}*** **(2)**
579	**Ok, I can see that this conversation is difficult for you, and it is difficult for your daughter but I think that it is important to go on a little bit longer**		
580		Veo que esta conversación está un poquito difícil para usted y para su hija, pero creo que sería **muy beneficioso si pudiésemos** continuar un poquito más hablando de este asunto, *I can see that this conversation is a little bit difficult for you and even for your daughter, but I believe that it would be **very beneficial** if **we could** continue a little bit*	*{cries}*

		longer talking about this matter	
581			*{cries}* *(4)*
582		**Si puede** ***If you can***	

The sensitive topic of interest in excerpt 22 is introduced by Dr. Sharpe as he attempts to elicit Irene's views on the treatments that she would like to receive during her terminal stage [S. 577]. The clinician's request for information naturally requires Irene to envisage herself in a very delicate situation, for instance suffering delirium or disorientation. This seems to distress her, and S. 579 shows how she struggles to provide an answer for Dr. Sharpe.

Dr. Sharpe's statement in S. 577 may well be seen as a rapport-threatening act. According to speech act theory, the clinician's statement could be classified as a 'request' speech act. 'Request' speech acts have been defined by some authors as naturally impositive, given that it is expected from the interlocutor to perform an action (Bustamante-López, and Niño-Murcia, 1995). The expectation to perform a specific action resulting from a request naturally restricts the interlocutor's negative face, that is, his/her freedom of choice and autonomy within the context of a given interaction (Brown and Levinson, 1987). That is why the illocutionary force of a request must be mitigated to protect the speakers' faces (*ibid*.). The imposition in the illocutionary force of Dr. Sharpe's request in S. 577 is attenuated through the indirect formulation of his utterance ["now might be the time to…]. However, this attenuation is removed by the interpreter, which enhances the impositive nature of the doctor's request, that increasing the threatening nature in the original utterance.

Following the logic of the classic politeness model (*ibid*.), and the adoption of the notion of face in RM theory, I posit that Dr. Sharpe's statement in S. 577 threatens Irene's negative face, or freedom from imposition, given that a specific response is expected from her. The imposition becomes heightened as the doctor is confronting Irene about her own death. As such, Irene's freedom from imposition is restricted for two reasons: firstly, she is asked to personally confront a topic that causes her distress and; secondly, she is requested to engage back even if she finds the topic aversive. The expectation for Irene to engage back clashes with her interactional goals to refuse the sustaining of this conversation topic, which means that the third base of rapport is

affected. Against this background, Irene's response in S. 579 seems like a reaction of involuntary resistance against the clinician's RTA.

S. 579 suggests that Dr. Sharpe recognises the negative impact of his request on Irene's serenity and as a response, he retries his request by employing two face saving acts. Firstly, he acknowledges the effort required from Irene to provide a response ["Ok, I can see that this conversation is difficult for you…"]. Secondly, Dr. Sharpe uses a face-saving act that may well be seen as an illustrative enactment of the 'Tact maxim' within Leech's politeness principle[18] (1983), consisting of two dimensions: on the one hand, he maximises the expression of benefit that Irene's effort could bring in to the session ["…but I think it is important to go on…"]; on the other, he adds the diminutive ["…a little bit longer."]. His use of the diminutive may be seen as an attempt to soften the impact of his imposition because, by inviting Irene to push through the discomfort that the topic causes her for just a short time, he minimises the expression of cost.

The interpreter seems to pick up on Dr. Sharpe's mitigation efforts. In fact, several moves in the interpreter's rendition [S. 580] suggest that she is tuned into the relational aims of S. 579 because she enhances the attenuation of the impositive force of the doctor's utterance. The interpreter's salient translational moves as well as their equivalent in the original are marked by the letters (*a*), (*b*), (*c*) and (*d*) below:

[S. 579 - Dr. Sharpe's original]:

- "But I think that it (*a*) **is** (*b*) **important** (*c*) **to go on a little bit longer**"

[Back translation of the interpreter's rendition in S. 580]:

- "but I believe that it (*a*) **would** be (*b*)**very beneficial** if (*c*) **we could** continue a little bit longer talking about this matter, (*d*) **if you can"**

At *(a*), the interpreter translates the indicative mode of the verb employed in Dr. Sharpe's original *("is" ... "to go on")* as a conditional *("would be" ... "could"*). The potential perlocutionary implication of the interpreter's move is for the clinician's original utterance to come across as more optional than intended in the original directive. The resulting effect could be the patient's potential perception of having the possibility to refrain from the doctor's request. Mitigating the effect of a request by

[18] The Tact Maxim goes as follows: 'Minimise the expression of beliefs which imply cost to other; maximise the expression of beliefs which imply benefit to other' (Leech, 1983:132).

offering optionality echoes the second of Lakoff's (1973) rules of politeness: *giving options*.

At (*b*), by translating "important" as "very beneficial" the interpreter's language choices indicate that she is aligned with Dr. Sharpe's attempt to maximise the expression of benefit in relation to the patient's efforts. This discursive movement could be seen as an enhancement of the initially intended Tact maxim behaviour (Leech, 1983).

At (c), by providing Dr. Sharpe's impersonal utterance with a first person-plural subject pronoun […to go on> …if **we** could continue…), the interpreter communicates a sense of teamwork that was not present in the original. This strategy was classified by Scollon and Scollon (1995: 40) as a linguistic tactic of associative expressiveness aimed at claiming in-group membership with the hearer and conveying social closeness.

At (*d*), by adding "if you can" [S.582], upon seeing that the patient could not respond [S. 581], the interpreter conveys a sense of optionality (Lakoff, 1973) that had not been previously endorsed by Dr. Sharpe.

This series of discursive moves suggests that the interpreter is tuned into the relational aims of S.579 as she enhances the mechanisms that Dr. Sharpe originally uses to mitigate the impact of his impositive statement.

Whilst the change in meaning is not substantial, there are discursive implications worth discussing from the point of view of transactional and relational alignment. Excerpt 22 has shown how Dr. Sharpe must elicit the patient's views on palliative care, or at least encourage her to think about them, even if that causes her distress. He is responsible for Irene's care. Therefore, he needs to sacrifice the relational aim of respecting her negative face, or freedom from imposition, for the sake of fulfilling the instrumental goals of the consultation. He uses several strategies to mitigate the force of his impositive act, which are further enhanced by the interpreter in what seems to be a display of alignment. However, a nuance must be noted: On the one hand, the interpreter is able to contribute to the fulfilment of Dr. Sharpe's goal of attenuating the impositive nature of his utterance by using the strategies described at (*b*) and (*c*). On the other hand, the interpreter also performs moves at (*a*) and (*d*) which, as explained below, grammatically and functionally decrease the certainty and decisiveness force of S. 579. As a result, I conclude from the analysis of this excerpt that the interpreter is attuned to, or aligned with, the relational aim of Dr. Sharpe's original utterance. At the same time, she is transactionally misaligned with the doctor's purpose of eliciting Irene's views, as the enhanced sense of optionality that comes across through the interpreters' rendition could have compromised the outcomes of the consultation.

7.1.4 Refusing a prescription

Excerpts 23 and 24 below show how Irene seeks a prescription for antidepressants, but Dr. Sharpe is reluctant to provide it to avoid the side effects potentially resulting from the interaction between the antidepressants and Irene's kidney disease medication. From the standpoint of relational pragmatics, the scenario presented through the two excerpts below is an illustration of two aspects: firstly, the potential for conflict that may arise when speakers have mismatching goals, therefore affecting the third base of rapport; and, secondly, the vital role of adopting face-saving acts to ensure the cordiality needed to peaceably reach an agreement when mismatching goals are at stake.

Excerpt 23. Consultation #1 – Ss. 442 - 447
Table 33 – Excerpt 23

S.	Dr. Sharpe	Elisa	Irene
442	I do prescribe antidepressants for people on dialysis but I try to avoid prescribing them		
443		Las pastillas contra la depresión, sí yo las receto para las personas que tienen diálisis a veces, **pero intento *[Interrupted]*** The pills against depression yes I prescribe them for people who have dialysis sometimes, **but I try *[Interrupted]***	**[S. 468]** ***[Interrupts]* No darlas**
444			**claro *{Nodding}*** *Not to give them* *Of course*
445	Like all medicines, they can have side effects		
446		Como todo medicamento tienen efectos secundarios *Like all medicines, they have side effects*	
447	Do you feel that you need antidepressants now?		

Dr. Sharpe's refusal to provide the medication that Irene has asked him for can be observed from segment 442 to 447. A first reading of this excerpt could easily draw on Politeness theory to offer an interpretation: according to Brown and Levinson's (1987) model of politeness, 'refusing' speech acts are intrinsically face-threatening. However, I posit that Dr. Sharpe's refusal does not necessarily overlook Irene's face sensitivities in any noteworthy way. Instead, I propose that a more accurate representation of what is happening relationally in excerpt 23 can be provided by drawing on RM theory. From a RM theory lens, the doctor is hampering a patient's interactional goal (third base of rapport) by not prescribing the medication that she requested, which could even be interpreted by Irene as obligation-omission behaviour (second base of rapport), if his decision was not justified in her view.

Dr. Sharpe seems to be aware that his decision might cause frustration for Irene, given that he uses multiple ways to attenuate the illocutionary effect of his refusal. For example, he shifts the focus from a personal matter to an impersonal statement by stating that he normally avoids prescribing antidepressants to dialysis patients, thus detaching the figure of Irene from his decision [S. 442]. Also, he provides an explanation to justify his position [S. 445]. Finally, he checks with the patient whether she truly seeks antidepressants in spite of the mood improvement that has followed her recent change of medication, once aware of the potential side effects of the medication [S. 447]. The interpreter competently relays the semantic totality of these three face-saving acts as well as their pragmatic intention of downgrading the illocutionary force of the refusal [Ss. 443 and 446], which is a first step to safeguard the cordiality needed to reach a consensus in the face of mismatching goals.

The linguistic data in excerpt 23, particularly the perlocutionary act of S. 443, provides evidence to suggest that Irene understands and reacts positively to Dr. Sharpe's refusal. In particular, I want to draw attention to Irene's overlapping talk in S. 444. Contrary to the negative implications for rapport resulting from the interruption described in excerpt 17 above [S. 130], I argue that, in this case, Irene's initiation of talk in S. 444 is aimed at showing cooperation rather than asserting conversational dominance. Irene's interjection suggests that she is actively engaged in following the logical flow of the conversation as she infers and completes what she perceives as the logical end of S. 443 ["not to give them…"]. Irene responds to the doctor's proposal within the same utterance, by providing an expression of agreement that could be read as positive reinforcement towards the doctor's stance ["…of course."]. By finishing off the interpreter's statement, Irene seems to indicate that she understands why the doctor has

made that decision and she 'shares the burden' inherent in the doctor's refusal, showing that her interactional goals are not hampered. Interestingly, the cooperative nature of S. 468 is not likely to be perceived by the clinician, as its expression stays within the constraints of the patient's dyadic exchange with the interpreter.

Excerpt 24. Consultation #1 – Ss. 481 - 486

This passage is located in consultation #1, a few segments after excerpt 23 is produced.

Table 34 – Excerpt 24

S.	Dr. Sharpe	Elisa	Irene
481			Podemos esperar un poco a ver cómo me sientan estas pastillas *We can wait a little to see how the pills affect me*
482		We can wait and see how I am doing with the new pills	
483	**I think you are right and that's what I would prefer to do. I am not ruling it out but at present I would prefer not to expose you to the risk of side effects specially if there is a change in your dialysis happening now**		
484		**Por el momento no te quiero exponer a los riesgos de los efectos secundarios especialmente si estás con un nuevo tipo de diálisis** ***For now I do not want to expose you to the risks of side effects especially if you are with a new type of dialysis***	
485			De acuerdo *Ok*
486		That's OK	

This sequence sums up the outcome of the doctor-patient discursive negotiation on the prescription of antidepressants. In approaching excerpt 24, it is worth noting the

patient's linguistic choice that she makes to propose waiting until it becomes clearer how her body settles with the new treatment. By using a statement initiated with a first person plural personal pronoun ["*we* can wait a little…"] she indicates taking shared ownership over the decision to not take antidepressants at that time. This is competently interpreted, which enables the closure of the negotiation on a relationally positive note. I would also like to draw attention to Ss. 483 – 484 within this passage as they provide relevant material to be analysed from the viewpoints of rapport management and goals-alignment between doctor and interpreter. In order to perform the analysis of Ss. 483-484, I am going to break down and analyse the semantic components in Dr. Sharpe's original speech act, following Spencer-Oatey's (2008) model:

Table 35 – Analysis of speech act components

Number	Semantic component	Pragmatic function
1	I think you are right and that's what I would prefer to do.	Expression of shared decision-making: downgrader
2	I am not ruling it out	Expression of flexibility: downgrader
3	But at present	Expression of provisionality: downgrader
4	I would prefer not to expose you to the risk of side-effects	(Indirect) expression of illocutionary force: Head act
5	Especially if there is a change in your dialysis happening now	Choice justification or explanation: downgrader

The table shows how Dr. Sharpe conveys the illocutionary force in his utterance through a head act that is framed by a series of mitigating supportive moves that act as downgraders. The head act conveys the illocutionary force of the doctor's utterance: a 'refusal'. Dr. Sharpe weakens the force potentially associated by his refusal through four steps. Firstly there is an expression of shared-decision making, which depicts his refusal as a bilateral choice. Secondly, he demonstrates an expression of flexibility in his position. Thirdly, he uses an expression of the provisional nature of his decision. Finally he gives a justification for his action. These four supportive moves have a mitigating effect in relation to the negative impact typically associated with a 'refusal' speech act (Spencer-Oatey, 2008: 23).

I argue that this pragmatics-informed analysis of an original speech act could be used as an analytical foundation to examine language use in an interpreter's rendition from a functional perspective. The semantic-pragmatic analysis in Table 35, indicates that the interpreter is able to competently render the head act, thus managing to relay the most essential component in Dr. Sharpe's utterance. By rendering the bulk of the information, the interpreter evidences her transactional alignment with the clinician's action. When it comes to the relational elements of the original utterance, the interpreter renders the downgraders (3) and (4) and omits (1) and (2) as shown in Table 35 above. In doing this, the interpreter misses the expressions of shared decision making and flexibility. This interpreter's partial omission move echoes the findings from previous studies that have pinpointed how interpreters tend to prioritise the rendition of factual information over strictly relational components of discourse (Aranguri et al., 2006).

The pragmatics-based analysis shown in Table 35 is an invitation for interpreting scholars to re-consider what might be regarded as 'irrelevant information'. This is because what might not seem transactionally relevant (that is, information-transferring) might seek to fulfil a relational purpose. For example, I suggest that in the case of S. 483, the expression of flexibility to make the patient aware that she might get antidepressants in the future was intended to fulfil the relational function of comforting the patient following the doctor's refusal to prescribe the medication that she wanted. All in all, a semantic-pragmatic analysis of the components that make up the speech acts in original and interpreted utterances might provide a good foundation to analyse language use for relational purposes. I argue that such an analysis would help interpreters to make a more informed choice around what counts as information that could be omitted without compromising the essence of the message. Furthermore it would support interpreters in re-conceptualising the nature of 'conscious strategic omissions' under the light of what the findings of this study suggest about the differences between transactional and relational alignment.

To conclude this sub-section, I argue that excerpts 23 and 24 above demonstrate that the friction that might arise between two speakers who have conflicting goals is not irreconcilable. Instead, both excerpts show how speakers' willingness to communicate their different views and to negotiate in the pursuit of common ground is the factor that determinates the preservation of rapport, or lack thereof. Both excerpts 23 and 24 also illustrate how such negotiation is enabled thanks to the competent performance of the interpreter involved.

7.2 Patient-interpreter (mis)alignment of goals

In this section I discuss the findings from the analyses of different excerpts that provide information on the alignment of transactional and relational goals between patient and interpreters. Alignments and misalignments between these two participants are explored in relation to three occurrences that bear rapport management implications: praising the doctor's demeanour (7.2.1), expressing agreement (7.2.2) and using informalities and humour (7.2.3).

7.2.1 Praising the doctor's demeanour

During the psychosocial discussion stage of consultation #3, Dr. Sharpe asks Irene about her views and feelings on the state of her memory. The dysfunction in Irene's memory skills is framed within an overall process of cognitive impairment accelerated by the physiological changes brought about by her kidney disease. As part of this discussion, Irene brings up the stress that her daughter's reactions to her forgetfulness causes her, which she contrasts with the doctor's demeanour.

Excerpt 25. Consultation #3 – Ss. 141 – 147
Table 36 – Excerpt 25

S.	Dr. Sharpe	Maya	Irene
141			Yo creo que me afecta todavía más porque **mi hija al ser tan nerviosa se queja siempre** de que se me han olvidao las cosas que si esto que si lo otro *I think it affects me even more **that my daughter as she is such a nervous person she always complains** that I have forgotten things and this and that*
142		I think it makes it worse that **my daughter always complains when she gets nervous** that I forget this or I forget that	
143	So is the fact that you are having trouble remembering things causing tension between you and your daughter?		

144		Entonces ¿el hecho de que tenga dificultades a la hora de recordar está causando tensión entre usted y su hija? *So the fact that you are having difficulties remembering is causing tension between you and your daughter?*	
145			Claro porque me estresa ella y **por eso** me gusta más hablar con usté [*chuckles*] porque **ella un día ella me va a dar un ataque de nervios** *Of course, because she stresses me out and **that is why** I like talking to you better [chuckles] because one day she is going to give me a nervous breakdown*
146		Yes, she makes me so stressed that **I fear I might get a panic attack because of her** one day, so it is good that I am talking to you	
147	Oh I see *[takes notes] (3)* *[Looks up]* Well that definitely complicates things but I am sure we can find a way to handle that		

Excerpt 25 shows how the patient admits to Dr. Sharpe that her daughter's nervous temperament worsens her own concerns about her memory loss [S. 141]. Dr. Sharpe reformulates the content of S. 141 through an interrogative statement to confirm whether there is a tension between Irene and her daughter [S. 143], which the patient responds to by providing further elaboration on this matter [S. 145]. In S. 145, Irene confirms that she finds talking with her daughter stressful and, as a result, she prefers talking to Dr. Sharpe. In saying that, the patient seems to be contraposing her daughter's nervousness with the doctor's calm demeanour, even though she is not explicitly saying it. Irene finishes her turn by saying that her daughter's character might end up causing her to have a nervous breakdown

There are two moves in the interpreter's rendition [S. 146] that are worth discussing from a relational point of view, given that the sum of their effect equals a sense-making shift with implications for rapport management. Firstly, there is a divergence in relation to the original, particularly when it comes to the reason for Irene's gladness about talking to Dr. Sharpe. While the patient's original utterance suggests a positive appeal to the doctor's calmness through a contrast with her daughter's nervousness, the interpreter instead relays that the patient is glad to see the doctor because she is somehow fearful of having a nervous breakdown, prompted by her daughter's manners. Secondly, the interpreter mistranslates *ataque de nervios* ('nervous breakdown'), a folk expression which may or may not entail a clinical bearing in its production, as "panic attack", a diagnosis concept associated with a psychopathological reaction (DSM-5, 2013). Some empirical studies have addressed the overlaps and differences between the symptomatic phenomenology of '*ataques de nervios'* and 'panic attacks' (see Lewis-Fernández, 2002). Currently, there is agreement on the fact that *ataque de nervios* is a more inclusive term than panic attack: whilst panic attack is clinically diagnosed as a sudden episode of acute anxiety, an *ataque de nervios* does not always meet the criteria given that it may just refer to a reaction to a stressful situation or troubling event (*ibid*.). That is, the meanings behind the two concepts might occasionally overlap, but the semantic and pragmatic purposes of their use may also be different. Drawing on this discussion, I argue that the patient's use of *ataque de nervios* is different to the use of 'panic attack' in the interpreter's rendition. Due to this divergence, the interpreter's rendition suggests that Irene is happy to talk to Dr. Sharpe because she is driven by her fear of suffering from a panic episode induced by her daughter's manners when, in reality, Irene was just making a rapport-enhancing remark by appealing to the doctor's calm demeanour. From the point of view of rapport management, I argue that the patient was intending to utter a face-flattering act as defined by Kerbrat-Orecchioni (2005). More specifically, she was positively acknowledging a positive trait of Dr. Sharpe, therefore performing an action that could be classified as aiming to affect the first base of rapport: face sensitivities.

The interpreter's shift in her interpretation of the original utterance and subsequent rendition, changes the rapport dimension that surrounds Irene's pragmatic intention in S. 141. Namely, her statement is a request for help or advice on the possibility of suffering a panic attack. However, the interpreter's rendition of the patient's relational intent comes across as a transactional request. This all means that this is an episode of relational misalignment between the patient and the interpreter. For this reason, it is not

surprising that Dr. Sharpe provides a transactional response as he adopts a problem-solving approach to Irene's possibility of suffering a panic attack ["we can find a way to handle that"]. I suggest that in doing this, Irene could perceive relational neglect in Dr. Sharpe's answer as he has not reciprocated her relational move.

7.2.2 Expressing agreement

Immediately prior to excerpt 26 below, the clinician and the patient had been engaged in a conversation in which the doctor was letting the patient know that, if she decided to interrupt her treatment, that decision would be respected and acted upon accordingly. At the end of this exchange, the clinician asks the patient whether she feels comforted about the information that he has provided.

Excerpt 26. Consultation #1 – Ss. 575 – 579

Table 37 – Excerpt 26

S.	Dr. Sharpe	Elisa	Irene
575	Does this give you any reassurance?		
576		¿Esto te da seguridad te da… confort? *Does this give you security give you comfort?*	
577			**Bueno de todas maneras era lógico** ***Well in any case it was logical***
578		**Yes, of course**	
579			Es que no sé cómo voy a estar diez años más conectada a una máquina y a saber en qué condiciones *I don't know how I will be attached to a machine for ten more years, and who knows under what conditions*

In S. 577, the patient reinforces her non-negotiable position concerning her choice to interrupt treatment by expressing that it would be reasonable, or 'logical', if the hospital staff respected her decision to not be treated. The tenor of S. 577 suggests that there is a slightly confrontational note in the patient's answer, as she does not just express agreement with the doctor's explanation but takes a step further and claims that his view is the only one acceptable. The interpreter seems to notice this tone, which is toned down as she translates with a more 'compliant' or non-confrontational answer: "yes, of course". Against this background, I propose that the interpreter's mitigating move

suggests her rapport maintenance orientation, aiming at preservation of cordiality between participants at the expense of the original intent of the patient.

7.2.3 Informalities and humour

Excerpts 27 and 28 below show how the patient aims to engage in a humorous exchange and the effect of the interpreting process on such attempts.

Excerpt 27. Consultation #2 – Ss. 410-413

The context of excerpt 27 is a wider discussion concerning the patient's cognitive decline, manifested through her memory problems. More particularly, Dr. Sharpe and Irene discuss how the patient is negatively affected by her daughter's reactions to her memory loss.

Table 38 – Excerpt 27

S.	Dr. Sharpe	Julia	Irene
410			Creo que me influye el que me hija me dice yay a estás con la cabeza mal y me lo acentúa *I think I am influenced by the fact that my daughter tells me your head is wrong again and this exacerbates [my problem]*
411		My daughter tells me all the time that there is a problem with my head	
412		***{smiles}***	**Me altera ella <me ESTRESA>** ***{addresses interpreter}*** **esta muje:r {*smiles} (2)*** *She upsets me <STRESSES ME OUT>* *This woma:n* Tiene malas pulgas *She is a cantankerous woman {Informal register equivalent}*
413		**She makes me fee:l altered {***hesitant}*** altered? No, affected. Affected**	

This excerpt displays Irene's account of how her wellbeing is affected by her daughter's nervous reactions towards the problems caused by her memory loss. The segment of interest is S. 412, which is in two parts. The first is of a serious nature, as the patient expresses how her daughter makes her feel stressed. The second part has a humorous tone. More particularly, the patient addresses the interpreter directly as she makes a joke on her daughter's overall character ("*esta muje:r*"), smiles, pauses and uses the informality *"tiene malas pulgas"*, an informal way of saying that someone is cantankerous or bad tempered. The interpreter acknowledges the joke by reciprocating the smile. However, the interpreter does not relay the second part of S. 412 to Dr. Sharpe. As she only relays the 'serious' part of the segment, the patient's humorous tone stays within the limits of her dyadic relationship with the interpreter. It is remarkable in terms of rapport management that Dr. Sharpe does not ask about their dyadic exchange, which leaves him out of this humorous exchange entirely.

Excerpt 28. Consultation #2 – Ss. 414-421

The first segment in excerpt 28 immediately follows the last segment of excerpt 27 above. Excerpt 28 shows the continuation of the doctor and patient's discussion on her memory problems.

Table 39 – Excerpt 28

S.	Dr. Sharpe	Julia	Irene
414	What do YOU think?		
415		¿Qué piensa usted? *What do you think?*	
416		*{Smiles}*	Bueno doctor yo sí pienso que **me está fallando el coco** {*Lively intonation, chuckles}* *Doctor, I do think that my head is failing*
417		**I think my brain is failing**	
418	**So you agree with your daughter**		
419		Entonces está de acuerdo con su hija *So you agree with your daughter*	

420			*{serious tone}* **Si lo que digo es que no creo que sea pa tanto** *What I mean is that I don' think it is that bad*
421		I don't think it's so bad	

This excerpt shows a similar reaction from the interpreter to the patient's humorous note. In S. 416, the patient acknowledges her memory problems by using the informal word 'coco' to refer to her head, uttered along with a chuckle. This informality is not conveyed by the interpreter, who opts to adopt a more formal register by using 'brain' to refer to the patient's head. This is similar to the interpreter's reaction to Irene's humour in excerpt 27.

Consequently Dr. Sharpe did not receive either the informality in S. 416 or the humorous tone of S. 412 in excerpt 28. He thus responds gravely by explicitly concluding that Irene agrees with her daughter's concerns over her memory loss. At this point, the patient adopts a more restrained disposition and explains that, what she is trying to say, is that her daughter's reactions are excessive. From a RM perspective, I posit that the patient may have felt that her humorous attempt was not acknowledged, and therefore her sociality right to 'association', or having a certain degree of closeness with her interlocutor in keeping with the tenor of the relationship, has been infringed.

These two episodes were shown to Dr. Sharpe during his retrospective interview, and he provided the following comments:

"I could tell that she [the patient] felt uncomfortable when asked about her memory loss. This is because she was an intelligent educated woman for whom the loss of cognitive functions would be a very significant loss so any discussion around this would have been a sensitive topic. I could also pick up that the patient found the daughter's approach distressing at times. I certainly picked up stress in their relationship. So then I would have not been surprised if the patient had resorted to humour as a defence, but I did not pick this up. It would have been useful, as it is always useful for us [MHC professionals] to know what the patient's defence mechanisms are, as this may help us tailor our own style in engaging with a patient."

I conclude, then, that the interpreters' tendency to formalise the patient's utterances prevented the clinician from directly engaging with the patient's way of dealing with a personally face-sensitive topic (memory loss) and tailoring his conversational style around this.

7.3 Concluding remarks

While chapter 6 paid equal attention to how each of the three RM bases were influenced by contextual factors in the analysed IMEs, chapter 7 is particularly concerned with the notion of interactional goals, the third base of RM. Two assumptions underpin the rationale for this chapter. Firstly, that the goals dimension of discourse is of heightened importance in an institutional setting such as the medical interactions analysed in this study. Secondly, that the success of the discursive negotiation of interactional goals between primary participants will at least partly depend on the interpreter's performance. Drawing on these ideas, this chapter is structured around how well interpreters are able to work with primary participants to deliver success in the negotiation of goals; namely, with the doctor (7.1) and with the patient (7.2).

Different relational scenarios were identified after a qualitative analysis of interactional episodes that were deemed as bearing substantial rapport implications among the participants involved. On the one hand, if interpreters are able to successfully infer the interactional goal intended with an original utterance as well as identify the linguistic/pragmatic means that the primary participant use to fulfil that goal, interpreters are likely to be 'aligned' with the primary speaker's goal and adjust their renditions around what is required to successfully fulfil the goal in the primary utterance. What is more, interpreters may even enhance the illocutionary force in the original utterance, making it more likely for the intended goal to be successfully achieved. This relational scenario is illustrated in excerpt 19 (7.1.1.2). On the other hand, however, interpreters may not recognise the goal intended with an original utterance or may not identify the discursive devices through which such goal is intended to be realised (see excerpt 18, in 7.1.1.1). When interpreters are unable to recognise the original goal or the linguistic means adopted to fulfil it, 'misalignment' between primary speakers and interpreters happens. Misalignment may happen in relation to the transactional or relational dimension of an original utterance. This means that, within a case of misalignment, different relational scenarios may result depending on the type of partial misalignment at play. For example, a first scenario may happen when an interpreter is aligned with the transactional aims of the speaker's utterance but not with the relational dimension of such utterance (see excerpt 21 in 7.1.3). A second scenario may happen when an interpreter is aligned with the relational dimension of an original utterance but misses the transactional aim pursued (see excerpt 22 in 7.1.3.2). One of the main aims of this chapter is to call attention to the importance of exploring the notion of misalignment, due to its potential clinical consequences (see excerpt 25, in

7.2.1) or consequences in terms of successful healthcare communication (see excerpt 28 in 7.2.3).

Before finalising this section, it must be acknowledged that an overarching finding distilled throughout both chapters 6 and 7 is that *all* participants have an equal role to play to ensure the successful handling of RM bases including interactional goals. This means that interpreters' involvement in relational processes is decisive but also partial. Every participant has a role in the collective negotiation of RM bases and primary speakers' relational predispositions will establish the boundaries of the relational frame for a given interaction, thus limiting interpreters' room for manoeuvre. In the next chapter, this idea along with other overarching findings from chapters 6 and 7 will be summarised and synthesised against relevant literature from interpreting studies.

Chapter 8 – Theory development and practical recommendations

In this chapter, I provide a summary of this thesis and its findings (8.1); I discuss the methodological advances of this work to fhe field of dialogue interpreting (DI) (8.2); its theoretical contribution to DI (8.3) and its practical applications (8.4). Finally, I offer recommendations for further research based on the learning produced through this thesis (8.5) before providing concluding remarks (8.6).

8.1 Thesis outline and summary of findings

In order to shed light onto how the relational dimension of language use (Brown and Yule, 1983) is perceived and discursively co-constructed in interpreter-mediated talk, this thesis explores relational dynamics between the participants involved in a series of interpreter-mediated mental healthcare (MHC) consultations. The relational dimension of language use is operationalised in this thesis as rapport management (RM), in line with Spencer-Oatey's (2008) RM theory. An MHC setting was chosen as the situational background for this exploration because relational dynamics are recognised in MHC work as a tool to promote the therapeutic alliance required to fulfil therapeutic goals (see 3.2.4). To build a holistic explanation of participants' rapport management dynamics, a concept that encompasses communicative practices and perceptions, I followed a multi-methods approach. Namely, I adopted a case-study research design wherein two datasets, containing the transcriptions of medical consultations (dataset 1) and data from retrospective interviews (dataset 2) were assembled and triangulated. This inquiry was underpinned by the epistemological stance of social constructivism. By triangulating the two datasets, I was able to investigate RM practices: firstly, as they discursively unfolded during the consultations, taking rapport-sensitive speech acts (RSSAs) as the unit for data analysis; and secondly, as they were inter-subjectively perceived by the parties involved in co-constructing them. The findings from the data collected yielded insights that addressed the following questions:

1. How do rapport management practices unfold, either triadically or dyadically, among participants involved in interpreter-mediated encounters in mental healthcare?
2. To what extent do contextual factors influence participants' rapport management practices?

3. Considering that medical encounters are a goal-oriented speech event and that the handling of interactional goals is a key component of rapport management theory, how are rapport-sensitive interactional goals discursively negotiated in interpreter mediated encounters in mental healthcare?

Some of the answers to the three questions above were touched upon throughout the analytical descriptions of the excerpts shown in chapters 6 and 7. More specifically, chapter 6 focused on the interplay between contextual factors surrounding the encounters under scrutiny and participants' rapport dynamics; and chapter 7 discussed participants' co-fulfilment of interactional goals. Drawing on the overarching findings of these two chapters I claim that, in essence, the theoretical contribution of this thesis to DI studies can be encapsulated in the following statements:

(*a*) Interpreters are fully-fledged social agents in the encounters in which they mediate. By extension, they are also actively involved in the discursive negotiation of the three rapport bases (face sensitivities, behavioural expectations, and interactional goals) between primary participants. This involvement is intrinsic to triadic communication because the interpersonal metafunction of language (which encompasses the management of the three bases and manifests through pragmatic markers), is integral to *all* language use. Thus, because interpreters are actively involved in meaning negotiation at large, they are also drawn into the discursive negotiation of pragmatic markers leading up to handling interactional rapport. For this reason, interpreters may intendedly or unintendedly influence such markers to different degrees, which may have repercussions on the representation of primary participants' relational dispositions; thus, ultimately influencing rapport outcomes. All in all, this means that interpreter-mediated rapport management is an essentially 'triadic' undertaking.

(*b*) rapport dynamics may also directly unfold between primary participants and/or between primary participants and interpreters. Interpreters are unavoidably involved in 'dyadic' rapport dynamics because they are social agents (albeit in their professional roles), who are visible in the eyes of primary participants; which prompts naturally occurring rapport dynamics with them.

Building on statements ***(a)*** and **(*b*)**, I conclude that the preservation of a positive interactional balance (or 'harmony') in an interpreter-mediated encounter (IME) depends on:

(*c*) the cumulative effect of the relational outcomes resulting from the combination of participants' dyadic and triadic rapport management practices, as dyadic and triadic dynamics may influence one another.

(*d*) Interpreters' full transactional and interactional alignment with the interactional goals embedded in primary speakers' utterances.

(e) the interplay between participants' rapport management practices and the contextual factors that frame the speech event, as such factors substantially influence both the production and interpretation of relational practices.

Statements in ***(a)*** – ***(e)*** capture the essence of my theoretical contribution to the literature, which is unpacked, developed and synthesised against previous relevant literature in section 8.3. However, before proceeding to provide such discussion I discuss the methodological innovations of this thesis in 8.2 below.

8.2 Methodological advances

I discuss in this section the innovations of the methodological approach that has articulated this study, as well as its strengths and shortcomings when it comes to gaining insights into the intricacies of rapport management dynamics in interpreter-mediated talk. This section is divided into two parts. Firstly, I discuss the implications of adopting a case study research design as the guiding protocol for the devised inquiry (8.2.1). Secondly, I discuss the strengths and limitations of applying rapport management theory to the study of interpreter-mediated talk (8.2.2).

8.2.1 Dialogue interpreting and case study research design

As explained in section 5.1.2, this thesis adopts Yin's (2018) guidelines for case study research design; namely, that a case study must be concerned with the in-depth investigation of a specific and contemporary phenomenon within its real-world context. The two sub-sections below discuss the methodological benefits that adopting Yin's guidelines had within the specific context of my study.

8.2.1.1 Uniqueness of case selected

If this study is compared with similar works conducted in the past (see 4.3), it may be claimed that one of the strongest methodological features of this thesis is that it is based on naturalistic data, with all the excerpts presented in chapters 6 and 7 illustrating the linguistic and relational complexity of real-life interpreter-mediated interactions in a highly-specific medical domain. Drawing on this statement, it may also be claimed that one of the novel elements of this study is the uniqueness of the clinical case selected as situational background for this research, as dialogue interpreting had not been explored before in relation to the remit of Psychological Medicine. As explained in 5.2.4, Psychological Medicine is a medical specialty that provides joint medical and psychological support for patients who present interrelated physiological and psychological co-morbidities. More specifically, my case study involves the clinical case of a terminal patient suffering from depression and chronic kidney disease. The complexity of the conversations that such a multifaceted clinical case involves poses unique challenges for interpreters which are worth describing and analysing. For example, in the excerpts presented in chapters 6 and 7, notions of patients' autonomy are negotiated over conversations on interruption of treatment and coping with end-of-life. In describing such excerpts, it was constantly shown how interpreters' agency may influence not just the progression of talk but also the relational dynamics underpinning difficult discussions on end-of-life care. It was also shown how cooperation from *all* speakers is needed to ensure success of the interaction in general and to safeguard a positive relational balance. In any case, by bringing to light the pivotal position of interpreters within such delicate and clinically-relevant conversations, it is possible to promote discussions about how their agency should, or could, be used for best outcomes. By highlighting these matters, this study joins a small number of academic studies on interpreter-mediated encounters involving terminal patients (see Silva et al., 2015). All in all, the discussions provided are situated in and tailored to a highly specialised area of medical specialty, which makes it possible to provide novel discussions on how interpreters respond to challenges that had not been fully explored in the past, and would even yet benefit from further research.

Another feature of interest associated with my case-study selection is that the doctor and patient are constant throughout the three consultations recorded, but there is a different professional interpreter in each session. This is a feature that has not been commonly explored in DI studies looking at naturalistic data. As chapters 6 and 7 demonstrate, analysing different interpreters at work makes it possible to observe different

interpreting styles, which encompasses different relational dispositions and, by extension, potential for conflict and resulting relational outcomes. The diversity in interpreters' practices helped enrich the findings of this study.

In conclusion, in this subsection I have described how the uniqueness of the case selected to be presented in this thesis contributed to provide a novelty element to DI studies through this work. To continue the discussion on how the adoption of a case-study research design benefited this inquiry, the next subsection focuses on the important role that triangulation played in helping articulate this case study.

8.2.1.2 Triangulating datasets

Another feature of interest in this study is that its analytical protocol involves supplementing the discourse analysis of transcribed medical consultations (dataset 1) with the analysis of retrospective interviews conducted with the participants featuring in such consultations (dataset 2). This means that two different types of qualitative data, obtained through two different methods of data collection, were triangulated in a converging line of inquiry. As explained in 5.1.1, the operationalisation of the object of study prompted the need to adopt a multi-methods approach. Namely, 'relational dynamics' between participants were operationalised as 'RM dynamics', which encompassed both RM discursive behaviours as well as participants' perceptions of interpersonal rapport, in line with Spencer-Oatey's (2008) RM theory. Due to the different nature of the two types of data required to effectively address the two-dimensional object of study, triangulation was used within a case study methodology. In this sub-section, I discuss how triangulation added value to this inquiry by helping to effectively address the research objectives set out for this thesis. I do so by firstly referring to how triangulation helped to endow the study findings with richer perspectives provided through multiple lenses and, secondly, by helping to counteract my own biases in interpreting the data.

Increasing depth of findings

Within the specific context of this thesis, it would have not been possible to fully explain some phenomena found in the data if it were not for triangulating behaviour and perceptions. An illustrative example of this is section 7.1.2. In this section, I provide an excerpt from consultation #2 in which the interpreter' unconscious bias, underpinned by her religious beliefs, prompt her to produce an enhanced rendition whereby she reminds

the patient that she might die if she does not accept a blood transfusion. After analysing the rapport implications of this move, I also comment on this interpreter's and the doctor's views on this action: on the one hand, the interpreter acknowledges that her own beliefs may have influenced her performance, potentially due to the sensitive nature of this interchange; on the other hand, the doctor admits feeling okay with this type of behaviour as long as it is aligned with the clinical goals that he pursues. The interpreter's and the doctor's views provide a psychosocial and biomedical perspective, respectively, on the same discursive occurrence. Their views are different, but they are also complementary, and provide two different kinds of evidence thus revealing two different dimensions of one single phenomenon: the interpreter's enhanced rendition. This principle is repeated in the analysis of other excerpts, and shows how, in this inquiry, breath of scope is relinquished for the sake of depth in analytical views and production of findings. Triangulation of different qualitative data sources seems useful in explorations on phenomena related to interactional pragmatics in general. In this regard, Thomas (1995) explains how pragmatic markers such as pronoun choice or indirectness can be observed in the text itself; however, there are other aspects of major importance in pragmatics that cannot be captured by discursive data, and therefore a supplementary data source is needed. These aspects include issues such as motivation, indeterminacy of meaning or pragmatic force, or how a certain utterance was perceived (*ibid*.). All in all, discursive data needs to be triangulated with participants' views in order to build a holistic account of interactional pragmatics phenomena, as it is important to explore issues such as how an interactant wants to be seen, how do they actually get a certain identity attribute across, or what the interplay is between communicative behaviours and attributions of identity. This issue is certainly of marked relevance in relation to the study of interpreter-mediated talk, given that interpreters can substantially influence how certain pragmatic markers come across for primary participants.

Enhancing rigour

This thesis is predominantly a qualitative inquiry and for this reason, one of the main purposes of triangulation in the context of this study was trying to reduce the potential to minimise my own bias and subjectivity in interpreting the findings, in line with the recommendations provided in Silverman (2017). More specifically, I used triangulation to make sure that the interpretation of the data was based on participants' own views and not influenced by my own research objectives (Aguilar-Solano, 2020). A clear

example of this is the analysis of excerpt 11 in section 6.2.2.1. In this excerpt Julia, the interpreter involved, breaches the principle of impartiality to make a joke to the patient while the doctor sorts out his paperwork, in what seems to be an attempt to provide direct encouragement. A first reading of this excerpt led me to think that the interpreter involved might not be as concerned by impartiality as she was with personally comforting the patient. However, as Julia recounted in her retrospective interview, her 'stepping-out-of-role' action was prompted by her close relationship with the patient, built over a number of years in which Julia occasionally interpreted for the patient. The interpersonal closeness shared between patient and interpreter influenced the interpreter's behaviour in that session so, in explaining this, Julia clarified that she would not do the same for any patient. Julia's account provided during her retrospective interview helped counteract my own bias, and her account was therefore included in section 6.2.2.1, complemented by a RM-based reading of the data. All in all, triangulation helped in this case to enhance research rigour and trustworthiness to the interpretative nature of this qualitative inquiry. Overall, triangulation of different data sources also helped to identify contradictions, tensions and shortcomings of the data yielded by individual methods, thus enhancing trustworthiness (Aguilar-Solano, 2020).

Conclusion

Triangulation did not only fulfil the purpose of achieving depth in analysis but also ensuring rigour in this thesis: accounting for the participants' views through the interview data not only helped me explain relational practices shown in the transcriptions of the consultations by accounting for different viewpoints, it also helped to counteract my own biases when analysing dataset 1. All in all, it seems that triangulating data is a promising approach to study facework and contribute to a stronger research design, as it helps enhancing the quality and trustworthiness required in the interpretative task of qualitative research.

8.2.2 Analysis of interpreted talk guided by rapport management theory

A novel element of this thesis is its full adoption of Spencer-Oatey's (2008) RM theory as a tool to provide scholarly basis and add rigour to the analysis of interpreter-mediated talk. RM was selected as a theoretical framework for this study because, as explained in section 4.2.3, it embodies the latest advancements in the field of interactional pragmatics (IP). This is partly because it overcomes the limitations of one of the most

influential theories within the field of IP: Brown and Levinson's politeness theory (1987), a theory that has been adopted in multiple studies on interpreter-mediated talk (see 4.3). By refining and broadening politeness theory, RM provides a theoretical and methodological advancement in the field of IP. However, as explained in 4.3, not many studies on dialogue interpreting to date have incorporated RM into their analyses; and those that have adopted it, have only considered isolated elements of the theory. As a result, it can be argued that the novelty that RM brings into the field of IP has not been entirely reflected in DI studies. By fully incorporating the RM framework, this study aimed to address this gap in the research. This decision had a number of methodological consequences.

8.2.2.1 The three bases and RSSAs

The main methodological advantage of using RM theory as a theoretical and analytical framework, is that the analytical focus is no longer exclusively placed on the notion of face when operationalising interactional dynamics. Instead, two more conceptual bases (sociality expectancies and interactional goals) are added to the notion of face sensitivities; and, in turn, the three bases together make up the notion of 'rapport'. By analysing interpreter-mediated talk by looking at manifestations of the 'three bases', it is methodologically possible to broaden insights, compared to studies that exclusively conceive relational work in terms of face concerns (see 4.3). In this regard, this thesis has shown how an exploration of the three bases of rapport in interpreter-mediated talk can be guided by the adoption of rapport-sensitive speech acts (RSSAs) as unit of analysis. The notion of RSSAs helps to locate RM strategies within a higher-order communication system, instead of beginning the analysis with a set of isolated strategies in mind and then guiding the analysis in relation to a set of discrete categories of strategies traditionally associated with the management of social relationships such as 'small talk', 'indirectness', 'displays of empathy' or 'humour' (see Iglesias-Fernández 2010, for a review of DI studies that have followed this approach). In other words, RM theory does not encourage the analysis of relational work through the exploration of one or a set of isolated strategies. Instead, it proposes that 'managing rapport' is intrinsic to *all* communicative action, either in its enhancement, conflict mitigation or challenging/neglecting dimensions. This all means that a RM theory-informed analysis of social interaction helps to deepen the analytical focus by directing the attention to what people are 'doing' with words (Austin, 1962) and, more specifically, what people

are ‘doing relationally’. Only after identifying the relational actions in each RSSA, the analytical protocol adopted for this study proceeds to identify the linguistic resources (strategies) that participants employ to fulfil their communicative goals. By following this protocol, a pragmatics-based analysis is undertaken while simultaneously considering other levels of linguistic description. In adopting this conceptual schema, the ephemeral nature of rapport is made concrete and tangible as it is operationalised into communicative behaviours. In this thesis, this analytical protocol has been proven relevant for an analysis of interpreter-mediated talk for several reasons. Firstly, this pragmatics-based analysis makes it possible to identify the extent to which interpreters are involved in the handling of the three bases of rapport between primary participants. Secondly, this type of analysis helps to elucidate the ways in which interpreters are directly or personally involved in dyadic rapport management dynamics with primary participants which, in turn, enables the making of connections between dyadic and triadic rapport management dynamics. This all helps to build an all-encompassing picture of interpreters’ involvement from the higher-order viewpoint of pragmatics and evidences how interpreters’ active involvement in triadic talk is an unavoidable reality; thus contributing to deconstruct the idea of interpreters as conduits or translation machines (See 2.2).

8.2.2.2 From rapport building to rapport management

In the discipline of dialogue interpreting, there are two strands of studies that use analytical frameworks rooted in interactional pragmatics, such as facework. One research branch is concerned with how interpreters mitigate face-threatening acts inherent in discursive practices unfolding in context of adversarial nature (Berk-Seligson, 1990, 2002; Hale, 1997; Mason and Stewart, 2001, Jacobsen, 2008; Lee, 2013; Martínez-López, 2016). Another line of inquiry is interested in exploring how interpreters actively intervene to positively enhance the quality of the relationship between participants who uphold a rapport-enhancing disposition, an action commonly referred to in previous literature as rapport building (Wadensjö, 1998; Iglesias-Fernández, 2010; Merlini, 2013; Major, 2013; Mapson, 2015; Cambridge, 2012/2020). Building on the approaches offered by the two research strands, this thesis is simultaneously concerned with three different types of rapport-management behaviours: firstly, the willingness to enhance perceptions of rapport in a relationship, commonly referred to as ‘rapport building’; secondly, the concern with mitigating the force of

rapport-threatening speech acts, referred in this thesis as rapport maintenance; and thirdly, the willingness to proactively threaten rapport.

The common factor underpinning these three behaviour types is a concern with how participants in a speech event may use language to maintain or bring about a change in the inter-subjective perceptions of (dis)harmony in a given relationship; in other words, these three behaviours encompass what constitutes a range of rapport management behaviours. This thesis has illustrated that it is possible to conduct an inquiry that jointly considers all three rapport-management behaviours by resorting to the notion of rapport-sensitive speech acts (RSSA) as a unit for data analysis. In doing so, the analytical scope of this thesis is not bound by any specific rapport-related behaviour (enhancing, mitigating threats or challenging) as previous studies on dialogue interpreting are; and, as such, the potential scope for findings is broadened. Ultimately, and in comparison to previous studies, the traditional terminology of 'rapport building' becomes just one out of the potential 'rapport management' behaviours that may be identified: rapport enhancement. In other words, all rapport enhancement (traditionally called building) is rapport management behaviour, but not all rapport management is rapport enhancement. All in all, analysing interpreter-mediated talk through a RM framework opens up the potential for broadened findings compared to a framework that restricts the search to enhance and/or mitigate.

8.3 Implications for theory development

In this section, I provide an account of how the findings of this thesis contribute to advance the current evidence base of dialogue interpreting studies.

8.3.1 The three bases of rapport in interpreter-mediated talk

In this sub-section, I discuss how this study contributes to build up the evidence base of DI studies by exploring how face sensitivities (8.3.1.1), social expectancies (8.3.1.2) and interactional goals (8.3.1.3) are negotiated in triadic talk. This three-fold structural division allows me to locate the findings of this thesis within the wider academic debate by comparing them with the findings of scholars that have previously explored DI dynamics in relation to each of the three bases. The ultimate purpose of this section is to illustrate that much knowledge on interpersonal dynamics in IMEs can be elicited by overcoming the traditional identification of relational dynamics with facework.

8.3.1.1 Face sensitivities

The findings of this thesis suggest that *all* participants involved in an IME, including interpreters, actively manage their own and their interlocutors' face needs and wants. Interpreters seem to be attuned with primary participants' face sensitivities and this awareness is reflected in their performance. Such attunement becomes particularly salient when interpreters downtone the illocutionary force of potentially rapport-threatening utterances exchanged between primary participants (for an example see Ss. 449 – 450 in excerpt 13 in section 6.3.1). In relation to this finding, my conclusions resonate with those of Major (2013: 262), who observed in her study how "interpreters worked to maintain and, at times, even actively sought to enhance relationships between other participants, and between other participants and themselves".

The most noticeable face-saving behaviour by interpreters in my case study is that of mitigating face-threatening acts (for example, see excerpt 22). This finding echoes the conclusions of a number of studies on DI that have previously explored interpreters' mitigation of FTAs and have found that interpreters soften face-threats or change the tone of witnesses' talk to reflect a more face-conscious discursive style. Such research includes the work of Berk-Seligson, (1990, 2002); Hale (1997, 2002); Mason and Stewart (2001), Jacobsen, (2008); Lee (2013) and Martínez-López (2016). These authors are representative of the majority of studies that have noticed interpreters' tendency to mitigate FTAs, set in adversarial contexts, namely court and police settings. It is relevant that in these settings, changes in style to reflect a more face-conscious approach are often considered to be inappropriate, as this may alter how a speaker would be perceived by others, a situation that could directly affect the outcome of a case (Hale, 2002). By contrast, a healthcare setting, such as the one in my case study, allows for more leeway in relation to interpreters' portrayal of participants' face presentation, as healthcare is a cooperative setting where participants are typically pre-disposed to work together to achieve a certain outcome.

Nonetheless, the findings of this thesis suggest that the potential for conflict in interaction, manifested through FTAs, might not only unfold in adversarial but also in cooperative settings; and that interpreters' tendency to downtone FTAs applies equally to both contexts. The fact that FTAs may also develop in contexts where participants share a cooperative disposition illustrates how complex and multi-faceted human interaction is. More particularly, the findings of this thesis suggest that conflict, or at

least some degree of tension, may inevitably arise when certain goals or social expectancies are to be negotiated. This is illustrated through interactional episodes such as the ones described in excerpts 20 or 22, where the fulfilment of goals/social expectancies necessarily involves a degree of face threat. These excerpts show how participants' ability to maintain a positive interactional balance helps fulfil interactional goals, which might in turn help accomplish clinical outcomes. Additionally, the findings described in chapters 6 and 7 suggest that interpreters' performance is critical when FTAs happen, as that can determine whether the threatening force of an original utterance is conveyed or mitigated.

An interpreter's rendition of an FTA depends on several factors. A significant factor seems to be the interpreter's pre-conceived ideas of rapport-management dynamics for a given speech event. In this regard, the findings of my study resonate with those of Merlini (2013: 267), who indicated that "interpreters' facework correlates with their understanding of the institutional goals being pursued during the interactions, their identification of power relations among participants, and their personal and professional status". The findings of this thesis second Merlini's statement and take the discussion forward by proposing that interpreters' facework also depends on interpreters' identification (or lack thereof) of other relational forces at play in interaction, namely social expectancies and primary participants' interactional goals; the two bases of rapport that Spencer-Oatey's framework (2008) adds to the classical model of Politeness (Brown and Levinson, 1987): the theory that guides most of DI studies on interactional pragmatics (see 4.3).

The interplay between face-sensitivities and the other two bases is well illustrated in the discussion of excerpt 14 (section 6.4.1). In this section, I describe how Dr. Sharpe challenges the patients' narrative in an attempt to help her realise the magnitude of her memory loss. Dr. Sharpe's 'confrontational' utterances are in direct opposition with the patient's claim that her memory is in a healthy state. Whilst there might be a face-threatening quality to Dr. Sharpe's confrontation, the clinician's performance of this speech act was necessary to increase the patient's awareness of her fading memory. By extension, the confrontational style was also necessary for Dr. Sharpe to fulfil his medical duties. In other words, face sensitivities are relinquished for the sake of fulfilling interactional goals. If the interpreter had made use of her agency by helping the patient provide an accurate account, the interactional balance might have been more

positive, but the clinician would have not been able to prove that the patient's memory was fading. As a result, interactional goals for that consultation could have been hampered and sociality expectancies unfulfilled.

These observations suggest that, when an encounter takes place in a goal-oriented institutional event that is also substantially marked by social expectancies, the second and third bases of rapport are actively at play in parallel to face sensitivities, and they may even occasionally take precedence over the preservation of face. Consequently, whilst interpreters' mitigation of FTAs might help to preserve interactional rapport in the short term, the attenuation of an FTA can turn counterproductive if that hampers the fulfilment of a participant's interactional goals or infringes social expectancies later in the interaction.

The purpose of this sub-section was to demonstrate that looking at interactional dynamics from the lenses of 'face' and 'facework' might prove useful to partially describe what is happening in an interactional episode at the surface level, but it does not fully explain participants' behaviour within a wider framework of communication. An exploration of relational practices in IMEs that entirely relies on the analysis of facework is insufficient. Against this background, the two sections below are aimed to illustrate how an analysis of relational dynamics can be enriched if the notion of Facework is broadened by considering the two conceptual dimensions that RM theory (Spencer-Oatey, 2008) adds to politeness theory (Brown and Levinson, 1987); that is: social expectancies (8.3.1.2) and interactional goals (8.3.1.3).

8.3.1.2 Beyond face (I): Behavioural expectations

As fully explained in section 4.2.3, RM theory (Spencer-Oatey, 2008) proposes that people develop beliefs around the sociality rights and obligations that they have in relation to other people. These beliefs might turn into behavioural expectations and, in turn, such expectations are to be negotiated through interactional behaviours. Consequently, if such expectancies are unfulfilled in an interaction, rapport might be negatively affected. Different interactional episodes extracted from dataset 1 in this thesis illustrate how the successful negotiation of social expectancies is crucial to preserve harmony in interpreter-mediated talk. Such negotiation can manifest dyadically or triadically among participants.

For example, the degree to which it is seen as acceptable that interpreters and service users engage in dyadic interactions is a useful behavioural marker to explore social expectancies at play. An instance is provided in section 6.3.2, where I explore the socio-interactional principle of 'association' in relation to unsupervised interactions between interpreters and patients in the waiting room, before the consultations started. In this section, I also discuss how the clinician involved in my case study believes that such interactions are not only allowable, but even potentially useful and relevant from a therapeutic standpoint. The stance of the clinician in this case study seems to be aligned with Monteoliva-García's (2017: 58) view that "rapport between the interpreter and the other participants seems a reasonable precondition to create rapport between primary participants". All in all, some people believe that interpreters and service users are entitled to a degree of direct interactional involvement, that it is a sociality right. However, as mentioned in 4.2.3, beliefs around sociality rights and obligations may be rooted in different sources, such as normative behaviours or more formal conditions such as contractual agreements or job roles. Because the delimitations of the interpreter's role are still under ongoing discussion (see 2.2.2), then it is understandable that different people may have different views on sociality expectancies around interpreters' behaviour, and this can have rapport-related implications. For example, whereas the participants in my case study believe that a degree of interpreter-patient interactional involvement might potentially be useful in preserving harmony later on in the triadic consultation, other studies have found that some MHC professionals believe that interpreters should not engage in unsupervised interactions with mental health patients as that may have negative therapeutic consequences (Hsieh and Hong, 2010). The diversity of views on sociality rights in the interpreter-patient dyad found across studies suggests that the potential for conflict might stem from diverging behavioural expectations. More particularly, it may be assumed that if a clinician sees interpreter-patient direct exchanges with suspicion, outside or inside the consultation room, then the overall interactional balance is susceptible to disruption. All in all, the findings of this thesis illustrate that "in order to achieve harmony in interaction, it is necessary for both speaker and hearer to share similar conceptualizations of face and rights and obligations or, at least, understand each other's worldview in order to manage rapport properly" (López-Hernández, 2008).

This statement does not only apply to the dyadic negotiation of sociality expectancies, but also to the way in which such negotiation is enabled between primary participants through an interpreter. Different interactional episodes in dataset 1 illustrate how success in the negotiation of sociality expectancies may unfold triadically. For example, in section 6.2.1.2, I discuss how different interpreters' adoption of the informal or formal versions of the second person pronoun 'you' in Spanish (*tú* or *usted*) might convey a more or less distant representation of the clinician's relational disposition. This is because each of these pronouns carries a different set of information around socio-pragmatic parameters, particularly in relation to power and distance. In turn, the expression of such parameters might be in more or less accordance with the interlocutor's sociality expectancies. For example, a patient might expect a degree of distance-closeness in the treatment that they may receive from a doctor. Furthermore, rapport perceptions may vary depending on the alignment between such perceptions and the actual communicative behaviour on the part of the clinician. This finding partly echoes the observations made by Berk-Seligson (1990) and Hale (1997) in their inquiries into courtroom interpreting. Both authors conclude that interpreters' renditions, or lack thereof, of some linguistic markers (honorifics) affected juror's perceptions of witnesses' trustworthiness. Building on their observations, I propose that interpreters' alignment with primary speakers' relational predispositions is key to successfully represent their interpersonal inclinations through the appropriate pragmatic markers. All in all, the overarching conclusion that I reach in this section is that interpreters' influence over the rendition of rapport-sensitive pragmatic markers might affect the portrayal of primary speakers' persona or relational dispositions, and that this might in turn affect rapport perceptions between them.

Ultimately, the aim of this section was to illustrate how the concept of social expectancies goes a step beyond the notions of face and facework. This is because the construct of face is individual whilst the notion of sociality expectancies belongs to the collective arena: the relational parameters at play are no longer about individuals' perceived sense of worth but about interlocutors' "concerns over fairness, consideration and behavioural appropriateness" (Spencer-Oatey, 2008:11) in relation to one another. I thus propose that analysing IMEs by examining not just participants' face sensitivities, but also their sociality expectancies, has a two-fold research potential: firstly, it enables the elicitation of a wider view of the relational dynamics at play in IMEs; and secondly, it opens the door towards deeper analyses of participants' pre-conceptions of the sociality rights and obligations that should rule interaction.

8.3.1.3 Beyond face (II): Interactional goals

According to the RM framework (Spencer-Oatey, 2008), all speakers in a speech event have goals that need to be interactionally negotiated as a pre-condition for their fulfilment. Interactional goals might be collective or individual, as well as relational (interactionally-focused) or transactional (task-focused) (*ibid*.). Regardless of the nature of participants' conversational objectives, failure to fulfil such goals as an interaction develops might lead to frustration, annoyance, and ultimately to a negative interactional balance among participants (*ibid*.).

Building on the idea that interpreters are active managers of discourse and therefore play a role in the triadic co-construction of meaning, chapter 7 was predicated upon the hypothesis that interpreters may be equally involved in the discursive negotiation of participants' goals. The findings I described in that chapter suggest that there are two potential scenarios for interpreters' involvement in participants' negotiation of goals. Firstly, evidence was found to suggest that interpreters might identify a speaker's interactional goal and adapt their role (see section 2.2.2 for a discussion on role fluidity) to enable the fulfilment of that goal through their performance. This type of behaviour was already identified and discussed in previous studies on dialogue interpreting. More particularly, scholars such as Bolden (2000), Davidson (2000), Angelelli (2004), Major (2013) and Hsieh (2016) have described how interpreters might actively adapt their role to help fulfil the clinical goals of the speech event. My findings particularly resonate with those of Major (2013: 267) who placed a special emphasis on relational goals in interpreter-mediated talk in healthcare and concluded that "interpreters diverge from 'faithful' interpretations for reasons that relate directly to the maintenance of relationships". In chapter 7, I also discussed that different relational scenarios may arise in relation to interpreters' alignment or misalignment with primary speakers' transactional or interpersonal goals. Nonetheless, an overarching conclusion of chapter 7 was that, even though interpreters' performance is key to ensure the co-fulfilment of primary participants' interactional goals, all participants have an equal role to play to ensure the successful handing of RM bases including interactional goals.

8.3.2 Context-based rapport management

In section 2.3, I reviewed a number of studies about interpreter-mediated relational dynamics and presented two main research strands: firstly, literature that proposes that

interpreters tend to refrain from engaging in rapport-related dynamics and/or disregard the initiation or rendition of interactionally-oriented communicative practices (Tebble, 1999, 2003; Bolden, 2000; Leanza, 2005; Bot, 2005; Dysart-Gale, 2005; Aranguri et al., 2006; Cambridge, 2012); and secondly, literature that claims that interpreters are actively engaged in rapport-related dynamics and may act as facilitators of relationships (Angelelli, 2004; Merlini and Favaron, 2005; Mikkelson, 2008; Merlini, 2009; Major, 2013; Mapson, 2015; Baraldi and Gavioli, 2015; Hsieh, 2017). Even though the findings of this thesis seem to align more closely with the conclusions of the second strand of studies (see 6.2.2.1), some interactional episodes discussed in chapters 6 and 7 also reflect the tendency in the former strand (see 6.4.3). In other words: it seems that exclusively locating this study within *one* of the abovementioned strands would not do justice to the complexity and diversity found across relational dynamics among the participants in this case study. There are two main reasons for this. Firstly, this thesis is a monograph exclusively dedicated to rapport management. Secondly, by following Yin's (2018) guidelines in adopting a case-study research design (See 5.1.2) it was possible to minimise variables in order to create consistent conditions required to fully appreciate the *situatedness* of rapport-management practices. In this these context is an important factor in the data; and, in deeply accounting for these contextual factors, the quality of findings is nuanced, complex and multi-layered. As a result, instead of locating the study within one of the research strands, it would be more precise to state that there is a marked interplay between participants' rapport dynamics and a number of contextual factors. Speakers' adoption of rapport-oriented strategies and their interlocutors' reception-interpretation of such strategies are substantially influenced by aspects surrounding the communicative event; for example: relational configurations and roles adopted by participants, speech event characteristics, participants' relational dispositions, the number of participants present in the event, and/or the overarching goals for the encounter (see chapter 6). For example, a 'request'/'order' speech act initiated by a doctor towards the interpreter is not perceived equally by the interpreter if initiated by a patient's family member (see 6.1). In other words, context matters and RSSAs should not be analysed in isolation.

The interplay between context and participants' decision-making processes regarding rapport management becomes salient when, for example, paying attention to the interpreter-patient unsupervised small-talk engagements in the waiting area. This type of interaction could have been seen as inappropriate under different circumstances. By

contrast, a number of contextual factors surrounding participants in my case study seemed to provide legitimacy for these interactions; for example: the small and intimate physical configuration of the waiting area (see 6.3.2), the patient's desire for company and interactions in Spanish, the mild condition of her psychopathology (see 5.2.4), the latent familiarity shared between the interpreters and the patient due to the chronic nature of the patient's health issue (*ibid*.) and finally, the doctor's calm attitude in relation to unsupervised interpreter-patient interactions (6.3.2). This set of circumstances allowed participants to perceive that a degree of interactional involvement was allowed in dyadic interactions between interpreter and this particular patient. However, I posit that, should the contextual circumstances change, perceptions of the same issue could also change. In sections 3.1.1 – 3.2.2, I provide an outline of potential features of mental healthcare encounters, which includes different degrees of patients' psychopathology, goals for the session and the type of professionals involved. Because of the variety of features that can be found across different speech events belonging to the mental health field, I propose that different contextual factors may condition views on relational practices for that event. For example, a patient with paranoid tendencies could be suspicious of interactions with any person, including interpreters; an interpreter might not feel safe enough to directly engage with a patient if they have not met previously; and a doctor might not feel comfortable about the idea of unsupervised patient-interpreter interactions.

The diversity in the circumstances to be found in the MH field suggests that it would be difficult to propose a single tendency for interpreters' (or any other participants') involvement in rapport-management dynamics. An alternative, and more accurate, statement would be that the adoption and interpretation/reception of rapport-management practices are dependent upon a subtle and dynamic balance between the two extremes of a relational continuum. By proposing this view, this thesis aligns with previous research work that has placed its focus on the dynamic interplay between context and IME participants' decision-making, such as Dean and Pollard (2011). Building on Dean and Pollard's (2011: 155) notion of "context-based ethical reasoning in interpreting", I propose that it is necessary to talk about 'context-based rapport management in interpreting'.

8.4 Practical applications and recommendations

In this thesis I have drawn on the analysis of a number of real-life interactional episodes to shed light onto how RM practices may unfold in MHC IMEs. It is envisioned that the material provided through this thesis, which encompasses the excerpts chosen for analysis and the resulting findings, will be of practical use for healthcare practitioners, interpreters, trainers and policy makers. The main practical outcome pursued through this thesis is the increase in these stakeholders' awareness of how important it is to appropriately handle RM dynamics in MHC IMEs to ensure the success of the communicative encounter. To fulfil this outcome, in this section I provide recommendations for MHC practitioners and interpreters to jointly ensure positive RM dynamics in their professional practice (8.4.1), I discuss how stakeholders' RM competencies may be fostered through education and training (8.4.2) and I offer ideas on how favourable conditions may be created to foster positive RM dynamics in MHC IMEs from the organisational and policy-planning standpoints (8.4.3).

8.4.1 Recommendations for interprofessional collaboration

Several interactional episodes scrutinised in this thesis provide evidence to suggest that MHC IMEs entail a high degree of clinical, linguistic and relational complexity. The multifaceted nature of this complexity calls for the joint efforts of the clinician and the interpreter. This is because each of these professionals holds a different repertoire of competencies that are relevant to the success of an MHC IME. As a result, a coordinated response by both professionals is required. Drawing on the findings of this thesis, I define 'coordinated response' as a mutually beneficial working relationship whereby MHC practitioner and interpreter share a set of expectations around which actions are most acceptable, useful or even appropriate to preserve positive, or at least neutral, relational dynamics in the encounter. For this to happen, both professionals need to be aware of the strengths that the other can contribute to the relational success of the encounter. Among such strengths should be counted the value of the interpreters' agency in relation to the preservation or even enhancement of rapport dynamics in the MHC IME.

The first factor that should be considered is both professionals' attitude towards their own and each other's potential contribution to the relational dynamics of the exchange. In this regard, interpreters' active contribution to the RM dynamics of an encounter should not be seen as a threat but as a force that can greatly contribute to the success of

the consultation. Interpreters do not only need to feel acknowledged for their potential contribution, but also welcomed by the MHC professional into three-way relational dynamics; as well as empowered to actively make use of their agency to manage rapport on behalf of themselves and others, given that MHC professionals hold the institutional power over the interaction. Once the interpreter's potential contribution is acknowledged, actions may be taken to harness this potential in a way that is beneficial for all parties. This raises the question that interpreter ethics and codes of practice should be observed without placing the emphasis on interpreters' job performance but on how the interactional demands of the encounter define expectations regarding what practices would be best.

If a MHC practitioner and an interpreter actively work together, then they may join their strengths to identify the linguistic, relational and clinical needs of the patient, and tailor the development of the encounter around those needs, as already suggested by Napier and Cornes (2004) or Costa (2017). Drawing on the findings of this thesis, I propose that ways to foster this type of working relationship are spending time together and negotiating decisions around what triadic and/or dyadic relational actions are most suitable for a given encounter. These actions might help maximise the value of their cooperative efforts. Recommended steps for inter-professional collaboration to take before, during and after an MHC IME are provided below.

8.4.1.1 Assignment brief

Hlavac (2017) establishes that when interpreters face unexpected challenges, their cognitive processing capacity required to successfully handle the interpreting workshop might be negatively affected and ultimately their job performance. Building on this statement, Hlavac (*ibid*.) proposes that preparation builds up interpreters' competency and, in turn, such competency might help them better anticipate challenges and better cope with them during the interaction and distribute their cognitive effort more effectively. With these statements, Hlavac refers to linguistic and behavioural challenges in mental health settings but makes no specific reference to relational challenges. Building on Hlavac' s recommendations, I propose that helping interpreters anticipate rapport-management challenges that might come up during an IME might help them deal with them more effectively when they arise. Whilst this recommendation may be applicable to a range of community settings, I posit that it is particularly salient in the mental health field for several reasons; namely, because interpreters might need to

deal with patient's unusual behaviour or dysfunctional use of language in this context and because this setting is likely to feature sensitive psychosocial discussions; and these two factors might result in atypical relational dynamics that interpreters need to be ready for. Preparation and anticipation starts with an assignment brief. That is, a brief set of instructions that interpreters receive when they are invited to take on an interpreting assignment. Whilst the importance of providing an informative assignment brief has been stressed (Kalina, 2015), the interpreters in my case study reported that this is not common practice. As mentioned in 6.5.2, Julia recounted how when she faced her first MHC interpreting assignment, the only information that she received from the interpreting agency was that she would work in 'ward 28' of a hospital, a ward that turned out to be an in-patient psychiatry unit. Julia also discussed how preparation for facing this type of setting left her feeling distressed herself, burnt out and exhausted. Julia's narrative suggests that an informative assignment brief does not only enable interpreters to abide by the professional value of 'competence' (that is, accepting or turning down an assignment depending on whether they believe they are fit to successfully handle it or not); but also helps preserve professionalism during the encounter and avoids negative reactions after the session, including professionalism in the handling of RM dynamics. All in all, if interpreters are focused on behavioural/linguistic irregularities, they might struggle to allocate the attention required by tasks that might be perceived as less pressing, such as calmly and effectively handling RM practices. As a result, I recommend that interpreters are informed of not just the name of the institution/clinic where they are going to work. Instead, they should be provided with an assignment brief that contains as much relevant information as possible without endangering the patient's confidentiality. This would grant interpreters the information needed for them to have the basis to refuse an MHI assignment should they believe that they are not fit for it. In turn, this course of action would also help preserve professionalism during the session and safeguard interpreters' wellbeing once the session is over.

8.4.1.2 Pre-interactional briefing

Beyond the information that interpreters receive as part of the assignment brief provided by the interpreting agency, they may also benefit from a briefing with the relevant MHC practitioner prior to the formal encounter. A pre-interactional briefing "is an opportunity to gain information on the general purpose of the interaction or what the mental health professional seeks to achieve in a general sense" (Hlavac, 2017: 6). Nonetheless, in

6.3.2, I report on Elisa and Julia's narratives, which suggest that briefings with MHC practitioners rarely happen. The two interpreters recounted how, in the absence of a briefing with the healthcare practitioner, they occasionally approach patients in the waiting area, partly driven by their desire to understand what the session will be about while engaging in small talk. This action may have relational consequences, so interpreters should be well-informed when approaching patients.

Additionally, the fact that a briefing is important for interpreters to get an idea of the purpose of a session is of paramount importance in the light of the findings of chapter 7. This chapter concluded that interpreters constantly have to manage clinical, linguistic and relational goals, and their knowledge of what is being pursued in interaction helps them align themselves with such goals and prioritise accordingly. In turn, helping MHC practitioners fulfil their goals helps promote a positive relational balance. Drawing on this notion, I propose that having some pre-interactional instructions on what dimensions should be prioritised would increase interpreters' awareness and help them prioritise accordingly. This is important from the relational standpoint, as the importance of the relational dimension might differ depending on the speech event (for example, a psychometric test or a psychotherapeutic session). From the relational point of view, topics that might be useful to discuss in a briefing include the following:

- Whether the consultation with a given patient is an initial or a follow-up consultation, as this will help determine whether there is any degree of familiarity shared between the speakers.
- Expected role of interpreter for this given section.
- Diagnostic and/or therapeutic purpose of session.
- Expected outcomes of this consultation.
- Overall format of the consultation.
- Negotiation of the overall role relationships.
- How to handle introductions in general and introducing the interpreter's role.
- Potential presence of family members. Advice for handling conflict related to multiparty interactions.
- Inclusion of potentially sensitive topics.
- Safety concerns.
- Effect of patient's condition on potential behavioural/linguistic irregularities.

8.4.1.3 During the encounter

From the findings of this thesis, I suggest that it is important that all participants are aware of rapport management dynamics during an IME. Interpreters should pay attention to the discursive negotiation of the three rapport bases and actively attempt to manage them. At the same time, clinicians should occasionally monitor interpreters' overall wellbeing within the type of interaction. The work of Costa (2017) is relevant to the issue of joint working during an IME. She understands the term 'supervision' as the mutually relationally conscious relationship established between a MHC practitioner and interpreter, whereby the following elements are contained: safety, trust and confidence; awareness of triangular dynamics and emotional impact; and collaborative practice. Building on Costa's (2017) view, I propose that the quality of rapport management dynamics during the interaction should also be actively considered in relation to interpreters' supervision.

8.4.1.4 De-briefing

None of the interpreters in any of the sessions that I observed (including the ones that I observed prior to the selection of this thesis case study) had a de-briefing session with the MHC practitioner once the consultation was over. This means that the benefits of de-briefings are being constantly missed, which is an area for improvement. A debriefing could help clarify problematic interactional episodes and/or tackle residual questions that interpreters might have about the patient's speech or behaviour. It also opens up a space for reflection about the emotional impact that a session might have had on interpreters themselves, which might indirectly help interpreters understand issues that might interfere with their capacity to appropriate handling RM dynamics in subsequent encounters.

A de-briefing after an MHC IME is also important for interpreters to fully understand some complex dynamics that take place in mental health work. It has been documented that some interpreters might regard MHC practitioners as 'cold' and 'detached' if, for example, they let a patient cry without offering immediate comfort. Whilst it may be frustrating to see this type of dynamic, it may be required by the protocol of the therapy type adopted (Gallagher et al., 2017). Consequently, informal conversations about what happened in the session might increase the interpreters' general understanding of dynamics in MHC interactions. This understanding might help contain potential complex emotional reactions in the future (Miller, 2005), thus minimising the potential for relational conflict. From a RM perspective, interpreters' understanding of relational

dynamics in MHC work is useful because they can adjust their behavioural expectations in relation to sociality rights and obligations expected from participants during the communicative exchange.

8.4.1.5 Final remarks on interprofessional collaboration

The purpose of section 8.4.1 was to recommend some steps for MHC practitioners and interpreters to develop a productive working relationship. It is hoped that these steps assist in the implementation of safeguards for conflict mitigation and subsequent preservation of a positive interactional balance ('harmony'). Much of what has been discussed in this section revolves around the value of managing expectations. It seems that it is important for clinicians and interpreters to share a set of expectations, as that provides a starting point to work jointly by regularly negotiating what actions are most useful to preserve a sustainable interactional balance. As Spencer-Oatey (2008) indicates, tackling mismatching expectations on time is important to help prevent and/or mitigate conflict, and that is why social expectancy is one of the key rapport bases.

Another general reflection that stems from 8.4.3 is that, ideally, MHC providers and interpreters should not see themselves as separate, fully autonomous workers with discrete and detached professional competencies. Instead, interpreters and clinicians should be aware of the interdependence that exists between their actions, as that may affect relational dynamics.

8.4.2 Education and training

The complexity of the content and relational dynamics in the consultations analysed in this thesis suggests that interpreters and MHC practitioners may benefit from receiving training that is context-specific, competency-based and specifically targeted. For this reason, in this section I propose a curriculum on RM in MHC IMEs. This curriculum has been designed as a CPD course to be delivered jointly to practicing or aspiring interpreters and MHC practitioners. Whilst delivering it to a multi-disciplinary audience would be ideal as a way to prompt discussions that integrate both professionals' perspectives, this curriculum can also be integrated separately as part of a larger training programme for each professional group. The curriculum can be found in table 40 below. After the table, I outline the rationale and main features of this curriculum.

Table 40 - Rapport management in mental health interpreting: a curriculum

Unit 1 – Rapport management
Theory 1) Definition of basic concepts: ✓ Rapport and rapport management (RM). ✓ Speech Acts. ✓ Rapport sensitive speech acts (RSSAs). ✓ Situatedness: the interplay between context and RM. ✓ Interactional balance. ✓ Rapport as an inter-subjective phenomenon. ✓ The four orientations of rapport. ✓ RM competencies applied to interpreter-mediated talk. 2) Pragmatic markers through which rapport is managed: domains and strategies. 3) How beliefs on Socio-Interactional Principles (SIPs) might influence behaviour. ***Practice*** • Discussion of how all these concepts may manifest: (a) in everyday relationships, (b) in monolingual healthcare interactions and (c) in interpreter-mediated healthcare interactions. • Guided reflection on beliefs about Socio-Interactional Principles (SIPs) that should rule interaction.
Unit 2 – Rapport management in interpreter-mediated interactions
Theory 4) Dialogue interpreting, 'dialogism' and triadic meaning co-construction. 5) Interpreter's agency and its impact on three-way relational dynamics. 6) Shifting along: interpreter's role fluidity. 7) Negotiation of role relationships and boundaries. 8) Triadic and dyadic rapport dynamics. 9) Joint working: (mis)alignment of goals. 10) Interplay between (mis)alignment of goals and rapport management. ***Practice*** • Display vignettes of different joint-working dynamics between interpreters and MHC practitioners, encouraging the use of terms explained so far. While doing this:

(a) Run a discussion on participants' RM-competencies or lack thereof
(b) Apply discourse analysis, using RSSAs as the analytical unit.

Unit 3 – Rapport management in interpreter-mediated mental healthcare

Theory

11) Potential influence of different psychopathologies on the patient's rapport-related perceptions.
12) Identifying the patient's relational needs and adapting RM accordingly.
13) Following recommendations for MHC practitioners and interpreters to develop an effective working relationship before, during and after the session.
14) Jointly handling complex emotional reactions.
15) Biomedical ethics in interpreter-mediated mental healthcare settings.
16) Achieving person-centred care through a joint effort.

Practice

- Role plays (I): Making the most of briefing and de-briefings.
- Role plays (II): Handling complex relational dynamics.

Below, I discuss four core elements of this curriculum to stress its uniqueness, relevance and practical value. These are: its rooting in the field of interactional pragmatics (8.4.2.1), its multidisciplinary nature (8.4.2.2) its integration of theory and practice (8.4.2.3) and the fact that it is domain-specific (8.4.2.4).

8.4.2.1 Pragmatics-based

Building on the knowledge gained by conducting the literature review required for chapter 2, I posit that one of the strengths of a training curriculum that addresses relational dynamics through the angle of rapport management is the fact that it is rooted in the field of pragmatics. The pragmatics-based notion of 'rapport management' transcends the everyday (and simpler) notion of rapport. A pragmatics-based view of rapport means that preserving the interactional balance of an encounter is a complex and multifaceted undertaking that needs to account for how rapport may be managed through multiple aspects of language use, belonging to five different domains. From this point of view, relational dynamics become more complex than handling an isolated set of strategies, such as positive reinforcement, humour or small talk; which stay at a more superficial level of language use. Additionally, following this operationalisation of rapport makes it possible to study rapport markers in a more systematic manner; for

example, by analysing the components of speech acts. Thus, a curriculum based on RM theory which is, in turn, based on interactional pragmatics notions, helps provide a higher-order conceptual frame of reference that might help professionals understand how multiple strategies might contribute to maintain or alter rapport in different ways (See the three conceptual layers in section 5.3.2). This approach might also help to increase speakers' capacity to identify local and global indicence sources, isolate them and develop the capacity to appropriately handling them.

8.4.2.2 Inter-professional approach

If MHC practitioners' and interpreters' competencies had to be plotted along a continuum, managing relationships through language use could be placed somewhere at a meeting point between both professions. Facilitating communication is interpreters' *raison d'être* but communicating with their patients is also at the heart of what MHC practitioners do. Rapport management theory is thus applicable to enhance the competencies of both professionals; even if RM strategies are expressed differently in the way that both groups need to use language in and around an IME, in keeping with their professional remits. For this reason, RM issues should ideally be taught, tackled and discussed as part of an inter-disciplinary training event where the teaching content has been adapted to suit an audience of healthcare practitioners and interpreters. In the curriculum proposed above, there are three core elements: a RM module (equally applicable to both groups), an interpreting-oriented module and an MH-oriented module. The rationale for this sequencing of contents is that MHC practitioners may benefit from learning about dialogic meaning negotiation processes and interpreters may benefit from learning about MH-related topics. As a result, throughout all three modules, members from each professional group are encouraged to think about IMEs as a fully coordinated achievement. This approach pre-requires increasing professionals' awareness of each other's distinct influence over relational dynamics.

8.4.2.3 Integrated theory and practice

The curriculum has a theoretical and a practical element to each of its three core units. This is because managing rapport is a skill that requires developing both awareness to identify primary speakers' relational needs and the competencies to adequately respond to them. Once MHC professionals and interpreters have learnt about the basic notions of

the RM framework, they can proceed to develop the six RM competencies set out in Spencer-Oatey and Franklin's (2009) work: developing contextual awareness, awareness of the three rapport bases, social information gathering, social attuning, emotion regulation and stylistic flexibility.

Developing professionals' RM competencies can be done through role-plays and/or exposure to evidence-based vignettes on interpreter-mediated MHC encounters that show illustrative examples of conflict management in action. Observance of vignettes may be followed by critical discussions on critical matters such as the application of codes of ethics to real-life interaction. Nuanced and potentially diverging standpoints should be welcome and integrated within a multi-factorial discussion that places RSSAs at the centre of the debate.

Another unique aspect of this curriculum is its 'guided introspection' component. In this thesis, it has been repeatedly mentioned that participants RM-efforts seem to correspond to their understanding of socio-interactional principles (SIPs) underlying interaction. The discussion of excerpt 20 in section 7.1.2 offered an example of how someone's internalised beliefs may condition, or at least influence, their behavioural responses. As a result, guiding participants' introspection on their own values regarding SIPs and promoting constructive criticism around them might help them become more aware of them and contain unwanted responses. The interpreter's behaviour discussed in section 7.2.2 certainly heightened the value of timely self-examination and could be used as a cautionary tale on the dissonance between best intentions and actual behaviour. Tackling these sensitive issues in a safe space, such as that of a classroom, could result in more effective responsiveness in actual practice.

8.4.2.4 Domain-specific

Some interpreting scholars have stressed the value of designing and delivering training that is tailored around the specificities of clinical specialties as that may be the path towards professionalisation and interpreters' increased competency (Hsieh, 2017). This view is certainly applicable to the field of MHI. There are many aspects of interpreted mental health interactions that make this domain unique and worth learning about as a distinct type of speech event. As Hlavac (2017: 1) noted, "an interaction between an MH professional and a person with an MH illness is in many ways different from an

interaction between a general healthcare professional and a person with a physical condition". Potential idiosyncrasies of MH patient's talk, as well as other features of MH interactions are outlined in chapter 3. Building on these notions, I propose that relational aspects should be factored in when it comes to planning for and delivering MHI training specifically. Drawing on sections of this thesis where MH-related aspects become salient (see, for example, 6.4.2 for a discussion on dealing with emotion-invoking discussion topics), I propose that it is necessary for interpreters to learn about how relational dynamics might unfold when dealing with patients who may be in a heightened state of emotional vulnerability, or even mood-related volatility. As well as learning about how different psychopathologies might influence the way certain MH patients might perceive rapport-management dynamics, it is also worth providing interpreters with training about different relational dynamics in different types of sessions. As Bot (2015: 261) suggests, different types of MH events might require different engagement from interpreters from a relational standpoint, depending on the outcomes sought. For example, structured interventions (such as psychometric tests or guided meditation) might require more focus on transactional aspects like 'utter accuracy' whereas other events such as counselling therapies might place a heightened focus on the therapeutic relationship between all parties as a tool itself to achieve different outcomes. I believe that it is important for interpreters to learn about these issues so that they can enact their role fluidity (see 2.3.3) accordingly. Other matters potentially of interest for interpreters would be matters related to triadic relationships, the nature of therapeutic change, and the extent and limitations of interpreters' behaviours in MHC practice.

8.4.2.5 Final remarks on the value of RM-focused training

There are different reasons why RM-focused training may be of great value for MHC interpreters and practitioners. Firstly, promoting RM as a specialist area of interpreting training to complement and extend interpreters' general interpreting ability may be useful not to broaden the extent of their role but to gain a deeper awareness of the implications of their actions. Additionally, specifically learning about how RM may unfold in MHI events may teach them that in certain MHC speech events, they may be required to work in different ways. Ultimately, learning how to apply RM strategies in an MHC setting may be useful for better applying context-based ethical decision-making models; for more effectively handling expectations; for overcoming any

internalised stigma; and ultimately, for engaging with RM practices while remaining within either ethical or practical performance guidelines. On the other hand, learning about RM in mental health interpreting events may also be useful for medical practitioners. Amidst a landscape marked by inconsistency of information about how to work with interpreters, the proposed training model may increase clinicians' willingness to establish a good working relationship with interpreters and to promote a positive approach towards joint working dynamics. All in all, the rationale behind a joint training curriculum is that fostering a common awareness of these issues might provide the necessary conditions for transactional and relational alignment in the job performance of members of the two professional groups.

As a final thought, I propose that training that follows the line of the presented curriculum should be promoted, legitimised and validated among the interpreting community through accreditation. That is, it should become part of National Occupational Standards in the UK as well as of a system of formal testing of candidates in a way that aspiring interpreters demonstrate their skillset in relation to RM in MHC IMEs.

8.4.3. Organisational factors and policy planning

In this section I draw on the findings of this thesis to provide recommendations for organisational and policy planning. The recommendations I make refer to the design and observance of codes of ethics (8.4.3.1), inter-professional collaboration (8.4.3.2) and continuity of interpreter provision for LACD mental health patients (8.4.3.3).

8.4.3.1. Codes of ethics for interpreters

The multi-factorial complexity of MHC IMEs, as demonstrated by the findings of this thesis, suggest that the design and observance of codes of professional interpreting conduct should account for this intricacy. In this regard, interpreting codes of ethics should be domain-specific, and include a section on recommended relational dynamics for a given speech event. Also, I would like to call attention to the notion of 'faithfulness' and propose that this concept should be revised in the light of the findings provided by this thesis: the notion of 'context-based rapport management' presented in this thesis should be mentioned in codes of ethics to promote a critical observance of guidelines, tailored to the needs of each consultation. This notion entails the idea that professionals should be mindful of the importance of fulfilling transactional and relational goals inherent to each encounter and adapt their positionings accordingly. In a

sense, this means that discussions on interpreting ethics should be aligned with ethical conceptions rooted in the field of healthcare, and a conciliatory position should be taken in relation to both. Interpreters should be mindful of how their performance fits into the pre-established routines of the institutional setting that they work for, how such setting will define what dynamics (including relational) are admissible, and how their own performance might help in enacting those or not. If interpreting is a technical undertaking applied to a social, interactive context, then codes of ethics should reflect this reality.

8.4.3.2. Promoting interprofessional collaboration

I recommend that the guidelines for interprofessional collaboration outlined in section 8.4.1 are integrated into healthcare interpreters' protocols. MHC staff are busy professionals and they might not prioritise the need to engage in briefings and debriefings with interpreters. The integration of this idea into their protocols should increase their awareness of the fact that engaging in joint working practices with interpreters may ultimately improve their own performance and therapeutic outcomes. This is because both groups of professionals have different fields of expertise, with MCH practitioners being experts in the clinical side of the interaction and interpreters holding the linguistic and potentially cultural expertise. Matters of interest would be how to engage actively with the language difference, maintaining non-coercive control over the session and creating a safe context in which clients might feel at ease with triadic communicative dynamics. Interpreters and MHC practitioners work according to different codes of professional conduct, so actively trying to maximise the value of collaboration might help offset any tensions between both approaches and conciliate their aims.

8.4.3.3. Continuity of interpreting provision

Within the particular setting of the case study presented in this thesis, it becomes clear that continuity of allocation between an interpreter and a patient is crucial, particularly when it comes to mental health patients enduring a chronic illness, as that means that they may need to access a healthcare clinic repeatedly. This should be considered on a case-by-case basis and judged with regards to what is in the best interests of the patient. Ideally, there should be a process for patients to nominate their preferred interpreters.

Among the benefits of continuity in the allocation of an interpreter to a given patient can be found improved lexical retrieval, potentially leading to a better interactional balance due to the decrease in potential for RSSAs; and enhanced trust dynamics. Interpreting agencies should liaise with healthcare venues to, at least, discuss whether continuity might be advantageous for a given clinical case and how to best coordinate actions to enable it.

8.5. Limitations of this study and suggestions for further research

This section offers a reflection on the limitations of this study and proposes recommendations to overcome such shortcomings in future research.

Firstly, I would like to acknowledge the implications of the small scale of the data presented in this thesis; mainly, the lack of potential for generalisability stemming from the findings. In this study, breadth of scope has been relinquished for the sake of depth of findings. The data shown in this thesis concern one single patient, medical practitioner, and a language combination as part of a clinical case bound in time and space. This means that there is a comparable set of data as coherence is ensured, but on the other side the findings are to a certain extent confined to the bounds of this case which makes such findings non-generalisable (Creswell and Creswell, 2017). The logic behind this study was a concern with building analytical discussions as detailed as possible, in an attempt to build explanations that might be helpful to understand phenomena elsewhere through contrast and comparison (Goertz and Mahoney, 2009). This means that the depth of findings produced through this study did not intend to be generalisable but to be potentially 'relatable' to other settings involving different clinical specialties, languages featured, or interpreting settings. Drawing on these ideas, I propose that an avenue for further research could follow a similar approach but consider a larger dataset.

It would also be valuable to follow a similar approach, using RM as a theoretical framework, to analyse how relational practices unfold under different circumstances: featuring different types of patients (acute vs. chronic conditions); different psychopathologies; different levels of competency in the institutional language; different language combinations; different MHC practitioners; different interactional goals for a given session, for example, counselling psychotherapy vs. structured encounters; and different settings, for example outpatient vs. inpatient psychiatry.

Beyond the limiting scope of the research design, it must also be mentioned that the findings of this thesis are mostly based on a set of audio-recorded consultations.

However, the non-verbal domain is one of the five core domains of rapport-management (Spencer-Oatey, 2008). Not having the visual input made it difficult to fully account for this domain of RM as I could only rely on my fieldwork observations, but it was nevertheless necessary to ensure confidentiality and protect the patient's wellbeing as she was in a very delicate state at the time of my fieldwork. It would be interesting for other studies to focus on the interaction between the non-verbal domain and other aspects included in the RM framework. This has research potential because dialogue interpreting studies could certainly benefit from more studies on kinetics and multimodality from a relational perspective, particularly in mental health settings.

Another avenue for further research is to integrate more culture-based components, given that there were not many occurrences of culturally-based incidents in dataset 1. Perhaps analysing encounters that feature a clinician and a patient from very different cultural backgrounds provides more opportunities to explore cross-cultural RM dynamics in interpreted talk, which could be studies from a pragma-linguistic or socio-pragmatics angle. Identifying culture-bound RM practices may have great research potential as each language has its own linguistic inventory to manage rapport.

In conclusion, three main avenues for further research, based on the achievements and limitations of this thesis, would be to feature a larger dataset, to use video-recordings and analyse the non-verbal domain of RM, and to collect data that is more suitable to research RM from a cross-cultural angle.

8.6. Concluding remarks

In chapter 8, I have provided a summary of the findings of this thesis as well as its contribution to the evidence base of interpreting and healthcare communication studies, in terms of methodological and theoretical outputs. Recommendations for enhanced professional practice and ideas to integrate the subject matter of this thesis into education and training are provided, as well as suggestions for further research so that the limitations of this study may be overcome. To conclude chapter 8, this section includes some closing remarks based on the learnings from this research.

The first point worth mentioning concerns the potential of RM theory to conceptualise and systematically analyse interpreter-mediated talk from a social perspective. This thesis has shown how Spencer-Oatey's (2008) framework offers an interesting line of research for the study of dialogue interpreting as its departure point is a higher order, pragmatics-based look into interaction. Nonetheless, this thesis has also shown that, in

order to maximise the value of RM theory for the analysis of interpreted talk, it must be combined with a complementary analytical tool that enables the comparison between source and target utterances, such as Wadensjö's (1998) taxonomy of interpreters' renditions. Combining both is necessary to holistically address the applied linguistics and interpreting studies angles required by a pragmatics-based study of interpreted talk. Following this approach makes it possible to: firstly, figure out what primary speakers are doing with their words and, more particularly, what they are trying to achieve relationally; secondly, recognise whether the interpreter has preserved or altered the nature the original illocutionary (relational) force; thirdly, identify whether interpreters are engaged in direct rapport dynamics with primary participants. This approach has proved useful in identifying the increasingly nuanced ways in which interpreters might be actively involved in the negotiation of interpersonal meanings, thus contributing to the evidence-base of works that deconstruct the myth of interpreters' invisibility.

By its very nature, interpreter-mediated talk features at least two different languages and potentially different cultures. Intercultural communication including interpreted talk has great potential to become a rapport-sensitive type of communicative encounter given that different cultures may have different conventions as to what counts as appropriate behaviour. From this point of view, interpreters become powerful agents in interaction due to their potential to identify what sequences of discourse might be problematic, which places them in a position where they can handle such incidents accordingly by adjusting their positioning.

This thesis has shown examples of how interpreters can reinforce, weaken or preserve the interactional intent of an original utterance depending on what they interpreted the illocutionary force to be. If they accurately interpret such force and identify the communicative means through which that force is intended to be fulfilled, there is 'alignment' between the interpreter and the primary participant. However, if interpreters fail to recognise rapport management-oriented practices in primary speakers' interventions, this increases the risk for 'misalignment' in communicative practices, potentially leading to the disruption of the interactional balance. Increasing mental healthcare practitioners and interpreters' awareness of relational dynamics and the importance of ensuring 'alignment' in their rapport dispositions and practices is key to ensure effective triadic communication.

Drawing on all these ideas, I conclude that quality in the interpreted consultation cannot be judged purely in terms of translation accuracy as that only refers to the transactional dimension of language use. The critical importance of fostering positive relational

dynamics for effective communication should be acknowledged in the conceptualisation of interpreter-mediated events; particularly regarding those encounters featuring vulnerable populations. Ultimately, I propose that the notion of ‘equality of care’ in interpreter-mediated (mental) healthcare encounters should encompass the importance of safeguarding the mechanisms by which patients benefit from positive relational dynamics with healthcare providers, as well as form the ulterior therapeutic alliance that such dynamics might lead to.

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Appendix 1

Transcription conventions

Symbol	Meaning
[ ]	Overlapping talk / interruptions
(.)	Micropause
(2)	Pause of indicate length (in seconds)
< >	Words spoken loudly
:	Lengthened sound
::	Very lengthened segment
CAPITALS	Capital letters indicate emphasised syllable/word
↑	Rising tone
↓	Falling tone
{ italics }	Relevant additional information including non-verbal features
Bold	Feature of interest for analysis
Grey italics	Back translation
Bold grey italics	Feature of interest in back translation
[…]	Omitted text (irrelevant to discussion)

Appendix 2

Interpreters' original quotes

Thia appendix includes the original version of the interviewed interpreters' quotes, provided in Spanish and presented as an English translation in the main text of the thesis for readibility purposes.

[1] Muchas veces habré podido ir a una cita y algún pariente me ha dicho tienes que irte a casa que ya interpreto yo, así no se empieza bien, ¿a que no? Esas actitudes merman mi trabajo. Pero sé que no es personal, es que ellos no quieren que un intérprete interfiera en sus asuntos tan íntimos familiares y así pues se podrán sentir incómodos por una presencia externa. Pero yo siento siempre que al interpretar ellos pues ponen al paciente en un riesgo porque traen su propia mochila y pueden no interpretar bien

[2] Yo estaba plenamente consciente de que la hija sabía inglés y castellano y sentía que la hija estaba escudriñando mi trabajo a ver si me faltaba información. Y estaba ahí como juzgando mi trabajo.

[3] Pienso que si uso tú o usted tanto da, solo va a suponer algo diferente en los ojos del paciente ya que de igual forma el médico no se va a enterar de ese cambio. Así que yo decido en base a lo que necesite el paciente o cómo esté yendo la consulta. Sí que admito que prefiero usar tú en general. Para mí lo hace todo más fácil y, quién sabe, quizá hasta consigas que el paciente vea al médico como una figura menos distante.

[4] El entorno de salud es un contexto formal así que uso usted, punto. Pero eso es un valor personal mío. Yo no iría a dirigirme a un médico usando el tú de la misma forma en la que no lo haría para hablar con el director del colegio de mis hijos.

[5] Digamos que no buscaba hacerme amiga de Irene con ese comentario. Tenía más bien que ver con lidiar con una situación tensa de tal manera que se vuelva un poco menos incómoda para todo el mundo, cortar el hielo […]. Me sentía moralmente obligada a hacer que la situación fuese tan llevadera para ella como pudiese. Tú no vas a cambiar la vida de nadie con comentarios tontos así pero quizás se la pongas más fácil a una persona que pase por un momento difícil. Esa es la cosa, ella no es solo una paciente, es una persona, de la misma manera en que yo no soy solo una intérprete, soy una persona. Vamos, que quieras o no, te involucras.

[6] Puedes notar lo que significa para algunas personas que tienen problemas de salud físicos o mentales el hecho de verte en varias sesiones. Gran parte del contenido que se trata en estas sesiones es muy privado y puede entrarles vergüenza, así que puedo ver por qué algunos no se sientan del todo cómodos hablando de algunos de estos asuntos frente a un intérprete diferente de por vez. Claro que importa quién sea el intérprete.

[7] Si la jefa del servicio de interpretación me ofreciera un encargo de interpretación al lado de mi casa y otro a dos horas pero que fuera para Irene, hubiera puesto como prioridad coger la sesión de Irene porque entiendo lo que significa mi presencia para ella. Nos llevamos conociendo varios años ya. La interpretación no cambiará pero yo creo que la experiencia en general sí que cambia para el paciente.

[8] Si me hubiesen ofrecido un encargo al ladito de mi casa y otro encargo a dos horas pero sabiendo que la paciente sería Irene, mi prioridad hubiera sido ir a por la sesión de Irene porque sé lo que mi presencia significa para ella. Nos llevamos conociendo años ya. Entonces la interpretación no cambiará, pero sí que creo que la experiencia así en general sí que cambia.

[9] Ellos es como que se aferran a ti porque al fin y al cabo un idioma es parte de tu subjetividad, de tu psicología, tu ser más íntimo […] especialmente en un país extranjero si se han podido sentir aislados o desprotegidos. Así que te hablan, ven que escuchas y parece que simplemente entablar una conversación sencilla con ellos les es un alivio.

[10] Como intérprete a veces tienes que llevar la respuesta del paciente hacia lo que el médico necesita oír porque igual responden de una forma que no tiene que ver con lo que el doctor preguntó así que eso hace que se pierda tiempo para todo el mundo. Los pacientes a veces responden solo a sus ansiedades a sus preocupaciones no a las preguntas que realmente preguntó el doctor

Appendix 3

Form 1 – Favourable letter by REC following IRAS application

NHS
Health Research Authority

East Midlands - Leicester Central Research Ethics Committee
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

16 July 2018

Ms Natalia Rodriguez-Vicente
PhD student
Heriot-Watt University
Henry Prais Building
Room 1.09
Heriot-Watt University Edinburgh Campus
EH14 4AS

Dear Ms Rodriguez-Vicente

Study title:	**An exploration into how interpreters influence doctor-patient communication and interpersonal interaction in mental healthcare settings with particular emphasis on rapport management**
REC reference:	**18/EM/0214**
Protocol number:	**N/A**
IRAS project ID:	**240309**

Thank you for your letter of 12/07/2018, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Form 2 – Letter of approval from Caldicott Guardian

University Hospitals Division

NHS Lothian

Queen's Medical Research Institute
47 Little France Crescent, Edinburgh, EH16 4TJ

3rd August 2018

Research & Development
Room E1.10
Tel: 0131 242 3330
Email: accord@nhslothian.scot.nhs.uk

Director: Professor Tim Walsh

Natalia Rodríguez-Vicente
Office 1.09
Henry Prais Building
Heriot-Watt University
Edinburgh Campus,
EH14 4AS

Dear Natalia

CALDICOTT APPLICATION CRD18080

Thank you for submitting your application for Caldicott review. This has been reviewed and approved under delegated authority granted to R&D by the NHS Lothian Caldicott Guardian.

Request received from:	Natalia Rodríguez-Vicente Caldicott Application signed: 26th July 2018 Countersigned by Prof. Jemina Napier 1st August 2018
Title of project/proposal: References	An exploration into how interpreters influence doctor-patient communication and interpersonal interaction in mental healthcare settings with particular emphasis on rapport management R&D No: 2018/0186 IRAS No: 240309
Identifiable information requested:	As specified in the application plus audio recordings
Application Approved:	3rd August 2018
Conditions of Approval:	Audio to be recorded using an encrypted audio recording device meeting the minimum recommended standards of 256-bit AES encryption Audio files to be removed from the portable device at the earliest opportunity
Recommendations:	

Yours sincerely

Pamela Linksted
eResearch Lead
Research and Development
NHS Lothian

On behalf of:
Professor Alison McCallum
Director of Public Health & Health Policy
NHS Lothian

Form 3 – Honorary research contract

Recruitment & Personnel Services

Research & Development
Queen's Medical Research Institute
47 Little France Crescent
EDINBURGH
EH16 4TJ

NHS Lothian

Private and Confidential

Miss Natalia Rodriquez Vicente
[redacted]

Date: 05 September 2018

Enquiries to: Accord@nhslothian.scot.nhs.uk
Telephone: 0131 242 6576

Dear Miss Rodriquez Vicente

HONORARY RESEARCH CONTRACT

1. I am pleased to offer you an appointment working on the following study within NHS Lothian from 5 September 2018 to 8 January 2021:

   'R&D number 2018/0186 entitled 'Rapport Management in interpreter mediated mental health encounters'

2. **Personal Property**

   The Division accepts no responsibility for damage to, or loss of personal property. You are, therefore, advised to take out an insurance policy to cover your personal property.

3. **Confidentiality and Disclosure of Information**

   3.1. You may have access to material of a confidential or sensitive nature relating to Division business which should not be divulged to any third party during the period of your honorary contract or any time thereafter without the proper authority having first been given.

   3.2. 'Confidential Information' shall include all information that has been specifically designated as confidential by the Division and any information that relates to the commercial and financial activities of the Division, the unauthorised disclosure of which would embarrass, harm or prejudice the Division.

   3.3. All confidential records, documents and other papers, together with any copies or extracts thereof, made or acquired by you in the course of your honorary appointment shall be the property of the Division and must be returned to the Division on the termination of your employment.

   3.4. (i) Obligations Arising from Data Protection Act 2018 /IT Security

   Particular regard should be given to your responsibility to abide by the principles of the Data Protection Act 2018, a copy of which is available for reference in the HR Department.

Form 4 – Letter of approval from NHS Lothian R&D department

University Hospitals Division

NHS Lothian

Queen's Medical Research Institute
47 Little France Crescent, Edinburgh, EH16 4TJ

HC/FM/approval

04 September 2018

Ms Natalia Rodriguez - Vicente
Heriott Watt University
Heriott Watt Campus
EH14- 4AS

Research & Development
Room E1.16
Tel: 0131 242 3330

Email:
accord@nhslothian.scot.nhs.uk

Director: Professor Tim Walsh

Dear Ms Rodriguez - Vicente

Lothian R&D Project No: 2018/0186 **REC No:** 18/EM/0214

Title of Research: Rapport Management in interpreter mediated mental health encounters

Participant Information Sheet:
(Practitioners) Version 2, dated 9 July 2018
(Interpreters) Version 2, dated 9 July 2018
(Patients) Version 2, dated 9 July 2018

Consent Form:
(Practitioners) Version 2, dated 9 July 2018
(Interpreters) Version 2, dated 9 July 2018
(Patients) Version 2, dated 9 July 2018

Protocol:
Version 2, dated 10 July 2018

I am pleased to inform you this letter provides Site Specific approval for NHS Lothian for the above study and you may proceed with your research, subject to the conditions below.

Please note that the NHS Lothian R&D Office must be informed of any changes to the study such as amendments to the protocol, funding, recruitment, personnel or resource input required of NHS Lothian.

Substantial amendments to the protocol will require approval from the ethics committee which approved your study and the MHRA where applicable.

Please keep this office informed of the following study information, **which is a condition of NHS Lothian R&D Management Approval**:

1. Date you are ready to begin recruitment, date of the recruitment of the first participant and the monthly recruitment figures thereafter.
2. Date the final participant is recruited and the final recruitment figures.
3. Date your study / trial is completed within NHS Lothian.

Appendix 4

Form 1 – Participant information sheet for patients

HERIOT WATT UNIVERSITY

Centre number: _____
Version: 2 Date: 9/07/2018
Pat-Participant ID: _____

Languages and Intercultural Studies (LINCS) Department
Centre for Translation and Interpreting Studies in Scotland (CTISS)

PARTICIPANT INFORMATION SHEET FOR PATIENTS

You are being invited to consider taking part in a research study entitled *"An exploration into the interpreter's role in practitioner-patient communication in mental healthcare settings"*. Please take time to read the following information carefully. Please ask me if there is anything that is not clear or if you would like more information. Thank you for reading this.

What is the purpose of the study?

This study is part of a fully-funded 3-year PhD project about interpreting in mental healthcare settings. The purpose of this study is to find out more about the strategies that interpreters adopt to face the communication challenges that may arise when assisting communication in mental healthcare assignments. Therefore, it would be extremely useful to observe one of your sessions to see how this type of interpreting happens in real life.

Why were you chosen?

You were chosen because you need language support (interpreting service) to help you communicate during a session related to a mental healthcare service.

What will you be asked to do?

The researcher will ask for your permission to:

1. Observe your session if it is mediated through an interpreter
2. Take field notes of what happens during the session
3. Record the session for her to transcribe it and analyse it.

You are free to refuse to all or to some of the three options above. E.g. you can let the researcher observe your session and take notes about it but not to record it. If you agree to any of the options above, you will be asked to behave as you would normally do, as if the research were not taking place. If consent is granted, the researcher will sit behind the speakers and will not interact with any participant during the session.

Confidentiality

There is a possibility that some patient-identifiable data is mentioned during the session (names, conditions, addresses, occupation, date of birth, treatment, etc.). There are strict laws which safeguard participants' privacy at every stage. As a result, the information gathered will be anonymised in order to comply with the Data Protection Act and NHS Scotland Information Security Policy. Data will be stored in a high-security data storage available to researchers handling highly confidential data located at Heriot-Watt University. The files that include the data will be encrypted and password protected in a way that they will only accessible by the researcher. Remember that the focus of this research is on the interpreter's performance, not on your personal information or the content discussed during the session.

Page 1 of 3

Languages and Intercultural Studies (LINCS) Department
Centre for Translation and Interpreting Studies in Scotland (CTISS)

What will happen to the results of the study?

The results of the study will be part of a doctoral thesis that will not be publicly available. The results might be published in a conference presentation or in an article. None of the participants will be identifiable in any published results. The results can be made available to you if you request them. In order to access the results, you can write directly to the researcher (Natalia) whose contact details are provided below.

What will happen to the data after the analysis?

For the cases where consent has been granted to record the session, the recording will be destroyed immediately after being transcribed and anonymised. The transcriptions will be destroyed within 3 months after data collection. The only way in which data will be kept after those 3 months will be in the form of non-identifiable participants' quotes.

Who is organising the research and why?

This study has been organised, sponsored and funded by Heriot-Watt University, a higher education centre that provides evidence-based and high quality training for Public Service Interpreters including healthcare interpreters working for the NHS.

Has any Ethical Committee reviewed this study?

Yes, this study has obtained a favourable opinion by an independent Research Ethics Committee as well as Ethical Approval by the NHS Lothian Research Governance & Management Approval office.

Benefits and risks

Helping patients to access high quality and equitable healthcare services is the main mission of healthcare interpreters. Research could help interpreters be more aware of the steps to be taken in order to respond not only to the patient's linguistic and cultural identity but also to their healthcare needs. Because research could help future interpreters become more aware of such needs, future patients would benefit from this project in the medium term. The only foreseeable risk to you in participating in this study is that sensitive information may be disclosed during the session. Please be assured that every effort will be made to safeguard the confidentiality of this information. Additionally, the researcher will be focused on the interpreter and will not make any judgments about your condition and/or personal circumstances.

Researcher's contact details

If you have any concerns or comments about this project and/or would like to access the results in the future, you are more than welcome to contact the researcher via e-mail: nr17@hw.ac.uk

Independent advice and complaints service

You may choose to ask for independent information or advice about your rights as a research participant or about being involved in this particular research study by contacting the PASS service. You can phone them on 0800 917 2127 or e-mail them at pass@cas.org.uk.

Form 2 – Consent form for patients

HERIOT WATT UNIVERSITY

Centre number: _____
Version: 2 Date: 9/07/2018
Pat-Participant ID: _____

Languages and Intercultural Studies (LINCS) Department
Centre for Translation and Interpreting Studies in Scotland (CTISS)

CONSENT FORM

Please initial the appropriate boxes

1. I confirm that I have read the information sheet dated 9/07/2018 (Version 2) for the above study. I confirm that I understand the information and that I have had the opportunity to consider it and ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that the participant-identifiable data collected during this session will be anonymised and therefore, it will be kept confidential at all times. ☐

4. I agree to the researcher observing this interpreter-mediated session. ☐

5. I agree to the researcher taking anonymised field notes during the session. ☐

6. I agree to the researcher audio-recording and transcribing this session. I understand that the researcher will be the only person who will listen to the recording and will have access to the transcription. ☐
(remember that you can agree to the observation and refuse to the recording)

7. I agree to take part in the above study ☐

_____ _____
Date Signature

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Appendix 5

Interview invitation for interpreters

Interview invitation

Dear interpreter,

I hope that you do not mind me contacting you. My name is Natalia and I am contacting you because I had the privilege to observe one of the sessions that you interpreted in [redacted] on one of the following dates:

- [redacted].
- [redacted].
- [redacted].

During that session, I was able to observe how communication was achieved between all the participants and the challenges that you had to face. Taking these data as a starting point, it would be extremely useful for the project if I could conduct a semi-structured interview with you. Here is some further information:

- The interview would last between 30 minutes and 1 hour.
- If you agree to be interviewed and provide an e-mail address that I could use to contact you, I can send you the participant information sheet and consent form beforehand.
- This interview can be conducted face-to-face, over-the-phone. Whatever is easier and most comfortable for you. If you are happy with the interview taking place face-to-face, I am happy to travel anywhere/meet anytime that you suggest to conduct this interview.
- This is a semi-structured interview so, even though I will be asking a number of set questions, you can talk to me about anything that you may consider relevant to better understand the difficulties of interpreting in a mental healthcare setting.
- If you agree to be interviewed, **you do not have to answer all of the questions that you are asked.**
- You can decide whether you want the interview to be conducted in English or Spanish.
- If you agree to be interviewed, your identity and answers will be anonymised. Procedures for anonymisation are further explained in the Participant Information Sheet.

Your input is vital for the project at this stage and it could potentially make a difference on healthcare professionals' and other interpreters' understanding of the challenges that interpreting in a mental healthcare setting entails.

If you would like to contact me, here is my e-mail address: nr17@hw.ac.uk and phone number (+[redacted]).

I look forward to hearing from you soon,

Natalia.