John Benjamins Publishing Company

Examining the "voice of interpreting" in speech pathology

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This paper investigates professional interpreting practice in the setting of speech pathology through a multifaceted analysis of the transcripts of three recorded sessions involving first-generation Italian-speaking immigrants to Australia and English-speaking healthcare professionals working in Melbourne. Applying Mishler's notion of "voice" to the context of interpreter-mediated communication and focusing on a selection of linguistic features — ranging from turn-taking and topic development to the interpreter's choice of footing, departures from the primary speakers' utterances, and use of prosodic resources — the discussion identifies the voice that interpreters, as third participants in the interaction, choose to adopt between the "voice of medicine" and the "voice of the lifeworld". The study is of a qualitative nature, although a general indication of the frequency of certain features is supplied, and interpreting conduct is described rather than prescribed. The reporting and interpretation of findings are, however, informed by and reflect issues of value revolving around the concept of "humane medical care".

Keywords: healthcare interpreting, speech pathology, voice, transcript analysis

1. The study

This study is an attempt to gain insight into how professional interpreters perform their task in a well-defined medical setting. When compared to other institutional contexts, doctor-patient encounters are found to offer a more heterogeneous scenario, in that their "shape, form, trajectory, content or character", in the words of Schegloff (1992: 111), are more open to "local" negotiation between the participants. As will be discussed below, this process may result in alternative discourse models, depending on each participant's choice of his/her

own "voice", which in the case of the healthcare professional may be more or less dominant, and more or less detached or "disaffiliative" (Drew & Heritage 1992: 24). The interesting question, from our perspective, is what voice the interpreter will choose to adopt in the ongoing interaction. Before answering this question, however, a brief outline will be drawn of the relevant healthcare setting, namely speech pathology, and of the data used for the analysis.

1.1   The setting

The branch of medical science which falls under the heading of "speech therapy" or "speech pathology" is concerned both with the general physiological and pathological aspects of the speech organs, and with the study and correction of speech defects (Critchley 1978: 1008), which may affect children or may occur at a later stage in life — e.g. following apoplexy and similar traumas. Speech defects are defined as impairments in the ability to (1) receive and/or process, (2) represent, and/or (3) transmit and use symbol systems (Jackson 1988: 257). The job responsibilities of speech pathologists thus range from the identification and assessment of a medical condition to the implementation of appropriate intervention programs, including the organisation of encounters with patients and their relatives.

When speech pathology sessions involve people speaking mutually incomprehensible languages, and an interpreter is called upon to facilitate their interaction, the picture becomes a complex one, for the very reason that language is not only the means, but also the object of communication. When no standard tests are available in the patient's primary language, the speech assessment is traditionally performed through "interest finders", which, depending on the client's age, might range from informal conversation to descriptions of personal experiences. Whilst topics are as close as possible to the patient's everyday life, the linguistic features of the questioning strategy are non-casual, as the aim is to elicit specific language samples, which may be words, phrases or longer sentences (Langdon 2002: 63). To this end, speech pathologists may decide to use either simple yes-or-no questions or open-ended questions, such as "tell me about…" or "how do you…?", which require full sentences to provide a complete answer. Alternatively, patients may be asked to produce narrative samples by retelling stories and movies, or by formulating tales from comic strips and wordless books (Langdon & Cheng 2002: 86–87).

Given the nature of the assessment process, the linguistic skills needed to interpret in this field include not only general requirements such as familiarity

with both cultures and with nonverbal communication, and knowledge of professional terminology, but also the ability to reproduce the language of people with speech disorders (see Langdon 2002; Langdon & Cheng 2002). Significantly, while stressing the importance of verbatim translation of the patients' utterances during assessment sessions ("do not edit what is said, and do not change sounds"), Langdon (2002: 7) also urges interpreters to explain to speech pathologists what is said versus what should have been said, thereby helping them recognise the extent and causes of the language impairment and provide appropriate feedback. Gentile et al. (1996: 125–135) further clarify that the interpreter's metalinguistic descriptions may refer to syntax, phonology and semantics.

1.2 The data

The data for this article come from three speech pathology sessions recorded at two healthcare facilities in Melbourne, Australia in 2001, and involve Italian-speaking first-generation immigrants, English-speaking healthcare professionals and in-house NAATI-accredited[2] interpreters. The three sessions, which are part of a wider corpus of 32 interpreted encounters presented elsewhere,[3] are schematically described in Table 1.[4]

Table 1. Summary information about the transcripts

	Transcript 1 (T. 1)	Transcript 2 (T. 2)	Transcript 3 (T. 3)
Place	Extended Care Centre, Melbourne	Extended Care Centre, Melbourne	General Hospital, Melbourne
Date	21 March 2001	12 July 2001	13 July 2001
Duration	10' 30"	25' 25"	18' 05"
Participants	– female speech pathologist, aged 25 (*Sheila*); – male in-patient, aged 80–90, affected by speech disorder, caused by apoplexy (*Patrizio*); – female in-house interpreter, aged 43 (*Ines*).	– female speech pathologist, aged 25 (*Sheila*); – male in-patient, aged 80, affected by speech disorder, caused by apoplexy (*Pino*); – female in-house interpreter, aged 43 (*Ines*).	– female speech pathologist, aged 30 (*Sara*); – male in-patient, aged 80, affected by speech disorder, caused by apoplexy (*Pietro*); – female in-house interpreter, aged 50 (*Ippolita*); – patient's wife.
Purpose	assessment of swallowing difficulties and explanation of future medical checks	therapy session	therapy session

Some observations must be made concerning the nature of the encounters. Since their purpose is either a routine check on an in-patient's condition, followed by an explanation of future diagnostic tests, as in T.1, or therapy with long-term patients, as in T.2 and T.3, all three sessions deviate substantially from the samples used in most studies of monolingual doctor-patient interaction, which focus almost exclusively on first meetings where the aim is history-taking and diagnosis of a current complaint. The specificity of the interactional contexts, where the medical practitioners are relating to patients they know, will have to be taken into account in the following analysis. Secondly, as we move from T.1 to T.3, the conditions affecting the three patients become progressively more severe, to the extent that, if Patrizio is fully able to converse, Pino utters simple sentences in response to the speech pathologist's questions, whereas Pietro only whispers single words, which are at times almost inaudible.

The transcription conventions applied in this paper are largely based upon the model first developed by Gail Jefferson (see Atkinson & Heritage 1984: ix–xvi). However, as each notation system is the reflection of specific research goals, some symbols have been left out as irrelevant (e.g. those indicating aspirations, inhalations and gutturalness), others have been modified (e.g. signs representing pauses) and a few added (e.g. fillers, which have also been assigned fixed meanings following Eggins & Slade 1997: 3). (For the full transcription key, see the Appendix). Recordings were transcribed jointly by the present authors, who returned regularly to the audiotapes to test and evaluate their analyses and interpretations.

2.   The theoretical framework

The availability of recorded sessions spawned the idea of a qualitative study[5] based mainly, though not entirely, on the investigation concerns of conversation analysis (hereafter CA). As a prelude to using some of the conceptual tools of this well-established research tradition, we will recall here the emphasis it places on the sequential nature of talk — on its being made up of "sequences" of activity emerging dynamically from the interplay between smaller units ("turns-within-sequences"; Drew & Heritage 1992: 18), also referred to as the "contiguity principle" (Fele 1999: 38–39). Through detailed and intensive analysis of naturally occurring conversation — an empirical perspective which has been the hallmark of CA since its appearance in the 1970s — researchers have come to the conclusion that the interpretation of an utterance as an *action*

does not depend on some elusive, intrinsic quality, but on preceding and successive turns in the conversation. In other words, each turn has a retrospective effect, in that it sheds light on what was previously said, as well as a prospective function, in that it projects the expectation that an appropriate response will be provided so that a given sequence may be continued or completed.

With reference to institutional talk, more specifically to medical encounters, the interest in how turns are taken and topics shifted by physicians and patients directed us to two seminal studies: Mishler (1984) and Fairclough (1992). Whilst the contribution of the latter to the present paper will become evident in the next section, Mishler's approach was also a source of inspiration at a more general level. The author presented us with the theoretical notion of "voice", which was found to offer a flexible interpretative framework as well as a ready-made metaphorical association to our field of study, speech pathology.

Without following Mishler's line of theorising through to his adoption of Habermas' (1970)[6] socio-political perspective, we have borrowed his basic distinction between two analytic categories, the "voice of the lifeworld" and the "voice of medicine" (henceforth VoL and VoM). Starting from an initial definition of "voice" as an ensemble of "relationships between talk and speakers' underlying frameworks of meaning" (1984: 14), Mishler uses the former label to refer to the expression of and attention to concerns stemming from events and problems of everyday life. In contrast, VoM designates an abstract, affectively neutral and functionally specific[7] interpretation of facts, as well as compliance with a "normative order", whereby the professional controls both content and organization of the interaction.[8] It should be noted that the two voices do not necessarily coincide with that of the patient and of the healthcare practitioner, respectively. Often it will be the physician who, being equally competent in both codes, decides to speak in either the VoM or the VoL, displaying a lower vs. higher degree of attentiveness to the patient's understanding of reality and communicative needs.

Whereas in a monolingual encounter, the "burden" of translating between the two voices generally falls on the physician, in cross-lingual and intercultural communication, dynamics become more complex with the appearance of a third voice, which will be referred to here as the "voice of interpreting" (VoI). The picture would be relatively unproblematic if the VoI were seen to confine itself to echoing the other two through a mechanical translation pattern, whereby each utterance in the source language is transformed into an equivalent utterance in the target language. But what if this were not the case and the VoI were found to express a separate identity, not only by conveying the needs

of its own operational mode, but by altering a primary speaker's selection of either the VoL or the VoM? In the first instance, we could even contemplate the case of the interpreter's clients using the VoI to express their acknowledgment of the difficulties, limitations and requirements of the interpreting process; in the second instance, the reinforcement, at the interpreting stage, of either the VoM or the VoL and, more radically, the conversion of one voice into another would signify an expansion of the VoI's scope. This would come to coincide with the voice of a third participant making independent choices between the alternatives available at any one point in the interaction, on the basis of his/her own analysis of the participants' communicative goals and needs.

In order to investigate the ways in which the three voices interact with one another, our analysis of the recorded sessions will include some linguistic features which are absent in Mishler's study, and exclude others to which he resorts. Hence, although the same attention will be paid to participants' behaviours in interactional management, the interpreter's conversational stances in terms of footing, her[9] additions to the original speakers' utterances and use of prosodic resources will equally be examined.

3.   The voice of interpreting: Analysis and exemplification

For the sake of a clearer exposition, the analysis will proceed through progressive steps along a pathway leading from sequences to single utterances and parts of them, to words and, finally, to prosodic features. It should, however, be pointed out that the levels of enquiry are not impermeable categories and will often show ample areas of overlap — a prime example of this is the case of autonomous interventions by the interpreter, which can be described from three different perspectives, turn-taking, footing and additions. Although these aspects will first be treated separately, in the conclusions an attempt will be made to present some of their combined effects. Owing to constraints of length, only one example will be offered for most of the points raised in the following paragraphs.

3.1 Turn-taking and topic control

Though opting for an alternative interpretative framework, in his discussion of "standard"[10] vs. "alternative" medical interviews, Fairclough (1992) makes use of CA tools to construct his argumentation — i.e. that the ongoing shift

in medical practice seems to be away from a model of interaction where the professionals overtly exercise their authority, towards a non-directive, informal approach, which underlines treating the patient as a person and not as a case, giving him or her space to talk and empathising with his or her account; in other words, a shift from the dominance of the VoM towards the VoL.

First among CA concepts is that of *adjacency pair* — a more general structural type than Sinclair and Coulthard's (1975) "exchanges" — which was first developed by Schegloff and Sacks (1973). Of all the adjacency pairs which have been studied in subsequent CA literature, the question-answer pattern has been recurrently identified as the predominant discursive format in many institutional settings. Doctor-patient interviews, in particular, have been shown to proceed through a recursive chain of interlinked pairings, giving rise to characteristic three-part sequences of question-response-acknowledgment (Mishler 1984; Silverman 1987; Frankel 1990). Moving from diagnostic interviews to the context of speech therapy, this basic sequence takes the slightly modified form of speech pathologist's question — patient's response — speech pathologist's assessment.

The obvious effect of a framework of this kind is that the doctor controls the **turn-taking** system, i.e. the way talking turns are distributed between participants. In their seminal study on turn-taking, Sacks, Schegloff and Jefferson (1974) propose a simple but powerful system consisting of two components: turn-constructional units and an ordered set of turn-allocation rules. The current speaker in an interaction constructs his/her turn with grammatical units, such as sentences, clauses, phrases or even single words, and other participants are able to determine the type of unit and predict its point of completion, i.e. the point — called "transition-relevance place" or TRP — where the floor is again potentially available.[11] At these points, the following rules apply: (1) the current speaker may select the next speaker, for instance by addressing him/her; (2) if this does not happen, the next speaker may self-select by taking the floor; (3) if this does not happen, the current speaker may continue. Whilst in ordinary conversation these options are equally available to all participants, institutional interaction often exhibits an asymmetrical distribution of talking rights and obligations between "powerful" (P) and "non-powerful" (N-P) participants, whereby, as Fairclough observes (1992: 153):

> (i)   P may select N-P, but not vice-versa; (ii) P may self-select, but N-P may not; […] (iii) P's turn may be extended across any number of points of possible completion.

With reference to medical encounters, what this means in practice is that the patient usually takes the floor when the doctor offers it by asking him a question. The doctor, in contrast, is not given the floor, but takes it when the patient has finished answering the question, or when she decides that the patient's response has become "irrelevant" to a strictly medical assessment of his problem. In the latter case, *overlaps* may be used by the doctor as a device to cut short the patient's turn. If, on the other hand, no response is given by the patient and the question is followed by a *pause*, the doctor may take the floor again to urge the patient to supply an answer. A corollary of this organisation relates to **topic control**. It is the doctor who introduces new topics through her questions, "polices the agenda" (Fairclough 1992: 155) by assessing, either explicitly or implicitly, the patient's answer, changes topic by interrupting the patient, or stays on topic by repeating the same question to counter the patient's silence.

In a less asymmetrical interactional format, as is displayed in the "alternative" medical interview studied by Fairclough (1992: 144–149), turn-taking is shown to be more collaboratively managed and topic development more extensively negotiated by the two participants. However, this is made possible only by the doctor's willingness to make the floor available to the patient. This sensitivity does not mean that she is surrendering interactional control, as the author acutely observes (1992:146):

> Notice that the initiative for yielding a measure of control to the patient in medical interviews of this sort invariably comes from the doctor, which suggests that doctors do still exercise control at some level, even if in the paradoxical form of ceding control.

If in a monolingual context "yielding a measure of control" to the patient can be a matter of personal choice between a more or less empathic, more or less formal, more or less directive interactional model, in linguistically mediated encounters professionals may have little or no alternative to ceding some of their control tools to the interpreter. The following paragraphs will illustrate the ways in which the interpreters, in particular in sessions 2 and 3, are actively involved in managing the exchange of turns as well as information between the primary interlocutors. The idea of organising examples into three sections — smooth transitions, pauses, and overlaps — is taken from Roy's (1996) inspiring article on turn-taking at an interpreted event involving American Sign Language.

Smooth transitions

The fact that interpreter-mediated encounters entail a specific turn-taking order to account for the interpreter's translation[12] may seem an obvious enough statement. What is not so obvious, however, is that the absence or delay of the interpreter's turn would be a noticeable occurrence or, as the case may be, a noticeable non-occurrence. This suggests that in an interpreted interaction, the above-mentioned concept of adjacency pair needs revisiting to account for a doubling up of actions which are expected to occur as a logical continuation of the first part of the pair. In other words, the utterance of a primary speaker "sequentially implicates" not only the utterance of the other primary speaker, but, prior to this, the translating act of the interpreter. We would therefore submit that a more appropriate way to designate this double implicature might be *adjacency trio*.[13]

In our field of study, one would expect the *unmarked* forms of this pattern to be:

1. SP's question — I's translation — P's answer
2. P's answer — I's translation — SP's assessment / SP's next question
(3. SP's assessment — I's translation — SP's next question)

where SP stands for speech pathologist, I for interpreter and P for patient. The variant in point 2 refers to the case in which the patient's response is implicitly acknowledged as correct by the therapist's simply proceeding to a new question. Sequence 3 is therefore marked as optional. The following excerpt illustrates a standard sequence of turns smoothly following upon one another, with no disruptions, such as pauses or overlaps:

> [1] **T. 2 (189–195)**[14]
> 189 SP: what would you need if you wanted to build some shelves
> 190 I: ecco che cosa occo:rre (.) se lei vole:sse (.) fare (.) una:: una libreria (.)
>   *now what would you need if you wanted to make a bookcase*
> 191   °che cosa le occorre (.) per farla°
>   *what would you need to make it*
> 192 P: umm (del) legno
>   *some wood*
> 193 I: wood
> 194 SP: mhm that's right
> 195 I: sì °giusto°
>   *yes right*

From the point of view of the present study, however, a more interesting feature is the presence of *marked* patterns, where the progression of actions described above is in some way altered. In the following excerpt, for instance, the

interpreter does not translate the patient's first answer. Instead, she asks him whether he really has no trees in his garden. The resulting pattern is thus: P's answer — I's question.[15]

[2]   **T. 2 (92–96)**
92   SP: °mhm° (.) what type of trees and flowers do you have in the garden
93   I: che:: quali alberi che tipo di a::lberi quali fio::ri↑ ha ┌ in giardino ┐
     which trees what kinds of trees which flowers do you have │ *in your garden* │
94   P: └ alberi no ┘ alberi no
                                                                       no trees   *no trees*

95   I: **non ce l'ha alberi**↑
     don't you have any trees
96   P: yeah

Soon after, she explicitly acknowledges Pino's answer as correct through the agreement token "mhm", translates for the SP, and then asks Pino what kind of trees they are. The sequence can be represented as: P's answer — I's assessment — I's translation — I's next question.

[3]   **T. 2 (95–98)**
95   I: non ce l'ha alberi↑
     don't you have any trees
96   P: yeah
97   I: **mhm uh I have trees mhm che tipo (.) sono (.) li conosce**↑
                                   what type are they do you know them
98   P: come i fichi↑
     such as figs

Again a few lines later, Ines, after translating for Sheila, gives an implicit assessment of Pino's answer by asking him to provide further examples of the trees which grow in his garden. The pattern is slightly modified into: P's answer — I's translation — I's next question.

[4]   **T. 2 (98–101)**
98   P: come i fichi↑
     such as figs
99   I: fi – fichi↑
     figs
100 P: yeah=
101 I: **=uh fig fig tree ((addressing the patient)) poi**↑ **altri**↑
                                                    then others

Through her interactional conduct, Ines thus exhibits the characteristic behaviour of a powerful participant, according to Fairclough's rules, in that she self-selects as next speaker, extends her turns across points of completion and re-allocates the floor to the patient. Her bypassing the SP's assessment and controlling of topic development could also be viewed as the adoption by the VoI of the typical contours of the VoM.

Also worthy of note are sequences containing the SP's assessment. Contrary to the findings of several studies on dialogue interpreting, which identify the extensive omission of feedback parts of utterances by interpreters as one of the trouble sources of this kind of interaction (see for instance Englund Dimitrova 1997: 160, and Wadensjö 1998: 236), the analysis of our transcripts has revealed a general tendency towards conveying them. Ines, for instance, is frequently seen to either translate Sheila's favourable assessment of the patient's response, as in [1] line 195, or in the case of non-lexical discourse markers, such as "mhm", repeat it, as shown in the following example:

[5]   **T. 2 (303–309)**
303 SP: tell me (.) two things you could buy at a liquor shop
304 I: ecco un negozio da una enoteca dove si vendono °insomma° dei liquori (.) che
           now in a shop in a wine shop where they sell liquors what
305   cosa potrebbe (.) comprare
           could you buy
306 P: (oh il) vino
           wine
307 I: the wine
308 SP: **mhm=**
309 I: **=mhm**

Whilst it is true that in therapy sessions feedback does not have a mere phatic function,[16] but generally carries semantic content, the systematic and often exuberant acknowledgment of the patients' correct answers by both speech pathologists speaks of an empathic communication model, in which the emotional distancing of the VoM is supplanted by the affective involvement of the VoL. In this light, the interpreter's decision to reiterate the therapists' positive feedback, although the English expressions are perfectly comprehensible to the patients, is, in our view, more than just a professional reflex towards scrupulous word-for-word translation. This reading is supported by the observation of Ippolita's behaviour in T.3. As illustrated in the following excerpt, she starts off by translating only questions and answers and leaving out Sara's feedback expressions:

[6]   **T. 3 (34–44)**
34   SP: is your name Pietro
35   I: si chiama Pietro
           is your name Pietro
36   ((the patient nods))
37   SP: **very good** (.) is your name umm D'Aquino
38   I: si ch — il nome è D'Aquino↑
           is your name D'Aquino
39   ((the patient nods))
40   SP: okay is your name Marcuccio

41   I: il suo nome è Marcuccio↑
            is your name Marcuccio
42   ((the patient shakes his head))
43   SP: °okay° ((soft chuckle)) **very good** Pi:::etro are you a man
44   I: lei è un uomo Pietro↑
            are you a man Pietro

Then, as the session unfolds, she shifts to a more involved model, in the wake of Sara's example:

[7]   **T. 3 (288–299)**
288 SP: show me the keys
289 I: e le chia:vi↑
            and the keys
290   ((the patient points to the keys))
291 SP: **that's right**
292 I: **bene:**
            good
293 SP: a:nd show me: the watch
294 I: e l'orologio
            and the watch
295   ((the patient points to the watch))
296 SP: **very good** ⌐**very good**
297 I: └**bravo**
                      well done
298 SP: **°without any problems°**
299 I: **bravo senza problemi**
            well done without any problems

            (325–327)
325 I: quattro: >cinque sei< ⌐°( )°   ⌐
            four five six   │   │
326 SP: └**good** ┘ **very good °lovely (.) nice°**
327 I: **yeah bravo bravo**
            well done well done

Both Ines and Ippolita are thus deliberately reinforcing the SPs' selection of the VoL, instead of systematically opting for the more widely documented operational mode of interpreted discourse, whereby feedback is omitted, especially when transparent.

Pauses

Sacks et al. (1974) distinguish between three types of discontinuities in talk: pauses, gaps and lapses. A *pause* is a silence which does not occur at a transition-relevance place, and, as such, is not perceived as a signal that the floor is made available to the next speaker. Whilst these pauses, which Hayashi (1996) calls "intraturn spaces", will be examined in the discussion of prosody (see 3.4),

this paragraph will focus on inter-turn silences. When a silence arises at a TRP and another speaker self-selects for the next turn, the discontinuity is called a *gap*. Gaps can turn into *lapses*, that is extended spaces of non-talk, if no speaker is willing to take the floor. To avoid or resolve lapses, the current speaker may resume talking, thus transforming these silences into *pauses* separating two turns by the same speaker. For the sake of simplicity, all instances of discontinuities "between turns" have been subsumed here under the heading "pauses".

In the specific context of speech therapy, pauses may lose some of the connotations attached to them in ordinary conversation. When a pause occurs in place of the patient's answer, it rarely signals reluctance to respond to a question and is instead the manifestation of his health condition. As such, pauses are tolerated by the other participants, who do not exhibit signs of discomfort as is generally the case in everyday talk.

Linking these considerations back to the concept of adjacency trio, the following excerpt is offered as an example of an unmarked sequence displaying the pattern: SP's question — I's translation — SP's question. Sheila is asking Pino to name two sports items, thus implicitly selecting first the interpreter and then the patient as next speakers. In the absence of an answer by Pino, Sheila resolves the resulting pause by taking the floor again to reformulate the question:

[8] **T. 2 (228–233)**
228 SP: =°okay° (.) two things you could buy at a shop that sells things you need to play
229   sport
230 I: °mhm° due cose che si possono compra:re in un nego:zio dove si ve:ndono (.)
          two things you can buy in a shop where they sell
231   eh:m arti:coli:: e – per quando uno deve andare a fare qualche tipo di sport
          items you can use when you practice some kind of sport
232   ((long pause))
233 SP: **what would you need to buy if you wanted to play cricket**

As in smooth transitions, analysis of sessions 2 and 3 has also shown instances of marked as well as unmarked patterns, where it is the interpreter who steps in after a pause instead of the SP. In the following example, Ines breaks the patient's silence by rephrasing her translation of Sheila's original question. In self-selecting as next speaker, she displays the behaviour of a powerful participant, and the VoI merges once again with the VoM:

[9] **T. 2 (280–285)**
280 SP: °mhm° what's a flower you could buy that has thorns
281 I: un tipo di fiore con le spine che lei potrebbe trovare da un vivaio come si chiama (.)
          a type of flower with thorns you can find at a nursery what is the name of

282   ques – una pianta con le spine che fa i fiori
         this a plant with thorns that has flowers
283   **((pause))**
284 I: **quella pianta che fa i fiori e che ha anche le spine**
         that plant that has flowers and has thorns also
285 P: yeah=

The last example in this paragraph, which unlike all others is taken from T.1 and does not refer to a therapy session, portrays an interesting conversational exchange, where the VoI's operational mode is in full swing. Here the discontinuity is caused not by the patient's but by the interpreter's silence, in that Ines initially waits for Sheila to go on speaking. Sheila's intention, on the other hand, is to ease the interpreter's task by breaking down her utterance into chunks, a frequently observed feature in the conduct of primary speakers who are used to being interpreted, and a clear example of how they can implicitly acknowledge the requirements of the interpreting process. Paradoxically, however, this sensitivity clashes with a higher-level interpreting need, that of delaying one's translation until more of the message has been delivered. Consequently, as the pause lengthens and turns into a lapse, Ines resolves it not by translating, as the SP expects her to do, but by completing Sheila's sentence, thus urging her to take the floor again and add more information:

[10] **T. 1** (73–81)
73   SP: =tomorrow (.) Luca (.) your son will go with you to the XXX[17]
74   **((pause))**
75   I: **and then you're meeting** ⌈(there)⌉
76   SP: ⌊and   ⌋ I am sorry and I will meet you at the hospital=
77   I: =alright=
78   SP: =and be with you while the X-ray is being done
79   I: quindi doma:ni (.) quello che succederà è questo (.) l – la viene a prendere suo figlio (.) e la porta al
         so tomorrow what will happen is that your son will come to pick you up and take you to
80   XXX (.) all'ospedale voi due (.) Sheila invece sarà lì ad aspettarvi (.) e Sheila sarà con le:i mentre si fa
         hospital XXX you two Sheila instead will wait for you there and Sheila will stay with you while
81   il raggio (.) va bene↑
         the X-ray is being done okay

Overlaps

Except for back-channels, which for constraints of length will not be discussed in this section, relatively few instances of overlaps have emerged from the three transcripts. The following paragraph will illustrate the most significant

ones, sorting them into three broad categories on the basis of their distance from TRPs.

Overlaps occurring *in the proximity of* a TRP were found to be brief, and were frequently the result of the interpreter's translation act, as in the following two excerpts, where Ines' right to the floor is acknowledged by the primary interlocutors' dropping out:

[11] T. 1 (165–167)
165 SP: okay it's been organized ⌐°okay°⌐
166 I: ⌊**hanno** ⌋ organizzato già è tutto apposto hanno già
                                    they have organised everything it's all right they have already

167   organizzato °va bene°↑
           organised okay

[12] T. 2 (107–110)
107 P: ehm come si chiama l'altra:
         what's the other one called
108 I: I'm not sure
109 P: ehm non me lo ⌐**ricordo**⌐
         I can't | *remember* |
110 I: ⌊**what's** ⌋ the other one called altra >I can't remember

Emblematic of the SP's willingness to cede the floor is also excerpt [13]. Here the overlap takes place *at* a TRP, after a gap in the turn-taking sequence, when no one has been selected as next speaker. As the interpreter is waiting to hear more of the patient's utterance to be able to translate, the two primary interlocutors self-select simultaneously. By dropping out and letting the VoL speak — the patient is not so much providing an objective reason for the large variety of vegetables that he grows in his garden, as showing his pride in owning quite a substantial amount of land — Sheila is seen to adopt a non-directive interactional style:

[13] T. 2 (61–68)
61 SP: oh (.) sounds like you have lots of variety
62 I: pare che lei a — ha — una buona varietà (.) di cose una buona scelta
         it seems you have a wide variety of things a wide selection
63 P: insomma
         well
64 SP: ⌐⌐**what** —
65 P: ⌊⌊**avendo avendo tanta terra no**
             when you have when you have a lot of land you know
66 I: more or less I mean having a lot of s — land or soil
67 SP: mhm °that helps° (.) what do you do to keep the snails (.) and birds (.) away from
68   the fruit and vegetables

Whilst the SP's behaviour may be a function of the specific activity being performed in the session, i.e. speech rehabilitation, it contrasts once again with the

findings of other studies on interpreted medical encounters (see, for example, Englund Dimitrova 1997: 155–156) where doctors are found to take and maintain their turn regardless of the patient's attempt to claim it.

A second instance of simultaneous self-selection, this time involving a primary speaker and the interpreter, is the one illustrated in [14]. Here Ines translates Pino's correct answer and, following a short gap, takes the floor again to voice her favourable assessment, which comes to overlap with Sheila's feedback. The resulting pattern, P's answer — I's translation — I's assessment + SP's assessment, deviates from the unmarked adjacency trio described under point 2 above, and its interpretation can be similar to that of excerpts [2], [3] and [4].

```
[14] T. 2 (465–469)
465  I:    chi è e    ⌐cosa fa
           who is it  │ what is she doing
466  P:               └è una lei è una donna
                        it's a she it's a woman
467  I:    it's a she it's a woman
468  SP:   ⌐⌐°good°
469  I:    └└mhm
```

The third group includes those instances of simultaneous talk which Nofsinger (1991: 102) calls "interruptions". Occurring *neither at nor near* a TRP, these overlaps violate the ordinary turn-taking mechanisms and are often considered as a threat to the current speaker's face. A rare example of interruption is shown in the following excerpt, where Sheila takes the floor during Ines' turn, to offer Pino a clue to the answer:

```
[15] T. 2 (284–289)
284  I:    quella pianta che fa i fiori e che ha anche le spine
           that plant that has flowers and has thorns also
285  P:    yeah=
286  I:    =eh  ⌐qual è la pianta
                │ what plant is it
287  SP:         └A RO:::
288  I:    una ro:: (.) una pianta di ro:::
           a ro a plant of ro
289  P:    rose
```

Whilst it is possible that the SP intends thus to reaffirm her right to the floor, the overall tenor of the session would point to a different explanation. In her eagerness to help the patient, Sheila's disregard of the basic conversational rule that one party speaks at a time is evidence of an enthusiastic, high-involvement style, rather than an attempt at controlling the interaction.

3.2 Footing

With the analysis of footing, we move from sequences and turns to the participants' conversational alignments, which can coincide with an entire turn, but can also change within the same turn. Footing, as defined by Goffman (1981: 128), is "the alignment we take up to ourselves and the others present as expressed in the way we manage the production or reception of an utterance". Starting from the author's pioneering notion of "production format", with its distinction between the roles of "principal", "author" and "animator", Wadensjö (1998: 91–92) develops a parallel framework, which she calls "reception format", to account for three modes of listening and subsequent response, namely "responder", "recapitulator" and "reporter". In the present paragraph we will illustrate a model which, though inspired by Goffman's and Wadensjö's work, redefines some of these typologies, and integrates new ones.

Three considerations should serve as a point of departure for the following discussion. First, the model shown in Table 2 is a revised version of the classification used in our earlier studies (see note 3), where readers can find the frequency distribution of the different categories in the corpus of 32 interpreted sessions.[18] Second, the table should be viewed simply as an attempt to systematise a number of communicative occurrences, in full awareness that it does not reflect either the richness or the complexity of interactional scenarios. Third, the classification suggested here should be subjected to severe scrutiny by other researchers and, in particular, checked against further samples of authentic interpreted interaction.

With the exception of the category of principal, the model is constructed on the interconnection between the primary speaker's alignment to the other primary speaker and to the interpreter, and the latter's role as interlocutor or as addressed/unaddressed translator. Moving from the assumption that the footing of *reporter*[19] is the "unmarked" alignment — only in the sense that the interpreting scenario in which one party addresses the other directly and the interpreter uses the first person to identify in turn with each speaker is generally considered to be the canonical one — all the other categories can be conceived of, to a greater or lesser extent, as departures from it. Taking a distance from the utterance of the primary speaker, the interpreter may shift from the first to the third person, i.e. from the footing of reporter to that of *narrator*. Alternatively, she may want to signal commonality of purposes with the current speaker through the use of the first person plural, thus opting for the footing of *pseudo-co-principal*. When, on the other hand, the primary speaker addresses the interpreter to ask her to refer what s/he is saying to the

Table 2. Categories of footing

Primary Speaker	Interpreter		FOOTING
	Initiator	Will you move over there, please?	**PRINCIPAL**
Who will take me there?	Interloctor	The doctor will.	**RESPONDER**
(Tell her) I'll ask her some questions now.	Translator — addressed	Ora ti farò delle domande. *Now I will ask you some questions.*	**DIRECT RECAPITULATOR**
		(Dice che) ora ti farà delle domande. *(She says) she will ask you some questions.*	**INDIRECT RECAPITULATOR**
Now I'll ask you some questions.	Translator — unaddressed	Ora ti farò delle domande. *Now I will ask you some questions.*	**REPORTER**
		(Dice che) ora ti farà delle domande. *(She says) she will ask you some questions.*	**NARRATOR**
		Ora ti faremo delle domande. *Now we will ask you some questions.*	**PSEUDO-CO-PRINCIPAL**

other party, the interpreter's choice is between the two categories of *direct* and *indirect recapitulator*, i.e. between, once again, the first person, to bring the interlocutors closer together, and the third person, to maintain the distance between them. As for the two remaining modes, which are farther away from the tenet of the interpreter's "invisibility", the footing of *principal* refers to the interpreter as initiator of a communicative act, whilst that of *responder* sees her relating as interlocutor to a primary speaker's utterance, which may or may not be explicitly addressed to her.

The following sections will illustrate the "marked" alignments which have been found in the transcripts. This means that, apart from the footing of reporter, which, though highly frequent, is the least interesting for the purpose of our discussion, the footings of direct and indirect recapitulator will also be

excluded. The absence of these two categories runs counter to the predominant trends observed in the above-mentioned corpus, of which the three sessions are but a small portion, and is evidence of the atypical nature of these encounters, where primary speakers were seen to either speak directly to each other or interact with the interpreter as interlocutor. The incidence of the footing of principal, which will be exemplified first, is also noteworthy.

Principal

Leaving aside the interpreter's metalinguistic comments on the patient's utterances, which will be discussed in the section on additions (see 3.3), three cases will be illustrated here of autonomous interventions by Ines and Ippolita.

In the first sequence, Ines has just translated "bakery" with the Italian term "panificio", which contains the word the speech pathologist is trying to elicit from the patient, i.e. "pane", "bread". Realising that she has made the question easier for the patient and that she should have used instead the less telling synonym "fornaio", she feels she has to inform Sheila, and remains on this topic even after the latter has acknowledged the mishap and moves on to a new question. The effect of her protracted explanation — which can be read as a face-preserving act through self-criticism — is that the translation of the new question is delayed and the floor is repeatedly reassigned to the SP, who is thereby brought back to the interpreter's topic. Ines' decision to alert Sheila to the implications of her lexical choice is a manifestation of the concerns of the VoI, as excerpt [10] above was of its needs.

[16] **T. 2 (355–374)**
355 SP: °okay° (.) two things you could buy at a bakery
356 I: due cose che si possono comprare a — in un panificio
            two things you can buy at a breadshop
357 P: oh il pane
            bread
258 I: bread
359 SP: ⌐⌐mhm
360 I: └└((addressing the speech pathologist)) **the word itself says it anyway so that**
361   **was a clue**
362 SP: yeah
363 I: ⌐⌐((laugh))
364 SP: └└okay (.) what else can you buy at a bakery
365 I: **°breadshop you know°**
366 SP: ⌐⌐oh yeah fair enough yeah
367 I: └└((laugh)) **that's the word in English**=
368 SP: =yeah=

369 I: **(it's) already used bakery I used the — the immediate term** yeah cos'altro allora il
                                                                           what else then
370   pa:ne e cos'altro (.) ((addressing the speech pathologist)) >°**yeah I should have**
          bread and what else
371   **used another word but anyway**°<
372   ((pause))
373 I: da un fornaio ((chuckle)) ((addressing the speech pathologist)) °**that's more**
          at the baker's
374   **bakery**° ((chuckle))

In the second sequence, Ippolita moves in the opposite direction. She takes off her interpreting hat and offers Sara some extra objects for the patient to identify. Seeing the interpreter's eagerness to help, the SP overcomes her initial reluctance:

[17] T. 3 **(197–204)**
197   ((the speech pathologist looks for other objects))
198 I: ((addressing the speech pathologist)) °**do you want — **°
199 SP: °no it's fine°=
200 I: =**something else**↑
201 SP: °no >it's alright<°
202 I: **I've got** ⌐**props**
203 SP: └ oh >that (sounds good)< (.) >props will be fine<
204 I: ((the interpreter gives the speech pathologist a pen)) pen

An even more dramatic departure from a merely "echoic" role is shown in the third sequence. Here Ippolita tells the patient's wife, who is overly eager to answer on her husband's behalf, to go and sit at a distance. Without having been prompted to do so by the SP, she thus gives instructions for a more effective running of the therapy session. Since, judging from her words, the reason behind Ippolita's behaviour is not that her interpreting task might be disturbed, but rather that the patient might be "confused", the interpreter is seen here to adopt the authoritative VoM.

[18] T. 3 **(14–21)**
14 SP: is your name Pietro
15 I: il suo nome è Pietro↑
         is your name Pietro
16 SP: yes: (.) or no
17 I: ⌐ ⌐sì o no↑   ⌐
18 W: └ └ma sì (.)   ┘ yes ( )
              but of course
19 I: **signora lei si siede di là (.) per favore (.) altrimenti si confonde si siede di là (.)**
         madam will you please sit there please otherwise he'll get confused sit over there
20   **signora**↑ **(.) si siede di là**
         madam sit over there
21 W: ((addressing her husband)) risponda risponda sai↑ ((she moves away))
                         come on answer answer

Responder

Besides taking the initiative to make clarifications, offer help or give instructions, the interpreter is also frequently seen to respond directly to a primary interlocutor's utterance. This is a natural enough reaction when, for instance, she needs clarifications in order to translate accurately, as in the following excerpt, where Ines has difficulty understanding the Sicilian dialect spoken by Patrizio:

[19] T. 1 (113–116)
113 P: ah ca a bocca ce l'ho piena di sti sti (scorco) tutta quanta murata di
           my mouth is full of these these it is all cemented with
114 I: **tutta quanta come**↑
           is it what
115 P: murata de scracchi lì (.) de a porcheria
           cemented with scum with rubbish
116 I: di porcheria in — in gola yeah but I feel that you know just my — my throat is full of
           gum (.)
           rubbish in the throat

or when the information has already been supplied by the other primary speaker earlier on in the encounter and the interpreter is simply reiterating it:

[20] T. 1 (153–154)
153 SP: I spoke to Rita this morning (.) **and she said that Luca could come**
154 I: Sheila ha parlato con Rita questa mattina e Rita ha detto che Luca può venire
           Sheila spoke with Rita this morning and Rita said that Luca can come

           (160–161)
160 P: appunto ma (alle sette) e mezza chi viene qua
           yes but at half past seven who is coming here
161 I: **chi:**↑ **Luca (.) Luca viene**
           who Luca Luca will come

or, clearly, when the interpreter is being personally addressed. In [21], as the session draws to a close, Patrizio, who has just been reassured by Ines that his son Luca will be present the following day at his X-ray, asks the interpreter when he will next see her. Ines' professional attitude is shown in her attentiveness to the SP's momentary exclusion from understanding, which she resolves by translating the patient's enquiry before answering it:

[21] T. 1 (182–184)
182 P: a lei quanno la vediamo
           when are we going to see you
183 I: **ehm io**↑ **>when is he going to see me< ehm mi ve::de ehm quando torna**
           dall'ospedale il
           me   you'll see me when you come back from the
           hospital

184   **pomeriggio o venerdì (.) mhm**↑
      in the afternoon or on Friday

A consequence of Ines' translation act is that the patient's VoL perspective is conveyed to the healthcare practitioner, instead of being judged by the interpreter as irrelevant and therefore not worth translating.[20]

Narrator

Highly frequent and equally natural is the interpreter's adoption of the footing of narrator in her translations of the SP's utterances. Differently from the trends observed in the larger corpus, where this alignment emerged as an attempt by the interpreter to separate her involved and sympathetic attitude from the therapist's disaffiliative stance, in the three recorded sessions the interpreter's decision is simply dictated by the need to avoid ambiguity, as in the following excerpt, where Ines is informing Patrizio that Sheila will take him to another hospital the next day:

[22] T. 1 (31–34)
31   SP: tomorrow morning (.) later tomorrow morning (.) I'm going to take you to the XXX
            Hospital (.) for about half an hour
33   I: doma:ni verso metà matti:na (.) **Sheila** ((addressing the speech pathologist)) °you're
            going
            tomorrow around mid morning Sheila
34   too° ((the speech pathologist nods)) **Sheila (.) la porta (.) all'altro ospedale (.) il XXX
            (.)**
                                          Sheila will take you to the other hospital the XXX

The sequence, which justifies the patient's later question in [21] above, is also an instance of an intra-turn shift in footing. Embedded in the translation is the role of principal displayed by Ines as she seeks confirmation from Sheila of the correctness of her statement.

A more interesting example is sequence [23], where Ines' explicit mention of Sheila as the agent of the action she is narrating clearly conveys to the patient the SP's caring attitude:

[23] T. 1 (56–58)
56   SP: I have even cooked some chocolate muffins to take up for you to try
57   I: **Sheila le ha preparato (.) una tarti:na (.) di cioccolata per dargliela domani (.)
            mhm**↑ **perfino**
            Sheila has prepared a chocolate cake and she'll give it to you tomorrow mhm she has even
58   **questo ha fatto** ((soft chuckle))
            done this

The mode of narrator was recorded only once in the translations of the patient's utterances — for which the footing of reporter was the norm — and appears to be motivated by the patient's use of English in his reply to the SP's question. Thinking that Sheila might not have understood Pino's unclear pronunciation, Ines instinctively shifts to the third person, producing, in a lower voice, a sentence which could be paraphrased as "He said he does not know":

[24] **T. 2 (275–277)**
275 P: I don't know ⌐ (the name) ⌐
276 SP: ⌐ what's   ⌐ the type of flower=
277 I: =°**he wouldn't know**° un tipo di fiore mi dica
                                    a type of flower can you tell me

Once again the turn contains a double footing, given that the interpreter proceeds to translate the SP's question as reporter.

Pseudo-co-principal

A more interesting, albeit rarer, mode is that of pseudo-co-principal, whereby the interpreter associates her identity with that of the SP, displaying the opposite attitude of the one described in the preceding paragraph. The following sequence is given as illustration:

[25] **T. 3 (8–9)**
8   SP: very good okay (.) u:mm I'm going to ask you some yes-or-no questions (.) °okay°↑
9   I: adesso **le facciamo** delle domande e: che lei deve rispondere col sì o col no
            now we will ask you some questions and you must answer yes or no

        (311–312)
311 SP: °okay° (.) Pietro I'd like you to do some talking for me now
312 I: adesso signor Pietro **vogliamo** che: lei fa: – che parla (.) un pochettino
            now Mr. Pietro we would like you to do to speak a little

A last example of an odd intra-turn coexistence between the footings of narrator and pseudo-co-principal is offered in the following excerpt:

[26] **T. 2 (403–406)**
403 SP: °mhm° okay what I want you to do is tell me (.) >who you can see in the pictures<
404   (.) and what they are doing
405 I: quindi ora **Sheila vuole** che lei **ci dica** cosa vede: in queste imma:gini >in queste
            so now Sheila wants you to tell us what you see in these pictures in these
406   foto< e cosa stanno (.) face:ndo
            photographs and what they are doing

Here, the boundaries between the different voices become disorientingly blurred.

3.3 Divergent renditions: Additions

In the literature which investigates how interpreted — or "target" — texts may depart from source texts, the main focus has traditionally been on the performance of simultaneous interpreters, and on the analysis of omissions, additions and substitutions in terms of errors, sometimes even in contrast to the explicit purpose stated at the outset by the authors themselves (see Barik 1994).[21] However, more recent trends in the field have shifted attention towards a reading of these departures as "strategies". Kopczynski (1994) describes the survey he conducted on the attitudes and expectations displayed by conference speakers and audience towards the provision of interpreting services, including the preference for a more or less active role played by the interpreter. In other words (Kopczynski 1994: 93):

> […] should s/he be the ghost of the speaker or should s/he intrude, i.e. omit, summarize or add portions of text? I suspect that the majority of speakers prefer the ghost role over that of the intruder. As bilingual and bicultural experts, however, we have a more or less conscious tendency to readjust or intrude.

Other authors stress not only the frequency, but also the advisability — under specific circumstances — of this intruder role. Analysing the function of additions in conference interpreting, Palazzi Gubertini (1998) points out that, clarity being the interpreter's main objective, there might be instances where the addition of material is necessary to explicate a potentially ambiguous original utterance. The same opinion is espoused by Falbo (1999), who distinguishes between "omission" and "loss", with the former being regarded as a deliberate choice. This perspective stems from two elements: on the one hand, the pivotal role attributed to the communicative goals of any one interpreted event (see Altman 1994), and, on the other, the influence of pragmatic factors, such as the situation and the recipients of the interpretation (see Kopczynski 1994; Viezzi 1996).

These contextual factors, which are undoubtedly significant in conference interpreting, are all the more crucial in face-to-face encounters. As a consequence, in this field, the departures from the speakers' original utterances acquire an additional value. As argued by Wadensjö (1998), the extent to which renditions relate to the preceding originals,[22] in terms of closeness versus divergence, allows for the understanding of the "potential interactional functions" performed by different kinds of interpreters' utterances (1998: 105).

In this section, an attempt will be made to explicate some of these functions. Given that omissions of information — Wadensjö's "zero renditions"

(1998: 108) — and instances of substitution, namely semantic shifts, were rare and mostly insignificant occurrences, attention will be focused on additions. Four categories were identified, i.e. phatic, emphatic, explanatory and other.

With the exception of "phatic" additions, which are not treated as a separate group by other authors, the following categories were taken as a point of departure for our classification:

Barik's (1994: 125–126)

i.   *qualifier additions*, i.e. additions of a qualifier or a qualifying phrase absent in the original, for emphatic purposes;
ii.   *elaboration additions*, i.e. additions in the form of an elaboration or any other straight addition to the text;

Cesca's (1997: 482– 493)
iii. *explanatory additions*, i.e. additions of elements in order to clarify the concept which is voiced;
iv.   *emphatic additions*, aimed at stressing the content of the utterance;

Wadensjö's (1998: 107–108)
v.   *expanded renditions*, which include more explicitly expressed information than the preceding original;
vi.   *non-renditions*, i.e. texts which are analysable as an interpreter's initiative or response which does not correspond (as translation) to a prior original.

In the following discussion, "emphatic" additions will include instances largely corresponding to i. and iv., "explanatory" to ii., iii. and v., and "others" to vi. A preliminary consideration is, however, essential. Barik himself points out that what he calls qualifier and elaboration additions "refer essentially to the same event and could in fact be combined" (1994: 126). Similarly, the distinction between emphatic and explanatory additions is not always clear-cut and has therefore posed classification difficulties.

Phatic additions

The adjective "phatic", which stems from the Greek *phátis*, meaning "speech" (Bussmann 1996), was originally used by Malinowski in the phrase "phatic communion" to identify the social task of language, i.e. the creation of "ties of union" among individuals through the mere exchange of words (see Abercrombie 1994; Crystal 1992). The term has subsequently been borrowed — although with a slightly modified connotation — by Roman Jakobson, who defines as

phatic one of the six basic functions of language,[23] namely the function per-
formed in those messages "primarily serving to establish, to prolong, or to dis-
continue communication, to check whether the channel works […], to attract
the attention of the interlocutor or to confirm his continued attention" (Jakob-
son 1990: 75). As stressed by Altieri Biagi (1985: 352), the word "channel" not
only suggests the physical medium, but can also be viewed as a metaphor to
express the presence of an empathic attitude between interlocutors. Therefore,
within the scope of this study the label "phatic" refers to those additions per-
forming the dual function of back-channelling and reassuring tokens.

Analysis of the three transcripts has revealed that phatic additions are
present only in the translations into Italian and that they serve two purposes.
Firstly, they are used by interpreters to check whether patients have thoroughly
understood the message, and as such they can be read as expressions of the
VoI's need to monitor the effectiveness of the interpreter's role as "communica-
tive channel". Secondly, they occur when potentially upsetting information is
conveyed to the patient and are thus the expression of a "louder" VoL than the
already caring one adopted by the SP.

The most frequent additions, which occur at the end of the information
chunk and are often accompanied by a rising intonation, are the filler "mhm"
— used as a request of agreement — and the expression "va bene" (all right).
Only in a few cases does the interpreter use "vero" (true) and "giusto" (right).
In [27], for instance, the SP wants Patrizio to understand that an X-ray is noth-
ing to be afraid of:

[27] **T. 1 (52–55)**
52   SP: the X-ray is just like having an X-ray taken of your a:rm or your leg only it's your
53   neck
54   I: questi raggi sono come quelli che si fanno per un braccio o per una gamba **mhm**↑
             solo che
             these rays are like those taken of an arm or a leg mhm it's just that
55   soltanto qui si fa alla gola
             only here it's taken of your throat

A few turns later, Patrizio is asked to try some mashed potato for lunch, so that
his swallowing difficulty can be assessed. Since he first complains about it and
then reluctantly accepts, Sheila underlines that he does not have to feel forced.
The phatic addition, clearly aiming at soothing him, occurs twice:

[28] **T. 1 (123–127)**
123   SP: have a try: (.) if it's too difficult you don't have to have it all
124   I: ci prova
             have a try
125   P: ((cough))

126   I: ci prova **va bene**↑ poi se è troppo diffi:cile mangiare la patata allora la lasci (.) **va**
            bene↑
            have a try all right then if eating the potato is too hard just leave it all right
127   P: yeah va be'
            yeah okay

Emphatic additions

This category comprises repetitions of words, phrases or even whole sentences, as well as the use of synonyms belonging to the same level of formality, to stress a concept already mentioned — either in the same or in a preceding turn — without providing any further information. Instances of these additions, which, it must be stressed, are not used as a compensation strategy for a loss of information in a previous rendition, frequently feature in the translations into Italian, whilst they are absent in those into English.

Depending on the context, emphatic additions perform different functions. In some cases, they are the expression of the VoM encouraging the patient to respond. In [29], for instance, given the lack of an immediate and audible answer, it is Ippolita who speaks in this voice by repeating Sara's question three times (a similar example is shown in [9]):

[29] **T. 3 (376–377)**
376   SP: now I've got you talking ((she points to her watch)) what's this
377   I: ((pointing to the watch)) cos'è questo (.) **cos'è questo** (.) cos — (.) **cos'è::**↑
                                        what is this what is this wh- what is it

But the most striking instances are those in which the SP's selection of the VoL, in response to the patient's concerns, is further reinforced by the interpreter. In the following excerpt, Sheila is telling the patient that his temporary transfer to another hospital for an X-ray has already been arranged and that he does not need to worry about it. Seeing the patient's perplexity, the same concepts are repeated over and over by Ines a few turns later:

[30] **T. 1 (155–159)**
155   SP: don't worry about it the staff have already arranged with your fa:mily who will take you
156   everything is organized all you need to do is come along
157   I: non si preoccupi che qui:: (.) ehm le infermiere (.) hanno già parlato con la famiglia
            hanno
            don't worry because here the nurses have already talked to your family they have
158   già (.) fatto l'appuntamento tutto è apposto lei solo deve andare lì e la portano (.)
            mhm↑ **non**
            already arranged the appointment everything is settled you just have to go there and they
            will take you mhm there're no
159   **ci son più problemi non si deve preoccupare di nient'altro**
            more problems you don't have to worry about anything else

(165–170)

165 SP: okay it's been organized ⌜°okay° ⌝
166 I: ⌊hanno ⌋ organizzato già **è tutto apposto hanno già**
                                   they have organised everything it's all right they have already
167   **organizzato** °va bene°↑
           organised okay
168 SP: they have worked something out
169 I: sono arrivati a — a qualcosa mhm↑ **a qualche decisio::ne si sono messi d'acco::rdo**
           quindi per
           they have reached so- something some kind of decision they found an agreement so for
170   **domani è apposto**
           tomorrow it's settled

The passage allows for similar comments to those made for [27] and [28]: the VoL, carried here by the over-repetition, is once again aimed at reassuring Patrizio. Evidence of their analogous function is the presence in this sequence of phatic additions, namely the filler "mhm" and the expression "va bene".

Explanatory additions

As pointed out by Mishler (1984: 172), in a medical encounter the only participant who is usually competent in both the VoM and the VoL is the professional, who has to decide whether or not to convert patients' lifeworld utterances into medical terms, and medical issues into lifeworld terms. In an interpreted medical encounter, this decision may be taken at a second level, if healthcare practitioners do not make code adjustments and interpreters do so in their stead, by adding information aimed at clarifying a message which they consider to be potentially obscure for the patient.

As was the case for the first two categories, explanatory additions were recorded almost exclusively in the translations for the patient. The pattern is rather straightforward: the literal translation of a word or phrase is followed either by the explanation of its meaning, or by a synonym belonging to a more informal level of language, as in the following example:

[31] **T. 1** (46–51)
46 SP: while we're at the XXX (.) I will give you some food and some drink (.) then we will
47   take an X-ray of your throat (.) so that I can watch (.) if the food and drink goes the right
48   way to the stomach (.) or the wrong way to the chest
49 I: sì quindi domani mentre le fanno i raggi (.) **prende una foto un raggio da questa**
           parte della
           yes so tomorrow while they're taking the X-ray she takes a photo a ray from this side of
           the
50   **faccia** per vedere la gola mentre le danno da mangia::re e un po' da bere così riesce poi a
           face to see the throat while they're giving you to eat and something to drink so that then
           Sheila can

51   vedere Sheila se va dalla parte giusta o se va dall'altra parte che non deve andare
          see whether it goes the right way or the other way where it doesn't have to go

Since the term "X-ray" is perceived as a possible source of perplexity, Ines resorts to a paraphrase, describing it as a photo. In other words, she translates not only English into Italian, but also the technical term into a language which is easily accessible to the patient. This trend, commonly found in the larger corpus, does not often figure in the three transcribed sessions, for two reasons: firstly, two out of the three encounters are therapy sessions, in which the SP is making reference to everyday activities and objects, and wants the patient to practice basic vocabulary and syntactic structures; secondly, it has repeatedly been stressed that both Sheila and Sara display an involved attitude, which manifests itself through their extensive use of the VoL.

Other additions

This category includes those instances which Wadensjö calls "non-renditions" (1998: 108), namely interpreter's utterances lacking a corresponding original. Based on their main functions, such instances can be subdivided into seven groups, four of which (points 1 to 4 below) are also mentioned in the *Guide to Good Practice*, published by the *British Association of Community Interpreters* in 1989 and cited by Leonor Zimman (1993: 219). With the exception of categories 6 and 7, all others are the expression of the VoI's operational needs.

    Adopting the footings of principal and responder as discussed in 3.2, interpreters may take the initiative to:

1. *ask for clarification if the concept voiced by one interlocutor has not been clearly heard or thoroughly understood*: an illustration of this are examples [19] line 114, and [33] line 74. Given that all three patients are affected by speech impairments, this was a frequent occurrence in all analysed sessions;

2. *point out if a client has not understood the message despite the correct rendition*. No examples have been found in the three sessions, although a few instances of this category were recorded in the larger corpus;

3. *alert a client to a possible missed inference*, as shown in the following sequence:

[32] T. 2 (246–253)
246 SP: two things you could buy at (.) a nursery
247 I: due co:se che: uno troverebbe da un vivaio (.) **sa cos'è un vivaio**↑
            two things you could find at a nursery do you know what a nursery is
248 P: ye:s

```
249  I:    ((addressing the speech pathologist)) sometimes the (.) the te:rms in Italian are no
250        longer ⌜(used) ((chuckle))=
251  SP:        ⌞oka:y ((soft chuckle))
252  I:    =they adopt the English one he's all right with that↑ ((turning to the patient)) da
253        un vivaio allora che cosa possiamo trovare
           at a nursery then what can we find
```

Ines is not sure whether Pino is familiar with the Italian word for nurs-
ery, i.e. "vivaio", given that it is not uncommon to see first-generation im-
migrants using expressions of the local languages in place of their native
tongue equivalents. Therefore, she first ascertains whether the patient has
understood the term, and proceeds to explain to Sheila the reason for her
intervention;

4. *ask a client to modify his/her delivery in order to accommodate the interpret-
    ing process,* as exemplified in [10] line 75, where Ines asks Sheila to com-
    plete the sentence before translating it;

5. *comment on their renditions,* as in [16];

6. *answer in the first person when directly addressed by one interlocutor,* as in
    [21];

7. *offer help,* as in [17], *give instructions,* as in [18], and *provide metalinguistic
    explanations of the client's utterances.* Given that the latter is a distinctive
    feature of interpreting in speech pathology, the following sequence is of-
    fered as an example among many:

```
[33]  T. 2  (73–85)
73   P:    (per le lumanchi) usi:: il veleno
           (for the snails) you use the poison
74   I:    come scusi↑
           pardon
75   P:    per le lumache
           for the snails
76   I:    per le lumache↑ mhm
           for the snails mhm
77   P:    gli (metto) il veleno
           I put the poison
78   I:    mhm I put the poison for the (.) snails and the word snail camed re — came really
79         mumbled at first I wasn't able to grasp it=
80   SP:   =mhm
81   I:    but then the second time he said it it was=
82   SP:   fixed
83   I:    yes  ⌜it was=
84   SP:       ⌞okay
85   I:    =fixed yeah
```

As already emphasised in the introductory paragraph to the present work,
the description of the patient's speech enables the SP to assess his progress

and provide appropriate feedback, as shown in the continuation to the above sequence:

[34] **T. 2 (86–87)**
86   SP: it's good that when (.) you said the word snail and it wasn't clear (.) you could fix
87   it yourself and say it again better

3.4 Prosody

Analysis of prosody — the term is used here in its broader meaning to refer to suprasegmental features of speech — will consider three aspects: speech rate, sound duration and loudness. When discussing pauses in turn-taking, passing mention was made of "intraturn spaces". As Hayashi (1996) observes, these brief silences, or unfilled pauses, may be due to a variety of factors, such as loss of words, distraction, hesitation, but also empathic involvement. Examples of the latter function abound in our transcripts, where the SP is frequently seen to slow down elocution. This is achieved not only through the insertion of pauses between and within intonational phrases, but also through the lengthening of vowel sounds, as in the following utterances:

[35] **T.2 (177)**
177   SP: I want you to tell me (.) two things (.) that you could bu::y in (.) a hardware shop

         (391–392)
391   SP: sometimes when (.) you're ta::lking (.) you know what you want to say but you
392   don't give enough (.) information (.) to repeat while we're listening

Whilst a slower speech rate is a common enough way to make utterances clearer and more easily understandable to elderly patients, especially patients with speech disorders, the SP's selection of this pattern is a consequence of her addressing the patient directly and speaking to him as naturally as if no interpretation were needed. Her attention to the patient's difficulties is emulated by the interpreters, who display the same prosodic behaviour in their translations, as shown in the following lines which continue the previous example:

[36] **T.2 (393–396)**
393   I: delle volte: quando uno si trova (.) parlando (.) uno (.) sa quello che vuole dire
        sometimes when one is speaking one knows what he wants to say
394   però (.) il modo in cui viene fuo:ri è ⌐ non c'è abbas – =
        but the way it comes out is | *there isn't enough*
395   P: └ °yeah yeah°
396   I: =l'informazio:ne che lei ha dato non è sufficiente=
         the information you have given is not enough

The interpreters' tuning in to the speech pathologists' overall conversational style goes beyond a mere echoic behaviour and results in their independent adoption of the same prosodic patterns, even when these are absent in the immediately preceding original utterances, as shown in excerpts [1] lines 189–190 (intra-turn pauses) and [2] lines 92–93 (lengthened vowels).

The very last example which concludes our analysis of the participants' voices is offered as an attempt to convey at least a glimpse of the relaxed atmosphere that characterised the encounters. Here, as in [15] line 287, a traditional indicator of a dominant verbal behaviour, loudness, loses all connotations of aggressiveness and becomes the index of a high-involvement style:

```
[37]  T.1   (144–147)
144  P:    no wanna no wanna quiddi taliani
           they don't want they don't want Italians
145  I:    ah:: they don't want Italian ones there↑ ((laugh))
146  SP:   ((amused tone of voice)) they take   ⌈ A:NYONE there        ⌉
147  I:                                          ⌊ ((wholehearted laugh)) ⌋ chiu:nque può
           andare lì ((chuckle))
                                                              anyone can go there
```

4. Conclusions

The study of interpreting conduct reported in this paper has revealed patterns of interaction whose complexity can hardly be described in terms of a voice simply "echoing", in turns, each of the other two. The concept of the "voice of interpreting" proposed here has emerged as a polyphonic and shifting variable, which was locally determined by the interpreters' perception of their own and the other participants' needs and orientations to the unfolding activity. Besides the numerous metalinguistic explanations of the patients' utterances, which are the more manifest instances of the interpreter's semantic autonomy and derive from the specific "activity system" (Bolden 2000: 415) characterising speech therapy, all of the three sessions have shown evidence of the interpreter's pronounced involvement in the interaction. This was seen as taking many forms: from her sharing in the speech pathologist's control of turn-taking and topic development, to her adopting the footings of principal, responder and, occasionally, pseudo-co-principal, to her making phatic, emphatic and explanatory additions and slowing down elocution for the benefit of the patient.

When read in the light of the chosen theoretical framework, these forms of conduct are seen to express a meaning and significance that we have attempted to explicate, albeit in a fragmented manner, in the successive layers of

our analysis, and that will be recomposed here in a more organic vision. Taking as a point of departure Mishler's description of voice in terms of functions of specific features of discourse, we have observed in all three sessions a clear predominance of the voice of the lifeworld, brought about not only by the SPs' frequent "translation" of the voice of medicine "into patients' terms" (Mishler 1984: 172), but by a second act of translation, this time of an inter-lingual nature, on the part of the interpreter. In other words, the latter's display of an interactionally powerful role, which at times took on the tones of authoritativeness characteristic of the VoM and at other times reflected the operational mode of the VoI, was encapsulated in her overall tendency to strengthen, by means of her competence in the patient's language, the healthcare practitioner's empathic model of communication.

The dynamics observed in the current study, where the medical providers were willing to cede the floor to both interpreter and patient, were open to the patients' concerns, and were ready to reassure and encourage them, are not representative of the findings of our earlier investigations (see note 3), where the translation of the VoM into the VoL generally occurred at the interpreting stage only. Underlying this minority medical practice is an ideal which has silently run through the entire paper and which, despite the descriptive nature of our research project, we have no difficulty in acknowledging as ours, the ideal of "humane medical care". Referring one last time to Mishler's work where he writes (1984: 185):

> […] it is clear that strengthening the voice of the lifeworld promotes both humaneness and effectiveness of care. The critical question is: How can the voice of the lifeworld be strengthened?

a partial answer to his question was given in this paper, where the creation of a relaxed and uninhibiting atmosphere was shown to be the product of a joint effort. In the specific circumstances of our sessions, where the patients' speech disorders necessarily limited their contribution to the interaction, this effort was made principally by the healthcare practitioner and the interpreter. Even in T.1, where the patient's ability to communicate was less severely impaired, the spontaneity of his remarks and the frequency of his questions were clearly encouraged by the attitudes of his interlocutors, although he was never found to actively share in their mirth. Whilst transcriptions might help researchers detect patterns that would otherwise escape attention owing to the evanescence of the oral medium, only by listening to the audio-tapes and, even more, by being physically present can this atmosphere be fully appreciated. And this is precisely what we witnessed in the three encounters, thanks not only to the

personalities of both the healthcare and interpreting professionals, but also to the latter's understanding of their role as "communicators", rather than "just translators".

As Wadensjö (1998: 284) points out, "primary parties are dependent on the interpreter's involvement in interaction to be able to contribute in their own right to a certain communicative atmosphere". This means that strict adherence to a dry, formal, passive and detached interpreting style, though it might be in line with an idealised notion of professional conduct, is not always the best way to serve one's clients, especially when their intention is to engage in a friendly and co-operative dialogue. Dialogue being an intrinsically relational activity, it would seem reasonable that "dialogue interpreters" should select their communication strategies on the basis of the relational models which characterise a given interaction. It is therefore a fortunate coincidence that the etymology of the term "dialogue" should point in that direction, as one of the meanings of the Greek verb *légein* is precisely "to choose", "to select".

Notes

1. Although this paper is the outcome of a joint research project carried out by the two authors, Sections 1.2, 2, 3.1, 3.2 and 4 were written by Raffaela Merlini, and Sections 1.1, 3.3 and 3.4 by Roberta Favaron.

2. The National Accreditation Authority for Translators and Interpreters (NAATI) was established by the Australian federal and state governments in 1977 and entrusted with the tasks of setting professional standards, developing and implementing accreditation procedures and approving interpreting and translation courses (Ozolins 1998: 40).

3. The 32 interpreted encounters were observed over a five-month period, from March through July 2001, in a number of Melbourne's healthcare facilities, including general hospitals, rehabilitation clinics, mental health centres, nursing homes and patients' houses. Since recording of most of the encounters (29 out of 32) was not allowed, the observation process was systematised through the use of an "observation sheet", containing a set of preselected parameters partly borrowed from systemic functional linguistics, which had to be filled in before, during and soon after the sessions. The results of this earlier investigation can be found in Merlini & Favaron (2003), Favaron (2004) and Merlini (2005).

4. For the purpose of straightforward identification with their roles, patients have been given fictitious names beginning with the letter "P", speech pathologists' names beginning with the letter "S", and interpreters with the letter "I". Moreover, to facilitate cross-referencing with the data contained in Favaron (2004), where the observational study is amply illustrated (see note 3), the interpreters' names have not been changed.

5. A research project run by Raffaela Merlini at the University of Macerata, Italy, is under way to build a corpus of recorded dialogue interpreting sessions in a variety of fields, including healthcare practice and immigration services. The long-term view is to integrate a quantitative perspective, once the corpus has acquired meaningful dimensions.

6. Habermas (1970) makes a distinction between two "modes of consciousness", the "technocratic", which is oriented to technical rules and transforms lifeworld problems into technical ones, and the "symbolic" expressed through ordinary language. In his view, the domination of the technocratic consciousness and the absorption of ordinary language by technical language lead to the distortion and suppression of human values.

7. Universality, affective neutrality and functional specificity are, according to Parsons (1951), the basic norms that underlie role relationships between patients and physicians.

8. In her insightful article on interpreters' involvement in history taking, Bolden (2000) uses Mishler's concept of the "voice of medicine" to show how medical interpreters can share the physicians' orientation towards obtaining objectively formulated and decontextualized descriptions of patients' symptoms.

9. In the remaining discussion, interpreters and doctors will be conventionally referred to as "she" and patients as "he".

10. Fairclough (1992: 138) engages here in a dialogue with Mishler (1984), from whom he takes the transcript of the medical interview in question, and elaborates on his dialectic representation of the interaction between the "voice of medicine" and the "voice of the lifeworld".

11. Conversationalists are able to detect a TRP through such signals as the end of a syntactic unit, pauses, changes in intonation and volume of voice, and kinesics.

12. Englund Dimitrova (1993) shows how some of the principles for turn-taking put forward by Sacks et al. (1974) do not apply to interpreted interaction. She mentions in particular principle 5 about non-fixed speaker order, a principle which is invalidated by the need for the interpreter to take a turn every other turn.

13. The term "trio" has been purposely chosen to convey both the general meaning of "group of three things" and, in a figurative sense, the reference to a performance by "three voices".

14. Examples are numbered consecutively. The acronyms T. 1, T. 2 and T. 3 identify the transcript from which a given excerpt has been taken, whilst the numbers in parentheses refer to the place of the reported lines in the transcript. For easier reference, the latter also appear beside each line. Idiomatic translations into English of the Italian utterances are shown in italics. Features of interest are shown in bold.

15. A much more extensive and questionable presence of this marked pattern is recorded by Bolden (2000: 393). In her study, the interpreter is frequently seen to proceed from a doctor-initiated question through an independent questioning sequence, which is then summarised for the doctor's benefit.

16. Englund Dimitrova (1997: 160) observes that the non-interpretation of feedback signals may be a deliberate strategy, since the interpreter might not perceive the feedback as an information-carrying part of the communication.

17. The 3 X's replace the name of the hospital.

18. It should be noted that in the earlier version of our model, the footing of principal also included those instances which are grouped here under responder. Moreover, the footings of recapitulator (a) and (b) have been renamed as "direct" and "indirect".

19. The mode of reporter outlined here goes beyond the restricted sense indicated by Wadensjö (1998: 93) of "animator" — which, as she rightly says, cannot apply to interpreting given the necessary production of linguistically different versions of the original utterances — and includes the notion of "author". As a result, the mode of recapitulator itself takes on new contours.

20. The opposite behaviour is recorded by Bolden (2000: 423–414), as she finds that patients' contextualized and subjective accounts are consistently dismissed and excluded from the interpreter's translations for the doctor.

21. Barik (1994 [1971]) created a "coding system" to classify how interpreters may omit, add or substitute material uttered by speakers, considering only the latter as a possible "error" and ruling out any attempt at evaluation; nevertheless, his system has crucially influenced subsequent research on *quality* in interpretation.

22. Following Wadensjö's terminology, a "rendition" is "a stretch of text corresponding to an utterance voiced by an interpreter", whereas "originals" are "all utterances voiced by primary interactants" (1998: 106).

23. A brief overview of Jakobson's model of the speech event is deserving of note: "Jakobson […] began to explore language as an interpersonal means of communication and developed his theory of the interrelation between the speech event and the functions of language. He argued that there are six factors of the speech event: speaker, addressee, code (language system), message (individual language usage), contact (means by which the message is transmitted), context — and that a predominance of focus on one of those factors determines one of the six major functions of language: emotive/expressive, conative (appeal-function), metalinguistic, poetic, phatic and referential, respectively." (Waugh 1994).

References

Abercrombie, D. (1994). Phatic communion. In R. E. Asher (Ed.), *The encyclopedia of language and linguistics*. Vol. 6. Oxford/New York/Seoul/Tokyo: Pergamon Press.
Altieri Biagi, M. L. (1985). *Linguistica essenziale*. Milano: Garzanti.
Altman, J. (1994). Error analysis in the teaching of simultaneous interpreting: A pilot study. In S. Lambert & B. Moser-Mercer (Eds.), *Bridging the gap: Empirical research in simultaneous interpretation*. Amsterdam/Philadelphia: Benjamins, 25–38.

Atkinson, J. M. & Heritage, J. (Eds.) (1984). *Structures of social action: Studies in conversation analysis.* Cambridge: Cambridge University Press.

Barik, H. C. (1994). A description of various types of omissions, additions and errors of translation encountered in simultaneous interpretation. In S. Lambert & B. Moser-Mercer (Eds.), *Bridging the gap: Empirical research in simultaneous interpretation.* Amsterdam/Philadelphia: Benjamins, 121–137 [First published in *META* 16 (4), 199–210, 1971].

Bolden, G. (2000). Toward understanding practices of medical interpreting: Interpreters' involvement in history taking. *Discourse Studies* 2 (4), 387–419.

Bussmann, H. (1996). *Routledge dictionary of language and linguistics.* Translated and edited by G. P. Trauth and K. Kazzazi. London/New York: Routledge.

Cesca, D. (1997). *Madrelingua versus non-madrelingua: studio sperimentale in interpretazione simultanea russo-italiano.* Unpublished thesis, SSLMIT, University of Trieste.

Critchley, M. (Ed.) (1978). *Butterworths medical dictionary.* London: Butterworths.

Crystal, D. (1992). *An encyclopedic dictionary of language and languages.* Oxford/Cambridge: Blackwell.

Drew, P. & Heritage, J. (Eds.) (1992). *Talk at work. Interaction in institutional settings.* Cambridge: Cambridge University Press.

Eggins, S. & Slade, D. (1997). *Analysing casual conversation.* London/Washington: Cassell.

Englund Dimitrova, B. (1993). Turntaking in interpreted discourse: Interplay of implicit and explicit rules. In K. Cankov (Ed.), *Problemi na sociolingvistikata. Ezikovata situacija v mikro- i makrosocialnite obstnosti.* Veliko Târnovo: Universitetsko izdatelstvo, 15–21.

Englund Dimitrova, B. (1997). Degree of interpreter responsibility in the interaction process in community interpreting. In S. E. Carr, R. Roberts, A. Dufour & D. Steyn (Eds.), *The Critical Link: Interpreters in the community.* Amsterdam/Philadelphia: Benjamins, 147–164.

Fairclough, N. (1992). *Discourse and social change.* Cambridge: Polity Press.

Falbo, C. (1999). Analisi degli errori: obiettivi, problemi, prospettive. In M. Viezzi (Ed.), *Quality forum 1997.* Trieste: SSLMIT, 73–80.

Favaron, R. (2004). *L'interprete ai raggi X.* Trieste: EUT.

Fele, G. (1999). L'analisi della conversazione come una sociologia particolare. In R. Galatolo & G. Pallotti (Eds.), *La conversazione. Un'introduzione allo studio dell'interazione.* Milano: Raffaello Cortina Editore, 23–42.

Frankel, R. (1990). Talking in interviews: A dispreference for patient-initiated questions in physician-patient encounters. In G. Psathas (Ed.), *Interaction competence.* Lanham, MD: University Press of America, 231–262.

Gentile, A., Ozolins, U. & Vasilakakos, M. (1996). *Liaison interpreting. A handbook.* Melbourne: Melbourne University Press.

Goffman, E. (1981). *Forms of talk.* Oxford: Blackwell.

Habermas, J. (1970). *Toward a rational society.* Boston, MA: Beacon Press.

Hayashi, R. (1996). *Cognition, empathy and interaction: Floor management of English and Japanese conversation.* Norwood, NJ: Ablex.

Jackson, C. A. (1988). Linguistics and speech–language pathology. In F. J. Newmeyer (Ed.), *Language: Psychological and biological aspects*, vol. 3 of *Linguistics: The Cambridge survey.* Cambridge/New York/Port Chester/Melbourne/Sydney: Cambridge University Press, 256–273.

Jakobson, R. (1990). *On language*. Ed. by L. R. Waugh & M. Monville-Burston. Cambridge/London: Harvard University Press.

Kopczynski, A. (1994). Quality in conference interpreting: Some pragmatic problems. In S. Lambert & B. Moser-Mercer (Eds.), *Bridging the gap: Empirical research in simultaneous interpretation*. Amsterdam/Philadelphia: Benjamins, 87–99.

Langdon, H. W. & Cheng, L. L. (2002). *Collaborating with interpreters and translators. A guide for communication disorders professionals*. Eau Claire, Wisconsin: Thinking Publications.

Langdon, H. W. (2002). *Interpreters and translators in communication disorders. A practitioner's handbook*. Eau Claire, Wisconsin: Thinking Publications.

Merlini, R. & Favaron, R. (2003). Community interpreting: Re-conciliation through power management. *The Interpreters' Newsletter* 12, 205–229.

Merlini, R. (2005). Alla ricerca dell'interprete ritrovato. In M. Russo & G. Mack (Eds.), *Interpretazione di trattativa. La mediazione linguistico-culturale nel contesto formativo e professionale*. Milano: Hoepli, 19–40.

Mishler, E. G. (1984). *The discourse of medicine: Dialectics of medical interviews*. Norwood, NJ: Ablex.

Nofsinger, R. E. (1991). *Everyday conversation*. Newbury Park: Sage Publications.

Ozolins, U. (1998). *Interpreting and translating in Australia: Current issues and international comparisons*. Melbourne: Language Australia.

Palazzi Gubertini, M. C. (1998). Des ajouts en interpretation. Pourquoi pas? *The Interpreters' Newsletter* 8, 135–149.

Parsons, T. (1951). *The social system*. New York: Free Press.

Roy, C. B. (1996). An interactional sociolinguistic analysis of turn-taking in an interpreted event. *Interpreting* 1 (1), 39–67.

Sacks, H., Schegloff, E. A. & Jefferson, G. (1974). A simplest systematics for the organization of turn-taking in conversation. *Language* 50 (4), 696–735.

Schegloff, E. A. & Sacks, H. (1973). Opening up closings. *Semiotica* 8 (4), 289–327.

Schegloff, E. A. (1992). On talk and its institutional occasions. In P. Drew & J. Heritage (Eds.), *Talk at work. Interaction in institutional settings*. Cambridge: Cambridge University Press, 101–136.

Silverman, D. (1987). *Communication and medical practice*. London: Sage.

Sinclair, J. McH. & Coulthard, M. (1975). *Towards an analysis of discourse: The English used by teachers and pupils*. Oxford: Oxford University Press.

Viezzi, M. (1996). *Aspetti della qualità in interpretazione*. S.eR.T. 2. Trieste: SSLMIT.

Wadensjö, C. (1998). *Interpreting as interaction*. London/New York: Longman.

Waugh, L. R. (1994). Jakobson, Roman (1896–1982). In R. E. Asher (Ed.), *The encyclopedia of language and linguistics*. Vol. 6. Oxford/New York/Seoul/Tokyo: Pergamon Press.

Zimman, L. (1993). Intervention as a pedagogical problem in community interpreting. In C. Dollerup & A. Lindegaard (Eds.), *Teaching translation and interpreting 2*. Amsterdam: Benjamins, 217–224.

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Appendix: Transcription key

Symbols	Meaning
A ⌈⌈well I said B ⌊⌊Yes	utterances starting simultaneously
A she's ⌈right ⌉ B ⌊huh mm⌋	overlapping utterances
A I agree= B =me too	latched utterances
(.)	untimed pause within a turn
((pause))	untimed pause between turns
↑	rising intonation
wo:::rd	lengthened vowel or consonant sound
word – word	abrupt cut-off in the flow of speech
<u>word</u>	emphasis
WORD	increased volume
°word°	decreased volume
>word<	quicker pace
((word))	relevant contextual information; characterisations of the talk; vocalisations that cannot be spelled recognisably
(word)	transcriber's guess
( )	unrecoverable speech

Fillers		Meaning
English	*Italian*	
umm	umm	doubt
mhm	mhm	expression or request of agreement
ah	ah; eh	emphasis
eh	eh	query
uh	ehm	staller
oh	oh	surprise