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同理心、態度中立和醫療口譯員角色

Empathy, Neutrality and Roles of Medical Interpreters

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Abstract

This study aims to understand how empathy is demonstrated in medical interpreting and explain the inconsistent views of medical interpreting service users on different medical interpreters' roles. Among the four roles adopted by medical interpreters, surveys on service users and interpreter's codes of ethics show that some tasks taken by an advocate are regarded controversial while behaviors of a conduit, a clarifier and a culture broker are considered appropriate.

Comparing settings, communicative skills and attitudes of neutrality between medical interpreters and empathizers, great similarities are identified. Based on the confirmation that medical interpreters empathize with service users, this study expands levels of expressed empathy and empathy cycle models in a monolingual two-way setting to a bilingual three-way setting. Published cases of medical interpreting are analyzed to find that:

- Roles of conduit, clarifier and culture broker perform interpreting and express empathy while an advocate neither performs interpreting nor expresses empathy in most of the cases. Roles of conduit, clarifier and culture broker are thus neutral while an advocate is mostly not neutral;
- A culture broker also empathizes with the receiver of the rendition and thus expresses advanced empathy with the speaker by making implicit culture factors explicit in rendition or domesticating the source utterance in the way the receiver is used to;
- A clarifier and a culture broker prioritize their tasks of communication facilitation over merely linguistic transformation like a conduit while an advocate values on defending service users' rights or more often on expressing personal opinions.

Findings of this study can be utilized to provide a theoretical framework of roles for medical interpreters in practice. Medical interpreters therefore can have a clearer awareness of role switching, the possible negative consequences of adopting the non-neutral role and how to demonstrate empathy. In addition, to establish an independent organization of medical interpreting is suggested. The organization should be responsible for medical interpreters' training and supervision, dispatch of medical interpreting services, mediation between interpreters and stakeholders of medical services when conflicts arise and so forth. Through this system, medical interpreters are more likely to maintain a neutral stance. In terms of training medical interpreters, results suggest that the content of training should include clear

framework of roles, concept and skills of empathy, the demonstration of neutral attitudes and how to work with the organization.

Key words: medical interpreting, roles of medical interpreters, empathy, neutrality

摘要

本研究的目的有二：了解同理心如何融入醫療口譯，以及試圖解釋為何醫療口譯服務使用者對不同醫療口譯員的角色看法不同。本研究整理醫療口譯服務使用者對醫療口譯員的觀點調查和醫療口譯員的倫理守則，發現醫療口譯員的四種角色中，傳聲筒、澄清者、文化中介者的角色行為被視為恰當行為，倡議者的角色行為則有許多爭議。本研究假設這個現象和口譯員的態度中立與否有關，由於中立態度非常抽象，但剛好是同理心的必備條件，因此本研究用同理心理論來檢驗各個口譯員角色的態度，以驗證研究假設並達成第二個研究目的。同理心理論同時用以探討同理心融入醫療口譯的方法，並達成第一個研究目的。

本研究比對醫療口譯和同理心，發現在情境、口譯員和同理者的溝通技巧與態度中立上有很多相似處，並由此驗證口譯員也有同理口譯服務使用者。本研究因此依據單語醫療情境中的同理心理論模型，加入雙語情境的特性，發展雙語醫療情境中的同理心理論模型，包括表達同理心模型和同理心環模型。用這些理論模型以及同理心的表達技巧檢驗各醫療口譯員角色的態度，研究結果發現：

1. 傳聲筒、澄清者、文化中介者都忠實翻譯使用者的語意，並表達對講者的同理心給聽者聽，但倡議者的多數角色行為既非翻譯，也沒有表達同理心。因此傳聲筒、澄清者、文化中介者的態度是中立的，而倡議者的態度多為不中立，此發現驗證本研究的假設。
2. 擔任文化中介者的醫療口譯員在翻譯講者的語意時，因為同理聽者和講者的文化差異，而表達對講者的高層次同理給聽者聽，亦即在譯文中顯化(explicitation)講者未明確說出的文化意涵，或歸化(domestication)講者的表達至符合聽者文化背景的表達方式，以增進雙方對彼此的了解並協助溝通。
3. 傳聲筒角色只負責語言轉換，澄清者、文化中介者則認為協助溝通是他們的首要工作，倡議者則最重視捍衛醫療口譯服務者的權利或表達其個人意見。

本研究提出醫療口譯員的角色架構，並強調同理心和態度中立的重要，應用至醫療口譯理論中，能幫助口譯員清楚覺察角色轉換、了解採取非中立角色行為可能的負面影響，並學習如何在醫療口譯中融入同理。本研究建議政府建立醫療口譯中介機構，由該機構負責培訓口譯員、提供口譯員諮詢、媒合口譯服務、協調服務使用者和口譯員的溝通、提供客訴服務…等，倡議者角色的非中立行為即可由該中介機構負責，讓口譯員的角色功能更一致。本研究結果亦可運用至口譯員訓練課程，幫助口譯員了解自己的角色及功能、同理心的概念與技巧、態度中立的重要，以及和中介機構的合作與角色分工。

關鍵字：醫療口譯、醫療口譯員角色、同理心、態度中立

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Chapter One
Introduction

1.1 Research Motivation and Purpose

This study is motivated by the interest in empathy, which has been said to be relevant to medical interpreting (Gentile *et al*., 1996; Hale, 2007). Nevertheless, there has been no in depth discussion about the reasoning behind this relevance and how to demonstrate empathy in medical interpreting. Empathy and medical interpreting literature share similar vocabulary but the interactions among these terms are not clear. If they use similar terms, can the two topics be integrated and may be reinforce the theoretical foundation of each other? For example, neutrality, an important factor that is influential to medical interpreting (Wadensjö, 1998; Hale, 2007; Roat, 2011), is a term used in both topics (VandenBos, 2007; Wadensjö, 2009); however, it is unclear whether neutrality refers to the same meaning in the two topics. Another motivation is that different roles the medical interpreters play are mentioned (Pöchhacker, 2000; Roy, 1993/2002) but no systematic analysis has been conducted to investigate how the roles relate to each other. If a theoretical foundation can be established, can it be applied to categorize roles that are mentioned in the literature? To sum up, the motivation of this study is to clarify the relevance between empathy and medical interpreting with interpreters' roles being the sub-category. This study is also motivated to understand how neutrality relates to these two topics.

The purpose of this study is thus to identify the similarities between empathy and medical interpreting so to understand how empathy can be incorporated into the process of medical interpreting. In addition, this study also aims to explore how different medical interpreters' roles demonstrate empathy and neutrality in the hope of having a clearer understanding of the differences among these roles. The ultimate goal is to propose a systematic framework of these roles as the theory foundation of

medical interpreters' appropriate level of involvement.

1.2 Research Scope

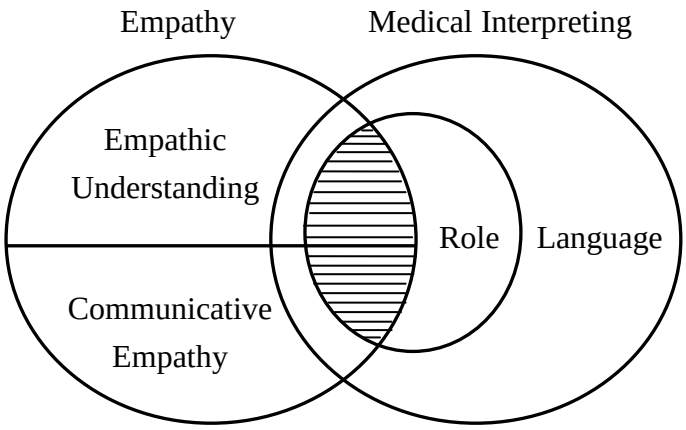

Figure 1.1 Research Scope
Source: compiled by this study

The scope of this research is empathy demonstrated under the setting of medical interpreting. Empathy is a concept that can be applied to various contexts (Gladstein, 1983; Duan & Hill, 1996). It is widely used in psychotherapy (Rogers, 1975; Egan, 1975,1998) and contains several components in the process (Truax & Carkhuff, 1967; Barrett-Lennard, 1981,1993). In this study, only the parts that are related to a mediated bilingual setting will be studied. On the other hand, medical interpreting refers to interpreter-mediated medical conversations between the healthcare provider and the patient (Hale, 2007). There are studies focusing on various aspects of medical interpreting. For example, medical interpreters' roles, job satisfaction, training, credentials, quality of interpreting (Fan, 2011), etc. This study aims to investigate how empathy is demonstrated when a medical interpreter assumes different roles. Therefore, certain aspects of medical interpreting, such as issues of language, power structure and service quality, will not be discussed. The research scope is visualized as *Figure 1.1*.

1.3 Research Questions and Method

Based on the research motivations and scope mentioned in previous sections, the research questions are compiled as the following:

1. Can empathy theory be applied to medical interpreting? If yes, how empathy is demonstrated in medical interpreting?
2. What are the empathy models in the context of medical interpreting?
3. Can neutrality distinguish appropriate roles of medical interpreters from the controversial one?

The method adopted to answer the first question is to compare the similarities between empathy and medical interpreting, which gives a clear picture of how to incorporate empathy in medical interpreting. To find the answer for the second question, two-party empathic interaction is compared with three-party communication. Empathic models in medical interpreting are developed based on the two-party empathic process model (Carkhuff, 1969; Barrett-Lennard, 1993). Answer to the third question is found through case studies by examining the neutral attitudes of different medical interpreters' roles with empathic theories and models in medical interpreting.

1.4 Research Structure

Subsequent to this introductory chapter, Chapter Two reviews the literatures concerning the essence and categorization of interpreting as well as the roles and neutral attitudes of medical interpreters. Chapter Three reviews the literatures related to the essence, process and communicative skills of empathy. In Chapter Four, similarities between medical interpreting and empathy are identified. It is followed by the development of empathic models in medical interpreting. These models as well as communicative skills of empathy are used in Chapter Five to examine medical interpreting cases performed by different roles. Chapter Six sums up the answers to

the research questions and discuss the implications of these findings to the field of medical interpreting in theory, system and training. Research limitations and recommendations for further studies are also given.

1.5 Definition of Terminology

Due to that it is a pioneering study applying empathic theories to medical interpreting, definitions of terminologies are compiled in this section for readers to have an overview in advance. The section that explores a certain terminology in detail is also given in brackets for readers' reference.

- Interpreting: To deliver the speaker's meanings to the addressee in another language (Hale, 2007). [Section 2.1.1]
- Medical interpreting: It is a communicative event that takes place in private practice and healthcare institutions and participated by the healthcare provider, the patient and the medical interpreter (Hale, 2007). [Section 2.1.2.2]
    - Narrow-sense of interpreting: The rendition that is based simply on primary parties' explicitly expressed utterances. [Section 2.4]
    - Broad-sense of interpreting: Medical interpreters make clarifications or include primary parties' explicitly and implicitly expressed utterances, such as unclear messages and social background of the primary parties, in the rendition. [Section 2.4]
    - Non-interpreting: Expressions that are not based on the source information given by the primary parties and are delivered without the presence of both primary parties. [Section 2.4]
- Role: It is a social position performing certain behavior patterns that are subject to expectations held by participants within the context (Borgatta & Montgomery, 2000). [Section 2.2]

- Conduit: A role that converts verbal and non-verbal information into another language faithfully, accurately, without omission, addition and edition. [Section 2.2.1 & Section 5.1.5]
- Clarifier: A role that facilitates primary parties' mutual understanding of non-cultural related factors and alerts primary parties of possible misunderstanding. [Section 2.2.2 & Section 5.1.5]
- Culture broker: A role that bridges the culture gap between primary parties to facilitate level of understanding. [Section 2.2.3 & Section 5.1.5]
- Advocate: A role that acts on behalf of a user, provider or patient, for his/her benefits and rights either within or outside of medical encounters. [Section 2.2.4 & Section 5.1.5]

- Empathy: To accurately perceive another person's internal meanings and feelings as if one were the person, but without losing one's awareness that the meanings and emotions belong to the other (Rogers, 1959). Then this perception is communicated back to the other without prejudice to check one's accuracy of the understanding (Rogers, 1975). [Section 3.2]
  - Empathy Cycle: The process of empathy involves five steps, Empathic Setting, Empathic Resonation, Expressed Empathy, Received Empathy and Feedback (Barrett-Lennard, 1981, 1993). [Section 3.5]
  - Basic empathy: One of the levels of Expressed Empathy indicating that what person B expresses is interchangeable in meaning and feeling with what person A responses (Carkhuff, 1969). [Section 3.3]
  - Advanced empathy: One of the levels of Expressed Empathy indicating that implicit and deeper meanings and feelings in person B's expressions are added to person A's responses (Carkhuff, 1969). [Section 3.3] Person B's implicit meanings and affect can be derived from his/her verbal and

non-verbal information as well as context, such as cultural expectations, register and education background. (Hill, 2009). [Section 3.4.4]

- Communicative skills adopted in empathy and medical interpreting:
    - Active listening: A concentrating state of mind (Gentile *et al.*, 1996; Egan, 1998) to grasp the meaning of and connections in the other person's expressions (Jones, 1998; Hill, 2009). [Section 3.4.1 & Section 4.1.2.1]
    - Paraphrasing: To rephrase the other's meanings in one's own words without alteration of meaning (Robinson, 1998; Smaby & Maddux, 2011). It is adopted to demonstrate basic empathy (Huang, 1991). [Section 3.4.2 & Section 4.1.2.2]
    - Emotional reflection: To rephrase the other's feelings derived from his/her verbal and non-verbal information as well as the context (Hill, 2009). It is adopted to demonstrate basic empathy (Huang, 1991). [Section 3.4.3]
    - Therapeutic interpretations: Give new meanings or explanations to the other's experiences based on the other's past experience, culture and so forth (Hill, 2009). It is adopted to demonstrate advanced empathy (Huang, 1991). [Section 3.4.4 & Section 4.1.2.3]
    - Explicitation: To explain the implicit meanings in the source utterance explicitly in the target utterance (Klaudy, 2009). [Section 4.1.2.3]
    - Domestication: To render the source language in a way the receptor of target language is used to (Munday, 2008). [Section 4.1.2.3]
- Neutrality: It is demonstrated by user-centered, preference free and non-judgmental attitudes (VandenBos, 2007; Hornby, 2010) to all service users. [Section 2.3 & Section 4.1.3]
    - User-centered attitude: No suggestions are given by the neutral person and thus the client's autonomy is respected. [Section 2.3 & Section 4.1.3]

- Preference free attitude: The neutral person does not imply agreement or side with any of the participating parties in a communicative activity. [Section 2.3 & Section 4.1.3]
- Non-judgmental attitude: The neutral person expresses neither judgments nor prejudice and is emotionally detached. [Section 2.3 & Section 4.1.3]

Chapter Two

Medical Interpreting

2.1 What Is Interpreting?

2.1.1 Interpreting as a Process

Interpreting is resulted from language varieties and the demand for communication between speakers of different languages throughout the history; it is therefore one of the oldest forms of human communication (Gentile *et al.*, 1996). The goal of interpreting is that the message expressed by the speaker creates same influence on an audience whose mother tongue is either the same as or different from the speaker's (Angelelli, 2000).

For a long time, interpreting had been considered a branch of translational activities (Hale, 2007). Practitioners later create a distinction between translation and interpreting, in which interpreter converts oral messages while translator converts written texts from one language to another (AIIC, 2012). The *immediacy* of interpreting is one of the major features that makes it different from translation (Pöchhacker, 2004). Interpreters are demanded to immediately comprehend and analyze the oral message that is presented only once "without the opportunity to consult references…or correct and edit their final product" (Hale, 2007, p.8). The communication between the participants – speakers, addressees and interpreters – is also immediate in contrast to the indirect contact between the author and reader of a written text (AIIC, 2012).

According to Hale (2007), various scholars define interpreting from different perspectives, but the general principle is to mediate the transformation of speaker's message to addressee in another language. The relation between source/input and target/output language is often described as equivalence; however, there have been

different arguments about levels of faithfulness to the source utterance, ranging from literal rendition to interpreting the meaning of the source utterance. The denotation of the word “interpreter” in Latin, referring to the person explains the meaning or facilitates others’ understanding of the things they find difficult (Pöchhacker, 2004), supports the idea that it is the meaning instead of form equivalence between input and output utterances. Interpreter’s professional organization, International Association of Conference Interpreters (AIIC, 2005) also states that interpreting is neither word-for-word or verbatim conversion nor parroting, but meaning transformation.

In addition, recognized by the field of interpreting as one of the influential theories (Angelelli, 2000), Seleskovitch (1978) proposed that interpreting is a process in which interpreter comprehends and produces the “sense” of source utterance. The process involves three stages: perception, comprehension, and expression. At the stage of comprehension, interpreters de-verbalize the source text to understand the sense. “Sense” is “(1) “conscious”, (2) “made up of the linguistic meaning aroused by speech sounds and of a cognitive addition to it,” and (3) “nonverbal”, that is, dissociated from any linguistic form in cognitive memory” (Seleskovitch, 1978b; cited from Pöchhacker, 2004, p.97). To understand the sense, she emphasized the importance to relate the meaning of source utterance with “background knowledge, familiarity with the speaker, the topic, and the purpose for delivering the message” (Roy, 1993/2002, p.348).

Other prominent scholars provide explanations of the knowledge that interpreters access to in performing accurate interpreting. Moser-Mercer (1997/2002), based on information processing theory, compiled the knowledge being stored in and extracted from interpreter’s long-term memory to short-term working memory during interpreting, including phonologic, syntactic, semantic, contextual and general knowledge. Hale (2007) highlighted the importance of the contextual knowledge such

as intention behind the source utterance and cross-cultural differences. The role of both long- and short-term memory is therefore crucial to interpreter's work.

2.1.2 Categorization of Interpreting

Alexieva (1997/2002) categorized currently existing parameters of interpreting into two broad headings: mode and elements of the communicative situation. Mode distinguishes consecutive interpreting from simultaneous interpreting while elements of communication refer to participants (with speaker and addressee as the primary parties and interpreter as the secondary party), topic, communicative goal and so forth. In this study, her demarcation is adopted and the elements are preserved but the heading of "elements of the communicative situation" is replaced by "setting". The scope of setting is therefore expanded to include not only the place where interpreting takes place, but also other elements involved during the process of interpreting.

2.1.2.1 Interpreting by Mode

Simultaneous interpreting (SI) and consecutive interpreting (CI) are two basic working modes of interpreting (Gentile *et al*., 1996). The distinction between the two occurred only in the 1920s when the development of ancillary equipment, such as headphones and microphones, made simultaneous interpreting possible (Pöchhacker, 2004).

The major difference between SI and CI is the time when interpreters start to render (Kelly, 2008). CI "entails waiting for the speaker to complete a speech or a segment thereof before the interpreting begins" whereas SI "entails starting the interpretation soon after the speaker begins and continuing until just after the speaker has finished" (Gentile *et al*., 1996, p.22). In addition, according to Alexieva (1997/2002), the continuous delivery of source and target utterances in SI makes

interactions between the primary parties as well as between primary parties and interpreter indirect, which in turn leads to a more formal and less culturally noticeable type of communication. On the contrary, CI is a direct and face-to-face interaction in which speaker, addressee and interpreter are present in the same room. Furthermore, Pöchhacker (2004) said that interpreters demonstrating CI of longer speeches usually adopt note-taking skills whereas the skills are less used in SI. However, using note-taking skills is labeled as 'classic' consecutive, in comparison to "short CI" without notes. The length of the segments of short CI can be considerable but is generally shorter than classic CI (Gentile *et al*., 1996). It is usually adopted in dialogic mode in community interpreting, which will be given more elaboration in the next section. Referring these features to medical interpreting, the communication between healthcare provider, patient and interpreter is direct, face-to-face, in dialogic form and short segments. Medical interpreter adopts short CI mode to perform rendition.

On the other hand, whispering and sight translation are two special types of SI (Pöchhacker, 2004). Whispering is adopted when ancillary equipment is not at hand. In contrast to rendering for large international audience through SI mode, interpreter working in whispering sits right next to one or a few number of addressees so his/her rendition could be heard (Alexieva, 1997/2002). This working mode is sometimes used in medical encounters (Hale, 2007). In terms of sight translation, or sight interpreting as a more correct name, the interpreter renders simultaneously with the reception of the source text in written instead of audio form. This type of interpreting service could be provided either to a large group of audience with the aid of ancillary equipment in a simultaneous mode or to a small group of people in a consecutive mode (Pöchhacker, 2004). According to Roat (2011), medical interpreters sometimes are required to assist sight interpreting of the documents provided by the healthcare institutions for patients to read, fill in or bring home. The purposes of this service are

to make sure that patients have ample information to decide their treatment plans and at the same time protect the healthcare institutions if unexpected negative result takes place. Since these documents and consent forms are legally binding, interpreters should render everything written on the document.

2.1.2.2 Interpreting by Setting

Interpreting, according to Pöchhacker (2004), takes place when people with different background in language and culture communicate for certain goal in inter-social or international settings. Interpreter-mediated communication also occurs in intra-social settings where diverse ethnic groups of people live within one country. Pöchhacker analyzes the features of interactions in inter- and intra-social settings and categorizes these features into different types of interpreting: conference and community interpreting, which as Hale (2007) said is the major classification in the field of interpreting.

Conference interpreting service has been applied to international meetings after World War II the Nuremberg war crimes trials, in which technology development enabled interpreters to work in sound-proof booths and conduct simultaneous interpreting with ancillary equipment (Gentile *et al*., 1996). On the other hand, community interpreting has only become the center of focus after 1980s when the interpreting service demand rises in public-sector institutions under the background of immigration (Pöchhacker, 2004). It often takes place "at police departments, immigration departments, social welfare centers, medical and mental health offices, schools and other institutions" (Wadensjö, 2009, p.43). The goals of conference and community interpreting are as follows: Conference interpreting aims to facilitate addressees of a communicative activity to comprehend a speaker whereas community interpreters help people obtain social services in public institutions (Kelly, 2008).

Apart from differences in places and goals, Gentile *et al*. (1996) also mentioned factors that distinguish community interpreting from conference interpreting, such as that a community interpreter renders into both language directions, works by him/herself rather than with a partner in a dialogue with participants often having different social status. The status difference can also be manifested in different linguistic varieties and registers. Moreover, Hale (2007) highlighted the importance of accurate rendition and negative consequences of inaccuracy. Differences of community and conference interpreting are compiled as *Table 2.1*.

Since medical interpreting is one of the major domains under community interpreting (Pöchhacker, 2004), more elaboration of community interpreting will be given. Community interpreting is a three-party interaction, with the bilingual interpreter being the secondary party (Alexieva, 1997/2002) to mediate communication between two monolingual primary parties speaking different languages (Pöchhacker, 2004). Each primary party may consist of an individual or more people (Gentile *et al.*, 1996). According to Alexieva (1997/2002), communication in community interpreting is composed of instinctive, extemporized utterances and personal issues, the intensity of direct interaction between three parties – speaker, addressee and interpreter – is therefore high. In addition, the roles of speaker and addressee are adopted by different primary parties in turn (Gentile *et al*., 1996). As a result, each party pays close attention to the content and manner of speech of other participants, such as facial and body language (Alexieva, 1997/2002). To work on the message instead of language, the interpreter needs to *empathize* with the primary parties in turn at each exchange (Gentile *et al*., 1996).

Table 2.1 Differences between Community and Conference Interpreting

	Community Interpreting	**Conference Interpreting**
Language Directionality	Bidirectional/dialogic	Mostly unidirectional
Form of Communication	Face-to-face	One-to-many
Output Language	Equal amount of work into both languages	Most of the work into one language (interpreter's A language, generally)
Linguistic Varieties	Maximum potential for linguistic varieties of the same code (in both languages)	Minimum potential for linguistic varieties of the same code (in only one language, the speaker's)
Register	Maximum potential for different registers	Minimum potential for different registers. (formal, in general)
Consequences of Inaccurate Rendition	High	Medium
Level of Accuracy Required	High	Medium
Backgrounds and Status of Service Users	Maximum potential for different backgrounds and status between the parties	Minimum potential for different backgrounds and status between the parties
Interpreter's Control over the Flow	Possibility of controlling the traffic flow	Less likely to control the speaker
Number of Interpreters	One (working alone)	Two (working as a team)
Social Status of Interpreters	Community interpreting remains a low-status profession and have low levels of remuneration	Interpreters is recognized a high-status profession and therefore enjoy high levels of remuneration

Source: compiled by this study from Gentile *et al*. (1996), Angelelli (2000), Hale (2007), Pöchhacker (2004), Wadensjö (2009)

The size of the participants and the dialogic form of communication make community interpreters have opportunities to ask the speaker to repeat a segment that

they have not heard clearly or understood comprehensively (Gentile *et al*., 1996). They may also ask for explanation and clarification (Angelelli, 2000) or point out when they think there has been a misunderstanding (Hale, 2007). As a mediator who shares cultural background with at least one of the primary parties, community interpreter is more likely to discover how differences between primary parties, such as social status and background as listed in *Table 2.1*, affect the communication (Angelelli, 2000). A great amount of studies therefore suggest that community interpreters should assume broader roles with greater involvement in the communication, comparing to the role of conference interpreter as a conduit, which is only responsible for linguistic transformation (Pöchhacker, 2004).

However, community interpreters are demanded to perform "a high level of neutrality and detachment" (Wadensjö, 2009, p.44). While studies show that community interpreters should adopt broader roles, it is also interpreter's duty not to involve to the extent that may weaken professional performance (Gentile *et al*., 1996). Professional community interpreters and trainers of community interpreting have diverse opinions about the roles and proper level of involvement of community interpreters; therefore, debate about interpreters' neutrality and detachment has been one of the major issues of the field (Wadensjö, 2009). More exploration of issues related to roles and neutrality is given in the following sections.

Within studies of community interpreting, medical interpreting and legal interpreting are the two major domains (Pöchhacker, 2004). Features of community interpreting mentioned in the previous section are consequently applicable to both. Issues of neutrality and detachment are also the center of debate.

Although there is much in common between medical and legal interpreting, such as principles of impartiality, fidelity and confidentiality are emphasized and the consequences of communication in these settings affect clients' lives, there are also

significant differences in the practice of medical and legal interpreters (Hale, 2007). According to Hale (2007), medical interpreting takes place in "private practice, hospital settings and consultations with other health care professionals" (p.36) and is participated by healthcare provides, patients and an interpreter. On the other hand, compiled by Gamal (2009), legal interpreting takes place mainly in courtrooms, sometimes in police sections, attorneys' chambers, customs and immigration offices with legal professionals, clients and interpreter(s) as participants. Hale (2007) also mentioned that although the expressions used in these settings are important to both medical and legal interpreting because they may impact the result, the intentions behind the expressions in both settings are different. Medical consultations are not adversarial so physicians ask questions to gain information that facilitates them to help the patient. However, the courtroom is adversarial and lawyers tend to ask questions to draw forth the answers they want to support the case. In addition, patients are allowed to ask questions at any time in medical encounters while only lawyers can initiate questions in the courtroom. Finally, since medical consultation is a private and informal setting, rather than a public setting that is governed by strict rules of evidence as in the courtroom, the demand for neutrality is less apparent. However, there is yet consensus on this point.

The private and informal setting of medical encounters where the healthcare provider's goal of communication is to express clearly and be understood by the patient makes it possible for medical interpreters to assume tasks taken by non-conduit roles (Hale, 2007). Kaufert & Putsch (1997) argued that unlike legal interpreting, major disparities in cultural background often occur in medical interpreting. In order to enhance mutual understanding between primary parties, medical interpreters are required to "engage in explanations, culture brokerage and mediation when these actions are necessary" (P.75). Hsieh (2006) also observed that

medical interpreters take actions intending to manage interactions between healthcare provider and patient. Roles of interpreters are therefore important issues in studies of medical interpreting.

In addition, empathy has been found to be relevant to successful medical encounters. Hale (2007) said that successful communication in medical setting is relevant to attentive and empathetic listening to the patient, not only to his/her verbal expressions but also to the non-verbal responses (Vasquez & Javier, 1991). Harres (1998) also observed that providers use tag questions to express empathy with the patient. Reynolds and Scott (1999) found that research evidence supports empathy being crucial to a helping relationship and thus argued for applying empathy to clinical nursing. They offer operational definition of empathy in the setting which is to accurately perceive patient's world and communicate this understanding to the patient. Moreover, since the outcome of the medical consultation depends highly on the rapport between physician and patient (Tebble, 1999) while empathy produces supportive communication and develop relationship (Redmond, 1989), it can be argued that empathy is vital to successful medical communication. However, there have been no in depth discussions about how to demonstrate empathy in medical interpreting yet. One of the goals of this study is therefore about the ways of incorporating the concept and skills of empathy into medical interpreting.

2.2 Roles of Medical Interpreters

Role of community interpreters has been one of the most prominent topics in interpreting studies (Pöchhacker, 2004), particularly on the expanding roles other than conduit (Avery, 2001). Diverse names are given to describe medical interpreter's roles, such as "clarifier, explainer, cultural mediator, helpmate or agent" compiled in Pöchhacker's study (2000, p.65), communication facilitator, linguistic intermediary,

bilingual and bicultural communicator in Roy's study (1993/2002), leading to confusion in their definitions, duties and consequences of conducting a certain role (Hale, 2007). Based on the approximation between source and target utterance (Roy, 1993/2002), Avery (2001) proposed an incremental intervention model to compare roles, "ranging from the least intrusive role of conduit, to clarifier, to culture broker…and finally, to the most intrusive role of advocate" (p.9). Since this study will touch upon the issue of interpreter's involvement in the communication in section 2.3 and Avery has provided a preliminary model that distinguishes interpreter's level of involvement of each role, this study therefore adopts his way of classification and compiles descriptions related to those four different roles in this section to give a clearer shape of each role.

In addition, medical interpreting service users' expectations and medical interpreter's codes of ethics are reviewed to understand better their perspectives on the acceptability and appropriateness of the behaviors performed by each role. In sociology, role refers to a social position performing certain behavior patterns that are subject to expectations held by participants within the context (Borgatta & Montgomery, 2000). Many studies have demonstrated that interpreter is an active co-participant of medical encounters (Roy, 1993/2002; Wadensjö, 1998; Angelelli, 2004; Hsieh, 2007). Therefore, the appropriateness of medical interpreter's behaviors is shaped by expectations of healthcare provider (or "provider" in short), patient and interpreter. Surveys on primary parties' expectations are cited in this section, so are community interpreter's codes of ethics, which is the embodiment of working interpreters' collective expectations and regulations of proper behaviors (NCIHC, 2004).

2.2.1 Conduit

Adopting a conduit role implies that the medical interpreter bridges healthcare provider and patient who speak different languages (Hale, 2007), that facilitates them to communicate in a way that is similar to interaction in monolingual settings (Avery, 2001). Interpreters are required to reproduce the source utterance faithfully, accurately and completely in the rendition (Dysart-Gale, 2005). No addition, omission or editing is allowed (Avery, 2001). These requirements originate from the key assumptions behind conduit model of communication: "there is underlying objective knowledge in the world that has universal applicability; language can be a medium for representing objective knowledge and words have fixed meaning; human beings can achieve universality of understanding since fixed meanings of words can be communicated objectively from one person to another" (Boland & Tenkasi, 1995, p.354). The conduit role restrains the medical interpreters' duties from going beyond language transformation (Avery, 2001).

Interpreter's codes of ethics and surveys on users' expectations both reflect the emphasis on accurate rendition. In *National Code of Ethics for Interpreters in Health Care* developed by the National Council on Interpreting in Health Care (NCIHC) in the US, accurate rendition is highlighted as the second principle after confidentiality. On the other hand, Hale's (2007) survey conducted in Sydney, Australia found that accurate rendition is considered the medical interpreters' most important duty (50% of the responding doctors). To interpret accurately refers to convey both verbal and non-verbal information of speaker's expression faithfully. To be able to deliver speaker's verbal information, interpreter's language proficiency in source and target languages is the primary expectation (96%) of provider and patient toward interpreter (Mesa, 2000). Background knowledge of health issues, such as formality of service and professional jargon, is also considered vital to interpreting by provider (Hale,

2007) and patient (Alexander *et al*., 2004). On the other hand, "the manner of speech is just as important as the content of the speech" (Hale, 2007, p.152). The NCIHC National Code of Ethics (2004) suggested that "gestures, body language, and tone of voice… add significantly to the content of message" (p.13). Other non-verbal information, such as patient's talking speed, change in emotion and illogical expressions, is expected to be expressed in the rendition particularly by psychiatrists as critical clues of diagnosis and treatment (Roat, 2011).

There are consequences when accuracy is compromised. Mesa (2000), conducting survey on healthcare workers in Quebec, said that they attribute the difficulties of making accurate assessment and diagnosis with medical interpreter's addition, omission and alteration in meaning of the source language. From clinician's perspective, Vasquez and Javier (1991) also mentioned that these behaviors are mistakes which may detain clinicians' crucial interventions and put patients' life in danger.

Proponents of faithful interpreting, which is different from verbatim rendition, argue that this approach yields many advantages to both primary parties. First, it empowers patients by facilitating them to access all information and make decisions on their own (Hale, 2007). Patients' participation of deciding their treatment plans ensures their compliance with the treatment (Mesa, 2000). Second, language and ways of expression used by the provider to build relationship with the patient could be delivered, which affects outcomes of the encounter significantly (NCIHC, 2004). Third, provider can control the effectiveness of communication (Hale, 2007). Finally, it keeps the focus of communication on patient-provider interaction (Roat, 2011).

However, the conduit model is seriously challenged on its assumption of passively conveying meanings and limitation to language transformation. Rather than drawing out meanings that are already embedded in the sentences, Wilcox and Shaffer

(2005) argued that interpreters actively form the speakers' meaning according to their verbal and non-verbal expressions. Many prominent scholars also challenge the idea of interpreter being "invisible" (Angelelli, 2004). Interpreters' visibility refers to that they "influence the process and content of the provider-patient interactions" (Hsieh, 2007, p.925) and they, at the same time, are influenced by the interaction of social elements within the context. These scholars argue that interpreters conduct tasks more than rendering the speaker's explicit expressions and thus are visible (Angelelli, 2004). In addition, Avery (2001), Kaufert and Putsch (1997) argued that accurate rendition requires more than linguistic transformation, cultural and institutional contexts are also critical. Furthermore, an alienated attitude adopted by conduit in apparently ineffectual or offensive interactions is criticized "as unacceptable and as morally and legally irresponsible" (Avery, 2001, p.9). These arguments lead to expanding roles other than conduit in the medical setting.

2.2.2 Clarifier

Avery (2001) gave no clear description of the role of a clarifier when the term was first coined. Dysart-Gale (2005) based on Avery's study and depicted a clarifier as a role "in which the interpreter departs from the conduit model in cases of linguistic incommensurability" (p.94). Niska (2000), on the other hand, said that a clarifier illustrates technical or cultural related concepts for the receptor of target language to have a better understanding. Since there is no unified definition of a clarifier, this study refers the definition of "clarification" to *the American Heritage Dictionary of the English Language* (2000) as: "To make clear or easier to understand…To clear of confusion or uncertainty…" (p.342) and argues that a clarifier is the interpreter's role of facilitating primary parties' mutual understanding of non-cultural related factors and alerts primary parties if there is misunderstanding.

According to Angelelli (2004), interpreter's adoption of these tasks is influential to the communication and the interpreter is thus visible. Clarifier is different from a culture broker who makes clarification by explaining cultural facts. The role of a culture broker will be discussed later in the next section.

The importance of a clarifier's tasks is recognized by provider, patient and interpreter. In Pöchhacker's (2000) study, 88% of the responding providers and 100% of the responding interpreters surveyed said that "clarifying indeterminate statements by immediate follow-up questions to the client" (p.58) is part of the interpreter's tasks. In addition, 97% of the responding patients in Mesa's (2000) survey expected interpreters to facilitate them comprehending the situation. Hale (2007) who reviewed seven community interpreting codes of ethics also concluded that codes speak for interpreters to ask for clarification when it is necessary. In terms of alerting misunderstanding, 92% of the responding providers in Mesa's (2000) survey, 96% in Pöchhacker's (2000) and 65% in Hale's (2007) found that providers would like interpreters to tell them when interpreters think the patient does not understand or there is misunderstanding in the conversation. Pöchhacker's (2000) survey also shows that 94% of the responding spoken-language interpreters consider this task as part of their responsibilities. Therefore, interpreter adopting role of clarifier conforms to users' expectations and interpreter's perception of his/her profession.

2.2.3 Culture Broker

Since the end of the 1970s, cultural sensitivity has been highlighted as an important factor affecting cross-cultural communication (Roy, 1993/2002). In medical interpreting, "culture influences the meaning given to symptoms, the diagnosis of those symptoms, the expectations regarding the course of the related disease or illness, the desirability and efficacy of treatments or remedies, and the prognosis" (NCIHC,

2004, p.9). In addition, to interpret accurately, knowledge of culture is critical to understand the hidden or unstated meaning as part of the total experience of speaker (Avery, 2001). Before healthcare providers are fully aware of cultural differences, they rely on interpreters to provide such assistance. In fact, it has been observed that many inter-cultural healthcare services in the US, Canada and Europe have allowed interpreter's role of culture broker (Kaufert & Putsch, 1997). Assuming role of culture broker demonstrates that interpreters influence and are influenced by social factors; interpreters are therefore visible (Angelelli, 2004).

The concept "culture" used here is referred to social science as "all that in human society which is socially rather than biological transmitted…Culture is thus a general term for the symbolic and learned aspects of human society" (Scott & Marshall, 2009, p.152). As a result, social class, sex, schooling (Avery, 2001), language, ways of verbal and non-verbal expression (Roy, 1993/2002) and so forth are all included under the umbrella term of culture. Cultural differences are considered obstructions of communication in medical encounters (Avery, 2001).

Primary parties and medical interpreters all recognize the importance of supplementing cultural information in the encounter. Surveys on healthcare workers found that 78% of the respondents in Quebec (Mesa, 2000) think respecting for patient's values and beliefs is very important while 62% of respondents in Vienna (Pöchhacker, 2000) expect that interpreters illustrate foreign culture for them. In terms of addressing difficult communication resulting mainly from class and education differences, Pöchhacker (2000) found that 87% of providers expect interpreters to explain professional jargon and make their inner meanings more explicit to the patients. Mesa (2000) also discovered that 98% of the patients expect the interpreter to speak in terms and expressions that they can easily comprehend. When asking interpreters, they attached a significant level of importance to simplification and

explanation of technical expressions (75%) and illustration of foreign culture (81%) (Pöchhacker, 2000). These results support that medical interpreters are expected to adopt strategies of explicitation and domestication as a culture broker during interpreting service, which will be given more elaboration in Chapter Four.

Studies have indicated that taking the role of culture broker by medical interpreter is beneficiary to both of the primary parties as well as medical institutions. With the facilitation of cross cultural communication by interpreters, the explicit meanings of both primary parties can be shared and thus increase the possibility of faithful interpreting (Avery, 2001; Kelly, 2008). Primary parties' mutual understanding creates a good layer of foundation that enable providers to make a treatment plan that conforms to patient's cultural background (Mesa, 2000); patient's compliance to and the effectiveness of the plan are therefore enhanced (Kaufert & Putsch, 1997). Furthermore, Kaufert and Putsch (1997) argued that clear illustrations of the healthcare system and patients' rights in ways that conform to health service users' cultural background would improve health education.

However, medical interpreters should constantly remind themselves to respect for individual differences and to be aware of possible consequence of stereotyping. According to Kelly (2008), role of culture broker should only be adopted when it is indispensable. When in situations that interpreters have to temporarily stop the flow of communication and alert both parties the cultural facts, they should bear in mind that even they seem to share the same language and culture with one of the parties, their differences may still exist because of other social factors. Therefore, interpreters should avoid inference that their perceptive cultural knowledge is applicable to all people of a certain cultural community, such as people in the same race, gender or citizenship. Cautious checkups of an individual's culture norms are necessary (NCIHC, 2004).

2.2.4 Advocate

Definitions and descriptions of an advocate have been significantly confusing. Niska (2000) defined that an advocate's service extends to settings other than mediated medical encounters and takes actions on behalf of patients to help them deal with cases such as healthcare institutions' bureaucracy or discrimination. Roat (2011) further clarified that the role of an advocate, who is no longer a mediator, is adopted only when one of the primary parties is incapable of communicating his/her needs. On the other hand, Avery (2001) argued for a conditioned advocate who gives information about medical or other services, but acts directly on behalf of either primary party is forbidden. However, Hsieh (2008) observed that some interpreters as an advocate "have sought information, provided answers and requested services for a patient without consulting the patient" (p.1373). These behaviors overlap with Roy's (1993/2002) description of a helper, who "offer advice… and make decisions for one or both sides" (p.349). Though these definitions vary widely, the common point of view is that interpreter acts more than linguistic transformation as a conduit and is therefore visible. Another similarity between these descriptions is interpreters' argument that they act on behalf of users, either provider or patient, for their benefits and rights, such as quality of care or patient's well-being.

While acting on behalf of users' benefits seems to "justify" a wide range of an advocate's behaviors, not all the actions taken by an advocate are considered appropriate by service users. Pöchhacker (2000) discovered that providers oppose interpreter's omission to primary parities expressions with the intention of saving time. Although an advocate may be well-intentioned to enhance the efficiency of communication, making decision on what to interpret or leave out on behalf of the primary parties erodes provider's trust on interpreter (Hale, 2007). Interpreters have conversations with one of the parties and exclude the other is also unappreciated

(Roat, 2011); for example, suggest the patient to raise question if he/she has trouble understanding the provider without informing the provider about this suggestion (Hale, 2007). To use what interpreter wants to ask to substitute for primary parties' questions is even regarded as a mistake of interpreters by clinicians (Vasquez & Javier, 1991). On the other hand, there are cases when primary parties expect interpreter to act on behalf of them, such as making a diagnosis on behalf of the provider (Hsieh, 2007) or when the patient asking the interpreter to teach him/her the right ways to ask for the service and information they want (Hsieh, 2008).

There is no congruent point of view toward the appropriateness of advocate in code of ethics as well. After reviewing seven community interpreting codes of ethics, Hale (2007) concluded that the codes support interpreters to make clarifications, to supplement cross-cultural references or to sight interpret documents and forms given by the healthcare institutions, but do not approve of interpreters being an advocate. On the other hand, the code of ethics proposed by NCIHC (2004) argued for conditioned advocate. If it is very likely that one or both of the primary parties may face significant negative consequences and actions taken by other less intrusive roles cannot solve the problem, it is the interpreter's duty to advocate on behalf of them. Consulting with a supervisor is suggested before taking any action to advocate. Roat (2011) also supported the idea of conditioned advocate, but she added other criteria including service users' will for the interpreter to advocate on their behalf and approval of advocating by the agency and the institution that employ the interpreter.

From the literature reviewed above, it is shown that current controversy is not about total rejection or acceptance of advocate, but the incoherence of views between provider, patient and interpreter on appropriate behaviors of advocate. Not every action taken by the advocate is considered appropriate by primary parties and not everything primary parties expect an advocate to do is regarded appropriate by

interpreters. A unitary criterion that can integrate both sides of perceptions and distinguish the appropriateness of advocate's behaviors is required.

2.2.5 Summary

The involvement of interpreter in the medical encounter extends from least involved role of a conduit, to a clarifier, then a culture broker and lastly an advocate (Avery, 2001). The descriptions of each role are compiled as follows:

- Conduit: converts verbal and non-verbal information into another language faithfully, accurately, without omission, addition and edition.
- Clarifier: facilitates primary parties' mutual understanding of non-cultural related factors and alerts primary parties of possible misunderstanding.
- Culture broker: bridges the culture gap between primary parties to facilitate level of understanding.
- Advocate: acts on behalf of a user, provider or patient, for his/her benefits and rights either within or outside of medical encounters.

Surveys on users' expectation and interpreters' codes of ethics show that roles of conduit, clarifier and culture broker are considered appropriate while an advocate is controversial. However, the criterion that can distinguish interpreter's proper involvement from improper intervention is still missing (Roy, 1993/2002). This study therefore aims to propose a criterion that can explain the inconsistent views on medical interpreters' roles.

2.3 Medical Interpreter's Roles and Neutrality

Conduit, the role that involves in the mediated communication the least in Avery's (2001) incremental intervention model, "requires the interpreter to perform in a neutral, faithful, and machine-like manner" (Hsieh, 2006, p.721). Roy

(1993/2002) listed interpreter's non-neutral behaviors, including "to introduce topics, change topics, ask questions of their own, interject their opinion or give advice" (p.347), which covers the tasks of all non-conduit roles. In addition, Kaufert & Putsch (1997) argued that interpreters should adopt non-neutral roles such as culture broker or advocate. These arguments show that a conduit is the only role being described neutral. Non-conduit roles that take purposeful actions other than faithfully interpreting the primary parties' explicitly expressed utterances are not neutral. In other words, these studies consider making judgments on what actions to take and supplementing information other than primary parties' explicit message are non-neutral behaviors. However, other studies accept non-neutral non-conduit roles such as clarifier and culture broker based upon user expectations and interpreter's codes of ethics while an advocate is considered controversial. Why non-neutral roles are viewed differently? What does neutrality mean?

In *Oxford Advanced Lerner's Dictionary of Current English* (2010), the word "neutral" means "not supporting or helping either side in a disagreement, competitions, etc…deliberately not expressing any strong feeling…" (p.1027). In *APA Dictionary of Psychology* (2007), neutrality refers to a manner of behavior adopted by the therapist who "does not express judgments of right and wrong or suggest what is proper behavior on the part of the client" (p.629). These definitions show that neutrality includes three attitudes: user-centered, preference free and non-judgmental. User-centered attitude refers to that no suggestions are given by the neutral person and thus the client's autonomy is respected. Preference free attitude means that the neutral person does not side with any of the participating parties in a communicative activity while non-judgmental attitude indicates that the person expresses no judgments. Deliberately not to express any strong feeling or emotional detachment is also mentioned in the definition of neutrality at the beginning of this paragraph. This

concept is included in non-judgmental attitude in this study because it facilitates the neutral person not to express judgments. More explorations of these three attitudes will be given in the sub-sections of this section. In addition, all of these attitudes have to be demonstrated in one interaction so that the communicator can be neutral. The reason is that he/she cannot abandon one of the attitudes without violating the other. For example, it is impossible for a communicator to be judgmental on the user while putting the user at the center. The communicator can neither side with the user without making judgments on the user and his/her experience. Moreover, in three-party communicative activities like medical interpreting, interpreters holding the three attitudes of neutrality toward one of the primary parties is not neutral. Instead, whether the interpreter is neutral or not is dependent on holding these attitudes toward both of the parties.

All of the attitudes mentioned above are major conditions of empathy (Wispé ,1986), as will be illustrated in *Table 3.1*. It is therefore argued that empathizers are neutral. In Chapter Three, it will also be elaborated that deciding how to express empathy (Egan, 1975) or making the other person's implicit message explicit is regarded as empathy (Carkhuff, 1969). These behaviors are thus argued to be neutral, which is different from the point of view in studies of medical interpreting as mentioned at the beginning of this section. The difference can be visualized as *Table 2.2*. While non-neutrality refers to making judgments on the other or his/her experience in studies of empathy (VandenBos, 2007), it is used to describe an interpreter who takes any action other than what the primary parties explicitly express in studies of medical interpreting. In other words, non-neutrality in medical interpreter studies indicates a broader scope of actions than the scope indicated in studies of empathy.

Table 2.2 Neutrality in Medical Interpreting and Empathy

Difference / Topic	Express Service User's Explicit Message	Express Service User's Implicit Message
Medical Interpreting	Neutral	Non-Neutral
Empathy	Neutral	Neutral

Source: compiled by this study

This study adopts the definition of neutrality in empathic theories and argues that neutrality, referring to the three attitudes mentioned above, can explain the inconsistent views on medical interpreters' roles. In other words, it is argued that roles of conduit, clarifier and culture broker are neutral while an advocate is not. Since neutral attitudes are essential conditions of empathy (Wispé ,1986), empathy theories are adopted to examine each role's neutrality. If the role expresses empathy with service user(s), it demonstrates neutral attitudes. More elaboration will be given in section 4.1.3.

In the rest of the section, more studies of interpreting related to attitudes of user-centered, preference free and non-judgmental are elaborated. These attitudes will be used to compare with attitudes of empathizers in Chapter Four.

2.3.1 User-Centered

Avery (2001) argued that interpreters should be granted to interfere in the communication when misunderstandings may take place, but he also emphasized that interpreters should "stay in the background and to support communication and relationship building directly between patient and provider" (p.9). Choosing the least intrusive role that is already able to overcome communicative barriers is recognized as a major principle. Codes of ethics also affirm the centrality of primary parties

(NCIHC, 2004; Dysart-Gale, 2005).

Since interpreters are secondary instead of primary party (Alexieva, 1997/2002), it is inappropriate for them to take over the interaction. Alexander *et al*. (2004) found that patients do not want their interpreter to his/her personal interests in front of theirs. Mesa's (2000) survey also showed that providers expect interpreters not to take over their place. Vasquez and Javier (1991) even viewed interpreters assuming the role of primary parties as mistakes, such as replacing provider's questions with their own and answering patient's questions directly. According to Hale (2007), these actions exclude primary parties from making decision for themselves and hinder accurate diagnosis. The effectiveness of patient's treatment plans is also decreased because these behaviors have been identified as the contributors that minimize patients' compliance to the plans.

Primary parties' autonomy is respected when they are placed in the focus of communication. Though Avery (2001) supported interpreter's involvement when necessary, he argued that primary parties are "the ultimate resolution of the encounter" (p.9). They have the right to speak for and make decisions for themselves (NCIHC, 2004). Mesa's (2000) survey on patients also found that 95% of the respondents expect interpreters to respect their values and beliefs. As a result, interpreters are not in a position to make decisions, give advice, counsel or persuade either party.

2.3.2 Preference Free

Interpreters are expected to treat both primary parties equally instead of taking sides (Kelly, 2008). In Mesa's (2000) survey, healthcare providers expressed their concerns that if patient's family members or acquaintances assist interpreting, their interests may surpass the importance of faithful rendition. However, it is found that when provider and patient have conflicts, some interpreters take the side with

providers (Cambridge, 1999; Bolden, 2000; cited from Hsieh, 2006). Interpreter's preference leads to primary parties' mistrust (Hale, 2007) and lack of will to communicate (Wadensjö, 1998).

Neutrality is a notion that relates to primary parties' perception (Wadensjö, 1998; Marcus, Dorn & McNulty, 2011). Hence, when interpreter's communication style aligns with one of the parties than the other, the party that finds his/her style not adopted by the interpreter may perceive the interpreter non-neutral and biased (Wadensjö, 1998). Cambridge (2004) said it is the interpreter's responsibility "as 'alter ego' of each speaker" (p.50); therefore, interpreters should faithfully interpret the verbal and non-verbal information as well as the communicative style of the source utterance. Since medical interpreting is in dialogic mode where the role of speaker and addressee are assumed by different parties in turn (Gentile *et al*., 1996), interpreters have to regularly alter their communicative style to be aligned with the speaker. Adopting the style of one of the parties is non-neutral.

However, there are times when one of the primary parties intends to form an alliance with the interpreter. Avery (2001) argued that an interpreter should concentrate on placing primary parties at the center of the communication, consciously avoid being involved in a partisanship with one of the parties and lead their expressions to each other. It is interpreters' duty to take the interests of both parties and the healthcare goal into consideration during the interpreting service.

2.3.3 Non-Judgmental

As defined in the *APA Dictionary of Psychology* (2007), neutrality is demonstrated by non-judgmental attitude, which also refers to a non-critical attitude. People with this attitude act without prejudice either against the content of the messages or parties in medical encounters. However, it does not mean that interpreters

are not allowed to have opinions, but to avoid projecting these personal perceptions, beliefs or even biases onto one of the parties as if it is their reality (NCIHC, 2004). In order to do so, interpreters must be well aware of their opinions and constantly examine how their opinions affect their assignment so that they can fulfill their obligations, which as Hale (2007) stated are to prevent their feelings, points of view, convictions, interests, biases or values from intervening in the major goal of faithful interpreting. If they are unable to be non-judgmental, they should report it to the parties and transfer the case to other professionals (NCIHC, 2004).

Under no circumstances should interpreters make a decision to alter the meaning of source utterance because they perceive the messages are personally offensive or make them uncomfortable (NCIHC, 2004). NCIHC (2004) said that though it is not easy to detach from the expressions and interactions between primary parties, interpreters are required to have this capacity. Some people misconceive detachment as indifferent to the patient. On the contrary, NCIHC (2004) argued that detachment is the demonstration of understanding and accepting the patient's needs and respecting their autonomy. Providers also link the level of detachment with interpreter's professionalism (Hale, 2007).

Losing neutrality, according to Keller and Sticker (2004), may lead to countertransference, which indicates "feelings that arise in the therapist in response to the patient… [because of] a displacement onto the patient of feelings, beliefs, or impulses that were experienced previously by the therapist toward another person" (p.233). The concept, first introduced by Freud in psychotherapy, is identified as an obstacle to therapists' neutrality. It is argued that the therapist can only apprehend accurately and work effectively with the patient if he/she is neutral; therefore, countertransference feelings should be restrained or removed. Corey (2001) added that this inappropriate feeling hinders objectivity and is triggered by therapists' own

needs. Contertransference may happen to medical interpreters toward either side of the primary parties and impact interpreting assignment as well. Davou (2007) said that though the trigger of subjective emotion varies significantly between individuals depending on their experiences and histories, interpreters' cognitive capacities are decreased because of negative emotions. Roat (2011) warned that if interpreters with countertransference may find themselves "strongly attracted to a patient, wanting to take care of a patient, or particularly angry with a patient" (p.105), they are advised to consult a supervisor confidentially to examine how their internal opinions and conflicts affect their jobs.

2.4 Conclusion

Medical interpreting is a communicative activity participated by at least three parties in medical settings: the provider, the patient and the interpreter. Being the mediator between the provider and the patient (Alexieva, 1997/2002), interpreters need to render the source utterances initiated by one primary party to the other. Therefore, without the presence of all three parties and source utterances given by primary parties, what the interpreter does cannot be considered interpreting. Comparing this definition with the four interpreters' roles explored in section 2.2, advocates who assume the role of one of the primary parties, act on behalf of him/her and no source utterances are given by primary parties cannot be regarded performing interpreting. On the other hand, clarifiers and culture brokers clarify or explain explicit and implicit messages or social background of primary parties to facilitate mutual understanding. These behaviors make the target utterance not equivalent to primary parties' explicitly expressed source utterance, which is the way a conduit interprets. However, clarifiers and culture brokers in fact render even more faithfully the meaning and feeling of primary parties than conduits. It is because they make the

rendition more complete by involving primary parties' implicit, unclear messages and social factors, which are crucial factors of accurate rendition (Avery, 2001). Since clarifiers and culture brokers play the role of a mediator and render the source information explicitly and implicitly expressed by primary parties, it is argued that they perform interpreting. In order to distinguish different types of interpreting, rendition simply based on primary parties' explicitly expressed utterances is labeled as narrow-sense of interpreting as opposed to broad-sense of interpreting in which interpreters make clarifications or include primary parties' implicit or unclear messages and social background in the rendition. The mentioned concepts in this paragraph can be visualized as Figure 2.1.

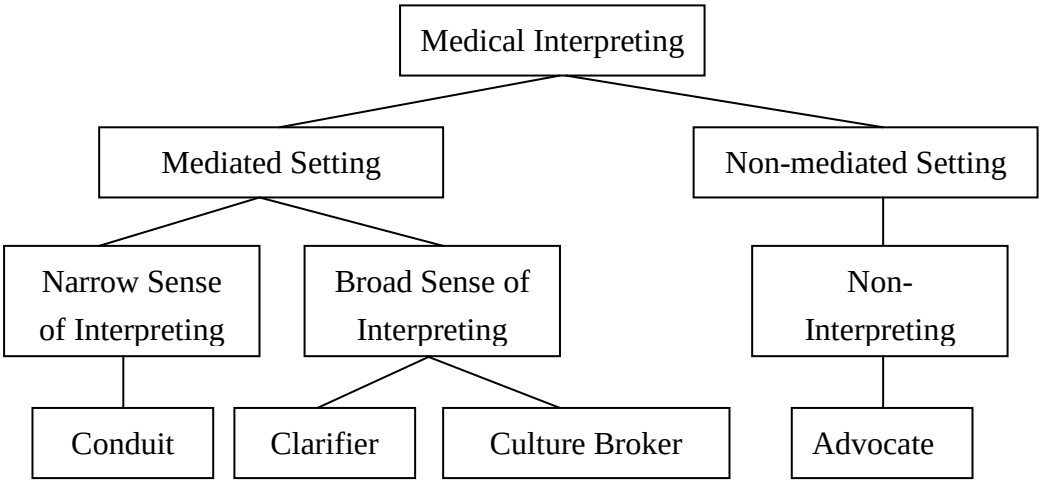

Figure 2.1 Different Types of Interpreting and Medical Interpreters' Roles
Source: compiled by this study

Neutrality, compiled by this study, can be demonstrated by user-centered, preference free and non-judgmental attitudes. There are three reasons supporting that neutrality is significantly important. First, it conforms to service user's expectations on interpreters (Vasquez & Javier, 1991; Alexander *et al*., 2004; Mesa, 2000; Kelly, 2008). Interpreters' codes of ethics also highlight its importance (Dysart-Gale, 2005; NCIHC, 2004). Second, it facilitates faithfulness of interpreting for that interpreters

do not project their own values, emotions and bias onto service users (NCIHC, 2004; Hale, 2007), which may distort speaker's meanings. Third, it avoids consequences that interpreters cannot be responsible for. Adopting non-neutral attitudes so to replace main points and meanings in the source utterance with interpreters' own may cause unexpected and undesirable ripple effects (Kelly, 2008). For example, acting on behalf of patients might reinforce their reliance upon the interpreter, cost the interpreter his/her job or lead to legal responsibility (Roat, 2011). Inadequate communication is also a contributor to erroneous diagnoses and improper treatment that may threaten patients' lives (Avery, 2001) and impact businesses of healthcare providers and institutions (Kelly, 2008). As a result, being neutral is vital and is argued to be medical interpreters' appropriate level of involvement.

This study aims to understand how to demonstrate empathy in medical interpreting and explain the inconsistent views on medical interpreters' roles. Since empathizers are required to understand the other people accurately like medical interpreters and hold the three attitudes of neutrality, which will be given more elaborations in Chapter Four, this study intends to use empathy theories to answer the research questions. By exploring the definition and communicative skills of empathy and developing the empathy models applicable to medical settings, the first and second research questions could be answered respectively. Moreover, these answers could facilitate the study to further examine each role of medical interpreters. If the role expresses empathy to both primary parties, it is argued that it demonstrates the attitudes of neutrality. Then it is possible to explain primary parties' different views on non-conduit roles, to argue for interpreter's proper line of involvement and to answer the third research question. Empathy theories are consequently reviewed in the next chapter.

Chapter Three

Empathy

3.1 Introduction to Empathy

This study aims to answer the following questions: the ways of demonstrating empathy in medical interpreting and its implication to roles of medical interpreters. Literatures of psychology are reviewed because empathy is a subject of psychology in which researchers take various approaches to analyze, define and explore the concept. In fact, ever since the beginning of forming the concept of empathy, psychological nature has been embedded in it (Duan & Hill, 1996). According to Wispé (1987), empathy originates from *Einfühlung*, a term used in German aesthetics, implying the projection of one's feelings into an external object, particularly a work of art. Later, a German psychologist Lipps applied *Einfühlung* to psychology in 1903. Duan and Hill (1996) said that *Einfühlung* was considered a process for people, not only to project emotions to aesthetic objects, but also to know and interact with each other through projection and imitation of feelings. The implication is to know about others by feeling the other's inner emotion, not understanding the other's experience (Barrett-Lennard, 1981).

The English term empathy is derived from Greek *empatheia*, constituted by "in" (*en*) and "suffering" (*pathos*) (Colman, 2001, p.241). Titchener made the translation from *Einfühlung* in 1909, which he defined as a "process of humanizing objects, of reading or feeling ourselves into them" (Titchener, 1924, p.417; cited from Wispé, 1987). His emphasis on the perception of others' feelings had been significantly influential to empathic theories in psychology until Mead (1934) included a cognitive factor into empathy: the capability of understanding (Deutsch & Madle, 1975; cited from Duan & Hill, 1996). Though Mead did not directly write about empathy, he

wrote “the given individual’s ability to take the roles of, or ‘put himself in the place of,’ the other individuals implicated with him in a given social situation” (Mead, 1934, p.218; cited from Wispé, 1987), which has clear implication linked to empathy.

In recent studies of psychology, cognitive empathy or role taking and affective empathy or emotional contagion are both included in specialties of counseling/psychotherapy, social psychology and developmental psychology, though different names are given (Gladstein, 1983). Cognitive empathy refers to “intellectual understanding of another’s experience” while affective empathy means “the immediate experience of the emotions of another person” (Duan & Hill, 1996, p.263).

However, each of these three specialties has its *own* literatures and focuses on empathy (Gladstein, 1983). Some social and developmental psychologists consider empathy as an ability to understand the others’ experience or to show the others’ experience vicariously (Duan & Hill, 1996). According to Gladstein (1983), social psychology studies focus on the relation between empathy and altruistic behavior, pro-social behavior or the development of measurement of the ability, etc. while developmental psychologists are mainly interested in how empathy differs in age, gender, social intelligence, hostile behaviors and so forth. On the other hand, major counseling/psychotherapy psychologists hold the view that empathy is either a cognitive-affective state to sense other’s experience or a process comprising multiple stages (Duan & Hill, 1996). Apart from the effort of giving clear definition of the concept of empathy from different perspectives, counseling/psychotherapy studies also explore how empathy is demonstrated in general interpersonal communication, such as mental health settings (Gladstein, 1983).

Since it is a pioneering study attempted to apply results of empathy research into medical interpreting, and there is time limitation on conducting this study, narrowing the scope of literature review is more practical. Because mental health setting is

covered in the scope of medical interpreting service and prominent contributors to detailed elaboration of empathy are Carl Rogers, Barrett-Lennard, and Kohut who are classified into the specialty of counseling/psychotherapy (Duan and Hill, 1996), it is argued that literature of counseling/psychotherapy is more applicable to medical interpreting than the other two specialties. Consequently, more exploration of this specialty will be given.

Two psychotherapists, Carl Rogers and Heinz Kohut, have been recognized as pioneers in studying the concept of empathy (Bohart & Greenberg, 1997; cited from Håkansson, 2003). According to Corey (2001), Rogers is the leading therapist of client-centered therapy while Kohut belongs to psychoanalysis therapy with Freud as the initiator. Client-centered therapy and psychoanalysis therapy are two of the different theories in the field of psychotherapy. Although these theories have different approaches, both of them aim to help the client. Kohut contributes significantly to modern psychoanalytic theory but he is not greatly influential to psychological academia (Wispé, 1987). The emphasis of psychoanalytic approach is to empathically understand the client's unconscious experience; on the other hand, Rogers emphasizes on empathizing with others' current perceptions and emotions (Håkansson, 2003). Since medical interpreting involves participants' conscious experiences, and studies of Rogers and his students on empathy have been considered the most persistent studies (Wispé, 1987), it is better to take Rogers's approach on empathy research in this study instead of Kohut's. As a result, Rogers's and his successors' important theories will be reviewed in the following sections.

The distinction between empathy and sympathy has been one of the significant issues in the study of empathy (Eisenberg & Strayer, 1987). When Titchener coined the term empathy, he already noticed the similarity between empathy and sympathy in etymology (Wispé, 1987). Wispé (1986), whose definition of sympathy has been

regarded as the most widely adopted one (Eisenberg & Strayer, 1987), defined that "sympathy refers to the heightened awareness of another's plight as something to be alleviated" (p.314). In the process of sympathy, "the pain of the sufferer is brought home to the observer, leading to an unselfish concern for the other person" (p.320). According to Wispé (1986), sympathizers place emphasis on communion and thus would take whatever actions to alleviate others' negative emotions. Actions taken out of sympathy imply that sympathizers agree with the other, which is different from empathy. Consequently, Wispé said that "sympathy does not facilitate accurate assessments… [and] can lead to closer emotional identification and to peremptory rescue actions in the patient's behalf" (p.319). On the other hand, Wispé defined empathy as a process in which one self-aware person tries to understand accurately the subjective experiences of another person without prejudice. Empathizers are non-judgmental and client-centered. They do not lose their own identity, which Wispé referred to Barrett-Lennard's saying in 1962 that they are well aware that the feelings belong to the client. Wispé used a case to clearly distinguish sympathy from empathy: sympathizing with a murderer might be difficult but one could empathize with him/her in the purpose of understanding him/her accurately while disagreeing with his/her actions. Differences between the two are compiled as *Table 3.1*.

Table 3.1 Differences between Empathy and Sympathy

	Empathy	**Sympathy**
Essence	A way of "knowing"	A way of "relating"
Main concern	Accuracy; whether one constantly check with the other and guided by the received response	Communion; how to open oneself to another's subjective experiences
Goal	To understand the other person	The other person's "well-being"
Active/ Passive	Empathizer "reaches out" for the other person	Sympathizer is "moved by" the other person
Implication	*I* act "*as if*" I were the other person (Rogers, 1975, p.3)	I *am* the other person. (Macfie, 1959, p.213)
Response	1. Express understanding of the other's experience with some level of emotional detachment 2. Provide a broader perspective that extends beyond the other's situational distress	1. Circumscribe to express compassion for the other's distressful condition 2. Change the topic of discussion to alleviate other's distress
Attitude	Non-judgmental	Judgmental, which reflects one's perceptions
Focus of Interaction	Client or patient-centered / We substitute ourselves for the others	Diverts from the client / We substitute others for ourselves
Preference	Not implying agreement, but understanding and acceptance	Side with and support the other's point of view
Boundary	The self never loses its own identity	Self-awareness is reduced

Source: compiled by this study from Wispé (1986), Egan (1998) and Clark (2010)

3.2 Empathy as a Process

Carl Rogers is the leading pioneer who strengthens the importance and popularity of the concept of empathy with his client-centered therapy in 1950s (Wispé, 1987). According to Duan and Hill (1996), Rogers's studies lead to the interests of researchers with diverse backgrounds to study in scientific approach about how empathy relates to various topics, such as altruistic behaviors, attribution and children's cognitive development. These diverse topics concerning empathy evidently

show that “empathy is the very basis of all human interaction” (p.262).

Rogers has offered two definitions of empathy successively. First, he wrote that empathy is to “perceive the internal frame of reference of another with accuracy and with the emotional components and meanings which pertain thereto as if one were the person, but without ever losing the ‘as if’ condition” (1959, p.210). The emphasis of the “as if” condition manifests the differentiation between empathy and losing one’s self (Wispé, 1986). Empathy here is described as an “experience” of others’ private world (Duan & Hill, 1996).

In 1975, Rogers wrote another definition describing empathy as a “process”:

> *“It means entering the private perceptual world of the other…It involves being sensitive…to…that he/she is experiencing. It means temporarily living in his/her life…without making judgments, sensing meanings of which he/she is scarcely aware, but not trying to uncover feelings of which the person is totally unaware, since this would be too threatening. It includes communicating your sensings of his/her world…frequently checking with him/her as to the accuracy of your sensings, and being guided by the responses you receive…To be with another in this way means that for the time being you lay aside the views and values you hold for yourself in order to enter another world without prejudice.*” *(p.4)*

The second definition not only provides a more comprehensive description of empathy, but also includes several differences from the first one. First, Rogers extends the idea of “accurate empathy” in the first definition to an operational process, from paying careful attention, sensing meanings, communicating meanings to constant rechecking the accuracy of the sensings. Second, Rogers points out the individual being empathized is the judge of the accuracy of the empathic understanding. It

corresponds with Rogers's core belief in human nature that people in a supportive environment – non-judgmental and unconditional positive regard – will move toward self-actualization and make the best decisions for themselves. Non-judgmental attitude refers to not evaluating or judging client's feelings, thoughts and behavior as good or bad, right or wrong while unconditional positive regard indicates recognition of clients' rights to have their own beliefs and feelings and acceptance of clients as they are. However, unconditional positive regard is different from approval (Corey, 2001). Therapists of Rogerian psychotherapy are there to help clients making their own decisions instead of diagnosing clients. Finally, prejudice needs to be put aside before empathic understanding could happen.

Though there is divergence in the emphasis of empathy studies after Rogers, some focus on cognitive empathy while others concentrate on affective empathy, Gladstein (1977) indicated that Rogers's definition in 1975 include both aspects (cited from Gladstein, 1983). On the other hand, Hackney (1978) reviewed empathy research from 1958 to 1978 and noticed emphasis on empathy as a communication skill in later studies. Communication skills here refer to responding to a client's meanings and feelings in correct and appropriate ways (cited from Gladstein, 1983). Despite Rogers (1975) regarded that empathy is not a skill but an attitude, communicative skills of empathy become one of the important training of therapists (Gladstein, 1983). Since the main subject of this study is medical interpreting, a communicative activity, studies of the communicative aspect of empathy are therefore given in the next section.

3.3 Basic Empathy and Advanced empathy

Rogers and Truax pointed out two essential components of accurate empathy in 1966. One is the perceptive aspect, which is "to sense the client's bewilderment, anger,

love or fear *as if* it were the therapist's (own) feeling"; the other is the communicative aspect, referring "to communicate this perception in language attuned to the client that allows him more clearly to sense and formulate his feelings" (cited from Truax & Carkhuff, 1967, p.286). Later, many research scales that operationalize empathy as observable expressions are presented in the public to evaluate the inner empathic understanding mentioned by Rogers. One of the most widely-used scales is Carkhuff's Empathic Understanding in Interpersonal Process Scale developed in 1969 (Gladstein, 1983).

Carkhuff (1969) divided the communication of empathic understanding in interpersonal interactions into five levels. The key determinant to distinguish each level is the *interchangeability* between a client's expression and a therapist's response in an interaction. The minimal level of facilitating interpersonal communication is defined as Level 3 as follows, "The expressions of the first person in response to the expressed feelings of the second person(s) are essentially *interchangeable* with those of the second person in that they express essentially the same affect and meaning" (vol. 2, p.316). Applying this definition to a psychotherapy setting, the first person refers to the therapist while the second person is the client/patient. Carkhuff (1969) also said that any communicative responses above or below Level 3 expressed by the therapist is subjectively additive or subtractive from the originally expressed sense and feelings of the client. Higher level of empathy, based on the achievement of Level 3 empathy, means to accurately add significant materials deeper than what the client was capable of expressing. By offering higher level of empathy, the therapist can be fully with clients and help them explore themselves comprehensively. On the other hand, levels below Level 3 indicate that what therapists express subtracts or detracts significantly the meaning and feeling from clients' expressions and that therapists do not communicate their understanding of clients.

Egan (1975), who defined empathy as "a fully human *communication skill*" (1998, p.84) and followed levels of accurate empathy put forth by Carkhuff (1969), offered a brief and clear two-level description of expressed empathy. He used the term "primary-level accurate empathy" to refer to Carkhuff's "interchangeable" level and "advanced accurate empathy" for the higher level of expressed empathy.

Primary-level accurate empathy, as Egan (1975) defined, is to communicate a *basic understanding* of the client's emotions, perceptions and behaviors in therapists' own words and ways. The understanding, based upon what the client has *explicitly* expressed, is communicated back to him/her. Demonstrating primary-level accurate empathy with respect and sincerity can facilitate building relationship and enhancing trust between therapists and clients. Egan (1998) later expanded "primary-level accurate empathy" to "basic empathy", which "involves *listening* to clients, *understanding* them… and *communicating* this understanding to them so that they might *understand themselves* more fully and *act* on their understanding" (p.81).

Different from basic empathy, which only communicates the understanding of what the client has *explicitly* expressed, advanced accurate empathy communicate the *implicit* core message that is expressed covertly by the client. In other words, basic empathy "gets at relevant *surface* (not to be confused with *superficial*) feelings and meanings, while advanced accurate empathy gets at feelings and meanings that are somehow buried, hidden, or beyond the immediate reach of the client" (Egan, 1975, p.135). In order to empathize accurately, one must make *therapeutic interpretations* of the experiences and emotions underlying the client's behaviors "from the context, from past interchanges, from the client's manner and tone of voice" (Egan, 1975, p.135). Offered with advanced empathy, clients are enabled to see themselves more comprehensively and to have an opportunity of reviewing their situations so to make decisions on actions.

The communication of empathy or "expressed empathy" (Barrett-Lennard, 1993) mentioned above could be compiled as *Table3.2*. In order to distinguish from basic and advanced empathy, levels below Level 3 in Carkhuff's (1969) scale are labeled as non-empathy in this study.

Table 3.2 Levels of Expressed Empathy

Correlation	Definition	Level of Empathy
Client's expression = Empathizer's response	Interchangeable in meaning and feeling.	Basic Empathy
Client's expression < Empathizer's response	Add implicit, deeper meaning and feeling in the client's expression to the response.	Advanced Empathy
Client's expression > Empathizer's response	The response subtracts or detracts significantly the meaning and feeling from the client's expression.	Non-Empathy

Source: compiled and adopted by this study from Carkhuff (1969) and Egan (1975, 1998)

According to Egan (1975), basic empathy is the basis of advanced empathy. Advanced empathy is only possible when the therapist gets a more or less complete picture of the client's perceptive world and when therapist-client rapport has been built by constantly offering basic empathy. What the client does not directly say could be shameful or painful to him/her, or it could be something beyond his/her awareness, or simply the rapport has not built yet, so the client does not feel safe enough to tell. As a result, advanced empathy should be "*tentatively* and *cautiously*" (p.149) expressed. The way of expression could either be manifested verbally or non-verbally such as tone of voice, facial and body gestures, etc. The practical communication skills of empathy are therefore explored in the next section to see if they are applicable to medical interpreting.

3.4 Communicative Skills of Empathy

Based on the literature reviewed in the prior sessions, empathy is defined as a process involving listening, understanding and communicating. In addition, empathic communication is distinguished into different levels, basic and advanced empathy, with the determinant being the interchangeability between what the client has expressed and what the therapist responds. However, the practical communicative skills of empathy still need further exploration. Counseling skills are therefore referred to in this section to understand the communicative skills of levels of empathy in different stages of empathy process.

3.4.1 Attending and Active Listening

Two of the guidelines for the use of empathy, suggested by Egan (1998), are attending bodily and mentally to the client, and listening carefully to the client's core meanings expressed directly and indirectly. It is an unselfish, non-judgmental and bias-free state of mind that therapists put themselves in clients' shoes. This state of mind can be considered the implementation of respect, and therefore contributes to building up interpersonal relationship. In fact, attending and listening "are so basic that they should be second nature in all forms of interpersonal communication" (p.62) and are the base of all other counseling skills (Hill, 2009). As a result, attending and active listening not only demonstrate empathy, but also are applicable and fundamental to other communicative settings including medical interpreting.

Egan (1998) defined attending as bodily and mentally being with clients. The manifestations of attending body postures include leaning forward to clients and keeping an open gesture with the arms and legs uncrossed. Hill (2009) also suggested therapists to nod head particularly when sentences end. Attending can also be demonstrated by communicating in linguistic and grammatical ways that the client is

used to. In other words, how therapists communicate must conform to the client's cultural background and level of educational so that building a bond with him/her is possible. Attending tells the client that the therapist is with him/her and what he/she has said would be carefully listened to (Egan, 1998). Attending also functions as an aid for a therapist to get into a listening state in which he/she clears the mind from distractions and pays full attention to the client's messages, rather than focusing on forming his/her response or his/her inner thoughts and feelings (Hill, 2009).

Active listening is defined by Egan (1998) as the ability to capture and comprehend the messages that clients explicitly or implicitly communicate, including client's verbal and nonverbal information (e.g., body language, facial gesture, intonation) as well as context, which refers to all of the social factors related to clients' lives. Verbal information not only includes the explicit expressions of the client but also his/her choice of words and deeper meanings, which form the bases of advanced empathy.

In terms of the meanings of non-verbal expressions, some are universally consistent. For example, Ekman and Friesen (1984) found that "people around the world cry when distressed, shake their heads when defiant, and smile when happy" (cited from Hill, 2009, p.102). Other studies have examined possible meanings of facial gestures. For instance, Nirenberg and Calero (1971) found that a scowl might suggest unhappiness or bewilderment; an elevated eyebrow may imply admiration or suspicion; tightened jaw and squinted eyes may suggest unfriendliness and etc. (cited from Hill, 2009). In addition, Hill (2009) wrote that "gaze avoidance or breaking eye contact often signals anxiety, discomfort, or a desire not to communicate with the other person... Clients who are scared might speak softly, look away, or have a closed posture" (p.101, 115). In terms of body gestures, McGough (1975) found that crossed arms and legs may imply insecure or judgmental state; clenched fists could mean that

the client is defensive or unfriendly and so forth (cited from Hill, 2009). What is worthy of noticing is that there are individual differences in meanings behind non-verbal expressions. Hill (2009) reminded us that "fidgeting can reveal anxiety, but it can also reveal boredom; folded arms can convey either irritation or relaxation…if a client sits with arms and legs crossed, he or she is not necessarily withholding or defending. It could mean he or she is cold or just habitually sits with arms and legs crossed" (p.115). As a result, though the non-verbal expressions are important implications, they could only be clues for the empathizer to form hypotheses which should be examined and verified carefully with more information.

Context, such as cultures and settings, would further complicate clients' verbal and non-verbal meanings. Dissimilarities existing between different cultures and between people with distinct backgrounds are not something new. Diversities may appear in expression, register, facial and body movement, pattern of greeting and so on. Thus, empathizers should always bear in mind neither to judge clients with their own cultural norms, nor to project personal feelings and perceptions onto the clients (Hill, 2009). It means not to "imagine that other people have the same feelings, problems, etc. as you, especially when this is not true" (Hornby, 2010, p.1214).

There are times when the other person speaks emotionally without logical order or in a rapid pace, which makes it hard to understand the speaker. Egan (1998) reminded us that instead of feigning to understand, an empathizer may request politely for the speaker to repeat what was said again. Communicating the vague understanding in the form of question to check if it's correct is also adoptable. These gestures manifest that an empathizer values, cares and respects the other. However, these strategies should not be used too often.

To sum up, attending and active listening form the foundation of basic and advanced empathy and of all interpersonal communications. This foundation also

serves as the base of bond building. Both clients' verbal and non-verbal expressions should be listened to carefully with the empathizers dismissing any internal distractions. Contextual and individual differences should be given extra attention and be respected while understanding and communicating with clients so to implement a non-judgmental state of mind. The skill of active listening is also mentioned in studies of interpreting, which will be elaborated and discussed in section 4.1.

3.4.2 Paraphrasing

Huang (1991) pointed out that paraphrasing is one of the counseling skills that demonstrates basic empathy. Paraphrasing, defined by Smaby and Maddux (2011), is to rephrase what the client has expressed verbally and non-verbally in an empathizer's own words without meaning alteration in a non-judgment and prejudice free attitude. Hill (2009), though naming the same skill differently, said that paraphrasing is briefer and more concise than clients' expressions most of the time. Instead of restating everything verbatim, the focus is on clients' main ideas with the irrelevant or unimportant details being omitted. In addition, both Smaby and Maddux (2011) and Hill (2009) considered that summarizing is a type of paraphrasing, but it organizes the perceptions and emotions expressed by the client in different interactions over a period of time, such as in many counseling sessions. Both paraphrasing and summarizing, said Hill (2009), can make the client reassured that he/she is being carefully listened to and allow him/her to check the accuracy of the understanding. In addition, paraphrasing could be applied to relationships outside of the counseling room for it is helpful to show others you are really listening to them.

The content of paraphrasing is the understanding of the essence of clients' expressions, which is based on previous stage of careful attendance and active listening to both clients' verbal and non-verbal information. According to Hill (2009),

non-verbal information could help to identify the most important content to the client (e.g., tone of voice might show what the client concerns the most). The expression of paraphrasing can be either in a tentative way or as a direct statement. Tentative paraphrasing, such as in the form of question, could lower the authority of the empathizer and show respect for clients' subjective frames of reference.

One of the mistakes often made by beginners of paraphrasing is to restate everything the client has said. It is not only impossible, but would also shift the attention away from the client because the paraphrasing consumes too much time. Other mistakes are to assume that certain content should be brought up or to offer suggestions to clients' problems. One should not presume that he/she has already understood the client's perceptions and feelings; instead, one should concentrate on helping the client to explore his/her experiences more. Finally, paraphrasing is not parroting. According to Egan (1998), parroting demonstrates to the client that one neither understands nor being with him/her. Instead, real understanding means that the client's core messages are actively processed and communicated in your way.

To sum up, paraphrasing is a communicative skill used after attending and active listening to express basic empathy. The aim is to communicate the essence and key components of clients' expressions so that clients know they are being listened to and understood accurately. When the accuracy of the paraphrasing is confirmed, clients could feel more confident in the relationship or even gain insights which allow them to actively explore more of their concerns. What empathizers should be aware of is not to restate everything the client said, remain client-centered and avoid parroting. Paraphrasing is also mentioned in studies of interpreting. Its demonstration, function and comparison with paraphrasing in psychotherapy will be discussed in section 4.1.

3.4.3 Emotional Reflection

Huang (1991) wrote that emotional reflection is another way to manifest basic empathy. Hill (2009) backed this view but further elaborated that reflection of feelings can both communicate basic and advanced empathy. She defined the skill as "a repeating or rephrasing of the client's statements, including an explicit identification of feelings. The feelings may have been stated by the client (in exactly the same or similar words), or the helper may infer feelings from the client's nonverbal behavior, the context, or the content of the client's message" (p.144). However, the empathizer's assumption of the client's feelings is not necessarily the client's reality. Additional supporting clues should be gathered and examined carefully. In addition to being careful with the accuracy of emotional reflection, the way to express the reflection should also be tentative and gentle so that the client can feel accepted, respected and valued, and he/she can feel free to express further clarification.

Hill (2009) also explained that emotional reflection facilitates clients to go into their inner experiences, recognize and reevaluate their feelings, and eventually accept the emotion when it is fully explored and expressed. It can also enhance relationship because the empathizer actively devotes lots of efforts trying to understand the client's feelings and check with the client the accuracy of the understanding.

Demonstrations of emotional reflection, according to Hill (2009), can be done by only stating clients most apparent feelings or both the emotion and the perception behind it (e.g., "You feel frustrated because the doctor does not take your case seriously?"). Those feelings should be present and experienced at the moment. One should especially avoid projecting their own feelings onto the client; for example, neglecting the client's expressed emotion because of the therapist's fear to deal with negative feelings, or over-identifying with the client, such as being sympathetic, that his/her emotion becomes very strong to the therapist. When these situations take place,

clients are no longer the center of the focus; hence, the effectiveness and objectiveness of emotional reflection are hindered. Under these circumstances, supervision is helpful and necessary.

Culture differences should also be taken into consideration when understanding and reflecting emotions. Pedersen, Draguns, Lonner and Trimble (2002) had found that Americans tend to express their feelings and experiences openly while non-American cultures discourage people from disclosing feelings, particularly to members outside of the family (cited from Hill, 2009).

To sum up, emotional reflection can manifest both basic and advanced empathy with clients' present feelings placed in the center of focus. It helps to build rapport with others when the reflection is expressed tentatively and when the client feels accepted and respected. What empathizers should pay attention to is to avoid projecting their feelings onto clients, and take culture differences into consideration when they understand and reflect clients' feelings. Reflecting the emotion of interpreting service users in rendition is also important, which will be given more explanations in section 4.1.

3.4.4 Therapeutic Interpretations

Huang (1991) wrote that advanced empathy can be demonstrated in the following ways: connecting islands, identifying themes, offering alternative frames of reference, expressing the implication, helping client to draw a conclusion from premises and to face their issues more directly. These demonstrations conform to that of *interpretations*, one of the counseling skills, compiled by Hill (2009) as follows: (1) point out the relevance between expressions or incidents that seem to be unrelated (e.g., "Could your anger toward the doctor right now be connected to the pressure you get from your family members?"); (2) provide new frames of reference to the

perceptions, emotions and behaviors of client's experiences (e.g., "You said you were disrespected by the nurse. Is it possible that the nurse was not familiar with your culture?"); (3) identify major issues or patterns in client's perceptions, emotions and behaviors (e.g., "It seems that you have consulted for similar problems many times. I wonder if your anxiety of death drives you to check the accuracy of treatment constantly?"); and (4) make client's defenses or transference explicit. "Transference is the client's unconscious shifting to the [psychoanalytic] analyst of feelings and fantasies that are reactions to significant others in the past" (Corey, 2001, p.89). Defenses and transference are implicitly expressed and often operate on an unconscious level (e.g., "I wonder if you're hoping that I act like your mother?"). In addition, Kohut (1959) regarded empathy as a significant component of therapists' understanding of clients, which forms the base of therapists' *interpretations* (Rubovits-Seitz, 1999). Therefore, it could be said that the communicative skill of advanced empathy is *interpretations*. In order to avoid a possible misunderstanding given the name of this empathic communicative skill may be confused with interpreting—language transference between source and target utterances—this skill is thus labeled as "therapeutic interpretations" in the rest of the study.

The definition of therapeutic interpretations is "a statement that goes beyond what the client has overtly stated or recognized and gives a new meaning, reason, or explanation for behaviors, thoughts, or feelings so the client can see problems in a new way" (Hill, 2009, p.226). Hill (2009) further explained that therapeutic interpretations can be based on sources such as the verbal information of client's speech, the client's experiences in the past and at the unconscious level, the cultural expectations perceived by the client and so on. It is important to notice that the culture beliefs of client may not only be different from our own culture, but also vary from our understanding of client's culture. Therapeutic interpretations, therefore, should be

done cautiously, considerately and respectfully. They should also be demonstrated infrequently with the prerequisites that the client is ready to hear therapeutic interpretations and he/she trusts the empathizer. The content of therapeutic interpretations should not go too far beyond what the client has already been aware of. The phrasing must also be easy to understand, or the client would not know what the empathizer is talking about. When therapeutic interpretations are given, the client's reactions are crucial indicators of his/her perceived helpfulness and are consequently needed to be observed carefully. If the given therapeutic interpretations are considered accurate, clients may continue the conversation by adding new information or offering further explanations. On the contrary, clients may decline the given therapeutic interpretations (e.g., "Yes, but…") when they are not prepared to listen to it or the interpretations are wrong.

To sum up, therapeutic interpretations are the demonstration of advanced empathy (Huang, 1991) in which the client's implicit core messages are made explicit (Egan, 1975), as mentioned in section 3.3. It is effective if they are based on clients perceptive experiences, expressed in a comprehensible and a tentative manner as well as when the empathizer is trusted by the client. Clients will generate new perceptions on their experiences when the content of therapeutic interpretations is regarded accurate by clients themselves. Ways to demonstrate therapeutic interpretations in psychotherapy overlap with explicitation and domestication in translation, which will be elaborated and discussed in section 4.1.

3.4.5 Summary

Compare literature reviewed above with the process of empathy put forth by Rogers and Truax in 1966, who indicated that the process involves perception and communication (cited from Truax & Carkhuff, 1967), the counseling skill of attending

and active listening corresponds to the stage of empathic perception while paraphrasing, emotional reflection and therapeutic interpretations are adopted at the stage of empathic communication. As for the level of expressed empathy, emotional reflection manifests both basic and advanced empathy while paraphrasing demonstrates basic empathy and therapeutic interpretations manifest advanced empathy.

There are many common emphases among these counseling skills. First, clients are always the center of the focus. At the attending and understanding stage, both clients' verbal and non-verbal information as well as context should be given careful attention to form the assumption of clients' reality. When empathizers try to communicate the tentative understanding, it should be expressed in a way that conforms to clients' contextual backgrounds, such as culture and education level, so that clients can easily receive and examine the accuracy of the communicated empathy. After the empathy is expressed, clients' responses should also be observed carefully as the feedback, a correction or confirmation, which determines directions of the following interaction. Second, empathizers should always adopt a careful and non-judgmental manner. Clients are the dominator of their own lives; hence, even though advanced empathy is offered to the client by adding meanings other than what the client has expressed, it should be expressed tentatively and in a gesture of trying to understand the client deeper instead of imposing other's judgments or perceptions on the client. In addition, empathizers should maintain awareness of differentiating their own feelings from clients'. Finally, individual and cultural differences should be taken into consideration when understanding and communicating with the client. With the effort of giving full respect to the client, the relationship can be built.

Egan (1975, 1998) also reminded empathizers to be aware of some common problems when expressing empathy. When the client speaks too emotionally without

logical order or too fast to comprehend, it is important not to feign that he/she has been understood. An empathic person may request politely for the speaker to repeat what was said again or communicate the vague understanding he/she has captured in the form of question to check if it's correct. This interaction manifests that an empathic person values, cares and respects the other. However, one should bear in mind that this strategy should not be used too often. Furthermore, advanced empathy should not be provided in early stages of interaction. A profound base of understanding and rapport should be established by expressing basic empathy before one can point out other people's implicitly expressed core messages. Clients would deny it, change subject matter, feel disrespected or threatened because empathizers want to move ahead at a pace of empathizers' agenda, not one that is good for them.

3.5 Empathy Cycle

In 1981, Barrett-Lennard, deriving from Rogers's theory, put forth an integrated empathy model, the Empathy Cycle, which includes cognitive, affective and communicative aspects of empathy under the context of human interactions (Gladstein, 1983). He said that empathic understanding involves " translating his words and signs into experienced meaning which matches at least those aspects of his awareness that are most important to him at the moment. All this is an experiencing of the consciousness 'behind' another's outward communication but with continuous awareness that this consciousness is originating and proceeding in the other" (Barrett-Lennard, 1962/1993, p.4). Barrett-Lennard's model provides the most comprehensive operationalization of how empathy works in an interactive model, and he is recognized as one of the prominent theorists in the scope of empathy studies (Duan & Hill, 1996).

Barrett-Lennard's Empathic Cycle (1981, 1993) is visualized as *Figure 3.1* and

detailed information is given as follows. P_A refers to the empathizer, usually the therapist in the counseling session, while P_B refers to the person being empathized with, that is the client at most of the times.

The first step of the Cycle is that the empathizer P_A actively pays close attention to P_B, the speaking person. The step is a prerequisite of empathy initiation and in which skills of attending and active listening take place.

Empathic Resonation (Phase I Empathy), relying on the previous step, is when P_A recognizes and resonates inside with P_B's perceptions and emotions. This is the step where P_B's world is converted to P_A's experiential understanding and is also the stage when explicit and implicit features of P_B's experience become alive to P_A.

Expressed Empathy (Phase II Empathy) refers to communicating Phase I empathic understanding in verbal or non-verbal ways. This response does not mean to imitate the literal meaning of other's words with manner of concern, but it should be an expression aroused from internal process of empathy.

Received Empathy (Phase III Empathy) indicates that P_B experiences being carefully listened to and deeply understood which impacts on P_B with an insight or a feeling of relief. The sense of being understood has more influence on P_B than previous phases of the empathic process.

The last column of *Figure 3.1* is Phase I empathy in repeat form with P_B providing more information about himself/herself. The expression at most of times carries implicit feedback indicating whether P_A's prior verbal and non-verbal expressed empathy make P_B feel being understood or not.

Barrett-Lennard (1993) also said that the existence of empathic process depends on P_B's "self-expressive, especially of feeling or felt meaning" (p.6) and P_A's "capacity to tune in strongly to these particular feelings and meanings" (p.6) of P_B.

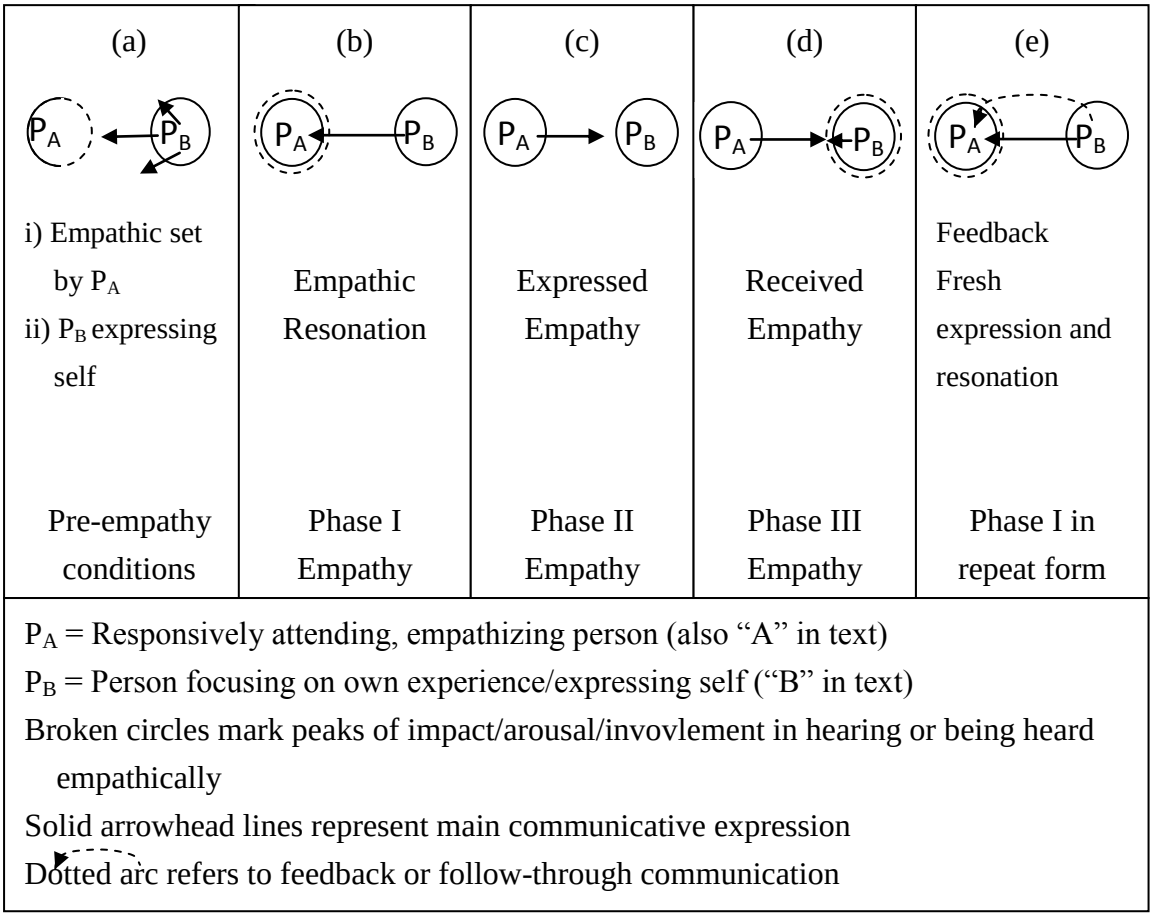

Figure 3.1 Schematic Outline of the Empathy Cycle

Source: Barrett-Lennard, 1993

The internal thinking process of forming expressed empathy, as in Phase I Empathic Resonation of the Empathy Cycle, can be explained by information processing theory. Liaw (2004) said that therapists first pay attention to external stimuli or the verbal and non-verbal expressions given by clients, then retrieve prior knowledge stored in long-term memory, recognize patterns, produce possible perceptions and feelings of clients' experienced world and form the content of expressed empathy.

3.6 Conclusion

Some prominent theorists of empathy studies define empathy as a cognitive-affective state of mind to sense other's private world as if it were one's own

(Rogers, 1959; Truax & Carkhuff, 1967) while some other important theorists define empathy as a process that involves producing and communicating an empathic state, such as the Empathy Cycle put forth by Barrett-Lennard (1981, 1993) (Duan & Hill, 1996). The Empathy Cycle is considered an integrated model of empathy that put cognitive, affective and communicative aspects together (Gladstein, 1983).

In communicating empathy, Carkhuff (1969) compared what a client has said and what an empathizer responses to define the level of expressed empathy. If the meanings and affect of these two expressions are interchangeable, it is basic empathy. If the communicative response is subjectively additive to the originally expressed sense and feelings of the client, which enables the client to explore deeper perceptions and feelings, it is advanced empathy. On the other hand, if what the empathizer responses is subjectively subtractive from what the client said, interaction is detracted from the client and his/her affect and meaning is distorted. In other words, the client is no longer the center of focus in the interaction.

Different communicative skills of empathy can be used to manifest the process and levels of empathy. Attending and active listening to client's verbal and non-verbal information are skills at the stage of Empathic Set and Empathic Resonation, which serves as the base of understanding the client's perceptions and feelings. In communicating the resonation, paraphrasing the essence of client's expression and reflecting client's stated emotion can demonstrate basic empathy while reflecting the implicit expressed feelings and therapeutic interpretations of client's perceptive experience with new frames of reference manifest advanced empathy. At the stage of client's giving feedbacks, attending and active listening to his/her confirmation or correction to the response launches the next cycle of empathy process.

Major characteristics of empathy include placing client at the focus center in the interaction, not agreeing with the client, holding non-judgmental attitude, valuing

individual and cultural differences and respecting client's autonomy. These characteristics not only distinguish empathy from sympathy that moves the focus away from the client and provides one's own judgment of right or wrong, good or bad, but also demonstrate respect for the client which leads to development of trust and establishment of relationship. If the therapist projects his/her feelings and perceptions on the client, supervision or transfer of the case is required.

Compiling concepts and skills mentioned in this chapter, the empathy model is visualized as *Figure 3.2*. This figure is based on the Empathy Cycle developed by Barrett-Lennard (1993). Rogers's (1975) definition of empathy process includes two components, understanding and communicating. Understanding in Rogers's theory, elaborated by Gladstein (1983), include both cognitive and affective empathy, which is described by Duan and Hill (1996) as a cognitive-affective state. If comparing Barrett-Lennard's and Rogers's definitions, the component of communication in Rogers's theory can refer to stage (c) in Barrett-Lennard's Empathy Cycle while cognitive-affective state of understanding in Rogers's theory conforms to other stages of the Cycle. At the stage of Expressed Empathy or empathic communication, it can be further divided into basic and advanced empathy according to Carkhuff (1969) and Egan (1975, 1998). This figure also incorporates communicative skills of empathy mentioned by Huang (1991) and Hill (2009) into each stage of the Empathy Cycle. *Figure 3.2* will be used in this study to compare with related concepts in studies of interpreting in Chapter Four.

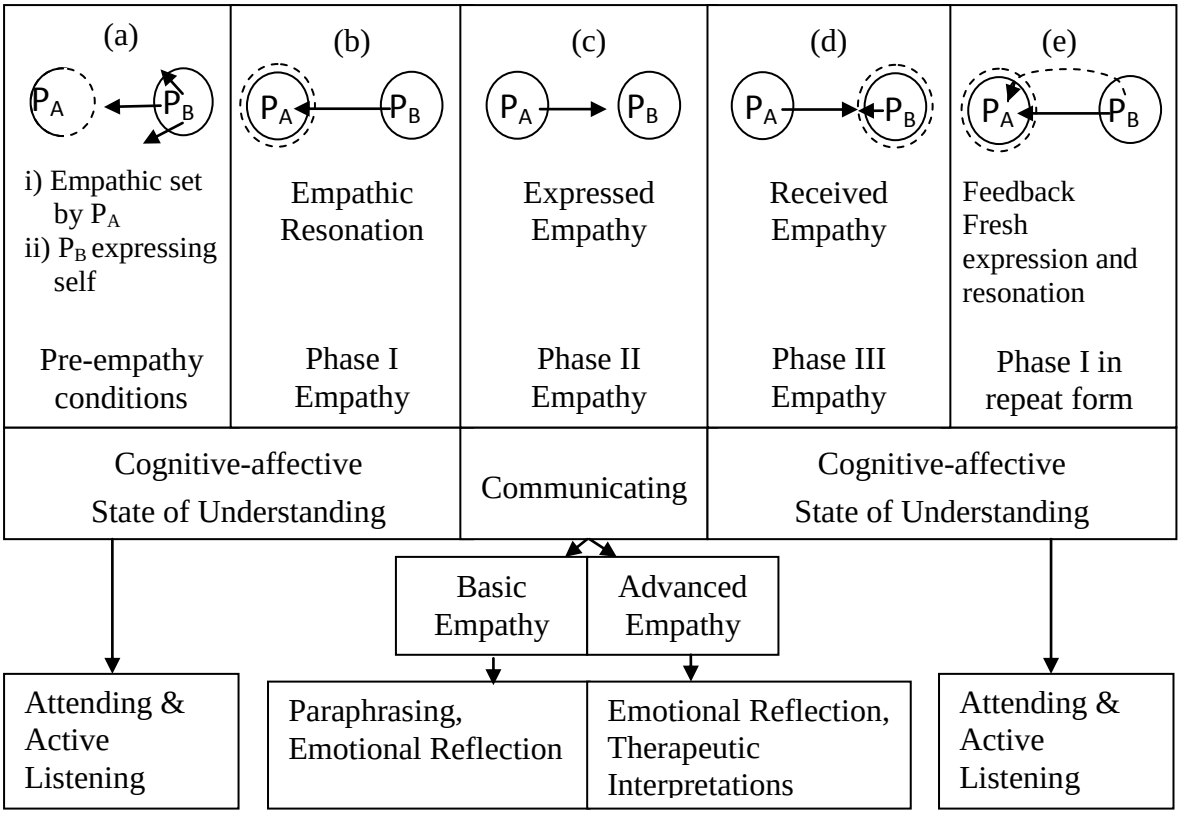

Figure 3.2 Empathy Cycle, Levels and Communicative Skills

Source: compiled by this study

Chapter Four

Medical Interpreting and Empathy

4.1 Similarities between Medical Interpreting and Empathy

Medical interpreting covers services provided in bilingual mental health encounters (Roat, 2011). Based on the literature reviewed in Chapter Two and Three, empathy, constantly demonstrated by therapists, shares many similarities with medical interpreting. These similarities are categorized into three parts in this section: settings, communicative skills and neutrality. Settings include elements involved in the communication, such as participants, goals, communicative context and so forth. Communicative skills refer to those of expressed empathy that are also mentioned in literature of interpreting and translation. Neutrality refers to user-centered, preference free and non-judgmental attitudes as mentioned in section 2.3.

4.1.1 Settings

Medical interpreting and empathy are both communication activities in which one of the aims is to help the patient/client alleviate suffering. Gentile *et al*. (1996) said that interpreting is one of the oldest forms of human communication while Duan and Hill (1996) emphasized that "empathy is the very basis of all human interaction" (p.262). In addition, interpreting in medical settings aims to help patients and the quality of communication (Hale, 2007). Empathy is also found helpful to the client of psychotherapy (Rogers, 1975) and is one of the determinants of the therapeutic outcome of psychotherapy and other medical encounters (Truax and Carkhuff, 1967; Hale, 2007).

Participants of medical interpreting and empathy both include at least a healthcare provider and a patient. However, an interpreter also participates in medical

interpreting as a mediator between the provider and the patient or the primary parties (Alexieva, 1997/2002). The goal of interpreters is to let the message expressed by the speakers create the same influence on the addressees speaking the same or different mother tongues (Angelelli, 2000). Therefore, the presence of interpreters does not change the goal of the encounter, except length of communicative time and the dynamics of communication that primary parties are incapable of interacting directly to each other (Gentile *et al.*, 1996). Both medical interpreters and empathizers are participants who can influence the settings of medical encounters (Angelelli, 2004; Barrett-Lennard, 1993).

Differences in social status, level of education and other cultural factors exist between providers and patients in both activities; however, the gap is even wider in medical interpreting where two languages are involved. In monolingual settings, providers of both activities are encouraged to empathize with patients to enhance the effectiveness of medical encounters (Reynolds & Scott, 1999; Hale, 2007), required to be cultural sensitive (Hale, 2007; Hill, 2009) and at the same time make correct diagnosis and treatment plans. On the other hand, interpreters in medical and psychotherapy bilingual settings may share the burdens of providers in overcoming language and culture differences, fostering a deeper professional understanding of patients and communicating in culturally sensitive ways (Pugh and Vetere, 2009). Both providers/therapists and interpreters are therefore encouraged to learn how to work with each other (Hale, 2007; Pugh and Vetere, 2009); nevertheless, interpreters' proper level of involvement in the medical encounters has been a major issue of debate (Wadensjö, 2009).

The theories of medical interpreting and empathy also share a wide range of common grounds. Both activities include three similar stages: "perception" in Seleskovitch's (1978) theory and "Empathic Set" in Barrett-Lennard's (1981, 1993)

theory, “comprehension” and “Empathic Resonation”, “expression” and “Expressed Empathy”. Interpreters and empathizers pay close attention to the speaker’s utterances in the first stage so to understand the speaker’s experience or meanings of the message in the second stage. At the stage of “comprehension” and “Empathic Resonation”, Seleskovitch and Rogers (1975) both emphasized that interpreters and empathizers are required to understand the sense or sensings of the other person’s expressions. This “sense” refers to the other person’s conscious, current perceptions and emotions (Håkansson, 2003) and is derived from his/her verbal and non-verbal information (Seleskovitch, 1978 b; cited from Pöchhacker, 2004; Barrett-Lennard, 1993). Seleskovitch (1978) said that to understand the meaning of source utterance, discard of linguistic forms or de-verbalization is required by interpreters. What empathizers intend to understand is also the other’s experience rather than literal meaning (Barrett-Lennard, 1993). At the stage of “expression” and “Expressed Empathy”, interpreters and empathizers are both required to express their understandings toward the other in their own words, instead of parroting the speaker’s words (AIIC, 2005; Egan, 1998). Their expressions must also be in a way that the receiver is used to (Seleskovitch, 1978; Hill, 2009). Moreover, both interpreting and empathy studies adopt information processing theory to highlight the importance of retrieving from long-term memory the stored prior knowledge that is related to the elements involved in the communication in order to perform accurate rendition and empathy (Moser-Mercer, 1997/2002; Liaw, 2004).

4.1.2 Communicative Skills

The communicative skills of expressed empathy are directly mentioned or share common ground with concepts in literature of interpreting and translation. It will be discussed under three sub-sections: active listening, paraphrasing, therapeutic

interpretations vs. explicitation and domestication. In each section, the common grounds of the skill shared by studies of interpreting and empathy are first elaborated. Then the differences of the skill existed between the two specialties are also covered.

4.1.2.1 Active Listening

Active listening has been described as one of the conditions of effective interpreting (Gentile *et al.*, 1996), the base of all other psychotherapy skills (Hill, 2009) and of all types of interpersonal communication (Egan, 1998). Studies from fields of interpreting and psychotherapy both define active listening as an attending and concentrating state of mind (Gentile *et al.*, 1996; Egan, 1998) to grasp the meaning of and connections in the other person's expressions. This understanding goes beyond words and refers to the meanings (Jones, 1998; Hill, 2009). This form of listening is a skill (Egan, 1998) that has to be learned (Jones, 1998). It requires high level of attention, energy and mentally watchfulness at all times (Jones, 1998). When actively listening to others, both interpreters and empathizers have to keep asking themselves "What are the ideas others want to express? What do they want me to understand?" (Jones, 1998; Egan, 1998).

Literature of psychotherapy gives more explanations about how to demonstrate active listening, which can be references for interpreters. Apart from mentally concentrating on others' verbal, non-verbal information and backgrounds, empathizers also demonstrate active listening by body movements such as using open postures (Egan, 1998) and nodding at the end of others' sentences (Hill, 2009). Attending and active listening can also be showed by communicating in linguistic and grammatical ways that the patient is used to (Hill, 2009). These ways of demonstration can also be implemented by medical interpreters which may enhance the quality of service.

4.1.2.2 Paraphrasing

Paraphrasing is defined in the literature of both interpreting and psychotherapy as rephrasing speaker's meanings in an interpreter's and an empathizer's own words without alteration of the meanings (Robinson, 1998; Smaby & Maddux, 2011). Paraphrasing is applicable to all interpersonal relationships because it is helpful to show others that you really understand them (Hill, 2009). Anderson (1994) regarded paraphrasing as unilingual interpreting or rephrasing speakers' meanings in the same language. Its only difference from interpreting is that interpreting comprises an additional stage of switching the source utterance to different language codes. She found that the language code-switching stage does not make any measurable processing time longer, which might indicate that this stage does not increase much extra cognitive load on interpreters. It can therefore be argued that paraphrasing is one of the main components of accurate interpreting. In fact, many studies have found that ability to paraphrase simultaneously has statistically significant correlations with students' chances of succeeding in performing conference interpreting (Pöchhacker, 2004). Although consecutive interpreting, the most often adopted mode in medical interpreting, is different from simultaneous mode (Pöchhacker, 2004), the internal processing of interpreting remains the same. Paraphrasing is thus crucial.

Paraphrasing is demonstrated by both interpreters and empathizers; however, there are several differences in paraphrasing adopted in settings of interpreting and psychotherapy. The major difference is that empathizers paraphrase the clients' meanings back to them to reassure them that they are being listened to and allow them to check the accuracy of empathizers' understanding (Hill, 2009). Interpreters, on the other hand, paraphrase speakers' messages to another people, the addressees, for them to understand the speaker and make reactions according to the understanding (Pöchhacker, 2004). In addition, empathizers are only required to paraphrase the

essence of clients' expressions (Hill, 2009) while interpreters should remain faithful to all of the meaning segments (Hale, 2007). Nevertheless, both empathizers and interpreters do not parrot what speakers have expressed (AIIC, 2005; Egan, 1998). The purpose and content of paraphrasing and the target person that listens to the paraphrasing are therefore different. Differences in these aspects in fact occur in all communicative skills because three-party interactions with interpreters being the mediator are different in nature from two-party interactions with empathizers being the interlocutors, which will be elaborated more in section 4.2.

However, differences in purpose, content or receivers of paraphrasing between interpreting and empathy do not change the fact that paraphrasing is an important stage in the process of both communicative activities. Since both interpreters and empathizers are required to understand the speaker before they are able to paraphrase the meaning accurately, it can be argued that they have an empathic state of understand of the speaker or that they enter the speaker's world like empathizers. Being empathic can therefore be argued that it facilitates interpreters to perform accurate interpreting.

4.1.2.3 Therapeutic Interpretations vs. Explicitation and Domestication

Therapeutic interpretations, one of the communicative skills of empathy, share common features with explicitation and domestication in literature of translation. Before exploring these similarities, a brief introduction of explicitation and domestication is given respectively in the following paragraphs.

Vinay and Darbelnet (1958/1995) are the first to introduce the concept of explicitation (Klaudy, 2009). They defined it as "a stylistic translation technique which consists of making explicit in the target language what remains implicit in the source language because it is apparent from either the context or the situation" (p.342).

It is a translator's conscious decision-making process (Baker, 1992), in which translators aim to enhance the level of understanding of target users when there are gaps of linguistic and cultural information between source and target languages (Chen, 2006). Klaudy (2009) said there are four types of explicitation. Among these types, two are resulted from language differences; one is caused by translation process while the other is dictated by culture differences. The last type, named pragmatic explicitation, refers to that translators explain the culture of the source language in the target language. Since cultural disparity is wide between primary parties in medical interpreting (Kaufert & Putsch, 1997), the pragmatic explicitation has been observed being adopted by medical interpreters (Roat, 2011).

Domestication, on the other hand, is termed by Venuti (Yang, 2010) to refer to translation "in a transparent, fluent, 'invisible' style in order to minimize the foreignness of the TT [target text]" (Munday, 2008, p.144) to the readers of the target language. Venuti (2008) considered that domestication could lead to different cultural effects depending on "the relation between the translation project and the hierarchical arrangement of values in receiving situation at a particular historical moment" (p.19). Venuti (1994) said that values of translators are the reflection of domestic attitude toward foreign cultures so he argued that domestication may create stereotypes, hinder communication between cultures and thus did not favor domestication. However, he also said that domestication is inevitable in translation. On the contrary, Nida is the representative who favors the domesticating way of translation (Yang, 2010). He used "functional equivalence" to refer to that the function of the target utterance to receivers is the same as that of the source utterance to its addressees (Nida, 1995). Nida (1995) argued that it is justifiable to use domestication when translation is accompanied with non-verbal information or when misunderstanding may occur or make no sense to the target receivers without domesticating the source

language or when it requires the target receivers too much effort to understand.

In bilingual medical settings, great disparities of cultural factors exist between primary parties (Kaufert & Putsch, 1997) which may lead to misunderstandings. The consequences of misunderstandings in medical settings, such as misdiagnosis or inappropriate treatment, can be extremely serious (Avery, 2001). It is thus argued that enhancing the level of understanding between the primary parties should be prioritized than other values, such as retaining culture diversity. Explicitation and domestication are ways for interpreters to bridge the cultural gap and facilitate primary parties' mutual understanding. Cases of using explicitation and domestication by medical interpreters have also been observed (Hsieh, 2007; Roat, 2011), which will be discussed in Chapter Five. However, minimum level of interpreter's involvement such as explicitation and domestication should be adopted if direct rendition of the source language could already be understood by the receivers of the target language (Avery, 2001).

Comparing therapeutic interpretations, a communicative skill to demonstrate advanced empathy as mentioned in section 3.4.4, with explicitation and domestication, similarities are identified. According to Hill (2009), therapeutic interpretations are statements that go beyond what the client has explicitly expressed and give explanations to the client's behaviors, thoughts or feelings based on the client's culture, verbal information, experiences in the past, etc. One of the categories of explicitation happens to be giving explanations to the implicit culture factors embedded in the source language (Klaudy, 2009). Domestication, on the other hand, is similar to therapeutic interpretations in expressing the implication of the source language or the client's utterance. In addition, therapeutic interpretations, explicitation and domestication are all suggested to be done cautiously because the service users' culture values may be very different from our own and our perceptions of their

cultures. Avoid stereotyping or generalizing is crucial (Venuti, 1994; Kelly, 2008; Hill, 2009).

However, therapeutic interpretations cover wider aspects than explicitation and domestication. For example, explicitation and domestication in medical settings focus more on cultural related factors, such as language and common knowledge of history (Klaudy, 2009; Venuti, 2008). Therapeutic interpretations in psychotherapy settings, on the other hand, include not only cultural related factors but also clients' experience in unconscious mind (Hill, 2009). Moreover, the purpose of therapeutic interpretations is for an empathizer to help the client understand him/herself better while explicitation and domestication are adopted by the medical interpreter to help other parties to understand the speaker better. However, both medical interpreters and empathizers make the implicit messages in the source language explicit and express the implication in the speaker's expressions. It is therefore argued that when medical interpreters demonstrate explicitation and domestication, they also display the empathic skill of therapeutic interpretations and thus advanced empathy.

To sum up, medical interpreters adopt skills of empathizers in performing their duties. In fact, the skill of emotional reflection of empathizers is also emphasized in medical interpreting literature. As Gentile *et al*. (1996) and Roat (2011) said that medical interpreters are required to convey the complete nature of the primary parties' responses in mental health settings, including their emotions. The communicative skills mentioned in this section could reflect that medical interpreters actually display empathy. It also provides solid foundation for the emphasis of interpreters' ability to empathize with interlocutors in literature of community interpreting (Gentile *et al*., 1996). Ways to demonstrate empathy in medical interpreting, as the first research question, are also found.

4.1.3 Neutrality

Neutrality is demonstrated by user-centered, preference free and non-judgmental attitudes in medical encounters as mentioned in section 2.3. These attitudes are also major conditions of empathy as showed in *Table 3.1*. Similarities as well as differences of these attitudes across the studies of medical interpreting and empathy are discussed respectively in the following paragraphs.

The user-centered attitude is emphasized by both *National Codes of Ethics for Interpreters in Health Care* (NCIHC) and empathic studies. It is stated in NCIHC (2004) that communication and relationship between the primary parties should be put at the center of the focus. Rogers (1975) and studies of communicative skills (Egan, 1998) of empathy also highlight that clients are empathizers' focus center. Since users of both services, medical interpreting and psychotherapy, are placed at the center, their autonomy should be respected. In other words, no advice is allowed to be given (Rogers, 1975; Hale, 2007). Even though medical interpreters and empathizers are influential to the communication, users are the ultimate decision-makers (Rogers, 1975; Avery, 2001). However, different from psychotherapy, there are at least two parties who sometimes have conflicts of interests in medical encounters. Medical interpreters therefore have more complicated tasks than empathizers because both primary parties have to be placed at the center of focus.

Both medical interpreters and empathizers are required to be preference free. As mentioned in section 3.1, one of the major features of empathy is that empathizers do not agree with or side with clients but understand and accept them (Wispé, 1986). It is also mentioned in section 2.3.2 that medical interpreters are required not to side with either of the primary parties (Kelly, 2008). Negative impact on the communication may occur if interpreters have preference (Wadensjö, 1998; Hale, 2007). However, medical interpreters are different from empathizers who are unlikely to favor one

party over the other. This is because medical interpreters are the mediator in a three-party communication while empathizers are interlocutors in a two-party interaction. Medical interpreters consequently have to pay additional attention to avoid taking side with either of the primary parties, which makes maintaining neutrality more difficult in bilingual medical settings.

Non-judgmental attitude refers to therapists' noncritical attitude that does not evaluate or judge client's feelings, thoughts and behavior as good or bad, right or wrong (VandenBos, 2007) in psychotherapy. Rogers (1975) said that non-judgmental attitude is the prerequisite of understanding the other accurately. Medical interpreters are also required not to project their opinions, beliefs, biases or values onto service users so to render users' meanings accurately (NCIHC, 2004; Hale, 2007). These arguments support that maintaining objectivity facilitates accurate understanding and communication of others' messages. Moreover, detachment from the service users and their experiences, which is a requirement for both medical interpreters and empathizers, is argued to be the demonstration of non-judgmental attitude in this study. According to NCIHC (2004), a detached medical interpreter does not take the messages in the encounter personally, so none of his/her discomfort is triggered to distort service users' meaning. Detachment is argued by NCIHC as a gesture of truly accepting users without judgments. Empathizers are also required to be emotionally detached (Wispé, 1986) so that they enter into others' world without losing the awareness that those experiences belong to others (Rogers, 1959). In addition, both medical interpreters and empathizers are warned to be aware of countertransference, which occurs when they lose objectivity. Countertransference refers to displace one's own feelings, beliefs or compulsions to others (Keller & Sticker, 2004). When medical interpreters and empathizers lose objectivity, both of them are advised to talk to a supervisor or withdraw from the case if necessary (Roat, 2011; Corey, 2001).

To sum up, both medical interpreters and empathizers are required to adopt these three neutral attitudes in practice. However, different from empathizers, medical interpreters need to demonstrate these attitudes to both users of the service, namely the provider and the patient, to be neutral. In addition, the final step of Empathy Cycle (Barrett-Lennard, 1981, 1993) is that the person being empathized with receives expressed empathy. Therefore, the person that the interpreter expresses empathy with needs to be at present. He/she can consequently confirm the accuracy of the interpreter's expressed empathy, whether through observing non-verbal information given by participating parties in the encounter or receiving the rendition of the other party's response. Moreover, all of the information exchanged in the encounter needs to be transparent to all parties, or the party being excluded from the conversation may perceive the interpreter taking the other party's side. Consequently, as primary parties speak in turn, medical interpreters can be neutral when they empathize with both parties respectively or at the same time in mediated encounters and keep all information transparent.

In conclusion, medical interpreters and empathizers face similar settings, use similar skills and hold similar attitudes. These similarities show that empathy exists in medical interpreting, which answers the first research question. Concepts emphasized in empathy theories can also be the reference for medical interpreters. For example, it is highlighted to pay attention to the receiver's feedback after he/she receives expressed empathy from the empathizer, particularly when empathizers express advanced empathy. By doing so, empathizers can check the accuracy of their empathic understanding. In addition, it is also highlighted to form the content of expressed empathy upon the speaker's verbal and non-verbal information as well as cultural context. The expressed empathy should also be delivered in ways

corresponding to the background of the receivers. If medical interpreters increase emphases on these concepts in their tasks, it is argued that the accuracy and flow of communication can be enhanced. Empathy is therefore argued to be able to facilitate medical interpreting. Furthermore, since all of the attitudes of neutrality are conditions of empathy (Wispé,1986), empathy can be used to examine the neutrality of each medical interpreters' role through medical interpreting cases. Case study may answer the third research question: explaining inconsistent views on the appropriateness of medical interpreters' non-conduit roles.

4.2 Expressed Empathy in Monolingual and Bilingual Medical Settings

In a monolingual medical setting, the content of empathizers' expressed empathy is based on clients' expressions (Carkhuff, 1969). Let P_B be the client and P_A be the empathizer, their interaction is as follows:

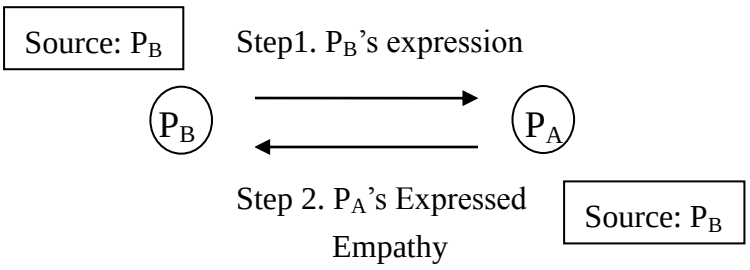

Figure 4.1 Process of Expressed Empathy in Monolingual Medical Settings
Source: compiled by this study from Carkhuff (1969)

It is clear that P_B is the center of this interaction for P_B provides the source utterance for P_A to generate the response and deliver it back to P_B. In addition, empathizers are required to use ways of expression that align with the client's background (Hill, 2009), which means that the empathizer have to empathize with the client's explicitly expressed meaning and implicitly demonstrated background at Step 2 of *Figure 4.1*.

The level of expressed empathy, as showed in *Table 3.1*, is determined by the interchangeability, or whether same feelings and meanings are shared between the client's expression and the empathizer's response. Interchangeable thoughts and emotions are not demonstrated by parroting but by paraphrasing (Egan, 1998) and reflection of feelings (Hill, 2009). If Step 1 and 2 in *Figure 4.1* deliver same feelings and content, what P_A expresses is basic empathy. If implicit feelings and meanings in Step 1 are expressed explicitly in Step 2, it is advanced empathy that P_A expresses back to P_B.

On the other hand, there are three participants in bilingual medical settings, provider, patient and interpreter (Hale, 2007), with two primary parties having diverse languages and cultures (Kaufert & Putsch, 1997). It has been discussed in the previous section that medical interpreters empathize with primary parties and express empathy with them by adopting empathic communicative skills. It has also been mentioned in section 4.1.2.2 and 4.1.2.3 that medical interpreters' expressed empathy with the speaker is communicated to the addressee, instead of back to the speaker. If extending *Figure 4.1* with P_B being the patient, P_C the provider and P_A the interpreter, expressed empathy in bilingual medical settings can be demonstrated as follows:

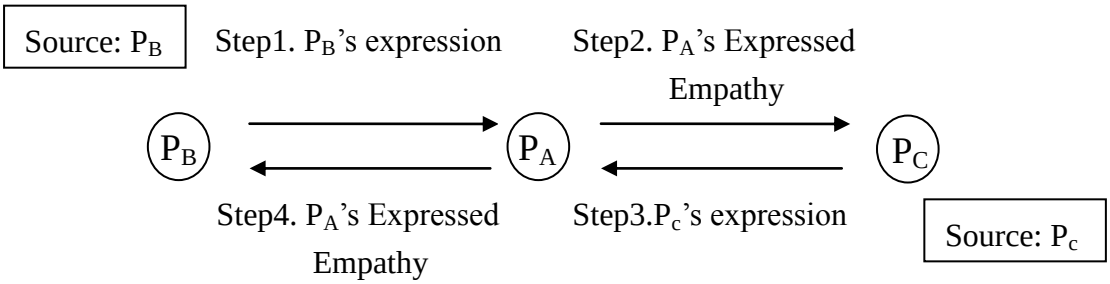

Figure 4.2 Process of Expressed Empathy in Bilingual Medical Settings
Source: compiled by this study

Comparing *Figure 4.1* with *Figure 4.2*, Step 1 and 2 change from a two-way

direction communication to a one-directional process because the receiver of the interpreter's expressed empathy with the patient changes from the patient to the provider. Nevertheless, the focus of communication in these two steps is still the patient or P_B. This process can also be observed in Step 3 and 4 when the interpreter has the empathic state of understanding of the provider's expression and expresses this understanding to the patient with the provider or P_C being the focus.

Changing the receiver of the expressed empathy from speaker to addressee also leads to the change of the way to express empathy. As stated in a monolingual setting, the way to express empathy should be in line with the client's background (Hill, 2009). If the receiver of the expressed empathy is the same as the person who gives source utterance, empathizers only need to express in ways that this person is used to. However, in a bilingual setting, great differences exist between primary parties (Kaufert & Putsch, 1997) which lead not only to expressing empathy in a different language but also in a way that is used to the receiver. It is similar to what Angelelli (2000) said that medical interpreters work in both primary parties' forms of speech. This change results from interpreters' empathic state of understanding toward the receiver's background. For example, patients with a lower level of education may speak in different register from the provider (Cambridge, 2004). The interpreter thus may lower the register of the provider's utterance in rendition so to achieve the goal of communication facilitation .

Figure 4.2 also reflects that though the interpreter or P_A empathizes with both parties respectively, he/she does not assume the role of empathizer, who is responsible for expressing empathy to the person being empathized with. Empathizers in monolingual settings, or P_A in *Figure 4.1*, can decide how to express empathy back to the client; on the other hand, interpreters are mediators in the bilingual settings where primary parties make the decision on what to say to each other. Although interpreters

use empathy to enhance their understanding of the speaker and express this understanding in different language to the addressee, whether there is an empathic relationship between primary parties or not still relies on the provider. If the provider does not express empathy with the patient, the interpreter can only faithfully render the provider's meaning in the rendition. In other words, an interpreter's empathy with both parties and patient-provider empathic relation are two different matters. Therefore, even if patients and providers are in conflict, interpreters can still have empathic state of understanding of and express empathy with one party to the other in neutral attitudes.

Expressed empathy in a bilingual medical setting, like in a monolingual setting, includes basic and advanced levels. However, definitions of expressed empathy in a monolingual setting (*Table 3.1*) cannot apply directly to the interpreter's expressed empathy in a bilingual setting before factors of language switch and changing the receiver of expressed empathy are given a closer look. First question that has to be answered is whether Step 1 and 2 or Step 3 and 4 in *Figure 4.2* could deliver same meanings and feelings in different language. In both monolingual and bilingual settings, interchangeable meanings and feelings are delivered by adopting skill of paraphrasing, not parroting (AIIC, 2005; Egan, 1998) and reflection of feelings (Roat, 2011; Hill, 2009). According to Anderson (1994), the only difference between paraphrasing and interpreting is that interpreting comprises an additional stage of switching the source utterance to different language codes, which possibly does not increase much extra cognitive load on interpreters. In addition, equivalence in meaning has been used to describe the relationship between source and target utterances (Hale, 2007). Therefore, it can be argued that speaker's expressions and interpreter's expressed empathy with the speaker could be directly compared in meanings and feelings without consideration of the language factor.

On the other hand, changing the receiver of expressed empathy changes the function of empathy in a bilingual setting. While expressed empathy is used to help the speaker understand him/herself better in a monolingual setting, it is used to help the other party understand the speaker's experience in a bilingual setting. Unlike expressed empathy demonstrated by empathizers to explore the client's inner experiences in depth, the aim of interpreters' expressed empathy is to fill the gaps of language and culture between primary parties and meet providers' and patients' expectations of understanding the situation better (Hale, 2007; Mesa, 2000). To provide this service, it is unnecessary for the interpreter to understand the service users as comprehensively as the empathizer in a monolingual setting does. Interpreters only have to assume part of the empathizer's tasks, which is to understand and express service users' meanings and feelings at the moment and pay attention to cultural factors that may influence the meaning of users' verbal and non-verbal information. However, medical interpreters still empathize with the primary parties as mentioned in previous section. Therefore, it is argued that the definitions of levels of expressed empathy in monolingual medical settings are applicable to bilingual medical settings.

Levels of expressed empathy in bilingual settings are thus defined as follows: if Stage 1 and 2 in *Figure 4.2* are interchangeable in perception and feeling, medical interpreters express basic empathy. Interpreters express advanced empathy when Stage 2 is more additive in meaning and feeling than Stage 1 in *Figure 4.2*, resulting from cultural factors such as class, education level or other reasons. These definitions can also apply to another communicative direction, or Stage 3 and 4 in *Figure 4.2*. If what interpreters express subtracts or detracts significantly the meaning and feeling from users' expressions, it is non-empathy, meaning that interpreters do not communicate their understanding of the users. *Table 4.1* illustrates the definitions of

the level of expressed empathy in a bilingual setting based on *Figure 4.2*.

Table 4.1 Levels of Expressed Empathy in Bilingual Medical Settings

Correlation	Definition	Level of Empathy
Step 1 = 2	Interchangeable in meaning and feeling.	P_A's Basic Empathy with P_B
Step 3 = 4		P_A's Basic Empathy with P_C
Step 1 < 2	Explicitation of deeper meaning and feeling in rendition but does not change the speaker's meaning and feeling.	P_A's Advanced Empathy with P_B
Step 3 < 4		P_A's Advanced Empathy with P_C
Step 1 > 2	The rendition subtracts or detracts significantly the meaning and feeling from the speaker's expression.	Non-Empathy
Step 3 > 4		Non-Empathy

Source: compiled by this study

Although definitions of levels of expressed empathy are similar between monolingual and bilingual medical settings, it is more important for medical interpreters to be cautious when expressing advanced empathy than empathizers. The reason is that the receiver of advanced empathy is not the person being empathized with. It is possible that interpreters' advanced empathy is incorrect. Therefore, as mentioned in section 3.3, advanced empathy should always be expressed in a tentative manner (Egan, 1975). In addition, when making cultural factors explicit or domesticating source utterances, interpreters should avoid generalizing or stereotyping (Kelly, 2008) as mentioned in section 4.1.2.3. The speaker should also be notified with the content of the interpreter's advanced empathy with him/her so that he/she has opportunities to verify the accuracy. By making all the information transparent to both primary parties, they are respected as the decision-maker of the

content of the communication.

To sum up, expressed empathy in bilingual medical settings has five major differences from monolingual settings: (1) more languages and participants are involved; (2) the receiver of the expressed empathy is not the person being empathized with; (3) the interpreter provides empathic state of understanding to the receiver when expressing his/her empathy with the speaker; (4) interpreter empathizes with and expresses empathy with both parties but does not assume the role of empathizer; and (5) the scope of advanced empathy, process and function of expressed empathy change.

4.3 Empathic Process in Medical Interpreting

Interpreting and empathy are both communicative processes composed of different stages (Seleskovitch, 1978; Barrett-Lennard, 1981). Since medical interpreting is a type of interpreting and there is no interpreting process theory especially developed in the studies of medical interpreting, theories of interpreting are adopted to compare with those of empathy. In section 4.1, it is argued that process of interpreting (Seleskovitch, 1978) and process of empathy (Barrett-Lennard, 1981) both comprise stages of perception, comprehension and expression. Communicative skills used in these stages and neutral attitudes are also adopted by both medical interpreters and empathizers. Therefore, it is argued that medical interpreters do empathize with service users.

However, the process of empathy changes when an additional party joins the dialogic interaction in medical settings. The stage of expressed empathy diverges in the bilingual empathy cycle for two different situations. First, medical interpreters express empathy with the speaker to the addressee; expressing empathy with the

patient to the provider is an example. Second, medical interpreters express empathy with the speaker back to him/herself in situations when what the speaker said has been misheard or not fully comprehended. Interpreters may take several actions, such as seeking from the speaker for the repetition of the segment (Gentile *et al*., 1996), asking the speaker for elaboration and clarification (Angelelli, 2000) and expressing what the interpreter has captured in the form of question to check if it's correct (Egan, 1998). These actions show that medical interpreters demonstrate empathy, respect for and place importance to what the speaker said (Egan, 1998). When interpreters interact with the speaker to clarify what was said, Roat (2011) suggested that interpreters should also inform the other party about the situation so that no party is excluded from the conversation. In addition, expressed empathy in bilingual settings is communicated in a different language. However, it has been clarified in section 4.2 that the speaker's expressions and the interpreter's expressed empathy with the speaker can be directly compared in meanings and feelings independent of the language factor.

The language difference and participation of interpreters also prolong the process of empathy. It therefore takes more time for one party to receive empathic response from the other in bilingual medical settings. In monolingual empathy cycle, as *Figure 3.2* shows, the client receives empathy right after the therapist expresses empathy. However, in the bilingual empathy cycle, the speaker has to wait for the interpreter's rendition, the addressee's response and the interpreter's rendition of the response before he/she enters the stage of received empathy.

In addition, the response that the speaker receives is not just expressed empathy from the addressee. It can also be an answer to what the speaker has asked, diagnoses, suggestions or expressed empathy with what the speaker has said. Expressed empathy is more likely provided by the provider to the patient than the other way around, but it

is also possible that the provider does not express empathy with the patient and the interaction between primary parties is simply questions and answers. It depends on different provider's style of communication. However, no matter primary parties have empathic relationship or not, medical interpreters empathize with them respectively so to express empathy in another language. Therefore, as mentioned in section 4.2, an interpreter's empathy with both parties and patient-provider empathic relation are two different matters. An interpreter is able to be the 'alter ego' of the speaker (Cambridge, 2004), which is assumed by different parties in turn, and expresses empathy with him/her. An interpreter is also able to demonstrate attitudes of neutrality even when there are conflicts between primary parties.

Moreover, an additional stage is added to the bilingual empathy process in medical encounters, which is that the interpreter empathizes with the addressee's background when expressing empathy. As mentioned earlier, there are great disparities in cultural factors between primary parties (Kaufert & Putsch, 1997) and they expect interpreters to help them understand the situation (Hale, 2007; Mesa, 2000). Consequently, interpreters should empathize with the background of addressees and interpret in ways that are more comprehensive to him/her.

To sum up, based on the Empathy Cycle developed by Barrett-Lennard (1993), the interpreter's empathic process in medical encounters can be illustrated as *Figure 4.3* with the primary parties coded as P_B and P_C and the interpreter is presented as P_A. P_B can refer to either the provider or the patient, so can P_C, but P_B and P_C represent different primary parties respectively. The number of the people in each primary party does not affect the process. P_B regards P_C as the respondent of his/her expression but P_B and P_C assume the role of speaker in turn from the medical interpreter's perspective. From stages (1) to (7), the speaker is P_B while from stages (9) to (15), P_C is the speaker. Interpreter's goal is to render what the speaker says; in other words,

interpreter renders for P_B from stages (1) to (7) and for P_C from stages (9) to (15). From stages (1) to (7), the process diverges at phase of expressed empathy for two situations. The first is that the interpreter expresses empathy with P_B back to him/her at stage (4) to clarify what he/she said. Then P_B receives the interpreter's expressed empathy and gives feedback at stage (6) and the process starting again from stage (1) in repeat form. When the interpreter fully understands P_B at stage (3), he/she jumps to stage (7) to express this understanding to the addressee or P_C. The other situation is that the interpreter comprehends P_B's meaning and feeling when he/she expresses the first time from stages (1) to (3); therefore, the interpreter jumps to stage (7) directly to express his/her understanding of P_B to P_C in another language. These two situations may happen between stages (9) to (15) as well. In addition, it has been mentioned in section 4.2 that changing the receiver of the expressed empathy from speaker to addressee also changes the way for the interpreter to express empathy. In order to facilitate understanding between P_B and P_C, when the interpreter expresses empathy with the speaker at stage (7) and (15), he/she also needs to empathize with the background and expectation of the addressee, as stage (8) and (16) shows, so to express in a way that is easier to comprehend by the addressee. After P_B receives P_C's response at stage (17), P_B can judge whether he/she is understood by P_C. If yes, he/she proceeds to the next topic; if no, some corrections or clarifications may occur as the feedback. The feedback starts another round of interactions with P_B's expressions.

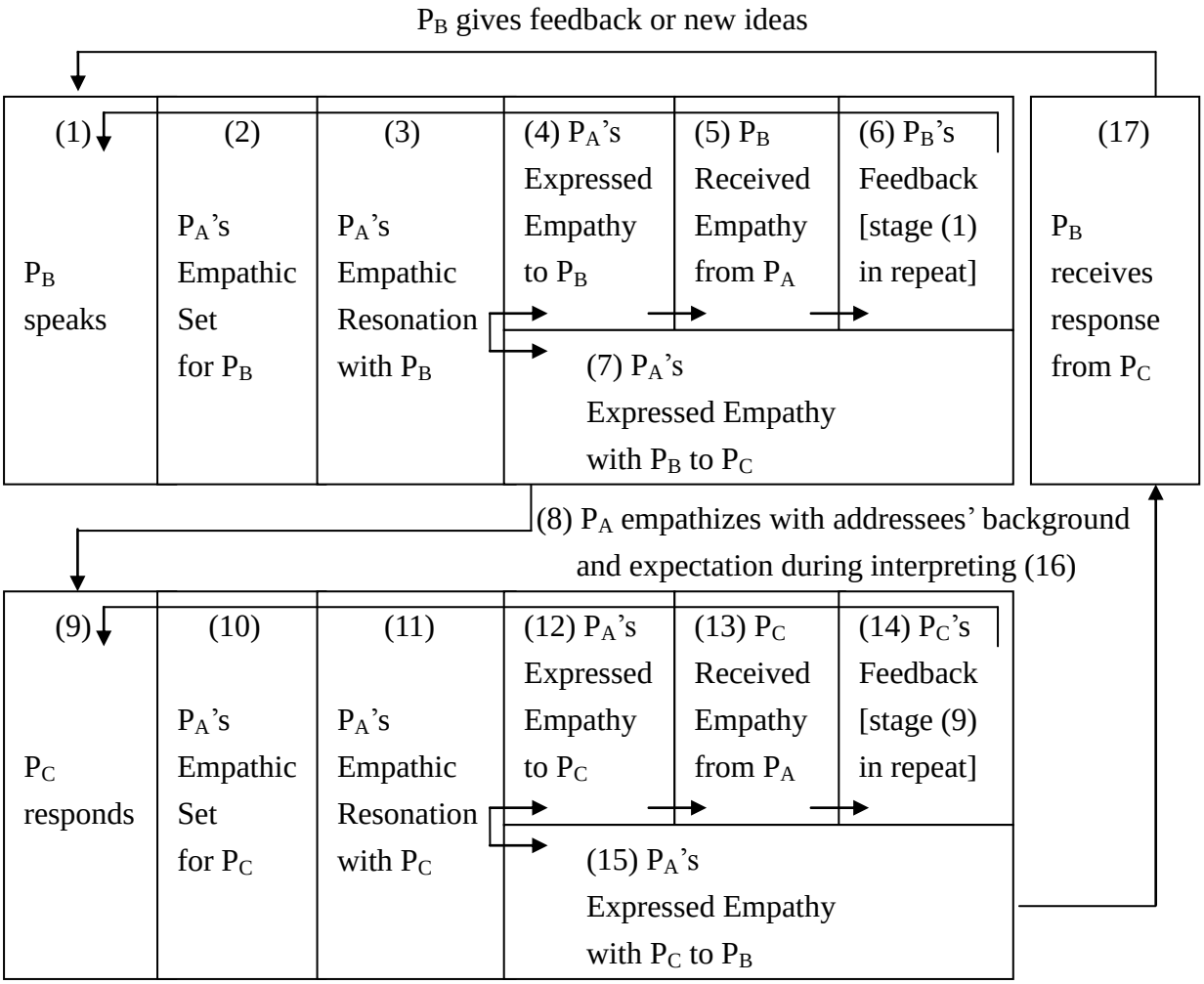

Figure 4.3 Interpreters' Empathic Process in Bilingual Medical Settings
Source: compiled by this study

In conclusion, similarities between medical interpreting and empathy in settings, communicative skills and attitudes of neutrality support that medical interpreters do empathize and express empathy with users. The comparison of communicative skills and attitudes answer how empathy is demonstrated in medical interpreting, which is the first research question. On the other hand, models of levels of expressed empathy as showed in *Figure 4.2* and interpreter's empathic process in bilingual medical settings as *Figure 4.3* answer the second research question. Moreover, similarities between medical interpreting and empathy provide solid ground for examining the attitudes of medical interpreters through empathy theories so to answer the third

research question. Communicative skills and models of empathy in bilingual settings are therefore adopted to examine cases of medical interpreting performed by different roles in the next chapter.

Chapter Five

Case Studies

Previous chapters have reviewed and compared theories of medical interpreting and empathy. To apply these theories to medical interpreting practice, cases are important tool to bridge the gap. To be more specific, based on the characteristics and definitions of the four medical interpreters' roles that Avery (2001) proposed, as showed in *Figure 2.1* and section 2.2, medical interpreting cases should be able to be categorized by roles. Through the categorization, each role's behaviors in practice can be specified, which can strengthen the connection between theory and practice. Cases categorized into different roles can also be examined by the empathic models (*Figure 4.2* and *4.3*) developed in Chapter Four. The examination facilitates understanding of the connection between each role and empathy as well as neutral attitudes, which can answer the third research question. As a result, the first section in this chapter will collect medical interpreting cases and categorize them into different roles with the help of experts in community interpreting. In the second section, at least three cases of each role are randomly selected and analyzed with empathic models.

5.1 Cases Categorization

The study process of cases categorization includes five steps and is visualized as *Figure 5.1*. Each step will be elaborated in the following sub-sections.

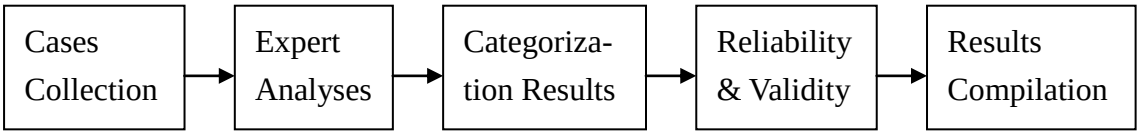

Figure 5.1 Study Process of Cases Categorization
Source: compiled by this study

5.1.1 Cases Collection

Published cases are gathered and selected randomly from studies conducted by researchers who have persistently dedicated efforts to medical interpreting studies and have the most comprehensive collection of medical interpreting cases in real practice. A total of 30 cases are collected and arranged according to its year of publication as showed in *Table 5.1*. Full text of these cases can be found in appendix.

Table 5.1 Collected Cases of Medical Interpreting

	Description of Interpreter's Behavior	**Source**
Case 1	Repeated provider's questions that the patient had not answered	Hsieh, 2007, p.927
Case 2	Instructed the patient what to say and not to say	Hsieh, 2007, p.928
Case 3	Replaced the role of the provider and asked the patient about the symptom	Hsieh, 2007, p.931
Case 4	Initiated attention requirement for the provider to notice the patient's symptom	Hsieh, 2007, p.932
Case 5	Explained cultural-specific phrases instead of interpreting literal meaning	Hsieh, 2007, p.933
Case 6	Explained to the patient on behalf of the provider about their situation	Hsieh, 2007, p.933
Case 7	Replaced the provider's role and made a diagnosis based on the patient's symptom	Hsieh, 2007, p.933
Case 8	Added the information interpreted before to make the current expression more complete	Hsieh, 2008, p.1371
Case 9	Interpreted everything the provider and the patient said	Hsieh, 2008, p.1372
Case 10	Advised the patient that he could file a complaint against the provider	Hsieh, 2008, p.1374
Case 11	Reminded the patient to ask the provider the question she mentioned before the encounter	Hsieh, 2008, p.1374
Case 12	Coached the patient to get the service she wanted	Hsieh, 2008, p.1374
Case 13	Explained the meaning of "Equal" for the patient	Hsieh,2008, p.1375
Case 14	Replaced the patient's role and answered the provider's question on behalf of her	Hsieh, 2008, p.1376

Case 15	Expressed sympathy with the patient by telling her not to worry	Hsieh, 2008, p.1377
Case 16	Altered the provider's expressed negative feelings in the rendition	Hsieh, 2008, p.1377
Case 17	Instructed the patient to say no more because the provider had done everything he could	Hsieh,2008,p.1377-8
Case 18	Altered the provider's meaning to avoid culturally inappropriate questions	Hsieh, 2008, p.1378
Case 19	Clarified the meaning of what the provider said	Hsieh, 2008, p.1379
Case 20	Advised the provider to do culturally appropriate behaviors	Hsieh, 2008, p.1379
Case 21	Clarified everything the provider wanted to express before starting to interpret	Hsieh, 2008, p.1380
Case 22	Requested the patient to repeat what she unclearly said	Roat, 2011, p.23
Case 23	Reflected that the patient's culture background could be the cause of frustrated communication	Roat, 2011, p.27
Case 24	Replaced the cultural term with the term that has the same meaning in target language	Roat, 2011, p.36
Case 25	Preempted to seek out the nurse who forged the patient's signature on a consent form on behalf of the patient	Roat, 2011, p.48
Case 26	Reflected the patient's level of speech in the rendition	Roat, 2011, p.71
Case 27	Lowered the register of legal documents provided by the provider to the patient	Roat, 2011, p.87
Case 28	Reflected the patient's actual pattern of speech in the rendition	Roat, 2011, p.100-1
Case 29	Explained to the provider the relation between the patient's perception with cultural belief	Roat, 2011, p.102
Case 30	Made sure that the patient understood the meaning of the provider's oblique expression	Roat, 2011, p.113

Source: compiled by this study

5.1.2 Expert Analyses

In order to verify the researcher's categorization of the interpreter's role of each

case, three experts are invited to do the classification. They have taken a course of community interpreting at the graduate school and worked for at least six months in a nonprofit organization that organizes training programs and provides service in community interpreting.

5.1.3 Expert Categorization and Results

Before analyses, the researcher explains the rationale behind each medical interpreters' role to the experts. After they discuss and agree on the definitions of roles compiled by this study, they read the 30 cases and label the role of each case. Their answers and the researcher's categorization are compiled as *Table 5.2*. Answers different from those of the researcher, highlighted in the *Table*, are further discussed. Descriptions of the interpreter's behavior in *Table 5.1* are also verified by experts.

Experts all consider labeling the interpreter's role simply based on theories difficult, which shows that it is necessary to make theories more complete with cases in practice. The consensus among the researcher and experts on the way to categorize is their perception of the intention behind the interpreter's action. For example, in Case 19 in which the interpreter asked about "Adefovir" mentioned by the provider, experts who perceive that the interpreter wanted to ask for what he/she did not understand or clearly hear is a clarifier. On the other hand, Expert 1 perceives the interpreter as a culture broker because he/she intended to bridge the culture gap between primary parties. Another example is Case 13 in which the interpreter explained "Equal" as substitute sugar for the patient. Experts who perceive the interpreter as a culture broker attribute the action to his/her intention to fill the culture gap for the patient. On the other hand, Expert 3 perceives that the interpreter also intended to show that he/she took the patient's side ("*They* call it substitute sugar. *Americans* call it substitute sugar."), so he/she is an advocate.

Table 5.2 Experts' Categorization

	Researcher	**Expert 1**	**Expert 2**	**Expert 3**
Case 1	Clarifier	Clarifier	Clarifier	Clarifier
Case 2	Advocate	Advocate	Advocate	Advocate
Case 3	Advocate	Advocate	Advocate	Advocate
Case 4	Advocate	Advocate	Advocate	Advocate
Case 5	Culture Broker	Culture Broker	Culture Broker	Culture Broker
Case 6	Advocate	Advocate	Advocate	Advocate
Case 7	Advocate	Advocate	Advocate	Advocate
Case 8	Clarifier	Clarifier	Clarifier	Conduit
Case 9	Conduit	Conduit	Conduit	Conduit
Case 10	Advocate	Advocate	Advocate	Advocate
Case 11	Advocate	Advocate	Advocate	Advocate
Case 12	Advocate	Advocate	Advocate	Advocate
Case 13	Culture Broker	Culture Broker	Culture Broker	Advocate
Case 14	Advocate	Advocate	Advocate	Advocate
Case 15	Advocate	Advocate	Advocate	Advocate
Case 16	Advocate	Advocate	Advocate	Advocate
Case 17	Advocate	Advocate	Advocate	Advocate
Case 18	Advocate	Advocate	Advocate	Advocate
Case 19	Clarifier	Culture Broker	Clarifier	Clarifier
Case 20	Advocate	Advocate	Advocate	Advocate
Case 21	Clarifier	Clarifier	Clarifier	Clarifier
Case 22	Clarifier	Clarifier	Clarifier	Clarifier
Case 23	Culture Broker	Culture Broker	Culture Broker	Culture Broker
Case 24	Culture Broker	Culture Broker	Culture Broker	Culture Broker
Case 25	Advocate	Advocate	Advocate	Advocate
Case 26	Conduit	Conduit	Conduit	Conduit
Case 27	Culture Broker	Culture Broker	Culture Broker	Culture Broker
Case 28	Conduit	Conduit	Conduit	Conduit
Case 29	Culture Broker	Culture Broker	Culture Broker	Culture Broker
Case 30	Culture Broker	Culture Broker	Culture Broker	Culture Broker
Number of Codings That Agree with the Researcher		29	30	28

Source: compiled by this study

Experts and the researcher's consensus manifests that interpreters' actions are important indicators to others' perception of their roles. Since it is impossible for others to know the interpreters' actual intention, interpreters need to consider how others may perceive before taking any action and try to make all of their actions transparent to both primary parties. The consensus on the behaviors of each medical interpreters' role will be compiled in section 5.1.5.

5.1.4 Reliability and Validity

To make the results of analyses more consistent and convincing, Brown (2001) said researchers should invite at least two experts to do the analysis and then calculate the reliability of the analyses through intercoder agreement. Intercoder agreement is defined by Brown as "the degree to which two raters agree on assigning categories" (p.233). The format of this coefficient is as the following:

$$\text{Intercoder Agreement} = \frac{\text{The total number of codings agreed}}{\text{The total number of codings}} \times 100\ \%$$

The intercoder agreement ratios are 96% (29/30×100), 100% (30/30×100) and 93% (28/30×100) respectively. The figures demonstrate that experts support the researcher's categorization of the cases. The researcher thus adopts the categorization and will select at least three cases of each role to analyze its relation with expressed empathy and neutral attitudes in the next section.

In terms of validity, this study adopts the expert ratings approach (Brown, 2001), in which experts are invited to examine the rationale and definitions of interpreters' roles as well as the matching degree of these theories with cases in real practice. When experts' categorization varies from that of the researcher, discussions took place to clarify the reason of choice. The consensus of how to categorize roles is therefore

formed, which has been mentioned in section 5.1.3.

5.1.5 Results Compilation

Combine the descriptions of the interpreter's behaviors in *Table 5.1* with the results of role categorization in *Table 5.2*, examples of each role's behaviors can be demonstrated. Together with the definitions of roles mentioned in section 2.2.5, the theories and examples of each role's behaviors can be manifested as the following.

Conduit

- Definition: converts verbal and non-verbal information into another language faithfully, accurately, without omission, addition and edition.
- Examples of behaviors:
    1. Interprets everything primary parties say, such as meanings, emotions and tone of voice;
    2. Reflects the patient's level of speech and actual pattern of expression in the rendition.

Clarifier

- Definition: facilitates primary parties' mutual understanding of non-cultural related factors and alerts primary parties of possible misunderstanding.
- Examples of behaviors:
    1. Repeats one of the primary parties' questions that the other party has not answered;
    2. Adds the information interpreted before to make the current expression more complete;
    3. Clarifies everything one of the primary parties wants to express before starting to interpret;
    4. Asks for the meaning the primary parties want to express to elevate the

interpreter's understanding;

5. Requests primary parties to repeat what they unclearly said.

Culture broker

- Definition: bridges the culture gap between primary parties to facilitate level of understanding.
- Examples of behaviors:
    1. Explains cultural-specific phrases and oblique expressions instead of interpreting literal meaning;
    2. Reflects that primary parties' culture background could be the cause of frustrated communication;
    3. Replaces the cultural term with the term that has the same meaning in target language;
    4. Lowers the register of legal documents provided by the provider to the patient without changing the meanings;
    5. Explains to one of the primary parties the relation between the other party's perception and cultural belief as a reference.

Advocate

- Definition: acts on behalf of a user, provider or patient, for his/her benefits and rights either within or outside of medical encounters.
- Examples of behaviors:
    1. Instructs the patient what to say and not to say;
    2. Replaces the role of primary parties, such as asking the patient about the symptom, asking the provider to pay attention to the patient's symptom, making a diagnosis, explaining to the patient about their situation without the provider's presence, and answering the provider's question for the patient;
    3. Gives advice to primary parties, such as suggesting the patient to file a

complaint against the provider and advising the provider to do culturally appropriate behaviors;

4. Reminds the patient to ask the provider the question he/she mentioned before the medical encounter;
5. Coaches the patient to get the service he/she wants;
6. Expresses sympathy with the patient by telling him/her not to worry;
7. Alters primary parties meanings, such as their feelings and what the interpreter perceives culturally inappropriate expressions;
8. Preempts to seek out the provider who makes decisions against the patient's will without notifying the patient.

5.2 Medical Interpreters' Roles, Empathy and Neutrality

Based on the categorization of cases in medical interpreters' roles in prior section, at least three cases of each role are randomly selected and examined with empathic communicative skills as discussed in section 4.2, levels of expressed empathy in bilingual settings (basic, advanced or non- empathy mentioned in *Table 4.1*) and stages of empathic process in medical interpreting as shown in *Figure 4.3* in this section. The definitions of these concepts have also been compiled in section 1.5. This examination can identify the relation between roles and empathy, which can further clarify the relation between roles and neutral attitudes. It is due to that in three-party co-present medical encounters, interpreters who express empathy with primary parties in turn or empathize with both parties at the same time are argued to be neutral as mentioned in section 4.1.3. While maintaining neutral is regarded the appropriate line of involvement in this study (concluded in section 2.4), understanding the relation between roles and neutral attitudes can be the supportive evidence for arguing interpreters' proper roles.

In order to facilitate smooth reading, the parties of all medical interpreting cases cited in this section will be coded as follows: “H” for healthcare provider, “P” for patient and “I” for medical interpreter. At the left side of the cited cases, if the interpreter does express empathy, the corresponding stage in empathic process as *Figure 4.3* shown is noted in brackets as a reference.

5.2.1 Conduit

Case 9

[Stage (1) ~ (3)]	*201*	*H: Does she have any family history of diabetes?*
[Stage (7)]	*202*	*I: Do any of your family members have diabetes?*
[Stage (9) ~ (11)]	*203*	*P: No [in Chinese]. No[in English].*
[Stage(17) (1) ~ (3)]	*204*	*H: Is this her first pregnancy?*
[Stage (7)]	*205*	*I: First pregnancy?*
[Stage (9) ~ (11)]	*206*	*P: Yes.*
[Stage (15)]	*207*	*I: Yes.*
[Stage(17) (1) ~ (3)]	*208*	*H: Is she on any medication?*
[Stage (7)]	*209*	*I: Are you taking medicine now?*
[Stage (9) ~ (11)]	*210*	*P: No [in English] (cited from Hsieh, 2008, p.1372).*

During the study process of cases categorization, Expert 3 proposes to discuss the interpreter’s behavior of changing the subject of the provider’s expression in the rendition (change “she” to “you”). Experts later reach consensus that this change is different from meaning alteration. In fact, it is the provider’s “mistake” to address the patient in third person. What the interpreter chose to do was to direct the question to the patient, which they perceive conforming to a conduit’s behavior. Directing messages of one party to the other is also argued by Avery (2001) as a proper behavior.

The meaning of what the interpreter rendered is therefore argued to be interchangeable with that of the provider, as well as the patient. Moreover, in this mediated interaction, the interpreter paraphrased what the speaker expressed in another language to the addressee. The accurate rendition also reflects that the interpreter had actively listened to the speakers (Hill, 2009). Consequently, what the interpreter expressed was basic empathy with both of the primary parties respectively.

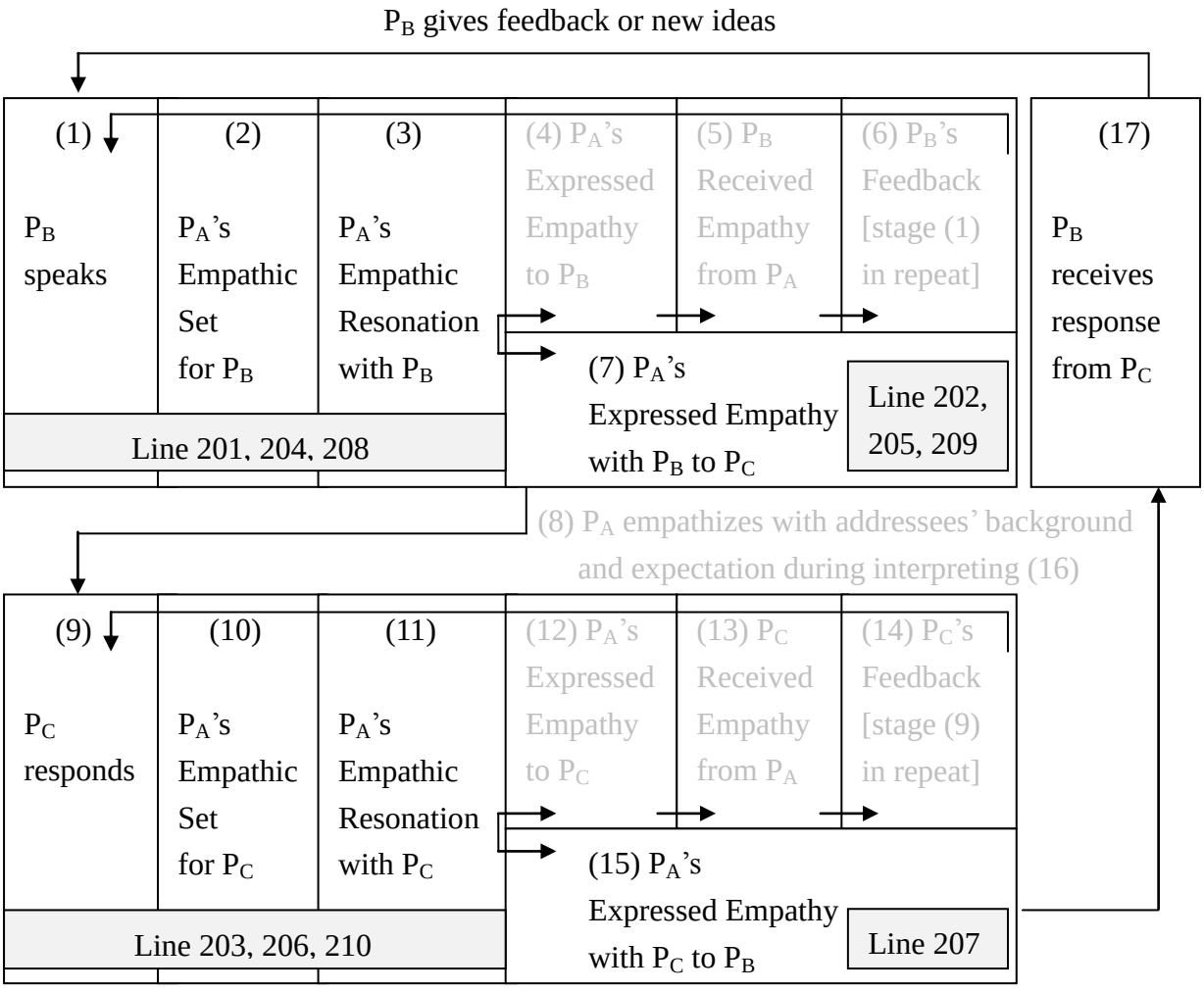

Figure 5.2 The Medical Interpreter's Empathic Process of Case 9
Source: compiled by this study

The interpreter's empathic process of this case is demonstrated in *Figure 5.2* with P_B being the provider and P_c the patient. The dialogue can be divided into three

rounds of interactions with the provider initiating a new question in lines 201, 204 and 208. From lines 201 to 203, stages (1) to (3) took place in line 201 where the interpreter prepared empathic set and resonated with the provider's expression. The interpreter then expressed basic empathy with the provider to the patient at stage (7) as line 202, which is followed by the patient's answer at stage (9) as lines 203. At the same time, the interpreter prepared empathic set and resonated with the patient's expression as stages (10) and (11). Since the patient did the interpreting herself, the interpreter did not express his/her understanding of the patient to the provider. After the provider received the patient's response as stage (17), he/she initiated another question at stage (1) as line 204. Same process repeated from lines 204 to 207, except with an additional stage (15), in which the interpreter expressed empathy with the patient to the provider as line 207. Lines 208 to 210 process like lines 201 to 203.

Since empathic communicative skills, levels of empathy and empathic process all support that the interpreter empathized with the primary parties in turn, it can be argued that he/she also demonstrated the three attitudes of neutrality: user-centered, preference free and non-judgmental.

Case 26 & 28

Interpreting in settings of pediatrics and mental health highly requires accuracy and completeness. Interpreting in pediatrics as Case 26, reflecting the child's level of speech could help the provider have accurate assessment of the child's development and form responses in accordance with the child's development (Roat, 2011). On the other hand, interpreting in metal health settings as Case 28 requires the following:

"…pauses and uncertainty…both content and tone of voice in the response…patient's mood swings…pace of speech, the repetition of certain words,

even the errors in word choice. An even greater challenge may come when the patient's speech makes no sense…In this case, you can see how important it is to recreate the actual pattern of speech, so that the provider can perceive the symptom…" (Roat, 2011, p.100-101).

The requirement for accurate interpreting is high in this setting because what and how the provider expresses has his/her intention (Hall, 2007) and what and how the patient expresses are important to diagnosis (Roat, 2011). The rendition thus keeps all of the provider's and the patient's verbal and non-verbal information as well as communicative manner, such as the incoherence of source utterance. If the communicative manner is too difficult to be delivered in the rendition, it is suggested that the interpreter should at least describe it (Roat, 2011).

To faithfully interpret what and how the speaker has expressed him/herself in both cases reflects that the interpreter adopts skills of paraphrasing and emotional reflection. In addition, the interchangeability in meaning and feeling between source and target utterances demonstrates that the interpreter expresses basic empathy with both primary parties.

If these cases are further analyzed with the empathic process as *Figure 4.3*, P_B represents the patient while P_c is the provider. The interpreter provides empathic set to resonate with the patient's experience and his/her way of expression from stages (1) to (3), then expresses his/her empathy with the patient at stage (7). Afterwards, the interpreter switches focus to the provider's expression from stages (9) to (11) and expresses empathy with him/her at stages (15). After the patient receives the provider's response or expressed empathy at stage (17), he/she gives feedback as the process restarts at stage (1). Same process continues in the medical encounters.

Empathic communicative skills, levels of empathy and empathic process all

support that the interpreter empathizes with the speaker, which is assumed by primary parties in turn. It can therefore be argued that the interpreter demonstrates the three attitudes of neutrality.

To sum up, cases of conduit reflect some important information. A conduit, a role adopted in mediated communication, delivers explicitly expressed verbal information and observable non-verbal information of the primary parties in another language. The communicative manner of the source utterance is also kept in the rendition, which is particularly important in pediatric and mental health settings. In addition, interchangeable meanings and feelings between source and target utterances reflect that a conduit expresses basic empathy with both primary parties. Interpreter's demonstration of empathy supports that he/she is neutral.

5.2.2 Clarifier

Case 1

[Stage (1) ~ (3)]	*101 H: And she's giving how long and how frequent?*
[Stage (7)]	*102 I: 那你每一次大概給她餵多少，一天多少次？*
	103 (How long do you feed her each time and how many times a day?)
[Stage(9)~(11)]	*104 P: 他因爲我不知道是不是她不夠力，虛。她都要 40 分鐘。*
	105 (I am not sure if she does not have enough strength or [if she is]
	106 weak, but she takes about 40 minutes.)
[Stage (7)]	*107 →I: 你說每次要 40 分鐘。然後一天大概要幾次？*

	108	*(You said 40 minutes each time, and how many times a day?)*
[Stage (9)~(11)]	109	*P: 我兩個小時就餵一次*
	110	*(I feed her every two hours.)*
[Stage (15)]	111	*I: Okay. Every tow hour, every time, probably around 40 minutes. And mom*
	112	*was concerned, maybe because the baby's- I mean it's very difficult*
	113	*to suck the milk or what, it takes 40 minutes every time (cited from Hsieh, 2007, p.927).*

In this mediated communication, the interpreter adopted paraphrasing to express empathy with both parties in another language because the interpreter rephrased primary parties' expressions in his/her own words without adding or omitting any meanings. Although the interpreter interpreted again the second question that had been raised by the provider but partially answered by the patient as a clarification in line 107, the meaning is still the same as that of the provider. Since the renditions are interchangeable in meaning with either the provider's or the patient's expressions, it could be argued that the interpreter expressed basic empathy with both parties.

If the case is further analyzed with *Figure 4.3*, P_B is the provider while P_C is the patient. Line 101 indicates the interpreter's empathic set and resonation with the provider expressions as stages (1) to (3). Lines 102 and 103 are the demonstration of stage (7) where the interpreter expressed his/her understanding of the provider to the patient. Then, lines 104 to 106 are stages (9) to (11) in which the patient responded and the interpreter actively listened to and resonated with her. However, the interpreter skipped back to stage (7) in line 107 to express again his/her empathy with

what the provider said earlier. After listening to the patient's answer through stages (9) to (11) as lines 109 and 110, the interpreter expressed his/her empathy with the patient to the provider as lines 111 to 113 show, which is demonstrated as stage (15).

This case is supported by empathic communicative skills, levels of empathy and empathic process that the interpreter empathized with both primary parties. The interpreter thus demonstrated neutrality. In addition, the clarifier in this case chose to clarify the answer of the unresponsive question instead of leaving the task to the provider. It reflects that a clarifier perceives his/her tasks more than language transformation like a conduit, but a communication facilitator.

Case 19

[Stage (1) ~ (3)]	*1201*	*H: Has he ever been given Adefovir before?*
[Stage (7)]	*1202*	*I: Did he give you – I think it's called Adefovir.*
[Stage (9)(17)]	*1203*	*P: No.*
[Stage(4)]	*1204*	*I: Excuse me, the interpreter would like to*
	1205	*clarify, do you mean is it a brand name of*
	1206	*medication? Adefovir.*
[Stage (5)(6)(1)]	*1207*	*H: Hepsera is the trade name, Adefovir is the*
	1208	*generic name.*
[Stage (2)(3)(7)(8)]	*1209*	*I: Adefovir is the name of the drug, the drug*
	1210	*name for the brand (cited from Hsieh, 2008, p.1379).*

In this mediated provider-patient communication, the interpreter clarified the meaning of the provider's expression. During study process of case categorization, three out of four experts (including the researcher) regard that the interpreter made the clarification because he/she did not fully understand what Adefovir is, referring to

his/her uncertainty ("*I think it's called Adefovir*" as line 1202) and the following question from lines 1204 to 1206. Asking for the speaker's meaning instead of feigning to understand, as mentioned in section 3.4.1, is a demonstration of empathy and respect (Egan, 1998). Apart from making clarification, the interpreter paraphrased both primary parties' expressions without meaning alteration, which means that he/she had also actively listened to them. Since no meanings were added to or subtracted from the source expressions when the interpreter expressed empathy with both primary parties, what the interpreter expressed was basic empathy.

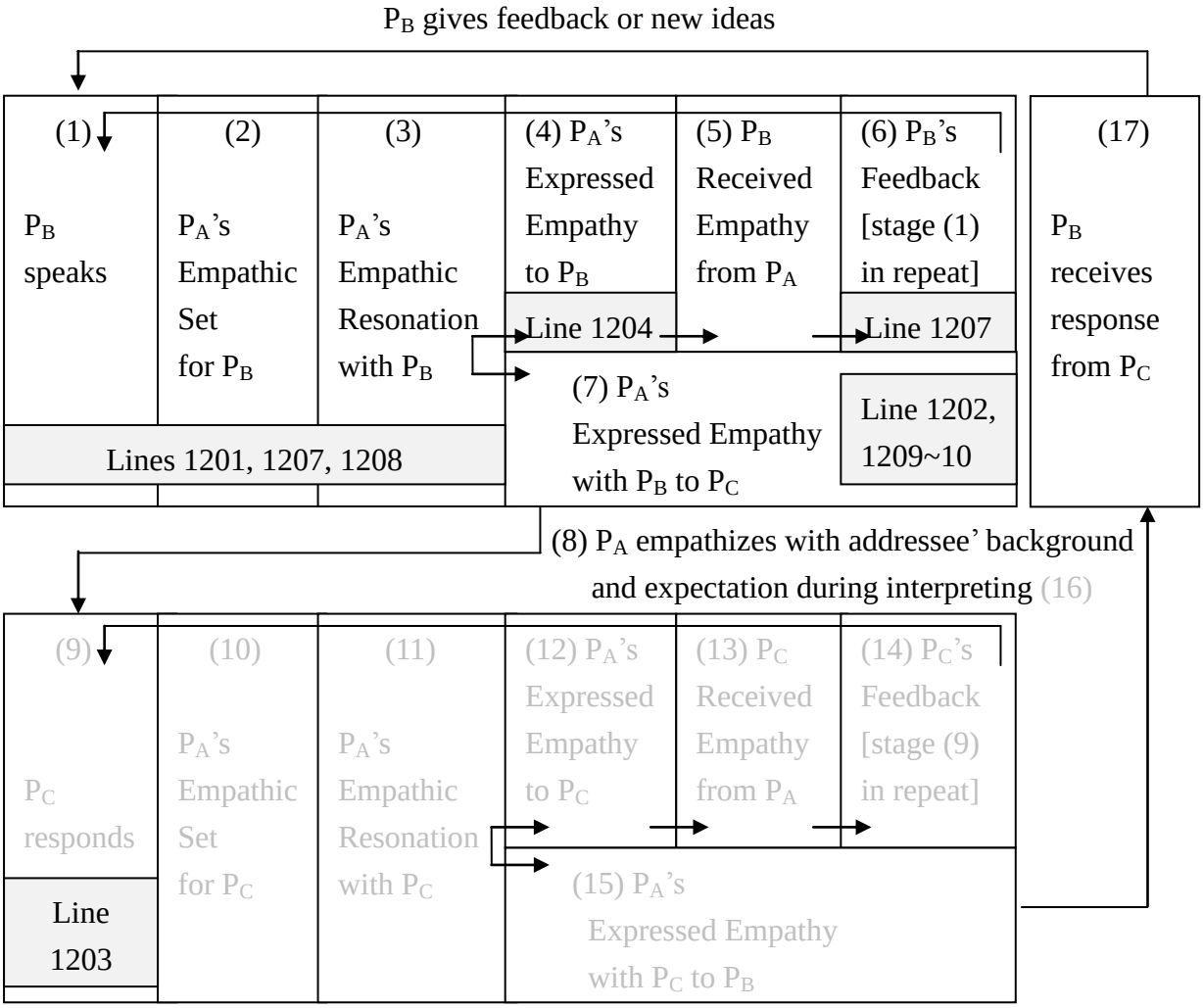

Figure 5.3 The Medical Interpreter's Empathic Process of Case 19
Source: compiled by this study

If analyzing the case with empathic process in medical interpreting as demonstrated in *Figure 5.3*, P_B is the provider while P_c is the patient. When the provider spoke in line 1201, the interpreter attended and actively listened to the provider so to resonate with him/her, which conforms to stages (1) to (3). Then in line 1202, the interpreter expressed empathy with the provider by paraphrasing what he/she said as stage (7). After the patient responded in the dominating language at stage (9) for the provider to understand at stage (17) in line 1203, the interpreter made clarification to understand better the provider's meaning as stage (4) from lines 1204 to 1206. The provider gave feedback from lines 1207 to 1208 as the process goes through stages (5), (6) and (1). The interpreter again actively listened to and resonated with the feedback so to express empathy at stage (7) to the patient from lines 1209 to 1210. The rendition in last two lines is also a gesture of empathizing with the patient's expectation of understanding the situation completely (Mesa, 2000) as stage (8). The interpreter could have chosen not to interpret because the clarification was to elevate his/her understanding of the provider.

Analyses above show that empathic communicative skills, levels of empathy and empathic process all support that the interpreter empathized with both primary parties. The interpreter thus demonstrated neutrality. What is worthy of noticing is that the interpreter could have left the patient to understand the provider. However, like the previous case, the interpreter chose to clarify the speaker's meaning to facilitate communication. It again shows that a clarifier perceives his/her function more than a language converter as a conduit, but as a communication facilitator.

Case 22

[Stage (1) ~ (3)]	[The patient:] *"The baby wouldn't stop crying and so I gave*

	mumble, mumble, mumble."
[Stage (7)]	*Interpret what you did understand to the provider first: "The baby wouldn't stop crying and so I gave ---"*
[Stage (8)]	*Tell the provider that you need the patient to explain the rest: "The interpreter says, I need her to clarify the last part of what she said."*
[Stage(4)]	*Ask the patient to explain to you: "As the interpreter, I'm asking, could you repeat what you said?"*
[Stage (5)(6)(1)]	[The patient repeats herself.]
[Stage (2)(3)(7)]	*Once you understand, go back to interpreting:"I couldn't get the baby to stop crying, so I gave her a bottle with chamomile tea" (cited from Roat, 2011, p.23).*

In this three-party communication, the interpreter initiated questions to clarify the patient's expressed but unclear meanings. Both the provider and the patient were informed about and agreed to the interpreter's behavior of clarification. The meaning of source language given by the patient was neither added nor subtracted in the rendition. The unclear parts of source utterance were also interpreted faithfully.

In terms of communicative skills, it has been mentioned in section 3.4.1 that politely requesting for the speaker to repeat what was said is one of the demonstrations of empathy and respect (Egan, 1998). The interpreter's accurate rendition manifests that he/she demonstrated active listening as well as paraphrasing after fully comprehending the patient's meaning. The interchangeability in meaning and feeling between source and target utterances shows that the interpreter expressed basic empathy with the patient to the provider.

If explaining the case with empathic process as demonstrated in *Figure 4.3*, P_B is

the patient while P_c is the provider. The interpreter actively listened to the patient at stage (2) but found it hard to resonate with her comprehensively at stage (3) which led to partially expressed empathy in another language at stage (7). Consequently, the interpreter requested for the provider's approval to clarify the meaning, a gesture that empathized with the provider's expectation to fully understand the interactions between the interpreter and the patient (Hale, 2007) at stage (8). Then the interpreter expressed empathy with the patient at stage (4) by politely asking the patient to repeat herself. The patient received the interpreter's empathy at stage (5), started to repeat herself at stage (6) and the communication process restarted at stage (1). The interpreter then resonated with the patient again from stages (1) to (3) and jumped to stage (7) after he/she had understood the patient completely and expressed this understanding to the provider.

Since empathic communicative skills, levels of empathy and empathic process all support that the interpreter empathized with the primary parties, it can be argued that he/she also demonstrated the three attitudes of neutrality. What is worthy of noticing is that the interpreter could simply assume the role of a conduit which only interpreted what was heard and left the clarification to the provider. Instead, he/she chose to make the clarification, which again reflects that a clarifier has a different perspective on his/her function in the interaction from a conduit.

To sum up, cases of clarifier reveal some important information. First, although the communication flow is temporarily interrupted for clarification, the clarifier puts his/her focus on primary parties' earlier expressions. Second, interpreter's role changes within a case. Interpreters play the conduit role at most of the time and have the option to simply be a conduit in the interaction. However, they choose to be a clarifier when the speaker's expressed messages are unclear, which reflects that a

clarifier regards his/her function more than merely a language converter but a communication facilitator. Finally, a clarifier expresses basic empathy with both parties respectively and thus demonstrates the attitudes of neutrality.

5.2.3 Culture Broker

Case 23

[Stage (1) ~ (3)]	*The surgical scheduler has called a patient to tell her that he cannot schedule her surgery because she has not sent in the appropriate referral.*
[Stage (7)]	*The patient says the doctor said for her to have the surgery.*
[Stage (8)]	*The conversation goes around and around, with each side getting more and more frustrated.*
[Stage(15)(16)]	*You [the interpreter] start to suspect that the patient may not understand the word "referral," since there is no exact equivalent for this term in the patient's language. You say to the scheduler, "As the interpreter, I'd like to ask the patient how she understood my interpretation of "referral," since this term doesn't exist in her language" (cited from Roat, 2011, p.27).*

In this mediated communication, though the interpreter rendered the meaning expressed by both parties without addition or omission, the communication process between the surgical scheduler and the patient could move forward only if the interpreter explained the implicit but objective fact: there is no equivalent term of scheduler's expression in patient's language. According to Klaudy (2009), this is a type of explicitation in which the interpreter explains the cultural difference between

primary parties in the rendition. The assistance, as a result, falls into the scope of a broad sense of interpreting.

If the scheduler is P_B and the patient is P_c in *Figure 5.4*, before the interpreter made the language difference explicit, the interpreter rendered for both primary parties by listening to, resonating with and paraphrasing their meanings respectively, which can be demonstrated in order as stages (1), (2), (3), (7), (9), (10), (11), (15), (17) and (1) in repetition. However, the interpreter later interrupted the flow at stage (15) where he/she expressed empathy with the patient that the background difference between the primary parties may be the cause of communication breakdown. The interpreter informed the scheduler first instead of checking directly the patient's level of understanding, which is a demonstration of empathy with the scheduler's expectation that interpreters do not have side conversations with patients (Hale, 2007) at stage (16).

The interpreter adopted therapeutic interpretations, as mentioned in section 3.4.4, by providing new frames of reference to the situation, which is the language difference in this case. The interpreter also adopted explicitation, which shares similarities with therapeutic interpretations as mentioned in section 4.1.2.3, by making the implicit messages or the feature of the patient's language in this case explicit. The patient's culture background was therefore added in the rendition; however, it did not change her original meaning because her argument with the scheduler was in fact resulted from language difference. The interpreter made the difference understood by both primary parties since he/she was the only person that was capable of recognizing the difference. What the interpreter expressed was thus advanced empathy with the patient to the scheduler. Checking with the patient of the accuracy of his/her empathy as the last sentence of the case also shows that the interpreter expressed advanced empathy tentatively.

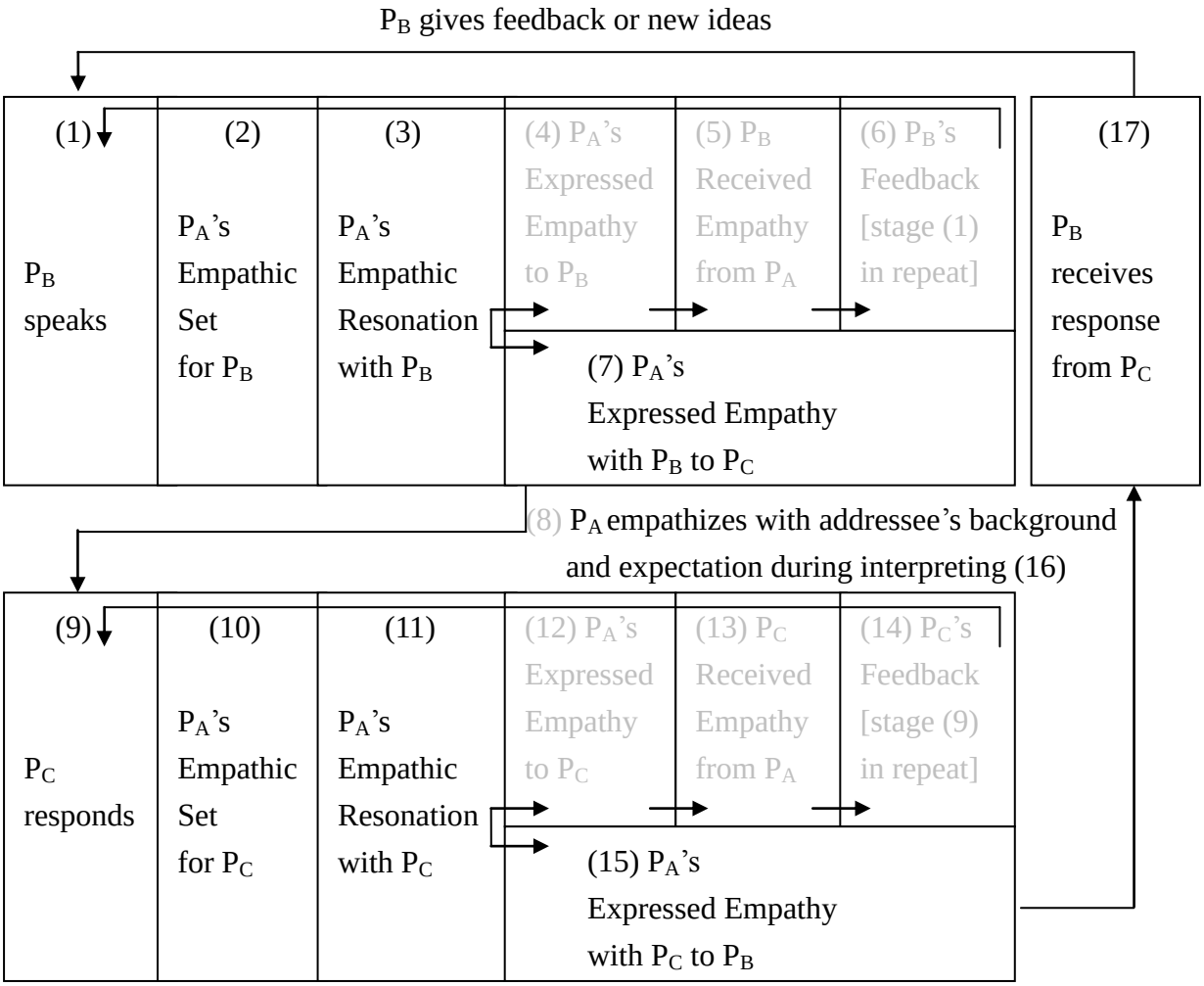

Figure 5.4 The Medical Interpreter's Empathic Process of Case 23
Source: compiled by this study

Analyses above show that the culture broker adopted therapeutic interpretations and explicitation to express advanced empathy with the patient. The interpreter's demonstration of empathy with both primary parties reflects that he/she was neutral. The interpreter's choice of actions other than merely being a conduit shows that a culture broker regards him/herself as a communication facilitator.

Case 24

When there is no equivalent terminology between different languages or there is equivalent terminology but receivers of the interpreting may not know the term,

interpreters may domesticate the expression or express in a way that receivers are used to. As mentioned in section 4.1.2.3, domestication modifies the source utterance but keeps the same meaning of the utterance in rendition as the following case:

> *…a doctor is explaining to a mother when to bring her baby back to the ER. He tells her that "the following are red flags." If you focus on interpreting words, you're in trouble. If you interpret meaning though, it should be easy to find a term that means "warning signs," "signs of trouble," "signs of danger" or something similar (cited from Roat, 2011, p.36).*

In this mediated communication, the interpreter adopted therapeutic interpretations by pointing out the connections of two seemingly different words or phrases, which was mentioned in section 3.4.4. It refers to "warning signs" and "red flags" in this case. The interpreter also adopted domestication, which shares similarities with therapeutic interpretations as discussed in section 4.1.2.3, by making the cultural related content more comprehensible to the receiver of the target utterance. Similarities between domestication and therapeutic interpretations support that the interpreter demonstrated communicative skills of empathy in the case. Moreover, although deeper meanings were added in the rendition comparing to the provider's source utterances, the meanings were unchanged. The meanings of these additions, based on culture, were in fact embedded in the source utterances but unexpressed. Consequently, the interpreter expressed advanced empathy with the provider.

If the case is explained with *Figure 4.3*, the provider is P_B and the patient is P_c. The interpreter provided empathic set and resonated with the provider from stages (1) to (3) so to make expressed empathy in another language possible. However, while performing interpreting at stage (7), the interpreter simultaneously empathized with

the patient at stage (8) that she might not understand the directly interpreted phrase due to cultural difference. Consequently, the interpreter chose to domesticate the provider's meaning for the patient.

Since empathic skill, levels of empathy and empathic process can all be used to explain the case, it can be argued that the interpreter did empathize with both primary parties. His/her empathy with both parties reflects that he/she was neutral. This case also shows that a culture broker bridges the gap when two cultures encounter instead of leaving these tasks to primary parties like a conduit does.

Case 27

It is a sight translation case in which the provider's stance or source text appeared in the form of documents as the first paragraph. The interpreter lowered the register and changed the passive voice construction of the source text in the rendition as showed in the second paragraph. Both of the paragraphs are written in English to make it easier to compare. Roat (2011) said that documents provided by health institutions to patients usually are legally binding and may influence patients' health; the provider therefore has to be present so to answer patients' questions when the interpreter sight translates these documents.

> *"By my signature, I hereby authorize Dr. ____ and/or such associates or assistants as may be selected by said physician, to treat the following condition(s) which has (have) been explained to me."*

> *"By signing this document, I am giving my permission for Dr. ____ to treat me for the medical problem that is described here. I am also giving my permission for this treatment to be done by anyone that this doctor chooses to help or*

replace him. The doctor has explained my medical problem to me" (Roat, 2011, p.87).

It is showed in the rendition that changing register and passive voice construction of the source text does not change its meanings. However, some messages that were implicitly written in the source text were explicitly expressed in the rendition. Roat (2011) said that it could be resulted from that passive voice structure does not exist in the target language. In order to fit in with the sentence structure of the target language, the interpreter added more words in the rendition. According to Klaudy (2009), it is a type of explicitation that is resulted from language differences. On the other hand, it is possible that explicitation was adopted out of the interpreter's intention to make the source text easier to comprehend for the patient. Since the patient has different social status and cultural background from the provider (Angelelli, 2000), rendition that has the register as high as these legal documents may cause misunderstanding. Therefore, it is argued that the interpreter took the patient's social background into consideration during interpreting.

The interpreter adopted the skill of therapeutic interpretations by expressing the implication of the source text. For example, it was not expressed explicitly that the authorized doctor could designate other providers to replace him, but it is specified in the rendition. What the interpreter expressed was therefore advanced empathy. In addition, to be able to give accurate therapeutic interpretations, the interpreter must also have actively attended to the source text in order to understand (Hill, 2009).

If the case is further explained with *Figure 4.3*, the documents or the provider's explanations of the documents are symbolized as P_B while the patient is P_c. The interpreter resonated with the provider by attending to the given visual or audio information, which can be demonstrated from stages (1) to (3). Then when the

interpreter expressed his/her empathy with the provider at stage (7), he/she at the same time empathized with the patient by lowering the register of the source text at stage (8). If the patient had questions, the interaction moved on to stage (9) where the interpreter listened to, understood and expressed empathy with the patient as stages (10), (11) and (15). After the provider received the patient's question at stage (17), he/she gave feedback as the process restarted at stage (1).

The above analyses with empathic communicative skills, levels of empathy and empathic process support that the interpreter empathized with both primary parties, which manifests that the interpreter was neutral. What is worthy of noticing is that the interpreter also has the choice not to change the register and construction of the source text in rendition. However, culture brokers value their function of facilitating understanding of culture factors more than merely language conversion, such as factors of language and social status. They consequently involve more in the communication than a conduit.

To sum up, cases of culture broker reveal some important information. First, culture brokers make the implicit messages in the source utterance explicit or domesticate cultural factors embedded within the source utterance in the rendition to facilitate the receiver of target utterance understanding better. Second, a culture broker expresses advanced empathy with both parties and thus demonstrates the attitudes of neutrality. Third, cases of culture broker shows that interpreters have empathic understanding of the addressee when they express advanced empathy with the speaker. This action enhances mutual understanding between primary parties as well as facilitates faithful rendition of their meanings, either expressed implicitly or explicitly. Finally, interpreter's role changes within a case. Interpreters play the conduit role at most of the time but change to the culture broker when the encounter of two cultures

may lead to misunderstanding. As a result, a culture broker values his/her function of communication facilitation over merely language transformation like a conduit.

5.2.4 Advocate

A wide range of interpreters' behaviors conform to the definition of advocate. To facilitate readers understanding the eight cases in this section, the description of the interpreter's behavior as mentioned in *Table 5.1* is noted at the heading.

Case 2 Instruction

Interpreters instruct patients how to present themselves appropriately, such as to sit straight in the waiting room (Hsieh, 2008) to empower the patient or to save provider's time by giving the following instructions:

> *If [the patients] feel comfortable with you, they will tell you, "Please tell the doctor this, this, this." [I would tell them,] "Okay. Slow down. Let's talk about today's symptoms. Not the symptoms we have a week ago, a month ago. […] Don't bother him with too much information" (cited from Hsieh, 2007, p.928).*

The interpreter's expressions in this case did not have source utterances; in other words, the interpreter him/herself judged the subjectively "better" behaviors and gave instructions. Without source utterance, the interpreter was simply sharing his/her own opinions rather than interpreting. Empathy is an understanding and expression based on other's utterance; consequently, the interpreter's expression of personal opinions makes it impossible that he/she empathized with primary parties. Some people may argue that the interpreter was advocating for the patient or empathizing with the provider's expectation. However, patients' and providers' expectations vary from

person to person and none of these parties in the case request for these "helps". The interpreter, as a result, neither performs interpreting nor empathy in this case. He/she thus cannot be neutral. In fact, the last sentence of the cited case clearly reflects that the interpreter had a preference for the provider and intended to direct the dialogue in a way the provider might prefer. This stance may erode the patient's trust in the interpreter (Alexander *et al*., 1997/2002).

Case 7 Role Replacement

Interpreters in some cases take over the patient's role by answering the provider's questions for the patient or assume the provider's role by initiating questions to learn the patient's symptoms with or without the presence of the provider. For example, the provider asked whether it was the first time the patient gave birth, the interpreter replied without asking for the patient's answer that it was her second child as Case 14 cited in this study (Hsieh, 2008). Another case is that the provider assigned the interpreter to understand the patient and make an accurate diagnosis after he/she had a frustrating communication with the patient.

> *So, I asked the mother, "What's the problem?" "Well, you know, it's itching at night." [I asked,] "How does it itch, okay? Does it run? You have blocks?" She said, "Yes." [I said], "Well, the child has hives." […] So, the doctor gave her [name of a drug]. And that's it. […] So, you know, it's just hives. I used the Vietnamese term to describe it. "Yes," the mother said. I said, "Why couldn't you say it?" Because she wasn't sure if it was that (cited from Hsieh, 2007, p.933).*

In both cases, the interpreter did not mediate the communication between the patient and the provider even though these two parties were at present. During the

communication between the interpreter and one of the parties, the other party was isolated from the interaction; in other words, it became a two-party communication where the interpreter acted as a primary participant. Users of the interpreting service were no longer the center of the focus. Instead, the interpreter made the judgment call to give answer or ask the questions that he/she thought were subjectively right and necessary. Taking the role of primary parties makes the interpreter's behaviors non-interpreting. Expressions that were not responses based on the primary parties' expressed utterances also make the interpreter's behaviors non-empathy. The interpreter was consequently not neutral.

Interpreters' behaviors of excluding one of the primary parties from the conversation and replacing the provider's questions with their own are unappreciated (Hale, 2007) or even regarded as mistakes by some providers (Vasquez & Javier, 1991). Opinions among interpreters also suggest that such intrusive actions should only be taken when less intrusive roles cannot solve the serious negative consequences that primary parties might face (Avery, 2001; NCIHC, 2004), but it is not the case in either of these cases. Some might argue that in the second case, the interpreter only acted because he/she was requested by the provider. However, the interpreter could have adopted less intrusive roles such as clarifier or culture broker to continuously mediate the dialogue between primary parties. In addition, the interpreter did not receive formal education of medical treatment which might lead to inaccurate diagnosis and cause serious negative consequences. Therefore, what the interpreter should do was to further use his/her proficiency of communication to facilitate primary parties' mutual interaction when facing the provider's request. The act of 'following' the provider's request reflects that the interpreter did not have clear understanding of his/her role and the provider did not know the appropriate way to work with the interpreter.

Case 10 Advice Provision

> *After witnessing a provider's prejudicial attitude, Colin informed the patient that if he wished to file a complaint, he would be able to take him to the complaint office and interpret for him (cited from Hsieh, 2008, p.1374).*

It is an objective fact that hospitals provide complaints filing service. However, the interpreter informed the patient in a non-mediated interaction with his opinions implying that the patient was treated discriminatorily. His opinion could possibly affect the patient's judgment, which makes his action non-neutral. The interpreter, as a result performed neither interpreting nor empathy. Non-neutral behaviors could erode service users' trust (Hale, 2007), the provider in this case, and even cost the interpreter his/her future working opportunities (Roat, 2011).

If the information of the service was provided before the medical encounter and interpreting service, the patient could decide by himself whether or not to file the complaint after his encounter with the provider. It highlights the problem that there is no standard procedure to fully inform and explain the rights and duties of patients before they receive medical services. These explanations are particularly important to foreign patients who usually are not familiar with how medical institutions work. Before this procedure is established and standardized, if the interpreter wants to take any action to advocate in such discriminating cases, he/she should consult with a supervisor in advance (NCIHC, 2004). The supervisor could be the mediator to solve the conflict. Establishing a supervision system to handle issues that complicate the interpreters' role and responsibility is therefore suggested by this study. A supervisor can give advice to interpreters about the difficulties they encounter at work and being the mediator to coordinate different perceptions between stakeholders of medical services and interpreters. More discussions will be given in the next chapter.

Case 11 Reminder

The patient mentioned her worries that her baby was losing weight in an earlier conversation with the interpreter. The interpreter initiated the following dialogue to advocate for the patient after the provider had finished asking the patient about her feeding pattern in the medical encounter.

[Stage (4)]	*501 I: Didn't you want to ask the doctor why she*
	502 [weighs] less today than when she was born?
[Stage (5)(6)]	*503 P: Yes.*
[Stage(7)]	*504 I: Another question, before, the nurse weighed*
	505 her, and she was born 7 pounds 11 oz., then
	506 today, the weight is only- It lost about 6 oz.
[Stage (9)~(11)]	*507 H: 6 oz. It's normal.*
[Stage (15)(17)]	*508 I: She said it's normal (cited from Hsieh, 2008, p.1374).*

Though this case was participated by provider, patient and interpreter, it was a non-mediated communication. To be more specific, between lines 501 and 503, the provider was isolated from the conversation while between lines 504 and 506, the interpreter initiated the question and expressed information obtained from the patient before this mediated event took place to the provider. Even though what the interpreter expressed from lines 501 to 502 and lines 504 to 506 seemed to be in line with the patient's perceptions—inferred from the patient's confirmation in line 503 and the patient's reception and acceptance of the interpreting of the provider's feedback which ended this round of conversation—there was no source language presented during this medical encounter. It seemed that the interpreter did facilitate

the communication between primary parties, but the conversation took place in a non-mediated setting. As a result, this cannot be regarded as an act of interpreting.

In terms of the level of expressed empathy, what the interpreter expressed was basic empathy with the patient for two reasons. First, the patient gave feedback in line 503 to confirm that the interpreter had understood her needs accurately. Second, the patient did not raise follow-up question or give comments after receiving the rendition of the provider's response, which reflects that she had had her question answered. Consequently, it could be inferred that the interpreter had actively listened to and paraphrased the essence of the patient's perceptions correctly at the stage of expressed empathy. The interpreter also expressed basic empathy with the provider to the patient because the meanings of line 507 and 508 are interchangeable.

If the case is further examined by the model of empathic process in medical interpreting, the result is demonstrated as *Figure 5.5*with P_B being the patient and P_C the provider. The interpreter provided empathic set and resonated with the patient before the medical encounter, which conforms to stages (1) to (3). Then during the encounter, the interpreter expressed empathy with the patient back to herself by paraphrasing what she said in a tentative form at stage (4) or lines 501 and 502. The patient gave feedback to the interpreter indicating that she would like to have her question interpreted and answered by the provider at stage (6) as line 503 shows. It is followed by that the interpreter expressed his/her empathy with the patient to the provider according to his/her memory at stage (7) as showed from lines 504 to 506 and then actively listened to the provider's response as line 507 from stages (9) to (11). Afterwards, the interpreter expressed empathy with the provider back to the patient at stage (15) or line 508 when the patient simultaneously received the response at stage (17).

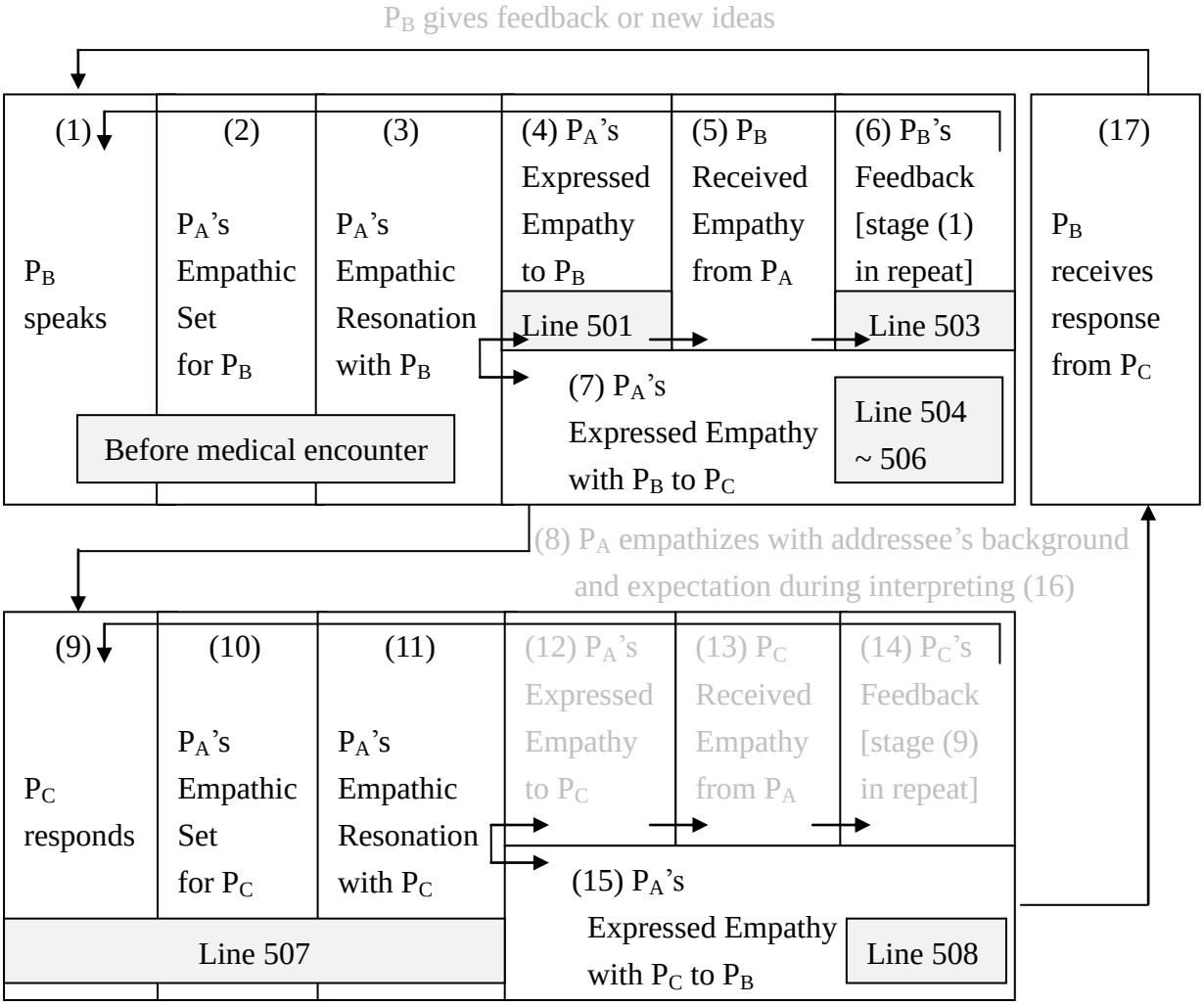

Figure 5.5 The Medical Interpreter's Empathic Process of Case 11

Source: compiled by this study

Since communicative skills of empathy, levels of empathy and empathic process can be adopted to analyze this case, it could be argued that the interpreter empathized with both primary parties. The interpreter therefore held attitudes of neutrality. However, the provider was excluded from the conversation in lines 501 and 502, which could result in his/her mistrust of the interpreter (Hale, 2007). The interpreter thus should also inform the provider what was said between he/she and the patient. Furthermore, this case also shows that an advocate may empathize with primary parties but not performing interpreting. In addition, an advocate's choice of initiating action to remind the patient reflects that he/she regards the function of interpreter

more than language transformation like a conduit or communication facilitation like a clarifier and a culture broker, but a defender of service users' rights.

Case 12 Coaching

The following dialogue is about the patient complaining to the interpreter that the hospital only gave her water with ice which ran against Chinese customs.

401 P: Yeah, these days- I drank chilled water in
402 the hospital.
403 I: Actually, they have hot water in the hospital.
404 If you tell the nurse, she'd give you hot water.
405 P: I said- I told her that I don't want ice. So,
406 it's not icy. She didn't put ice in it.
407 I: No ice. Right. Right. You should tell her,
408 "[switch to English] hot water."
409 P: Hot water [in English] (cited from Hsieh, 2008, p.1374).

This case is a non-mediated communication in which the interpreter became the primary participant of a direct communication instead of mediating provider-patient interaction. Therefore, the interpreter did not perform interpreting but advocate for the patient's rights by empowering the patient's ability to communicate more efficiently with the hospital staff.

In this case, the interpreter provided objective information from lines 403 to 404 and coached the patient about how to express her needs in another language from lines 407 to 408 after understanding the patient's situation. Providing objective information is a non-judgmental behavior; however, coaching the patient by

expressing personal opinions is judgmental. All empathy theories – empathic skills, levels of expressed empathy and empathic process – indicate that what an empathizer expresses should be based on what the client's perceptive experience rather than his/her own opinions. The interpreter thus neither expressed empathy with the patient nor was neutral.

Case 15 Sympathy

901 P: They tested the blood and said it was a genetic
902 disease. But now, when I had this baby, we
903 test the amniotic fluid; my husband and I
904 tested our blood, and there was no such
905 condition. I don't know why my son had this
906 problem. All my family members, everybody,
907 none had this condition.
908 I: None had this condition. (2 sec) Don't
909 worry about it.
910 P: No. This is really a worrisome problem.
911 Because his situation is very difficult, he has
912 granulation everywhere. The granulation
913 just happens without any patterns.
914 I: I understand. I know what you mean. (5 sec)
915 But you have to face the problem with ease (Hsieh, 2008, p.1377).

This case happened in a non-mediated communication where the interpreter took the role of primary participant. The interpreter gave his/her own response instead of interpreting source utterance of other parties who do not share the same language with

the patient. Therefore, what the interpreter performed was not interpreting.

On the other hand, the interpreter's response in lines 908 and 909 reflects that he/she tried to comfort and alleviate the patient's distress. He/she intended to demonstrate an understanding toward the patient's situation in line 914, but lines 908, 909 (i.e. "*Don't worry about it*.") and 915 all show that the interpreter had diverted from the patient's perceptive experience. Telling the patient not to worry or suggesting the patient to change her attitude implied the interpreter's judgment and negation to her distress. What the patient responded in line 910 also reflects that the patient did not perceive that she was understood by the interpreter. These behaviors indicate that the interpreter was sympathizing with the patient instead of empathizing. The interpreter was therefore non-neutral.

Case 18Alteration

Considering cultural differences, interpreter changed what provider had said to avoid provider-patient misunderstandings.

> *[Providers] ask about sexual contact outside of the marriage, which is really [a] very bad question. BUT, I ask them. It is very offensive…I said, "Does your husband go to other woman?"…In that way, you give the responsibility to the husband, because Muslim women are very faithful to their husbands. That is the way that I get the answers (cited from Hsieh, 2008, p.1378).*

The provider's expression cannot interchange in meaning with the rendition in this case, which demonstrates that the interpreter changed the expression by him/herself. The answer the interpreter rendered was not to the provider's question but the provider was not told because the interpreter judged that the alteration would

not affect the provider's diagnosis or put the patient's health at risk. Although the interpreter knew more about cultural differences than primary parties, his/her medical knowledge was not adequate to evaluate the possible outcome, not to mention his/her behavior had departed from interpreting. If the interpreter adopted the role of culture broker in this case, he/she could already decrease the possibility of misunderstanding. For example, he/she could make the implicit cultural fact explicit for the provider to decide whether to change the expression or he/she could make the provider's intention of careful examination explicit for the patient before rendering the provider's expression. Instead, the interpreter chose to take a more intrusive role by terminating the mediation of provider-patient communication and adopting non-neutral attitudes, which was neither interpreting nor empathy. The interpreter projected his/her own opinions that infringed the autonomy of primary parties and thus is non-neutral.

Case 25 Preemption

> *Seeking out the charge nurse in Labor and Delivery because you* [the interpreter] *saw one of the OB nurses forge the patient's signature on a consent form for a C-section, a procedure that the patient has repeatedly refused (cited from Roat, 2011, p.48).*

It is reasonable to conjecture that the interpreter had rendered for the patient that she wasn't willing to have C-section so the OB nurse had to forge the patient's signature. When the interpreter rendered the patient's will without addition or subtraction in a mediated communication, it can be said that the interpreter was performing interpreting. However, the interpreter preempted to protect the patient's right and tried to expose the nurse's wrong conduct under his/her own will when neither the patient nor the provider was present. These actions are not interpreting.

Although the interpreter as indeed conveying the patient's perception, he/she did not express empathy with her. It is because that the patient was not at present to confirm the accuracy of expressed empathy, which does not conform to empathic theories. In addition, the interpreter took a stance to identify the misbehaved nurse, which was not out of the patient's opinion but his/her own. Since all of the empathic related theories, such as empathic skills, levels and process, indicate that an empathizer does not tell right from wrong or give suggestions, the interpreter thus was not empathic. He/she was consequently not neutral.

To sum up, cases of advocate reveal some important information. First, interpreters could assume this role in non-mediated settings either inside or outside the medical encounter, with or without the presence of both primary parties. Second, an advocate may express basic empathy with service users but not performing interpreting. This behavior might take place under the circumstances that the interpreter renders what the speaker expressed before the medical encounter to a third party, like being a reminder in Case 11. When the interpreter only expresses empathy with one party without informing the other or when the interpreter tries to convey one party's meaning without his/her presence, the interpreter does not demonstrate neutral attitudes. Third, in most of the advocate cases, the interpreter performs neither interpreting nor empathy because his/her action is out of his/her own opinions. The interpreter could have assumed less intrusive roles than an advocate, such as a clarifier or a culture broker, to facilitate communication in some cases. It reflects that some interpreters do not recognize the importance of neutrality and do not take the expectations of both primary parties into consideration. Fourth, assuming primary parties' roles show that the interpreter does not know well enough about the limits of their roles. His/her proficiency of communication facilitation is therefore not

prioritized when other parties' inappropriate requirements occur. Finally, establishing a supervision system to handle issues that complicate the interpreter's role and responsibility is advised in this study. A supervisor can be responsible for giving advice when interpreters encounter difficulties at work and mediating communication between interpreters and stakeholders of medical services when conflicts arise.

5.3 Conclusion

The analysis results of all cases are compiled in *Table 5.3*. Cases of conduit and clarifier show that these roles express basic empathy with both primary parties. Conduits and clarifiers are thus argued to be neutral. A culture broker expresses advanced empathy with the speaker and empathizes with the addressee at the same time, which makes it a neutral role. Advanced empathy is demonstrated by explicitation or domestication.

Cases of advocate reflect the complexity of the tasks taken by this role. Multiple behaviors are initiated by the interpreter on behalf of the primary parties, including instruction, role replacement, advice provision, reminder, coaching, sympathy, alteration and preemption. Among these behaviors, only reminder (case 11) was fully based on the meaning of primary parties' expressions while most of the expressions given in other cases were based on the interpreter's opinions. However, the interpreter who expressed empathy with the patient at the beginning of case 11 was also possibly perceived non-neutral unless he/she informed the provider that he/she had confirmed with the patient to raise the concern the patient mentioned before the medical encounter. Advocates in rest of the cases performed neither interpreting nor empathy and thus are non-neutral. To sum up, to be neutral, medical interpreters not only have to hold neutral attitudes toward both primary parties, but also need to express when the person being empathized with are at present and both parties are informed with

any interaction between the interpreter and one of the parties. Moreover, cases of advocate highlight the problems that some medical interpreters do not know well enough about the limits of their roles and the importance of neutrality. Furthermore, this study suggests that a supervisor should be the responsible person for advocating for service users when necessary so that the interpreter can remain neutral.

Table 5.3 Analyses Results of All Cases

Role	Case No.	Empathic Communicative Skills	Basic / Advanced Empathy	Empathic Process of Medical Interpreting	Neutrality
Conduit	9	✓	Basic	✓	✓
	26	✓	Basic	✓	✓
	28	✓	Basic	✓	✓
Clarifier	1	✓	Basic	✓	✓
	19	✓	Basic	✓	✓
	22	✓	Basic	✓	✓
Culture Broker	23	✓	Advanced	✓	✓
	24	✓	Advanced	✓	✓
	27	✓	Advanced	✓	✓
Advocate	2	×	×	×	×
	7	×	×	×	×
	10	×	×	×	×
	11	✓	Basic	✓	✓/×
	12	×	×	×	×
	15	×	×	×	×
	18	×	×	×	×
	26	×	×	×	×

Source: compiled by this study

The results of case study can extend *Figure 2.1* to *Figure 5.6*, which integrates

each medical interpreter's role's types of interpreting, expressed empathy and neutrality. This framework not only provides a systematic way of understanding about the differences between each role but also explains the possible causes of inconsistent views of participants on non-conduit roles.

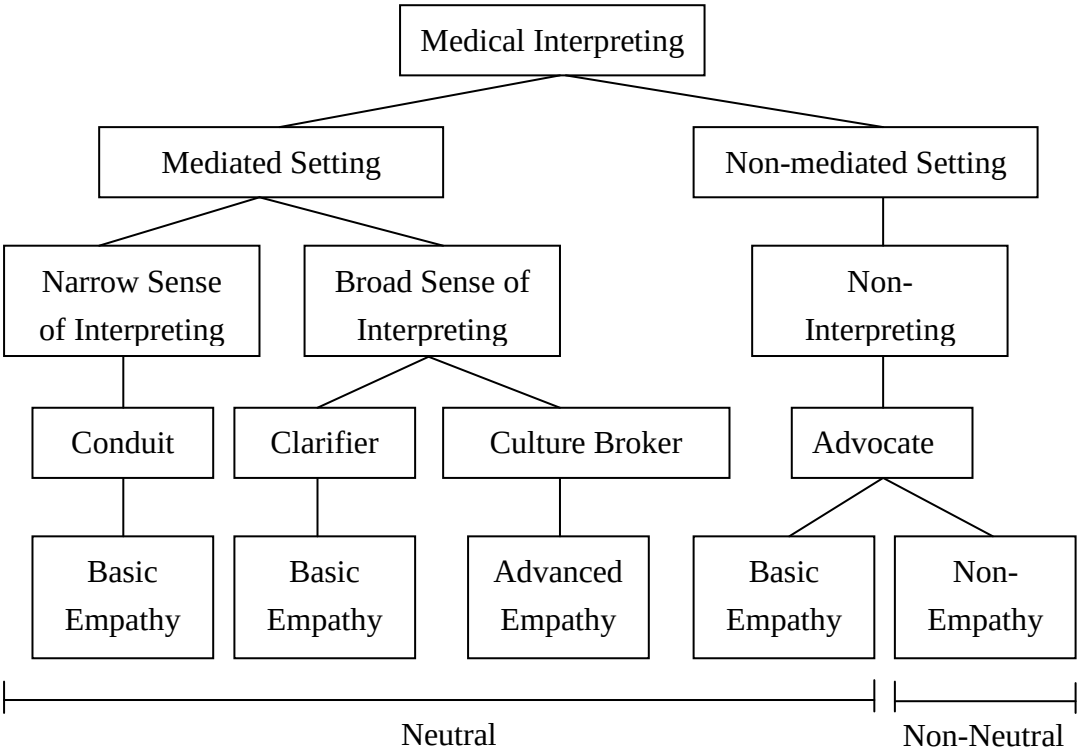

Figure 5.6 The Framework of Roles of Medical Interpreters
Source: compiled by this study

The case results of neutral roles also reflect that, a conduit only has empathic understanding with the speaker, which is assumed by primary parties in turn. It is because that this role's task is limited to transferring language codes of the speaker's meanings (Avery, 2001). On the other hand, a clarifier and a culture broker empathize with both primary parties at the same time. A clarifier not only empathizes and expresses empathy with the speaker's meanings, but also explains to the addressee about what happened in the temporarily non-mediated conversation. It is argued that the intention behind the action is his/her empathic understanding with the addressee's

expectations, which is to fully understand all the information exchanged in the encounter (Alexander *et al*., 2004; Hale, 2007). Consequently, different from a conduit, a clarifier also empathizes with the addressee. Similar to a clarifier, a culture broker empathizes with both primary parties as well, but for different reasons and take different actions. It is argued that the interpreter's empathic understanding of the culture gap and language structure difference between primary parties makes him/her express advanced empathy with the speaker. It is because that without making the speaker's meanings explicit or domesticating the speaker's expressions, the addressee who does not share the common knowledge of the speaker may not understand (Klaudy, 2009). No motivation or case has been identified for the interpreter to express advanced empathy with the speaker if the interpreter does not empathize with the addressee. The above result is visualized as *Table 5.4*.

Table 5.4 Empathic Understanding and Expressed Empathy of Neutral Roles

Expressed Empathy / Empathic Understanding	Express Basic Empathy with Speaker	Express Advanced Empathy with Speaker
Only Empathize with Speaker	Conduit	×
Empathize with Both Primary Parties	Clarifier	Culture Broker

Source: compiled by this study

Case study in this chapter reflects that only advocate is not a neutral role. This result could explain the inconsistent perceptions of primary parties on different medical interpreters' roles and thus answer the third research question. Due to limited time and resources of this study, only 17 cases were analyzed. Readers who are interested in more healthcare interpreting cases could find reference materials in Hale

(2007), Hsieh (2006, 2007, 2008), Kelly (2008) and Roat (2011).

Chapter Six

Conclusion and Implications

This final chapter sums up the research findings, lists the implications and illustrates recommendations for further studies. The contribution of this study may include four aspects. First, when Avery (2001) proposed the incremental model of roles, no clear definitions were given. This study thus compiles studies of primary parties' expectations and community interpreters' codes of ethics to make the definition of each role more concrete. Second, the gap between theory and practice of medical interpreters' roles is bridged through case study and experts' examination. The behaviors of each role are also identified and compiled. Third, a framework of roles that integrates each role's relation with types of interpreting, empathy and neutrality is developed. While it helps medical interpreters in practice have a clearer awareness of their tasks, it also explains why conduit, clarifier and culture broker are considered appropriate but advocate is controversial in medical interpreting literature (Mesa, 2000; Pöchhacker, 2000; Avery, 2001; Hale, 2007). As neutrality is argued in this study to be the interpreters' appropriate line of involvement based on studies of Avery (2001), Kelly (2008) and Roat (2011), conduit, clarifier and culture broker are argued to be proper roles. Finally, the relation between medical interpreting and empathy is clarified. The findings of this study can facilitate demonstrating empathy in medical interpreting, which may increase service quality. The research findings and their implications for theories of medical interpreting as well as medical interpreters' roles are categorized in section 6.1 in accordance with the research questions.

6.1 Research Findings and Implications to Theories

6.1.1 Demonstration of Empathy in Medical Interpreting

Great similarities between medical interpreting and empathy support that medical interpreters empathize with service users. Similarities have been found in their settings, such as the process (Seleskovitch, 1978; Barrett-Lennard, 1993), participants (Angelelli, 2004; Barrett-Lennard, 1993) and goals (Hale, 2007; Rogers, 1975). Similar communicative skills adopted by medical interpreters and empathizers are also identified, such as active listening (Gentile *et al*., 1996; Jones, 1998; Egan, 1998; Hill, 2009), paraphrasing (Robinson, 1998; Pöchhacker, 2004; AIIC, 2005; Egan, 1998; Hill, 2009; Smaby & Maddux, 2011) and therapeutic interpretations vs. explicitation and domestication (Venuti, 1994; Munday, 2008; Kelly, 2008; Klaudy, 2009; Hill 2009). Moreover, it is emphasized that both medical interpreters (Avery, 2001; NCIHC, 2004; Hale, 2007; Kelly, 2008; Roat, 2011) and empathizers (Rogers, 1975; Wispé,1986; Corey, 2001) should demonstrate neutral attitudes.

These similarities show that medical interpreters empathize with service users. In addition, concepts highlighted in empathy theories can be applied to medical interpreting to enhance service quality. As mentioned in empathy theories, an empathizer values how to demonstrate empathic communicative skills to make the client feel being empathized. Medical interpreters, being an influential participant of the encounter (Angelelli, 2004), should also incorporate service users' perception in practice. For example, use body language to demonstrate active listening; form faithful understanding of the primary parties based on their verbal and non-verbal information as well as culture context; express empathy in another language in ways that the receiver is used to; and take notice of the primary parties' feedback to check the accuracy of interpreters' expressed empathy.

6.1.2 Empathy Models in Medical Interpreting

Models of expressed empathy in medical interpreting as showed in *Figure 4.2* and medical interpreters' empathic process as *Figure 4.3* are developed. These models expand the traditional monolingual empathy model (Carkhuff, 1969; Egan, 1975, 1998; Barrett-Lennard, 1993) by incorporating the third party into the communication process. These models provide a clear picture of how empathy is demonstrated along with the provider-patient interaction. It is also shown that empathy is adopted to help one of the primary parties to understand the other in medical interpreting.

These models also indicate that medical interpreters face a complicated setting. The interpreter has to switch focus between primary parties as they assume the role of speaker in turn (Gentile *et al*., 1996). While the interpreter expresses empathy with the speaker, as *Table 5.4* shows, roles of clarifier and culture broker also empathize with the addressee about his/her expectations (Mesa, 2000; Pöchhacker, 2000; Hale, 2007) and culture differences (Kaufert & Putsch, 1997). These roles thus express empathy with the speaker in ways that conforms to the addressee's expectancy or custom. This process shows that the intensity of communication in medical interpreting is relatively higher. Not to mention that the medical interpreter has to demonstrate neutral attitudes to both of the primary parties who sometimes have conflict of interests. The complexity of medical interpreters' tasks support that it is a profession and it is inappropriate for any person without formal training to provide medical interpreting service.

6.1.3 Neutrality of Medical Interpreters' Roles

Neutrality conforms to primary parties' expectations of interpreters (Alexander *et al*., 2004; Mesa, 2000; Kelly, 2008) and medical interpreters' codes of ethics (NCIHC, 2004; Dysart-Gale, 2005). Neutrality can also avoid negative influence on primary

parties, interpreters and quality of mediated communication (Wadensjö, 1998; Hale, 2007; Roat, 2011). In addition, neutral interpreters tend to prevent projecting their values and belief onto users as well as take the messages personally; it is thus argued that neutrality facilitates faithful interpreting. The importance of neutrality support that it is the interpreters' appropriate line of involvement.

Figure 5.6 is a clear framework showing the correlation between neutral attitudes and medical interpreters' various roles. It is found that conduit, clarifier and culture broker demonstrate empathy to both primary parties; consequently, they are argued to be neutral. On the other hand, role of advocate is non-neutral in most of the cases. Neutrality is therefore argued to be the criterion that can distinguish appropriate roles from the controversial one. In addition, this finding implies that the scope of neutral roles is extended from conduit to clarifier and culture broker, which is different from perceptions on neutrality in current medical interpreting studies (Roy, 1993/2002; Kaufert & Putsch, 1997; Hsieh, 2007). It means that the interpreter can remain neutral while enhancing the effectiveness of communication by incorporating empathy.

Among neutral roles, different levels of involvement in medical interpreting as showed in *Table 5.4* provide an in depth analysis of differences. The result also supports and enhances Avery's (2001) incremental model of roles. A conduit only empathizes and expresses basic empathy with the speaker in another language, while a clarifier chooses to adopt an additional task of empathizing with the addressee. Compared with a clarifier, a culture broker not only empathizes with both primary parties, but also expresses advanced empathy with the speaker. It is argued that different levels of involvement are a result of the interpreter's choice. A conduit prioritizes the task of language transformation between source and target utterances. A clarifier also considers language transformation important, but fulfilling primary parties' expectations of fully understanding the information exchanged in the

encounter is prioritized when necessary. A culture broker values bridging culture gaps the most in order to facilitate in depth communication. On the other hand, an advocate prioritizes the tasks of defending one of the primary parties' rights or promoting his/her own opinions even though he/she runs the risk of abandoning neutral attitudes. An advocate provides a service extends language and culture.

6.2 Implications to System

This study argues that an independent medical interpreting service organization should be established to maintain medical interpreter's neutrality as well as defend primary parties' rights. This organization is also to simplify medical interpreter's roles. If an interpreter senses his/her role is to be expanded to more than a culture broker, issue at hand should be referred to the organization for further review and response. This study argues that a professional organization should include at least the following tasks:

- Training: Design professional curriculum based on research results to cultivate talents of medical interpreting in different languages;
- Control admission into the profession: Issue credentials to qualified interpreters after they receive formal training and are approved for their professional ability;
- Define the interpreter's scope of responsibility and establish unified codes of ethics: These are used to explain to service users about the service they will get;
- Dispatch medical interpreting cases: The organization facilitates service users to find the interpreter, but it should be financially independent from them;
- Mediate conflicts among stakeholders of medical interpreting: Handle complaints from service users. Responsible for administrative communication and dispute resolution between the primary parties and interpreters;
- Supervise interpreters and clarify their tasks: Consultations are offered by

supervisors in the organization to help interpreters identify non-neutral attitudes and countertransference, relieve negative emotions and stress. The supervisor is also the decision-maker and action-taker as an advocate for a specific case. Senior interpreters or social workers who have attended formal courses of medical interpreting can assume the role;

- Promote public awareness: To inform the society as a whole of the importance of medical interpreting in safeguarding human rights and quality of health service.

In order to maintain the neutral stance of the organization, government should sponsor this organization so that both primary parties use the service without charge. To establish this organization is not very difficult in Taiwan. In fact, there have been many interpreting service programs funded by the government. For example, New Taipei City public health centers are providing interpreting service (Fan, 2011). Taipei City Government also subsidizes some nonprofit organizations (NPO) to train and facilitate interpreting services. However, each institution has different views on the role of medical interpreters and standard of practice. Fan (2011) found that medical interpreters have poor knowledge of their roles and undertake diverse tasks other than interpreting, which she considered a waste of medical interpreting human resources. This study therefore argues that government should centralize resources of medical interpreting in one organization. By doing so, these resources can be used more efficiently, service can be standardized and medical interpreters can have a more systematic training as well as maintain their service quality.

However, in the transitional period before the organization is established, it is argued that the government should first work with interpreting academia to develop a professional training curriculum for medical interpreters and institutions that provide medical interpreting services. Standard of practice and the roles of medical

interpreters can therefore be coordinated between different institutions.

6.3 Implications to Training

The research results and implications mentioned in previous sections show that several concepts should be included in the training programs for medical interpreters:

- The concept of empathy, skills of expressed empathy as well as empathic process models;
- The importance of medical interpreters' neutral stance and possible consequences of non-neutral behaviors;
- The framework of roles and the reasoning behind each role;
- The way to work with the professional organization to maintain the interpreters' neutral stance;
- Where and when to seek professional consultation, such as dealing with countertransference and pressure.

The core message related to these concepts is that the major task of medical interpreters' work is interpreting. To incorporate these concepts into medical interpreting practice, the interpreter should be trained to explain his/her role to primary parties before each service takes place. For example, to explain that he/she will facilitate interpretation and supplement objective cultural information as primary parties' reference to avoid misunderstanding when necessary. When he/she provides cultural information to one of the primary parties, the other party will also be informed. In addition, if the interpreter faces a culturally inappropriate source utterance given by the provider, he/she should be trained to express empathy with the patient to the provider. It should be expressed in a tentative manner to avoid generalization. If the provider still wants his/her expression to be rendered, the interpreter should respect his/her autonomy. The interpreter can discuss with a

supervisor afterwards for the supervisor to be the decision-maker and action-taker to communicate with the provider and understand the provider's reason behind the action. Nevertheless, if the patient's life is in immediate danger, this study considers adopting an advocate appropriate.

6.4 Limitations and Recommendations for Further Studies

The first limitation is that due to limited time and resources, the cases analyzed are of secondary data sources. The disadvantage of using secondary data is that the researcher cannot clarify with the primary parties in person about the reason behind their actions. It is therefore encouraged to conduct further studies to collect medical interpreting cases in Taiwan so to enable in depth analyses of the practice.

The second limitation is that under time pressure, only 17 cases are analyzed. The complexity of medical interpreting may thus be overlooked. Further examination of medical interpreting cases with the theories and models used in this study is encouraged. By doing so, the framework of roles and the reasoning behind appropriate level of involvement can be more comprehensive.

The third limitation is that all of the cited studies are conducted in western culture and language, such as surveys on primary parties' expectations toward medical interpreters and medical interpreting cases. These studies should be conducted in Taiwan and compared with foreign results to verify whether the framework of roles of medical interpreters as showed in *Figure 5.6* is applicable to Taiwan. This study consequently encourages further studies on primary parties' expectation toward medical interpreters as well as their perception on interpreters' neutral and non-neutral behaviors in Taiwan. The results of these studies not only can enhance the understanding of status quo of medical interpreting, but also can help develop measures to close the gap between foreign and local situations. Design training

courses to improve the awareness of medical interpreters' different roles is an example.

Finally, during the study process of categorizing medical interpreting cases, experts think that the scope of tasks assumed by the role of advocate is wide. They suggest that more roles can be categorized under advocate. This study consequently encourages researchers with the interests in medical interpreters' roles studying on this topic in the future.

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Appendix: Medical Interpreting Cases

- "H" for healthcare provider, "P" for patient and "I" for medical interpreter.
- Conduit: converts verbal and non-verbal information into another language faithfully, accurately, without omission, addition and edition.
- Clarifier: facilitates primary parties' mutual understanding of non-cultural related factors and alerts primary parties of possible misunderstanding.
- Culture broker: bridges the culture gap between primary parties to facilitate level of understanding.
- Advocate: acts on behalf of a user, provider or patient, for his/her benefits and rights either within or outside of medical encounter.

Case 1

In this case, the patient only partially answered the provider's question in her first reply. The interpreter then interpreted the provider's question again before continuing rendering.

101 H: And she's giving how long and how frequent?
102 I: 那你每一次大概給她餵多少，一天多少次？
103 (How long do you feed her each time and how many times a day?)
104 P: 他因爲我不知道是不是她不夠力，虛。她都要 40 分鐘
105 (I am not sure if she does not have enough strength or [if she is]
106 weak, but she takes about 40 minutes.)
107 →I: 你說每次要 40 分鐘。然後一天大概要幾次？
108 (You said 40 minutes each time, and how many times a day?)
109 P: 我兩個小時就餵一次
110 (I feed her every two hours.)
111 I: Okay. Every two hour, every time, probably around 40 minutes. And mom
112 was concerned, maybe because the baby's- I mean it's very difficult
113 to suck the milk or what, it takes 40 minutes every time (cited from Hsieh, 2007, p.927).

Case 2

If [the patients] feel comfortable with you [the interpreter], *they will tell you, "Please tell the doctor this, this, this." [I would tell them,] "Okay. Slow down. Let's talk about today's symptoms. Not the symptoms we have a week ago, a month ago. […] Don't bother him* [the provider] *with too much information" (cited from Hsieh, 2007, p.928).*

Case 3

In this case, "a patient who is pregnant (Paula) asked the provider (Hilary) about stem cells, because it may be helpful to her first son's genetic illness. At this point, Paula only briefly mentioned her son's illness but did not provide any details. The provider left the room to find more information, leaving the interpreter (Christie) and Paula in the same room. Christie then initiated the conversation with Paula."

501 →I：那他現在生活上面有什麼不方便嗎？
502 (Does he experience any incontinence in daily activities?)
503 P：他現在每年都去醫院照這個大腦
504 (He goes to the hospital to examine his brain every year now.)
505 I：照大腦
506 (Examining his brain.)
507 P：還有這個腎臟，還有這個眼
508 (And his kidney and his eyes.)
509 →I：他會有什麼明顯的，比如說-
510 (Are there obvious- such as-)
511 P：他皮膚全部都一粒粒
512 (His skin is granular everywhere.)
513 I：硬硬的啊？
514 (Is it hard?)
515 P：很像這個小瘤
516 (Like the little wart) (cited from Hsieh, 2007, p.931).

Case 4

In this case, "the patient…has given birth to the baby. The provider (Heather) is examining the baby for the first time and the interpreter (Christie) initiated a comment that required the provider's attention."

601 H: She looks a little bit like (a rash). But I don't think that's a-
602 I: 她說她臉看起來有點紅腫
603 (He said her face looks like a bit reddish and swollen.)
604 [H examines the baby]
605 →I: 膝蓋那邊也有一點 [points at the reddish spots on the baby's knees.]
606 (There's a little bit on her knees.)
607 H: Hmm?
608 →I: I said, around the knees area.
609 H: Yes, she has here a rash (cited from Hsieh, 2007, p.932).

Case 5

In this case, the interpreter "talked about using the western, biomedical concepts to replace the patient's cultural-specific comments so that the providers can understand the illness"

> *[The patients] would use terms that cannot even be translated in the English language. They would say, "I caught the wind." So, how do you understand that? "Caught the wind." It means she got a cold, she got it by standing at a place where the wind was passing by and she got a cold (cited from Hsieh, 2007, p.933).*

Case 6

> *I* [the interpreter] *had to talk to [a HIV patient] because the social worker at [the hospital] really didn't do much at a cultural level. […] Since [the patients] know that I am from [name of agency], they often call and ask for other things. That was the case when they asked me to meet with them separately and explain more what actually was said in the appointment because they were shocked and they lost the ability to comprehend clearly (cited from Hsieh, 2007, p.933).*

Case 7

In this case, "the provider requested her [the interpreter's] presence after a long, frustrated interaction with the patient because the provider was unable to understand the patient's complaint and make an accurate diagnosis:"

> *So, I asked the mother, "What's the problem?" "Well, you know, it's itching at night." [I asked,] "How does it itch, okay? Does it run? You have blocks?" She said, "Yes." [I said], "Well, the child has hives." […] So, the doctor gave her [name of a drug]. And that's it. […] So, you know, it's just hives. I used the Vietnamese term to describe it. "Yes," the mother said. I said, "Why couldn't you say it?" Because she wasn't sure if it was that (cited from Hsieh, 2007, p.933).*

Case 8

101 H: Does he see a diabetic doctor here?
102 I: Have you seen a diabetes doctor here?
103 P: No.
104 I: No.
105 P: I didn't before. I just discovered it.
106 I: I just discovered it.

107 Before, I didn't see a diabetes doctor.
108 H: But now he does?
109 I: Now you've seen a doctor? A diabetes doctor?
110 P: No.
111 I: No (cited from Hsieh, 2008, p.1371).

Case 9

201 H: Does she have any family history of diabetes?
202 I: Do any of your family members have diabetes?
203 P: No [in Chinese]. No[in English].
204 H: Is this her first pregnancy?
205 I: First pregnancy?
206 P: Yes.
207 I: Yes.
208 H: Is she on any medication?
209 I: Are you taking medicine now?
210 P: No [in English] (cited from Hsieh, 2008, p.1372).

Case 10

After witnessing a provider's prejudicial attitude, Colin informed the patient that if he wished to file a complaint, he would be able to take him to the complaint office and interpret for him (cited from Hsieh, 2008, p.1374).

Case 11

In this case, "the patient (Paula) indicated her concerns in an earlier conversation with the interpreter that her baby was losing weight. After the provider (Heather) asked the mother about her feeding pattern, the interpreter (Christie) initiated the following information exchange sequence."

501 I: Didn't you want to ask the doctor why she
502 [weighs] less today than when she was born?
503 P: Yes.
504 I: Another question, before, the nurse weighed
505 her, and she was born 7 pounds 11 oz., then
506 today, the weight is only- It lost about 6 oz.
507 H: 6 oz. It's normal.
508 I: She said it's normal (cited from Hsieh, 2008, p.1374).

Case 12

In this case, "the patient (Paula) complained that the hospital provided water with ice for her to drink after her delivery."

401 P: Yeah, these days- I drank chilled water in
402 the hospital.
403 I: Actually, they have hot water in the hospital.
404 If you tell the nurse, she'd give you hot water.
405 P: I said- I told her that I don't want ice. So,
406 it's not icy. She didn't put ice in it.
407 I: No ice. Right. Right. You should tell her,
408 "[switch to English] hot water."
409 P: Hot water [in English] (cited from Hsieh, 2008, p.1374).

Case 13

In this case, "the interpreter (Claire) elaborated on the provider's (Hilda) comment to improve the patient's (Pam) understanding."

601 H: Has she ever heard of Equal?
602 I: Have you heard of Equal? The English term
603 for this sugar, Equal, they call it substitute
604 sugar, it's not a naturally produced sugar.
605 They call it substitute sugar. Americans call
606 it substitute sugar; the brand name is Equal.
607 P: No.
608 I: No (cited from Hsieh, 2008, p.1375).

Case 14

In this case, "the patient (Paula) had brought her newborn baby for the first follow-up after her delivery. She and the interpreter (Christie) had met before in several prenatal appointments, whereas the provider (Heather) was meeting both the patient and the interpreter for the first time."

701 H: Is it her first baby?
702 I: No, the second one.
703 H: Boy or girl?
704 I: Boy or girl?
705 P: Girl.

706 I: A girl (cited from Hsieh, 2008, p.1376).

Case 15

In this case, "a pregnant mother (Paula) talked to the interpreter (Christie) about her concerns for her first child, who suffered from a genetic disease."

901 P: They tested the blood and said it was a genetic
902 disease. But now, when I had this baby, we
903 test the amniotic fluid; my husband and I
904 tested our blood, and there was no such
905 condition. I don't know why my son had this
906 problem. All my family members, everybody,
907 none had this condition.
908 I: None had this condition. (2 sec) Don't
909 worry about it.
910 P: No. This is really a worrisome problem.
911 Because his situation is very difficult, he has
912 granulation everywhere. The granulation
913 just happens without any patterns.
914 I: I understand. I know what you mean. (5 sec)
915 But you have to face the problem with ease (Hsieh, 2008, p.1377).

Case 16

1001 H: The baby is growing fine and everything
1002 looks normal. It's measuring normal.
1003 I: She said that the baby is growing well.
1004 All measurements are very normal.
1005 P: Then, last time she said that –
1006 I: How about last time you mentioned that the-
1007 H: It's measuring normal. That's what I'm
1008 saying [in an abrupt and mildly irritated
1009 tone]. (Everything's) measuring normal.
1010 I: It is measuring normal now. [in a calm tone] (cited from Hsieh, 2008, p.1377).

Case 17

Valerie [an interpreter] *talked about an incident of provider-patient conflict in which she eventually informed a patient, "[You] made the doctor upset so don't*

ask [the physician] any more. Because if he could have done it, he would have done it for you already…Don't try to convince him that you are right" (cited from Hsieh, 2008, p.1377-1378).

Case 18

[Providers] ask about sexual contact outside of the marriage, which is really [a] very bad question. BUT, I [the interpreter] *ask them. It is very offensive…I said, "Does your husband go to other woman?"…In that way, you give the responsibility to the husband, because Muslim women are very faithful to their husbands. That is the way that I get the answers (cited from Hsieh, 2008, p.1378).*

Case 19

1201 H: Has he ever been given Adefovir before?
1202 I: Did he give you – I think it's called Adefovir.
1203 P: No.
1204 I: Excuse me, the interpreter would like to
1205 clarify, do you mean is it a brand name of
1206 medication? Adefovir.
1207 H: Hepsera is the trade name, Adefovir is the
1208 generic name.
1209 I: Adefovir is the name of the drug, the drug
1210 name for the brand (cited from Hsieh, 2008, p.1379).

Case 20

Vicky [an interpreter] *explained that because of her cultural norms, if a provider asks her to inform a patient of a poor prognosis, she replies, "I would rather discuss this with the family. I would tell the husband"(cited from Hsieh, 2008, p.1379).*

Case 21

In this case, "after the provider (Hannah) tried several times to explain the use of testing strips and the patient (Pam) remained confused, the interpreter (Claire) stopped the provider-patient interaction and asked the provider to explain again."

1402 H: Yeah, every time you are going to check
1402 your blood sugar, you are going to use one of
1403 the strips. You are going to use 10 strips in this

1404 [disk] and that's finished. You are going to-
1405 I: Open another new one.
1406 H: You are going to change four times.
1407 I: Yeah, that's what I meant.
1408 H: Four times you are going to change. But the
1409 first one that you are going to put in a box, okay.
1410 I: Yeah, only the first time.
1411 H: If it comes two in a box, then, every time you
1412 get a new box, you have to check the first one.
1413 I: Only the first one. The rest is-
1414 H: The rest is the same number. They are the
1415 same. So they don't have to.
1416 I: Yeah, that's what I understand. Okay.
1417 [Switch to Chinese and went on to explain
1418 to the patient] In a new box, there are
1419 usually four strips…(cited from Hsieh, 2008, p.1380).

Case 22

"The baby wouldn't stop crying and so I gave mumble, mumble, mumble."

1. *Interpret what you did understand to the provider first:*
   "The baby wouldn't stop crying and so I gave ---"
2. *Tell the provider that you need the patient to explain the rest:*
   "The interpreter says, I need her to clarify the last part of what she said."
3. *Ask the patient to explain to you:*
   "As the interpreter, I'm asking, could you repeat what you said?"
4. *Once you understand, go back to interpreting:*
   "I couldn't get the baby to stop crying, so I gave her a bottle with chamomile tea" (cited from Roat, 2011, p.23).

Case 23

The surgical scheduler has called a patient to tell her that he cannot schedule her surgery because she has not sent in the appropriate referral. The patient says the doctor said for her to have the surgery. The conversation goes around and around, with each side getting more and more frustrated. You [the interpreter] start to suspect that the patient may not understand the word "referral," since there is no exact equivalent for this term in the patient's language. You say to the scheduler, "As the interpreter, I'd like to ask the patient how she understood my interpretation of "referral," since this term doesn't exist in her language" (cited

from Roat, 2011, p.27).

Case 24

…a doctor is explaining to a mother when to bring her baby back to the ER. He tells her that "the following are red flags." If you focus on interpreting words, you're in trouble. If you interpret meaning though, it should be easy to find a term that means "warning signs," "signs of trouble," "signs of danger" or something similar (cited from Roat, 2011, p.36).

Case 25

Seeking out the charge nurse in Labor and Delivery because you saw one of the OB nurses forge the patient's signature on a consent form for a C-section, a procedure that the patient has repeatedly refused (cited from Roat, 2011, p.48).

Case 26

[Interpreting in pediatrics] *"your rendering of the child's speech should reflect the level of speech the child is using. That will help the doctor assess the child's development and know how to pitch his or her own responses" (cited from Roat, 2011, p.71).*

Case 27

[Texts of patients' consent forms] *"By my signature, I hereby authorize Dr. ____ and/or such associates or assistants as may be selected by said physician, to treat the following condition(s) which has (have) been explained to me."*

[Interpreters' sight translation] *"By signing this document, I am giving my permission for Dr. ____ to treat me for the medical problem that is described here. I am also giving my permission for this treatment to be done by anyone that this doctor chooses to help or replace him. The doctor has explained my medical problem to me" (Roat, 2011, p.87).*

Case 28

[Interpreting in mental health settings] *"pauses and uncertainty…both content and tone of voice in the response…patient's mood swings…pace of speech, the repetition of certain words, even the errors in word choice. An even greater challenge may come when the patient's speech makes no sense…In this case, you can see how important it is to recreate the actual pattern of speech, so that the provider can perceive the symptom…" (Roat, 2011, p.100-101).*

Case 29

…[in mental health settings] *a Vietnamese patient may speak about being "visited" by a relative who is deceased. The patient insists this is not a dream. Is the patient hallucinating? Or is this a culture-specific experience that does not represent delusional thinking at all?...interpreters…need to…make sure that the mental health provider understands when a patient's utterance reflects a cultural view or belief that may not be shared by the dominant culture (cited from Roat, 2011, p.102).*

Case 30

…in both languages you may find that people use a peculiar oblique vocabulary when talking about death. In English, you will hear phrases like, "when she passes over," "when she moves on," "when the time comes," "as she fades," "when she goes to her rest," "when she goes to that better place." Other languages have equally indirect ways of talking about dying…For example, the doctor may feel that by talking about "comfort care" he has made it clear that he can do nothing more to save the patient's life, while that code word may mean nothing to the family. It is important that the family understand that the provider is indeed talking about death (cited from Roat, 2011, p.113).