Managing Affective Communication in Triadic Exchanges: Interpreters' Zero-renditions and Non-renditions in Doctor-Patient Talk

LETIZIA CIRILLO

Abstract

This chapter investigates how interpreters' initiatives may either promote or inhibit affective communication in doctor-patient talk. In particular, so-called 'zero-renditions' and 'non-renditions' (Wadensjö 1998) are analysed from a conversation analytical perspective. The exchanges discussed are part of a sample of consultations between healthcare providers and migrant patients from English-speaking countries recorded in the provinces of Modena and Reggio Emilia (Italy). The analysis suggests that affective displays are fairly numerous in doctor-patient talk; however, interpreters are not always at ease when dealing with them. The findings stimulate reflection on the relevance of a triadic management of affective sequences in interpreter-mediated doctor-patient talk.

1. Introduction

Affective communication is pervasive in everyday life, and has been variously investigated by psychologists, sociologists, anthropologists, and linguists from a wide variety of perspectives and for various purposes, both theoretical and practical. But what is affect and how can it be described? On a first, intuitive level, affect can be divided into two main categories: positive affect (joy, interest, excitement, etc.) and negative affect (distress, rage, shame, etc.). In addition, and moving from the folk psychological notion of involvement, affect can be said to have a scalar dimension, which makes it possible to distinguish between "more involved" and "less involved" (speakers, utterances, etc.). This chapter adopts a broad working definition of affect, which includes *expressed* feelings, attitudes, and relational orientations of all kinds (Ochs 1989). General as it may be, this definition highlights the methodological perspective of this study, which explores not so much speakers' inner states, but the ways in which these are displayed, and how such displays are negotiated and oriented to by speakers themselves. In other words, and in line with an interpersonal social perspective, the main concern is with how affect is made relevant by co-participants throughout the interaction.

Within this theoretical and methodological framework, the concept of affect can only be analytically useful if it is regarded as a continuum, so that both "more involved" and "less involved" modes can be seen as communicatively relevant ways of displaying affect (see Hübler 1987: 373). This leads to another question, i.e. how is affect displayed? A useful umbrella category here is Gumperz' (1992) notion of contextualization cues. These are verbal and nonverbal signs, which, by being assigned context-bound meanings, support speakers' foregrounding and listeners' inferential processes. Contextualization cues are thus fundamental in order to interpret utterances in their particular locus of occurrence, i.e. to contextualise them, and ultimately to understand what is going on in the interaction.

In § 3 and 4 the use of various affective cues (e.g. formulations, assessments, baby-talk, etc.) in interpreter-mediated encounters between patients and healthcare providers will be discussed. In particular, the following points will be considered: 1) who produces affective cues and when; 2) how these cues affect the ensuing interaction; and 3) how they are dealt with by interpreters.

This last point, i.e. how interpreters manage affective displays in doctor-patient interaction, is the main focus of the chapter. In addressing interpreters' initiatives, I will use two labels introduced by Wadensjö (1998). These are 'zero-renditions', i.e. originals left untranslated (*ibid*.: 108), and 'non-renditions', i.e. interpreters' autonomous contributions, which do not correspond – as translations – to prior original utterances by primary parties (*ibid*.). As discussed in § 4, and as pointed out by Wadensjö (1998) herself, despite being useful operational categories, zero-renditions and non-renditions cannot fully describe the complexity of dialogue interpreters' translational and conversational activities.

2. Methodological approach and description of data

The present study adopts a conversation analytical perspective. Conversation analysis (hereafter CA) is a microsociological, interactional approach based on a rigorous and detailed observation of naturally-occurring instances of talk. It assumes that conversation is orderly, and that this order is determined by a set of rules jointly constructed by participants in the interaction as it unfolds. In other words, interactants locally negotiate what is said and done (and why) by orienting to a series of mechanisms which regulate, among other things, allocation of turns, roles played, and activities performed throughout the interaction.

A fundamental aspect of conversation is its sequential character. To put it simply, a current speaker's turn projects a relevant next action (or range of actions) to be accomplished by another speaker in the next turn. Perhaps the best examples of this phenomenon, which is known as 'conditional relevance' (Schegloff 1972), are so-called 'adjacency pairs' (Sacks *et al.* 1974: 716), such as question-answer, request-grant, instruction-receipt, etc. Adjacency pairs have a normative nature, in that the utterer of a first pair part will monitor whatever utterance follows to see how that utterance works as a relevant second pair part, therefore, considering the non-occurrence of any such second as a noticeable absence and making inferences about this absence. Thus, not replying to a question, for example, might be seen as implying a failure to understand the previous utterance as being a question. Alternatively, it might be considered as rude or snobbish behaviour, or it might be interpreted as reticence and explained in terms of mistrust or a feeling of guilt, embarrassment, etc.

The fact that a given utterance projects for the following turns a range of relevant next occurrences means that it is 'sequentially implicative' (Schegloff & Sacks 1973: 296). The sequential organisation of talk makes the contextualization of utterances an essential procedure "which hearers use and rely on to interpret conversational contributions and […] speakers pervasively attend to in the design of what they say" (Heritage 1984: 242). Against this backdrop, Drew and Heritage (1992: 18) argue that the production of talk is doubly contextual: it is *context-shaped* in that speakers and hearers draw on preceding talk to produce their utterances and to make sense of what has been said, and it is *context-renewing* in that every single utterance provides the here-and-now definition for subsequent interaction.

The features outlined above are characteristic of all conversations, whether two-party or multi-party, monolingual or multilingual, 'ordinary' (Sacks *et al.* 1974) or occurring in institutional settings. In this respect, interpreter-mediated interaction is no exception: in making sense of what is being said and done, dialogue interpreters cannot disregard the trajectories projected by 'primary parties" (Wadensjö 1998: 148) contributions, and need to design their contributions accordingly. Interpreters' contributions (be they translational or conversational) shape, in turn, what comes next, showing that interpreters are themselves social

agents co-constructing the meaning of the interaction in which they take part (cf. Davidson 2000 and Bolden 2000, among others).

Interpreters' contributions to the construction of affective sequences will be analysed by looking at examples taken from a growing corpus of interpreter-mediated interactions between migrant patients and Italian healthcare providers. The interactions have been recorded since 2004 in hospitals (mainly obstetrics and gynaecology wards) and family support centres/planning clinics (*consultori* in Italian) in the provinces of Modena and Reggio Emilia (in North-East Italy). The corpus currently includes 220 multilingual encounters involving speakers of Italian, English, Arabic, Chinese, Igbo, Urdu, Punjabi, and Hindi. For the purposes of the present chapter, only the Italian-English subset was considered, which comprises 131 consultations (first visits, follow-ups, and routine discharge examinations). The length of consultations varies from less than five minutes to over one hour depending on the aim of the visit (from a simple prescription to an extensive examination). Most patients are women and the issues discussed have to do mainly with women's reproductive health (e.g. contraception, pregnancy, voluntary abortion). Some exchanges involve male outpatients seeking help for orthopaedic problems, respiratory tract infections, and other common pathologies often associated with occupational medicine.

All the patients use English as either their second language or a lingua franca, showing varying proficiency levels. Some of them also know Italian, although again with varying competence. Most patients come from West Africa and, in a few cases, from either the Indian subcontinent or Southeast Asia. The healthcare providers are doctors (gynaecologists or other) and other staff (e.g. obstetricians, nurses, trainee doctors) who are native speakers of Italian, although a few of them have some knowledge of English. The interpreters involved are three trained professionals who have attended ad hoc cultural mediation courses. Like many patients, they are from West Africa (one from Ghana and two from Nigeria), and have themselves experienced the process of immigration.

Given the delicacy of the issues involved, and to cause minimal disturbance to the healthcare institutions' routine activities, only audio-recordings were allowed. These were transcribed using conversation analytical conventions (adapted from Sacks *et al.* 1974: 731-734; Atkinson & Heritage 1984: ix-xvi; ten Have 1999: 213-214; see Appendix) and rationale (see above). To protect participants' privacy, transcripts were made anonymous by altering sensitive information (including references to people and places). Out of the 131 consultations transcribed and analysed, six excerpts will be discussed here (see § 3 and 4). The extracts chosen are representative of the English-Italian subset in terms of types of visit, participants involved, types of sequences (dyadic vs. triadic), use of affective cues by primary parties and interpreters, and ways in which such cues are dealt with by co-participants, especially interpreters.

As mentioned in the Introduction, affective communication is extensively employed in everyday life, where it tends to be associated with informal situations such as conversations among friends. More formal situations such as lay-professional encounters are characterised by so-called 'institutional talk', which, as highlighted by Levinson (1992), is goal-oriented, shaped by professional and organisational constraints, and associated with inferential frameworks as to what is appropriate to say and at what stage. Against this backdrop, one might think that affective communication is somehow out of place in such encounters; however, as we will see, affective displays are far from absent in institutional interactions (at least in doctor-patient talk).

In approaching an analysis of affective displays, an important consideration to keep in mind is that affective communication is not just *emotional*, i.e. the "spontaneous, unintentional leakage or bursting out of emotion in speech". It can also be *emotive*, i.e. "the intentional, strategic signalling of affective information in speech and writing […] in order to influence partners' interpretations of situations and reach different goals" (Caffi & Janney 1994: 328). Generally speaking, the relationships existing between specific affective cues and specific interactional settings are normatively explicable, i.e. any such cue is made contextually relevant by participants in the interaction and can thus be seen as a conventionalized way of establishing rapport (Tannen 1984: 371).

Although doctor-patient consultations are one of the most widely investigated forms of institutional encounters, the issue of affect in such settings is still relatively unexplored. There are, however, a few significant exceptions. Some work in oncology and palliative care has examined affect in connection with the emotionally challenging situations and delicate issues involved in the treatment of life-threatening illnesses (see Faulkner & Maguire 1994; Maguire & Pitceathly 2002, 2003; Kissane *et al.* 2010; among others). Being essentially practice-oriented and didactic in purpose, however, this work is mainly concerned with providing healthcare practitioners and students with practical guidelines on how to deal with outcome variables such as patient compliance and satisfaction, with the aim of improving patient quality of life and minimizing stress and legal risks for doctors.

A more interesting strand of research for the purposes of the present chapter is represented by a recent multidisciplinary volume on patient participation (Collins *et al.* 2007), which brings together a number of contributions based on different methods (CA, semi-structured qualitative interviews, retrospective 'think-aloud' techniques, non-participant observation, and focus groups). In the book in question, affect is variously referred to as 'mutuality', 'equality', 'rapport', 'empathy', and 'emotional reciprocity'. The last of these terms, introduced by Peräkylä and Ruusuvuori (2007) is particularly relevant for the present analysis, because it explicitly takes the sequential dimension into account. The authors

view reciprocity as an essential component of patient participation, together with 'patient's contribution to the direction of action', 'patient's influence in the definition of the consultation's agenda', 'patient's share in the reasoning process', and 'patient's influence in the decision-making' (*ibid.*: 168-173).

Examples (1) and (2), both instances of affective communication in healthcare settings, illustrate the importance of assuming a reciprocal perspective. Being dyadic conversational sequences, they involve two out of the three or more possible parties to conversation in mediated contexts, i.e. respectively the patient and the healthcare provider in (1), and the patient and the interpreter in (2).

(1) "quello è singhiozzo"[1]

1		D	va tutto bene e:h!
			everything is fine eh!
2			(0.8)
3		D	gli esami vanno be:ne,
			the tests are fine,
4			(0.3)
5		D	è tutto okay.
			everything is okay.
6			(0.3)
7		P	°okay.°
8		D	mh?
9			(1.1)
10	→	D	senti muovere bene il bimbo?
			can you feel the baby move alright?
11			(0.5)
12		P	.hh a:h (slb slb slb).
13		D	senti muovere? sì eh?
			can you feel it move? yes eh?
14			(1.0)
15		D	fa così >tac tac tac tac tac.<
			it goes like that tac tac tac tac tac.
16		P	e:h,
17		D	QUELLO E' SINGHIOZZO.
			THAT'S HICCUPS.
18		P	mh.
19		D	SINGHIOZZO.
			HICCUPS.
20			(0.3)
21		P	°I don't know.°

1 All Italian in the examples is followed by an English translation in italics to provide rough pragmatic equivalents of the originals.

The exchange takes place between a gynaecologist and a young pregnant patient at the beginning of a follow-up visit at a *consultorio* (see § 2). The interpreter has momentarily left the room to get some paper. The doctor reassures the patient about the results of some routine tests and then moves on to ask her if she can feel her baby and to describe what the baby is doing at that precise moment (having hiccups), thus mixing the 'voice of medicine' and the 'voice of the lifeworld' (Mishler 1984).

The playful reference to hiccups (note the sound reproduction in line 15), despite the somewhat tangential relation of the topic to the business currently underway (informing the patient of test results), is presumably used to acclimatise the patient into the consultation, especially given the temporary absence of the interpreter. In other words, the reference appears to serve the function of conveying mutuality, along the lines of the mention of "sub-issues" described by Chatwin *et al.* (2007: 93-95). In fact, an attempt at building common ground is initiated by the clinician in line 10, where, by shifting topic, she is probably trying to elicit some kind of response from the patient. The latter has kept silent after the clinician's previous turns (with the exception of a feeble echoing answer in line 7), including the "mh" in line 8, which is uttered with a rising intonation and would thus at least invite a display of understanding. In line 10, by designing her turn as a question, the doctor establishes the conditional relevance of an answer on the part of the patient. The latter's response at line 12, however, is not only inaudible, but also proffered with a delay.

The example just examined, in which we see the healthcare professional trying to create rapport with the patient by seeking direct contact with her, illustrates two important points: first, non-mediated institutional communication can in itself be potentially affective; second, it can be so only if affect is co-constructed, which does not seem to be the case here: the patient's replies are either minimal (ll. 7, 16, 18) or unclear (l. 12), and only in the very last line of the transcript, does the patient participate more actively, without aligning, however, with the trajectory projected by the doctor.

Example (2) is rather different in this respect, in that affective communication is here jointly constructed by the co-participants. The dyadic sequence in question is taken from a discharge visit at a neonatal ward. Such monolingual two-party conversations between patients and interpreters are rather frequent in the corpus. They often occur at the end of the medical encounter, as in this case, when, the visit by now over, the healthcare provider has either left the room or is engaged in other activities (such as filing charts), and the interpreter is "left" with the patient to provide further clarifications or instructions (usually concerning bureaucratic procedures). In the present interaction the clinician is physically present, but the interpreter does not do anything to involve her in the affective interaction. Her contributions are addressed exclusively to the patient and seem designed to support the patient in expressing her feelings.

(2) "I don't want to get embarrassed"

1		P	a:h woul- will there be any problem (with
2			those)?
3		I	no!
4			*((baby crying loud in the background))*
5		P	with the pack or (something) written or
6			you know:?=
7		I	=no >(slb slb slb slb) (coz they have)<
8			stamp one you know?
9		P	ah okay.
10		I	mh be- before there was no stamp.
11		P	mh mh.
12		I	now they stamp.
13		P	mh mh,
14	→	I	you know the stamp?=
15		P	=mh.
16		I	if you take it there will be no problem.
17		P	°o:kay°.
18		I	if there's any problem let me know.
19		P	o:kay.=
20	→	I	=m:h:?
21		P	and i just want with no stamp,
22		I	no problem.
23		P	mh,
24			(0.9)
25		I	no no this one is [(slb slb slb)
26		P	[no but they] know
27			it's from the °hospital° mh,
28			*((incomprehensible conversation for 5.8 sec))*
29	→	P	.hh £i don't want to: be get
30			embarrassed.£=
31	→	I	=no no no don't worry. if there's any
32			problem just let me know e:h?

The patient has just been given an exemption form to get free powdered milk for her baby and is asking the interpreter for clarifications about the procedure. In particular, she is trying to make sure that there will not be any problem in obtaining the milk from the chemist's by simply showing the form (ll. 1-2, 5-6). The interpreter's initial answer (ll. 3 and 7-8) to the patient's inquiry elicits a 'change-of-state token' (Heritage 1984) followed by "okay" in line 9; however, the interpreter's subsequent expansions (ll. 10 and 12), request for confirmation (l. 14), and offer of support (l. 18) are met with minimal acknowledgement tokens (ll. 11, 15, 17, 19) and a continuer (l. 13).

In line 20 the interpreter's "mh" – uttered with lengthening of sound and rising intonation – invites a stronger display of understanding and agreement with the solution proposed. However, the patient then expresses further doubts (l. 21).

The interpreter reassures her once again in line 22, but her contribution is followed by the patient's continuer in line 23 and a long conversational silence in line 24. At this point the interpreter elaborates on her previous answer (l. 25), and the patient explicitly mentions her concern that the chemist may not believe that the form has been issued by the hospital (ll. 26-27). She then formulates the gist of her previously mentioned worries (ll. 29-30), by using an 'affective formulation' (Baraldi & Gavioli 2007), or, more precisely, what Local and Walker (2008: 729) call a "self-attribution of affectual state"[2]. In doing so, she reveals her fear of embarrassment, and finally receives explicit reassurance by the interpreter ("don't worry").

In contrast to what we saw occurring in (1), here the affective trajectory is oriented to by both participants, who make affect relevant to possible practical problems related to the post-visit phase – the patient by voicing her concerns, the interpreter by addressing them. The latter does so by leaving room for the patient to express her doubts and concerns, inviting displays of understanding and encouraging uptake of the course of action projected (note especially "you know?" in line 8, "you know the stamp?" in line 14, and "m:h:?" in line 20). She provides reassurance and offers of help throughout the exchange, reiterating them after the patient's formulation – affectwise, the climax of the sequence.

The analysis of the above two examples taken from dyadic interactions in healthcare settings illustrates that affective communication can occur in healthcare encounters and that it is not initiated only by patients. It also illustrates the importance of adopting a sequential approach to analysis, one in which the contributions of all parties to the interaction are taken into consideration. In § 4 we turn to an examination of affective displays as managed in triadic sequences, i.e. sequences involving the patient, the healthcare professional and the interpreter. In doing so, special attention will be paid to the interpreter's contributions, particularly zero-renditions and non-renditions (see § 1).

4. Managing affect in interpreter-mediated doctor-patient interaction

Over ten years have passed since researchers started to acknowledge 'dialogue interpreters' (Mason 1999, 2001) as fully ratified participants in mediated interaction, highlighting their 'coordinating' role (Wadensjö 1998) in what are often referred to as 'triadic exchanges' (Mason 2001). Despite a growing interest in interactional approaches to interpreting practices, little work has been conducted on the affective dimension of interpreter-mediated communication, particularly on how interpreters deal with affect. According to Wadensjö (1998: 148), primary parties' need for the interpreter's assistance in understanding affective cues may

2 For further details on conversational formulations, see Heritage (1985); Heritage and Watson (1979); Beach and Dixson (2001); Hutchby (2005); Antaki (2008).

vary, so that the interpreter is "dependent on the interlocutors' interest in each other's emotions". Angelelli (2004: 132) also mentions affective communication only in passing, observing that communicating affect is one of the various activities that make interpreters "visible" in the interaction.

Other researchers have investigated how interpreters communicate affect in triadic exchanges in greater detail, in particular with reference to medical encounters. Among these, Davidson (2000) and Bolden (2000) observe that interpreters edit patients' contributions, filtering out affective displays in order to make such contributions relevant to physicians' questions. In so doing, they act as 'informational gatekeepers' (Davidson 2000: 400), sharing the physicians' normative tendency to collect as much objective – i.e. diagnostically relevant – information in the shortest possible time (Bolden 2000: 414).

Merlini and Favaron (2007) examine interpreter-mediated Australian speech pathology sessions involving English-speaking healthcare professionals and Italian-speaking patients. Drawing on Mishler's (1984) notion of voice, the authors acknowledge the appearance in cross-lingual and intercultural communication of the "voice of interpreting". While stressing that the voice of interpreting does not confine itself to echoing the other two (i.e. the voice of medicine and the voice of the lifeworld; see § 3 above), Merlini and Favaron (*ibid.*: 110-112) note a tendency on the part of interpreters to reinforce the speech therapists' selection of the voice of the lifeworld.

Baraldi and Gavioli (2007) analyse mediated consultations with Arabic-speaking patients, showing that the latter's affective contributions repeatedly project interpreters' affiliative responses. In their data, however, such responses emerge in monolingual conversations with patients, from which healthcare providers are systematically excluded. In line with these findings, Zorzi and Gavioli (2009) note that in interpreter-mediated legal and medical encounters affective displays occur regularly in dyadic interaction, while the intervention of a third party is likely to introduce cognitive, rather than affective, alignment.

Finally, in a recent paper I have claimed that interpreters may choose to translate, not translate, or autonomously use affective cues, and these choices in turn affect the ongoing interaction, by encouraging or inhibiting primary parties' involvement with each other. The relevance of affective cues to the ongoing talk, however, is jointly negotiated by the co-participants, and so is the relevance of what needs to be translated (Cirillo 2010). In what follows we will take a closer look at the ways in which interpreters manage affective communication in doctor-patient talk.

4.1. Communicating affect vs. promoting institutional mission

In § 3 we have considered examples of affective communication in dyadic sequences in medical interaction. In particular, we have seen that affective initia-

tives may be taken by either patients or institutional representatives and serve to enhance active participation by the patient and/or establish mutuality. In this section we will see that similar initiatives by the healthcare provider also occur in triadic sequences, although the affective trajectory thereby projected tends to be "resisted", or only temporarily aligned with, by the interpreter.

Excerpt (3) is an exchange between a ten-week-pregnant patient, a gynaecologist and an interpreter at the beginning of a routine check-up. The excerpt opens with an empathic formulation by the doctor, who attributes an affectual state to the patient in line 1 (cf. Local & Walker 2008: 729)[3]. The interpreter does not align with the doctor, providing instead a response which somehow discounts the doctor's hypothesis about the patient's emotional state and therefore the patient's concerns (l. 3). At the same time, her contribution is a non-rendition, which responds to the doctor's observation directly, without translating it for the patient, and therefore does not provide the latter with an opportunity to reply for herself.

After a pause and a partially unclear stretch of talk, in which the patient presumably starts reporting on her health conditions and the interpreter starts translating (ll. 4-7), the doctor asks for clarification (l.8). In line 9 the interpreter makes the doctor's request explicit, by formulating a direct question to the patient, maybe in an attempt to (re-)involve her in the conversation, but the patient remains silent (l. 10). In lines 11-14 the interpreter, speaking for the patient, explains the reasons why the latter feels unwell, making reference to the patient's job and elaborating her own account (note the adverb *forse*, "maybe"). The interpreter's candid explanation – again a non-rendition – triggers a fairly long account on the part of the doctor (ll. 15-24), which the interpreter rephrases in a postponed translation to the patient (ll. 25-32), after which the latter provides a minimal response (l. 33) and the doctor re-engages in "business as usual" (l. 34).

(3) "ha una faccetta un po' preoccupata"

1 →	D	ha una faccetta un po' preoccupata	
		she looks a bit worried	
2		a dire il vero ma,	
		to tell the truth but,	
3 →	I	no ma lei è sempre così.	
		no but she's always like that.	
4		(2.8)	
5	?	hhh	
6	P	(slb slb slb slb slb slb)	
7	I	dice che non sta bene non si sente	[bene.
		she says she is not well she doesn't feel well.	
8	D		[cioè?]
			meaning?
9	I	what do you feel?	

3 Note the diminutive *faccetta*, lit. "little face".

10 (9.4) *((people talking loud in the background))*
11 → I perché lei, devi sapere che lei è fa la parrucchiera.
'cause she, you know she's a hairdresser.
12 D mh,=
13 I =e non riesce più a stare in piedi. si sente
and can't manage to stand so much. she feels
14 debole (.) spesso. stanca forse. hh a stare in piedi.
weak often. tired maybe. when she stands.
15 D all'inizio della gravidanza,
at the beginning of a pregnancy
16 *((throat clearing))* i primi due tre mesi
the first two three months
17 è facile sentirsi molto stanche anche se non
you're likely to feel very tired even if
18 c'è la pancia stanno succedendo talmente tante
there's no belly so many things are happening
19 cose dentro che è il periodo pi- più
inside that it's the most
20 impegnativo per il corpo.
difficult time for the body.
21 I mh.
22 D ed è normale sentirsi più stanchi.
and it's normal to feel more tired.
23 I [mh.]
24 D [si] abbassa anche un po' [la pressione.]
blood pressure also goes down a bit.
25 I [sh said tha::] at
26 the beginning of the pregnancy, you know, t's
27 normal: that you feel we:- that you feel tired,
28 (0.4)
29 I and your pressure go:: down. you feel ve:ry
30 off.
31 (0.8)
32 I it's normal. (slb slb slb slb slb) you feel?
33 P mh,=
34 D =adesso jane ti dò gli esami del sangue da fare.
now Jane I'll give you some blood tests to do.

In excerpt (3) the interpreter's non-renditions seem to alternately encourage and discourage the primary participants' involvement with each other and hence their engagement in a three-party affective sequence. As mentioned, the affective communication is initiated by the doctor, who is apparently trying to open up a space for direct contact with the patient[4]. Her initial empathic formulation is not translated, but nonetheless influences the trajectory of the ensuing interaction. This affective display is dealt with at a later stage by the interpreter, who

4 This is also shown by the last two lines of the excerpt, where, in moving back to the agenda of the visit, the clinician addresses the patient directly by her first name.

addresses it because the doctor invites elaborations on the patient's state. This invitation results in a voluntary non-rendition by the interpreter, which somehow compensates for the brusque conclusions she expresses about the patient's condition (another non-rendition) after the doctor's initial other-attribution of affectual state. The second non-rendition elicits reassurance by the doctor, in the form of an explanation of how people usually feel in a pregnancy. This explanation finally makes a translation by the interpreter relevant.

Interestingly, both non-renditions discourage self-expression by the patient – the former by brushing off possible concerns on her part (as envisaged by the doctor), the latter by more subtly leading the conversation back to more 'doctorable' matters (see Gill *et al*. 2001; Halkowski 2006), such as pregnancy-related fatigue. It is as if the interpreter were trying to promote the institutional agenda of the visit and the achievement of its ultimate goal (i.e. checking that the pregnancy is progressing smoothly). In this respect, the interpreter's second non-rendition (ll. 11-14) can be regarded as an instance of emotive communication (see § 3 above), in that, in describing how pregnancy has affected the patient's physical condition and thus her working routine, the interpreter is using the voice of the lifeworld to restore the primacy of the voice of medicine.

The promotion of the institutional "mission" is more evident in example (4), where the interpreter is strongly aligned as supporter and promoter of the host country model of healthcare, particularly as far as reproductive issues are concerned. What immediately captures the reader's attention in perusing the extract is that there is little (if any) translation activity going on. In fact, virtually all the interpreter's initiatives can be seen as either zero-renditions or non-renditions. The sequence is taken from a routine examination at a neonatal unit. The doctor is visiting a newborn baby girl before discharging her from hospital; specifically, he is reviewing the baby's file and reporting on her health condition to her mother. Other participants in the interaction include the interpreter, an undergraduate student (who was in charge of recording the encounter), and three obstetricians.

(4) "brava pisciona"

1 →	D	((*to baby*)) ma hai fatto la pipì?
		have you done pee pee?
2		(0.4)
3	I	[hh he]
4	D	[bra::] va!
		good!
5	I	he he he he
6	D	bra::va pisciona.
		good pee baby.
7		(0.2)
8	P	£mh£
9		(1.2)
10	D	mh?
11		(1.5)

12 D m:h?
13 (0.3)
14 *((8 lines omitted))*
15 *((the baby sneezes))*
16 I bless you!
17 (3.6) *((background voices))*
18 D .hhh
19 I [bless you madame.]
20 D [be: ne be ne] bene.
good good good.
21 I madame (slb slb).
22 D bellissima.
beautiful.
23 I sì:,=
yes,
24 D =tutto bene questa bimba avevamo
=everything's fine with this baby we
25 già visto poi ieri (slb slb slb slb slb slb).
already saw yesterday.
26 hey! eh he.
27 (0.2)
28 P .h he he he .h.
29 → I how many girls do you ha:ve before?
30 (1.4)
31 I you have two °be° [fore.]
32 P [this] is tird one.
33 *((5 lines omitted))*
34 I sì: >no ma:< numero cinque que:sta.
yes >no but< number five this one.
35 (0.5)
36 D NUMERO CINQUE:?
NUMBER FIVE?
37 I sì::!
yes!
38 *((6 lines omitted))*
39 → I so:: if your hu:sband is going to make love go
40 an' buy co:ndom.
41 ((*P smiles*))
42 I <or: you go on wit der::
43 P it's true (i: know::)

As in example (1), the reference to the baby at the beginning of the sequence can be seen as an opportunity to establish emotional reciprocity between the healthcare provider and the patient. Here the doctor initiates and pursues affective communication by addressing the baby directly, and by using affective cues like baby-talk and assessments (see especially ll. 1, 4, 6, and 22)[5]. The affective

5 For further details on assessments, see Jefferson (1978); Pomerantz (1984); Goodwin and

sequence involves both the interpreter and the patient, although the latter participates only with minimal (laugh) tokens (ll. 8 and 28). The interpreter's zero renditions do not appear to prevent affective displays by the doctor from being understood and responded to (although minimally) by the patient, presumably because the clinician is using basic Italian and the patient has at least a passive competence of the language[6]. The interpreter, in turn, takes part in the affective sequence by laughing and addressing the baby, just as the doctor does (ll. 5, 16, 19, 21, and 26). Then, in line 29, she suddenly shifts the trajectory of talk and, as had also happened in (3), brings the conversation back "on track". Differently from (3), however, here the interpreter introduces a new, although pregnancy-related, topic, namely birth control.

In line 29, she asks the patient how many children she has[7], but hers is not a genuine lifeworld inquiry. On the one hand, she seems to already know the answer (l. 34), which is confirmed by the patient (l. 37). On the other hand, the piece of information thereby introduced is instead new to the doctor, as proved by his surprise in l. 36. The "news item" and the ensuing reaction give the interpreter an opportunity to bring up the issue of contraception and "educate" the patient to a "responsible" sexual life (ll. 39-42). In so doing, the interpreter not only speaks with the voice of medicine, but also virtually takes the place of the healthcare provider. The way in which she presents her "educational" message can be understood by reference to the context where the interaction takes place, i.e. a *consultorio*, where she regularly works and where most users are migrant women seeking help for issues related to their reproductive health (see § 2). In this respect, it is not surprising that the interpreter appears to see the dissemination of information and good practice regarding the use of contraceptives as part of her job, and that the patient may expect this to be her role, as shown by the way she aligns with the institutional trajectory projected (l. 43).

4.2. Communicating affect vs. promoting institutional image

In § 4.1. we have seen how the interpreter's translational and above all conversational initiatives may be geared towards the promotion of the institutional task and/or mission of the encounter (i.e. the delivery of healthcare and the dissemination of a "mainstream" model of healthcare delivery). In the present section,

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Goodwin (1992).

6 Including, presumably, the ability to interpret paralinguistic and extralinguistic cues and in turn use them – a hypothesis, which, unfortunately, cannot be confirmed due to the absence of video-recordings and therefore the lack of access to participants' non-verbal behaviour like gaze and gesture.

7 In fact, the interpreter asks about "girls", but she probably means children in general, as shown by her clarification in line 34.

we will look at how similar initiatives may also be designed to promote the image of institutions, i.e. to somehow protect or enhance their reputation.

Excerpt (5) is taken from an interaction recorded at an orthopaedic practice during the examination of a young patient who has had his arm and hand injured in a car accident. Differently from the first few lines of example (4), here the interpreter's non-renditions and zero-renditions do not encourage three-party affective communication, but rather serve to keep the patient-interpreter and doctor-interpreter dyads separate.

(5) "non sono un datore di lavoro"

1	D	APRI E CHIUDI LA MA:NO:!	
		OPEN AND CLOSE YOUR HAND!	
2	P	(apro)?	
		I open?	
3	I	close it and open. close open.	
4		(0.4)	
5	D	STRINGI FO:RTE DA:I!=	
		SQUEEZE TIGHT COME ON!	
6	I	=close it.	
7	D	STRINGI [FO:RTE!	
		SQUEEZE [*TIGHT!*	
8	I	[he said]	do it hard.
9	D	>FORTE FOR [TE FORTE FORTE!<	
		>*TIGHT TIGHT* [*TIGHT TIGHT*<	
10	I	[you cannot do it,]	
11	D	gli dica di stringere (il pugno).	
		tell him to clench (his fist).	
12	I	can you hol- hold it tight.	
13		(1.1)	
14	D	STRINGI:! FORTE:!	
		SQUEEZE! TIGHT!	
15 →	I	a lot of °pain eh?°	
16 →	D	che non sono un datore di lavoro. [stringi.]	
		I'm not an employer. [*Squeeze.*]	
17	I	[eh he]	he
18		he he noh: ho. .hhh	

The doctor is testing the patient's hand functions by asking him to clench his fist. Seeing that the patient cannot hold it tight, the interpreter produces an empathic non-rendition, asking him if he feels much pain (l. 15). In line 16 the doctor accompanies his invitations with a humorous remark, which the interpreter reacts to with laughter (ll. 17-18) but does not translate for the patient. The untranslated joke by the doctor is not responded to by the patient, and the analyst is left to wonder whether the latter has understood what the practitioner has just said.

Something similar occurs in example (6), where the interpreter edits the doctor's utterances by either omitting or adding bits of information. Here the patient presents a vast array of complaints, including congenital cardiopathy, testicular pain, and acute chest pain probably related to an ongoing respiratory tract infection. The doctor refers him to a charitable organisation, where migrant patients can undergo medical tests for free.

(6) "mi uccidono secondo me stavolta"

1 →	D	mi uccidono secondo me stavolta. hhhu hhu h .hh
		They're going to kill me I think this time.
2		janardan se si arrabbiano: te lo dico già eh?
		Janardan if they get angry I'm telling you eh?
3		non è cioè: non si arrabbiano con te si
		they won't be angry with you they'll
4		arrabbiano con me! ma [può dar] si che si=
		be angry with me! But [*they may*]
5	I	[er y-]
6	D	=arrahhb [bi no!]
		[*get angry*]
7	I	[if they] annohy
8	D	[.hh he he he he]
9	I	[if they that it is] they're annoyed >they're
10		not annoyed with you they're annoyed with her.<
11	P	°yeah,°=
12 →	I	=she say cause she has sent too many
13		people there. [he he] .hh
14	P	[°okay.°]
15	D	eh però non si paga £e quindi noi ci proviamo.£
		but you don't pay so we'll try.
16	I	eh hh
17	D	al massimo poi te la fac [ciam fa re] a
		Or if we have to we'll have [*it done for*]
18	I	[but you don't]
19	D	pagamento.=
		a fee.
20 →	I	=you don't pay you know so tha- she
21		continues sending people there.
22	D	°he he he°

In lines 1-4 the doctor produces a hyperbolic remark and subsequent laughter, and warns the patient about the possibility of facing annoyed reactions to her referral, while reassuring him that any such possible reaction will not be specifically against him. The interpreter omits the doctor's exaggerated statement ("they're going to kill me I think this time"), but clarifies for the patient the reason for possible "annoyed" reactions, elaborating on the doctor's previous comment

with some extra information (ll. 12-13), and reciprocating the doctor's laughter. The patient acknowledges receipt and shows understanding of the explanation (ll. 11 and 14). The doctor further expands her contribution, by explaining that the referral is worth a try since the tests would be free of charge and if worst comes to worst the same tests will be conducted for a fee (ll. 15-19). In lines 20-21, the interpreter provides a translation for the first part of the doctor's utterance, while omitting the second and rephrasing what she had already mentioned in lines 12-13.

In both (5) and (6), the interpreters involved avoid translating doctors' "jokes", and the resulting zero-renditions seem to contribute to preventing the patient from sharing laughter with the other participants. Filtering out "small", "ordinary" talk from the voice of medicine and, more generally, from the voice of institutions, may be read as a way of enhancing the institutional image by avoiding the introduction of potentially controversial issues, as in (6), where the institutions referred to are medical and where omitting hilarious remarks about them could also be a way to promote the patient's trust in the healthcare establishment (maybe as part of a strategy aimed at removing anything that could be face-threatening for the doctor herself). In any case, references to relationships with institutions and between institutions seem to be treated as irrelevant to the patient and to the manifest purposes of the medical encounter.

The interpreter's omissions, on the other hand, may be seen as "affective gatekeeping", in that they avoid conveying to the patient information which may be unnecessary or misleading, if not indeed harmful. This could be the case in (6), where, by cutting off the doctor's initial remark, the interpreter may want to spare the patient premature concerns, as also shown by the subsequent omission (ll. 17-19), which is consistent with the previous one. In other words, "they" may be annoyed, but not necessarily, and if "they" are, then "we" will consider further options.

5. Conclusions

The excerpts discussed in § 3 and 4 show that instances of affective communication do exist in lay-professional encounters within medical settings and that attempts at initiating communication of this kind are often made by the institutional party involved, i.e. the healthcare professional. Clearly, affective trajectories, like any other trajectory in conversation, after being projected by one of the participants need "verification" (Chatwin *et al.* 2007: 100) by the co-participants, who may either align with the trajectory proposed or reject it.

The analyses presented are representative of patterns of interaction in over 100 consultations in similar contexts. They illustrate that affective alignment is rather difficult to achieve, especially in triadic exchanges, where – in line with previous findings by Zorzi and Gavioli (2009) and Cirillo (2010) – three-party in-

volvement seems unlikely. Differently from the empathic three-party communication model emerging from the speech therapy data discussed by Merlini and Favaron (2007), in reviewing the examples examined in § 4, it becomes apparent that affective initiatives by healthcare providers are often "blocked" by interpreters, who usually try to bring the conversation back to the "medical realm". In general, interpreters tend to keep to the institutional agenda of the visit and to be strongly oriented to the normative and cognitive expectations associated therewith, sometimes apparently even more than doctors themselves (see especially example 4).

Affect is more likely to be conveyed within more or less extended dyadic sequences, be these healthcare provider-patient (as in excerpt 1), patient-interpreter (as in excerpt 2), or healthcare provider-interpreter (as in excerpts 3, 5, and 6). Regarding the latter two cases, i.e. excerpts (5) and (6), it must be noted that although all three parties may be physically present in the room, the interpreter has some difficulties in managing three-party affective involvement and recurrently leaves out either the healthcare provider or the patient, thus somehow hampering direct contact between the two. In the very few instances in which affective communication is shared by all three parties (as in excerpt 4), the triadic sequence proper is generally limited only to a few turns and is followed by (conversational) initiatives by the interpreter aimed to restore the institutional order of conversation.

Interestingly, any reference to lifeworld experiences and concerns (by either participant, including the interpreter) tends to be treated by the interpreter as emotive (see § 3), and is therefore strategic to the manifest purposes of the interaction (as in excerpts 3 and 4); and when the interpreter considers any such reference not to be functional to any visit- or post-visit-related objective, she filters it out (as in excerpts 5 and 6). As to zero-renditions and non-renditions, they can either promote or inhibit affective communication, depending on their sequential positioning and the activity in which co-participants are engaged. Overall, what emerges from the analysis is a nuanced picture of affect, whereby moments of meeting and divergence of perspectives alternate (see Peräkylä 2008: 116, 118). Thus, non-renditions and zero-renditions may encourage direct contact between primary participants (e.g. zero-renditions in excerpt 4), or hamper such contact (e.g. non-renditions in excerpt 3 and zero-renditions in excerpt 5), with the interpreter selecting "translatables" on the basis of their apparent relevance and appropriateness to the situation.

From a methodological point of view, some general considerations can be made. On a first, practical level, zero-renditions and non-renditions, while being useful analytical categories, cannot account for the complexity of interpreter-mediated doctor-patient interaction. For instance, the term 'non-rendition' does not account for translatables which may not be voiced (but rather expressed through non-verbal behaviour) or may have been uttered at some other point (e.g. during the pre-interview stage, as in excerpt 3), or are dictated by inferential

frameworks associated with the interaction (as in excerpt 4). Similarly, the label 'zero-rendition' does not account for translatables which may not need to be translated because of possible bilingual competences of primary participants (as in excerpt 4), or because they may be considered by interpreters to be addressed to themselves (as in excerpts 5 and 6), as if one of the primary parties (but especially the healthcare provider) were engaging in side talk with the interpreter. Hence, even in a simplistic, prescriptive model of interpreting – which holds that the interpreter should translate *everything* that is said in an *impartial* way and refrain from offering "original" contributions – it would be pointless and virtually impossible to say whether zero-renditions and non-renditions are either systematically "good" or "bad".

Clearly, responsibility for what is said and done cannot be attached solely to the interpreter, as the "why that now" of the interaction is always *locally* negotiated by all parties involved in conversation. Affective communication is multifaceted and, like the other components of patient participation (see § 3 above; Gafaranga & Britten 2007: 119), varies in relation to the interactional activity in which participants are involved (e.g. seeking/providing reassurance, paying/receiving compliments, etc.). Against this backdrop, CA can be a useful approach for understanding affect *in the consultation*, or, to be more precise, affective displays in the specific conversational activity within which they are observed. CA findings can thus be used to raise patients', doctors', *and interpreters'* awareness of what affective communication in relevant conversational activities is all about.

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I	interpreter
P	patient
D	doctor or other healthcare provider (nurse, obstetrician)
=	latching
[ ]	overlapping talk
(.)	time gap shorter than 0.2 seconds
(0.3)	time gap in tenths of a second
wo-	truncated word
:	sound lengthening
.	falling intonation
,	rise-fall in intonation
?	rising intonation
!	fall-rise in intonation
↑↓	marked falling or rising intonational shift
h/hh	out-breath
.h/.hh	in-breath
<word>	word uttered at a slower pace
>word<	word uttered at a quicker pace
#	creaky voice
£	smile voice
word	emphasis
°word°	word spoken more quietly
WORD	word spoken more loudly
(word)	reasonable guess at an unclear word
(slb slb)	number of syllables in an unclear segment
((nodding))	non-verbal activity or transcriber's comments
→	phenomenon of interest