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This is the final peer-reviewed author's accepted manuscript (postprint) of the following publication:

*Published Version:*

natacha niemants, a.c.t. (2021). Patients' disalignment in two different healthcare settings. HEALTH COMMUNICATION, 36(9), 1068-1079 [10.1080/10410236.2020.1735702].

*Availability:*

This version is available at: <https://hdl.handle.net/11585/829361> since: 2021-08-06

*Published:*

DOI: <http://doi.org/10.1080/10410236.2020.1735702>

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This is the final peer-reviewed accepted manuscript of:

**Natacha Niemants, Anna Claudia Ticca & Véronique Traverso (2021) Patients' Disalignment in Two Different Healthcare Settings, Health Communication, 36:9, 1068-1079, DOI: 10.1080/10410236.2020.1735702**

The final published version is available online at:  
<https://doi.org/10.1080/10410236.2020.1735702>

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## **Patients' disalignment in two different healthcare settings**

Natacha Niemants (Dipartimento di Interpretazione e Traduzione, Università di Bologna)

Anna Claudia Ticca (Laboratoire ICAR/Lyon)

Véronique Traverso (Laboratoire IFPO/Beyrouth-ICAR/Lyon)

### **Abstract**

Among the important bulk of research devoted to medical consultations, one recurrently discussed issue has been that of patients' alignment with practitioners' recommendations. If this question has not always been formulated in terms of alignment, all the studied cases deal with how patients comply, or not, with practitioners' first actions. They show that social actions such as suggestions, proposals, offers, etc., are not unilaterally offered by practitioners to patients, but frequently discussed and negotiated. This may result in patients being more willing to comply with jointly achieved solutions. In this paper, we will fill in some more details of this picture by focusing on interactional resources used by patients to show their disalignment towards less investigated types of first actions (i.e. non-medication recommendations, home remedies, proposals or suggestions to accomplish certain activities), thereby acknowledging the central role played by patients in two different healthcare settings (general and mental health). We will also compare how linguistic and cultural diversity are handled when patients and practitioners communicate directly as well as when communication is interpreter-mediated, thereby problematising the presence of an interpreter who needs to grasp the variety of resources used by patients in order to render both their disalignment and practitioners' responses to it. Taking into account audio and video-recorded naturally-occurring data collected in Italy and France, we will additionally show the relevance

of multimodal analysis for a better understanding of the resources involved, as well as of the dynamics of interpreter-mediated communication in healthcare.

## Keywords

Medical consultations, recommendations, disalignment, multimodal resources, interpreter-mediated communication

### **1. Medical consultations, patient's alignment and interpreting**

Among the important bulk of research on medical consultations, one recurrently discussed issue has been that of patients' alignment with healthcare providers' suggestions, advice, recommendation, treatment, etc. If this question has not always been formulated in terms of alignment, as we will do in this paper, but in terms of "agreement/disagreement" (Costello & Roberts, 2001) or "accepting/resisting" (Stivers & Barnes, 2018a), all the cases referred to by these designations deal with how the patients comply with providers' actions. Starting from the widespread view of medical consultations as an asymmetrical situation type, researchers have shown how things go in actual exchanges on the basis of fine-grained analysis of data recorded *in situ*:

- 1) Medical consultations are a co-construction, in which each participant plays a role, i.e. the patient is not a passive participant (Maynard & Heritage, 2005; ten Have, 2006; Teas Gill & Roberts, 2012 among others).
- 2) A way of studying power and authority in such situations is to examine in detail how practitioners and patients deal with sequences of talk (i.e. how practitioners' directives are formulated and responded to, West, 1990).
- 3) Recommendations (this term encompasses social actions such as suggestions, proposals, offers, etc.) are not unilaterally offered by doctors to patients, but frequently discussed and

negotiated (Costello & Roberts, 2001; Bergen et al., 2018), and patients may influence or orient doctor's prescription (Stivers, 2007; Stivers & Barnes, 2018a).

In this paper, we will fill in some more details of this picture by analyzing cases in which the patient expresses her/his reluctance to comply with doctors' first actions. We will first deal with non-medication recommendations and home remedies, which have received less attention in recent studies of recommendations actions and responses in general healthcare (Stivers & Barnes, 2018b). We will then widen the scope by observing other types of social actions which are similarly responded to with reservation, reluctance, or even resistance, and which occur in the context of mental care, where doctor's recommendations of the type above are less frequent. We will focus on patients' disaligned actions, following the definition proposed by Stivers in the context of storytelling:

«When a recipient *aligns* with a telling, he or she supports the structural asymmetry of the storytelling activity: that a storytelling is in progress and the teller has the floor until story completion. *Disaligned* actions undermine this asymmetry by competing for the floor or failing to treat a story as either in progress or – at story completion – as over. Thus, *alignment* is with respect to the activity in progress» (2008, p. 34)

If we assume that disaligned patients' actions after a doctor's first action can contribute to the joint construction of recommendations and thus to the achievement of solutions that patients may be more willing to comply with, sensing signals of verbal and non-verbal disalignment is crucial for doctors. Indeed, they would be able to adequately orient to patients' demands, and to possibly modify the trajectory initiated by their first action.

The second important background of this paper concerns interpreting studies, where two aspects of interpreter-mediated medical consultations deserve special attention. First, in this context, patients' actions showing resistance to align with practitioners' talk seem far less frequent than cases in which they do align (Gavioli, 2014; Farini, 2016). This is possibly the

case because: it may be difficult for the patient 1) to initiate a turn on a sequentially appropriate occasion, due to the more complex functioning of interpreter-mediated interaction; 2) to be understood, as this may require specific interactional competences on his/her part as well as on that of the interlocutors, even more so when patients do not know the institution's language; as for the interpreter 3) it may be delicate, and even somehow more difficult, to render disaligned turns. The role of the interpreter in the management of sequences following a patient's disaligned turn is one of the points investigated in this paper. The second aspect of interpreter-mediated medical consultations that is important for our research is the type of translation concerned. As shown in the literature, healthcare interpreting presents a large variety of configurations, where the AIBIA turn-model<sup>1</sup> is far from being frequently followed (Wadensjö, 1998; Davidson, 2000; Mason, 2006; Niemants, 2015). The presence of an additional participant has been shown to be consequential, not only for the way participation then functions (Baraldi & Gavioli, 2012), but also for the management of specific moments in interaction (such as expression of emotions, cf. Gavioli, 2015; Ticca & Traverso, 2017; Piccoli, 2019). In cases of delicate, disaligned actions on the patient's side, the interpreter's role becomes interesting to examine in terms of her/his positioning towards both the patient and the practitioner.

In this paper, we will analyse cases of disaligned patients' actions after a practitioner's first action, in two healthcare settings (general healthcare in Italy and mental care in France), comparing how linguistic and cultural diversity are handled when patient and practitioner communicate directly (non-mediated interaction) and when an interpreter is present (mediated interaction). Taking into account both audio and video data, we will progressively show the relevance of a multimodal analysis for a better understanding of the interactional resources

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<sup>1</sup> The expected turn pattern in interpreter-mediated conversations between A and B, where I is the interpreter and A and B the co-participants.

mobilised to show disalignment, as well as of the local dynamics of such interpreter-mediated interactions.

## **2. Audio and video corpora used for the study**

This study is based on data excerpted from two large corpora collected for two projects on interpreter-mediated medical consultations, in Italy and France.

The FAR 2014<sup>2</sup> corpus contains 20 mediated (664 minutes) and 20 non-mediated (552 minutes) practitioner-patient interactions recorded in obstetric and pediatric services of the Emilia Romagna region, for a total of about 20 hours audio recordings. As for the mediated interactions, the task of enabling understanding in bilingual talk is performed by so-called ‘intercultural mediators’, who typically have no academic background in interpreting/translating, but are professionally qualified by their lengthy experience in Italian healthcare institutions, where both accredited interpreters and untrained mediators can offer their linguistic services. We here opt for the umbrella term interpreter-mediator (henceforth IM), which also caters for IMs working in France, who follow different training programs depending on their professional affiliation (on interpreter-mediators see e.g. Falbo, 2013; Navarro, Benayoun & Humbley, 2016).

The French corpus consists of 91 video-recorded medical consultations between asylum seekers and migrants and healthcare professionals. The data were collected in the framework of the research project REMILAS – Refugees, Migrants and their Languages in healthcare services, funded by the French National Research Agency (2016–2019)<sup>3</sup>. This research deals

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<sup>2</sup> This is the project whose final event this special issue stems from, and whose title was *Analysis of communication with migrant patients and suggestions for improvements in the healthcare system* (see Niemants, 2018 for more details).

<sup>3</sup> All the data collected for this project were recorded with all the participants’ informed consent and a set of ethical precautions, established in agreement with the legal services and ethical committees of the academic and healthcare institutions concerned, were respected in the collection, analysis, storage and publication of excerpts of the data. See <http://www.icar.cnrs.fr/sites/projet-remilas/corpus/>.

with obstacles to mutual understanding in consultations in France in which participants do not speak the same language, with the way the presence of IMs is handled, etc. (see Ticca & Traverso, 2017; Traverso, 2017) The data include consultations with different types of professionals: general practitioners, psychiatrists, psychologists, social workers, nurses. The multi-view recordings were designed so as to enable fine-grained interactional multimodal analyses, which take into account, as far as possible, the large range of semiotic resources to which participants resort in order to communicate as well as the use of artifacts, such as the computer or the telephone (Piccoli, Ticca & Traverso 2019; Traverso, 2019).

### **3. Patients' disalignment**

The sequence we have identified starts with a first action by the practitioner (e.g. a recommendation) and develops with the patient displaying reservation about it. In the next step of the sequence, either the patient aligns with the practitioner or s/he displays her/his disalignment (West, 1990; Costello & Roberts, 2001). In our data, the patients' next action, be it aligned or disaligned, is often not accomplished in an overt manner. It is also rare that the sequence leads to a disagreement, with each participant supporting a position clearly opposed to that of their interlocutor. Things generally go in a much more indirect way (see also Ticca, 2013). In the two analytic sections, we will provide examples of both outcomes. The analysis enables a comparison between situations with and without interpreter: in section 3.1, practitioners and patients communicate directly, and in section 3.2 an IM participates in the consultation. Section 4 is devoted to a description of participants' verbal and non-verbal resources used to express disalignment, based on video-data.

It is of interest to stress here that the way of dealing with disaligned actions in our two sets of data may differ, not only because the consultations take place in two different countries, with different populations, but also because of the types of consultation concerned and of the



### 3.1 Examples from non-mediated interaction

Ex. 1

8

18 PATf [hoey]  
19 OBSf it's very important (.) yeah (1.0) yep  
20 PATf cause me ((throat clearing)) only th- juice capito juice [the]  
you understand  
21 OBSf [yes] yes yes  
22 but ehm [do you ]  
23 PATf [but if I] drink water after I vomit I:: [stanca]  
tired  
24 OBSf [.h but] dr- drink ehm:  
25 little (.) a half glass (.) and (.) after two hours other  
25 PATf ah

The patient's disalignment is first expressed by the repetition of a key word in the midwife's turn ("water?", line 4). The upward intonation of this questioning repeat (an other-repair initiator) is hearable as astonishment with respect to the midwife's proposal to drink a lot of water.<sup>4</sup> After the midwife's confirmation that the patient is supposed to drink almost half a liter (line 5), the patient starts explaining why she does not drink water, and in line 10 the midwife acknowledges what the patient says ("yes but"), while giving some sort of instruction about how to drink water (i.e. don't drink it all at once but many times during the day). Line 14, the patient displays her understanding (receipt tokens) and seems to start aligning with the midwife, who goes on and gives a more precise instruction (i.e. at least one liter per day). The patient reacts by uttering a rather loud sound ("hoey"), thereby displaying her surprise and disalignment, which she elaborates by giving other reasons for why she cannot drink water (lines 20-23). Such an explanation is interspersed with two follow-up turns by the midwife, who, just like in line 10 above, starts with "but" (22, 24). At the end of this extract, the patient produces the receipt token "ah" (line 25), whose prosodic quality is hearable as a first sign of

<sup>4</sup> See Robinson & Kevoe-Feldman (2010) about repeats problematising the relevance of first-pair parts such as questions.

In the second excerpt, the development of the sequence is rather different, although the interactional resources are the same. Here the midwife proposes the patient to do a smear test on that same day. We again find the patient's repetition of the word "today" (other-repair initiator, lines 1-2), and very quickly, the midwife shows that she is ready to address to the patient's viewpoint and feelings (see question line 5, receipt tokens lines 9-10).

[illegible]

*[you've got a little] .hhh look mm oh God (.) ((tongue click)) we can  
also do it the next time if you prefer*  
15 PATf     *va bene okay*  
              *alright okay*  
16 OBSf     *d'accor[do?]*  
              *all rig[ht?]*  
17 PATf             *[si] sì*  
                      *[yes] yes*

This excerpt shows how patient's disalignment is sequentially constructed by the use of several interactional resources: a questioning repeat (line 2), laughter and hesitations (line 4), and detailed explanation of the rejection (lines 6-8, 11). It is the midwife who finally proposes to postpone the date of the test (lines 12-14): the patient agrees by saying "alright okay", and the two final turns confirm they both agree on postponing this delicate issue. The outcome of excerpt 2 is thus the opposite of excerpt 1: here the patient does not align with the midwife's first proposal, but it is rather the midwife who meets the patient's wishes and offers an alternative solution, to which the patient finally aligns.

### 3.2 Examples from mediated-interaction

In the example below, communication is interpreter-mediated. The patient has just explained that she feels very tired, so the midwife has asked whether she takes any vitamins and eats regularly. What comes out from the patient's answers is that she eats little in general, only drinks a glass of milk for breakfast and nothing else until lunch time. Line 15, the midwife makes an indirect suggestion about eating some fruit or yoghurt at mid-morning: the IM's translation into Arabic provided in the next turn is as indirect as the corresponding original question (lines 20-21), and the patient shows her disalignment through a negative response, i.e. she tries to eat as suggested, "but" she is not hungry (line 22).

### Ex. 3

15 OBSf un bicchiere di latte va bene se non riesce a mangiare dell'altro (.)  
16 [però:] eh a metà mattina:ta neanche un frutto uno yoghurt qualcosa non  
17 riesce a mangia:re?  
*a glass of milk is fine if she can't eat anything else (.) [but] at mid-morning can't she eat something not even some fruit a yogurt?*

18 IMf [mm hm]  
19 (0.5)

20 IMf taqriban m'a la 'achara hukak la hdach matqdrich takhdi (.)  
21 tafaha huk danone (.) yogurt?  
*at about ten or eleven can't you have (.) an apple a pot of yogurt (.) yogurt?*

22 PATf nhawl (.) ama ma'ndich chahiya  
*I try (.) but I'm not hungry*

23 IMf ah: non ha appetito  
*ah she is not hungry*

24 OBSf eh non riesce a mangiare senza appetito? (.) una piccola cosa?  
*eh can't she eat without being hungry? (.) a little something?*

25 PATf no:  
26 (0.9)

27 IMf hawli wakha min ghir matkunch 'andk l'appetit hawli takli haja [hm]  
*have a try even if not being hungry try to eat something [hm]*

28 PATf [chawaya  
chawaya]  
*[little  
little]*

The disalignment sequence continues line 24 with the midwife's suggestion to eat without being hungry, which is again expressed through a question, and which answers the patient's implicitly taken for granted principle that one cannot eat without being hungry. The patient here answers directly, without waiting for the translation, and the IM turns that original

question (“can’t she eat a little something without being hungry?”, line 24) into a directive (“have a try even if not being hungry”, line 27). As far as resources are concerned, here the patient talks less than in the previous two excerpts and we only find the “but” we had identified beforehand (line 22). In terms of outcomes, we might say that the patient ends up aligning with the midwife.

In excerpt 4, the Italian midwife is filling in an anamnestic questionnaire and, after checking whether the pregnant patient smokes, she goes back to nutritional issues she had already addressed about fifteen minutes earlier, when commenting on tests results showing anemia, and asking whether the patient used to eat red meat, legumes, fish and other healthy food high in iron. Line 1, the midwife makes an indirect suggestion (to adopt a variety of food) expressed through a question, the IM produces a summarized rendition in English (line 3), then the patient responds in an apparently aligned way, by repeating part of that English turn (line 4). Nevertheless, after a short pause, she produces a “but” which inaugurates her account of the reason why she has not eaten beef and more generally red meat for a long time (a few turns later it will come out that she avoids eating red meat because she is afraid of putting on too much weight).

#### Ex. 4

01 OBSf     okay (1.0) quindi tu Carolynne mi hai detto che mangi di tutto vero?  
               *okay (1.0) so you Carolynne you told me that you eat everything right?*

02            (0.6)

03 IMf        (they) eat everything?

04 PATf       I eat everything (.) but (.) I can't remember (you know) I eat beef

05 IMf        mm hm

06 PATf       for a long time

07            (0.5)

08 OBSf       [cos'ha detto?]  
               *[what did she say?]*

09 IMF [ma- (.)] mangia tutto il manzo che è da tanto che non li mangia  
 [she ea- (.)] she eats everything beef that she hasn't eaten them for a  
 long time

This excerpt presents the same linguistic resources we have identified in previous ones, but here the IM does not immediately translate the patient's account (see the 0.5 silence, line 7), so the midwife encourages her to do so ("what did she say?", line 8).

To sum up, patients may disalign with practitioners' actions and stick with their position by producing repetitions and accounts (often introduced by "but"). These linguistic resources are recurrently used by patients when they sufficiently speak and understand the language of their interlocutors. Things may however go differently, depending on at least three conditions:

- 1) patients' fluency in the language used by the practitioner;
- 2) the action initially achieved by the practitioner, not only in terms of format, but also in relation to the type of action (i.e. the fact that the patient accepts to drink or eat may be more consequential than having the test done the same day);
- 3) the IM having to build her place in between the two primary speakers, where what she says – as well as the way she says it – can affect the disalignment sequence.

#### **4. Verbal and embodied disalignment in mental care**

We will now turn to the French data in order to examine in more detail how disalignment occurs after different types of therapist's first actions. In the mental care setting explored for this study, the types of actions to which patients tend to disalign are mostly proposal or suggestions to accomplish a certain activity (*in situ* or elsewhere), whose objective is alleviating psychological pain. On the basis of the video-recorded data, we will describe how disalignment is multimodally displayed in such consultations. We will also account for the

interpreter's ways to render such disalignment, and, more generally, for how disaligned actions are treated in such context.

We will analyze two excerpts from the same interaction in which the patient disaligns with an information-gathering question (Ex. 5a) and with a suggestion made by the psychologist (Ex. 5b). The interaction is a psychotherapy session with an Albanian-speaking patient (ALB), a psychologist (PYA), an assistant psychologist (PYS), and an interpreter-mediator (IMF).

Just before excerpt 5a begins, participants were talking about a job the patient had been doing recently and the fact that he had not yet been paid for it, so he is waiting for his money. After a few seconds silence, the psychologist asks how ALB's vacations went (line 1).

#### Ex. 5a

REMILAS\_BO\_170103\_PY1\_1\_H\_AL\_IP\_00:08:20-00:09:34

```
01 PYA      okei: comment ça s'est passé là les vacances avec les enfants/
             okay: how did the vacations now go with the children/
02 IMF      si ja kalove thote pushimet me femijen (.) me femijet/
             # how did your vacations go with your child (.) your children/ #1
03 ALB      *..h fff::* push*imet: nuk kalohet mire kur s'je terezi ca pushimi (.)
04          # pushimet jane per ato qe i kane punet ne terezi
             # *..h #2 fff::*#3 the vaca*tions: don't go well when you don't feel
             good (.) what vacations (.) vacation are made for those whose business
             is alright
alb         *opens up his hands then turns his head away*
alb         *takes his tea mug from the table and holds it with
             his two hands -->
```





FIG 1



FIG 2



FIG 3

05 IMF      comment o:- on peut passer des bonnes vacances\ les vacances c'est pour  
06            les ge:ns qui sont bien\

*how one can have good vacations vacations are for those who feel good*

07 PYA      ehm

08 IMF      pas pour nous qu'on est dans cette situation

*not for us who are in this situation*

09            (4.5)

10 PYA      vous [êt-

you [ar-

11 PYS [eh: ((coughs)) vous avez vécu toute cette période avec la  
12 préoccupation (0.2) de l'expulsion du foyer (0.2) j'imagine aussi  
*eh: ((coughs)) you spent all this time with the worry of  
being kicked off the households (0.2) I guess also*

13 IMF beson thote qe gjithe kete kohe e ke kaluar me shqetesimin qe do te heqin  
14 [nga fuajeja  
*he thinks he tells me that you spent all this time with the concern of  
[the exlusion from the households*

15 ALB [((nodds))  
16 (5) ((participants look twrds the table in front of them))

17 ALB m'ka ardhur dhe kjo letra tani edhe jemi  
*I have even received this letter now and now we are*

18 (1.3 +0.5)  
pya +looks at IPA

19 IMF depuis que j'ai eu ce papier/ (0.7) (j'étais) dans un état/  
*since I got this (piece of) paper/ (I've been) in such a state/*

20 (2.2)

21 ALB e pyeta edhe ate (.) asistenten po une kam bere nje kerkese per:  
22 kontrate (2) me tha nuk ka lidhje kontrate me kete me tha  
*I've even asked to this one (.) the (social) assistant / but I requested  
a: contract (.) she told me that the contract had nothing to do with that*

23 IMF j'ai parlé avec l'assistante sociale je lui ai dit mais normalement  
24 j'ai fait une demande: pour une promesse d'embauche\ (.) elle a dit que  
25 il n'y a rien à avoir le- une promesse d'embauche  
*I spoke with the social counsellor I told her but I normally I  
asked: for a job offer\ (.) she says that it has nothing the- job offer:=*

26 PYA =avec la mesure d'expulsion ouais  
*with the expulsion order yeah*

Before IMF finishes her translation in line 2, ALB begins to manifest a first embodied reaction to what he hears, by opening and closing his hands and turning his head away (Fig. 2-3). This is accompanied by a verbal response exhibiting disalignment (line 3). It starts with a heavy sigh, and then dismisses PYA's question by saying that he does not belong to the

category of people whose vacations go well (“the vacations: don’t go well when you don’t feel good (.) what vacations (.) vacation are made for those whose business is alright”, lines 3-4). The interpreter does not render the non-lexical vocalizations at turn beginning indicating the dispreferred reply, which can be seen, in the patient’s turn, as a way to mitigate his disaligned response. After a long pause (lines 5-9), it is the assistant who intervenes (line 11). Not only does she display her social solidarity with the patient, but she also expresses her alignment with his reply. After a pause during which nobody talks, ALB takes up the issue of a letter he received (where he is informed he has to leave the household, and the country), which had just been reintroduced by the assistant (“eh: ((coughs)) you spent all this time with the worry of being kicked off the households (0.2) I guess also”, lines 11-12). As a result, the therapist’s attempt to take the patient to a different thematic path (i.e. talking about his vacations) turns out to be unsuccessful.

In the following excerpt, the patient rejects the psychologist’s proposal to engage in a therapeutic exercise aimed at calming him down. The psychologist takes advantage of a long pause in the patient’s talk for proposing such exercise. He begins his turn with *okay*, closing down the previous topic, and then utters his proposal (lines 1-3). During the psychologist’s turn, the patient puts the letter they have been talking about (cf. Ex. 5a) in his bag, on the floor in front of him. This seems to show the patient’s alignment on turning off the previous topic and an orientation towards the new activity.

#### Ex. 5b

REMILAS\_BO\_170103\_PY1\_1\_H\_AL\_IP\_00:20:24-00:21:25

01 PYA        *okay:\ .h:: (1.7) est-ce que vous voulez qu’on fasse un:: un exercice*  
 02               *comme la dernière fois on l’avait fait pour vous (.) essayer de*  
 03               *vous apaiser un petit peu (.) avant d’repartir*  
                  *okay: .h:: (1.7) would you like to do an:: an exercise like last time*  
                  *we did it to (.) in order to try to calm you down a little bit (.) before*

04 IMF a don thote qe te bejme nje ushtrim sic beme hères tjeter thote qe  
# do you want he says to do an exercise#4 like last time ♦#5 he says  
alb ♦starts lowering  
down his head

05 # te kesh mundesi me [u qetesu perpara se te ikesh  
for that [you can calm you down a bit before leaving#6

06 ALB [.HHH

07 ♦(0.9)

alb ♦starts raising his hands toward his face->

08 ALB h.. une nuk du ushtrim du t:e (.) [me japin .HHHHH

# ♦#7h.. I don't want any exercise (.) [I want .HHHH

alb ♦head in hands

09 zgjidh par- ..h:: du  
to get the solution to-



19



FIG. 6



FIG. 7

- 10 IMF [°je veux pas d'exercice°  
[°I don't want exercise°
- 11 PYA hmm
- 12 ALB kam hmm: ku di une (.) po dush e bejme ushtrimin po une  
13 kam hall si do ja bejme per kete (1) edhe s' par-  
*I hmm want I don't know (.) yes if you want we do the exercise  
but my own problem is how to do for that (1) and then I don't hav-*
- 14 IMF il me dit si vous voulez on peut faire cet exercice mais moi mon  
15 problème (0.9) c'est:/ .tsk  
*he tells me if you want to do that exercise but me my problem (1) is/  
.tsk*
- 16 (9.8)
- 17 PYA .TSK ça fait euh: ça fait maintenant un peu plus de trois ans qu'on se  
16 voit hein/  
*it's been now ehm it's been now a little bit more than three years that  
we see each other right/*
- 17 IMF kemi afersisht tre vjet [tre vjet thote

*it's been around three years three years he says*

18 PYA [et en fait ça fait trois ans que vous traversez  
 19 le même problème  
*[and in fact it's been three years that you come  
 across the same problem*

20 IMF edhe tre vjet thote qe ke te njejtin problem  
*and since three years ago he says you have the same problem*

21 PYA °hein/° et jusqu'au là vous arrivez euh (0.2) tant bien que mal à à le  
 22 surmonter/ même si on sent que: ben vous portez tout le poids sur vos  
 23 épaules là hein/  
 °right/° and so far you are able ehm (0.2) somehow to to overcome it/  
 even  
*if we can tell that: well you carry all the weight on your shoulders  
 there uhu*

Here the patient embodies his disalignment during the interpreter's rendition in lines 4-5, by first withdrawing his gaze from IMF, as she mentions doing an exercise to calm him down (lines 4-5, Fig. 4, 5, 6), and then, more dramatically, by covering his face with his hands (from line 7, Fig. 7). He next verbalizes his disalignment, both formally and substantially: he produces hearable exhalations (first in line 6, with a very audible sigh "H", then in line 8 at the beginning of his turn "h..") and then, after a rather long pause (line 7), explicitly says he does not want to do any exercise (line 8). Although he does not resort to the same verbal resources (e.g. "but") as it was the case in the first excerpts, he manifests a strong opposition by using the negative mode for expressing what he refuses ("I don't want exercise", line 7), followed by the same syntactic structure, this time in the positive mode, for expressing what he does want ("I want to get the solution for", line 7).

Again, as also observed in Ex. 5a, the patient's rejection of the therapist's proposal is followed by the recovery of a previous topic (the need to find a solution to his precarious situation). This way, the patient builds a contraposition between a serious, concrete issue – his

own problem – and what he thus displays as a mundane activity – the exercise proposed by the therapist.

As for the interpreter's rendition of the patient's disalignment, she only translates the first part of the patient's turn ("I don't want exercise", line 10) and utters her rendition in a very low voice and in overlap with the patient's turn (as in *chuchotage* interpreting). This works as an *aparté* between the psychologist and the interpreter, since the patient, looking down, head in his hands, goes on talking. In line 11, the psychologist produces a receipt token (accompanied with a small grimace). It is also worth noticing that the interpreter's rendition is partial: it concerns only the first part of the patient's turn, while omitting the contrastive structure ("I don't want... I want", line 8) and thus softening the patient's manifestation of disalignment.

In his further talk, the patient modifies his stance by conceding to do the exercise, while at the same time remaining focused on his problem: he begins his turn with the implicit statement that the exercise is the professional's will ("if you want we do the exercise", line 13), and then goes on with "but" followed by his own need ("but my own problem is how to do for that", line 11). This time, the interpreter renders the two-part structure of the turn, but does not complete the second one ("he tells me if you want to do that exercise but me my problem (1) is/ .tsk", lines 12-13). We may assume that not naming the problem again, and not referring to it as the patient did in his turn ("that", line 13), is done in order to favor the activity transition.

At this point, the three participants keep silent for quite a long time (9.8), with the psychologist and the interpreter looking at the patient, who gazes down in the same posture as in picture 7. This silence seems to indicate the psychologist's will to abandon the exercise proposal. After that, he does address again the patient's worry, not in a problem-solution perspective, but in a more distanced one, offering a positive view on the patient capacity to cope with very serious problems. Such commentary may be seen as another way for the psychologist to stop dwelling on the patient's problem, and to straighten up, both emotionally

and physically, the patient, whose posture appears in itself somehow ‘disaligned’. Indeed, even though the patient’s verbal disalignment is mitigated by his own acceptance of the therapist’s proposal in line 13 as well as by the interpreter’s rendition, it is his body posture that manifests his lack of engagement in the current line of action.

Another worth underlining aspect is that, in this setting, the patient’s disalignment does not seem to be treated as problematic, with the therapist tending to display affiliation towards the patient’s position and situation. Echoing Costello & Roberts’s findings (2001) on the differences observed in patients’ disaligned actions management by the healthcare professionals according to the setting (general medicine vs oncology), the practices observed in the excerpts above are to be connected to mental healthcare (vs general healthcare). Indeed, in psychotherapy consultations, expressing one’s will, discomfort, worries or problems is somehow expected. Similarly, expressing one’s disalignment, if not disagreement, can be received as a positive or even beneficial practice for the patients in terms of care.

## **5. Conclusion**

This study of direct and interpreter-mediated communication shows some of the different forms that patients’ disaligned follow-up turns after a practitioner’s first actions can take. By focusing on the resources used by patients to show their disalignment towards specific types of first actions (i.e. non-medication recommendations, home remedies, proposals or suggestions to accomplish certain activities), this study recognises and pays tribute to the central role played by the patient, thereby contributing to research on patients’ participation. Starting from the observation that practitioners’ actions are not unilaterally offered but negotiated with patients, this paper also problematises the presence of the interpreter, who



needs to grasp the variety of linguistic and multimodal resources used by patients in order to give voice to their disalignment, and to practitioners' responses to it.

The analysis of audio-recorded consultations in general healthcare showed how disalignment sequences are initiated through linguistic resources like questioning repeats (e.g. "water?"), sounds displaying astonishment (e.g. "hoey"), and opposition markers (e.g. "but"), which are recurrently used by patients when they sufficiently speak and understand the practitioner's language.

The analysis of the video excerpts added further insights in the description of how disalignment is displayed in interpreter-mediated interactions. We found the same verbal resources observed in the Italian data, such as repetitions and the use of opposition markers (e.g. "but"), or contrastive syntactical structures (e.g. "I don't want... I want"). Multimodal resources such as gaze and objects' manipulation were shown to also play an important role in the expression of disalignment, and to be taken into account by the practitioners. Indeed, we observed how the patient, whose posture is globally very closed and tight throughout the consultation, displays his disalignment by withdrawing his gaze from the interlocutor and looking down to the floor. On the interpreter's side, we observed that the way she utters the translation turns seems to vary according to whether the turn is aligned or somehow disaligned with respect to the activity initiated by the psychologist. As shown in Ex. 5b, the interpreter uses a form of *chuchotage* translation for the disaligned turn (in overlap and very low voice), and she seems to resort to incomplete translation, as in line 8. Considering the patient's disalignment and even modulating it, as the interpreter does in this case, seems to be a constructive practice in terms of backing of a distressed patient whose will is in contrast with that of the therapist.

To conclude, it would be useful for both practitioners and interpreters to develop a greater awareness of the wide range of semiotic resources displaying patients' disalignment with

respect to practitioners' first actions, be them the widely studied medication recommendation or the more under investigated types of social actions we focused on in the present study.

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