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

Published Version:
Natacha Niemants, J.P.B.H. (2023). The Conversation Analytic Role-play Method: how authentic data meet simulations for interpreter training. London : Routledge [10.4324/9780429298202-25].

Availability:
This version is available at: https://hdl.handle.net/11585/905398 since: 2023-07-28

Published:
DOI: http://doi.org/10.4324/9780429298202-25

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(Article begins on next page)

11 October 2026

This is the final peer-reviewed accepted manuscript of:

Niemants N., Pedersen Belisle Hansen J. & E. Stokoe (2023) “The Conversation Analytic Role-Play Method: How authentic data meet simulations for interpreter training”. In L. Gavioli e C. Wadensjö (a cura di), Routledge Handbook on Public Service Interpreting. London/New York: Routledge. 342-361.

The final published version is available online at: https://doi.org/10.4324/9780429298202

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3.7 The Conversation Analytic Role-Play Method: How authentic data meet simulations for interpreter training

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Developed by Stokoe to train professionals working in communication-rich institutions like hospitals, tribunals, and schools, the Conversation Analytic Role-Play Method (CARM) uses anonymised extracts from authentic conversations to enable trainees to learn from what actually happens in encounters. We will here argue that CARM can prove useful for the professionalization of Public Service Interpreting (PSI) and detail how it may be used to train practising interpreters, interpreting students and trainers, as well as public service providers. After raising some theoretical considerations on role-played simulations vs. actual encounters and on the importance of students' observation and participation in training activities, we will review the literature available on CARM and then present its application. Two alternative training paths will be exemplified: the first is based on audio data with setting and language specific extracts of medical consultations interpreted onsite, the second on video data from various hospital encounters with remote interpreting in various languages. We will show how CARM takes CA research findings as a basis for training as well as how recordings and transcripts can be used together in presentation software to pave the way to relevant take home messages, and finally provide the reader with some further readings and resources.

Introduction

Developed by Stokoe (2011a) to train professionals working in communication-rich institutions (for instance, healthcare, police interviews, classrooms, sales, crisis negotiation), the Conversation Analytic Role-Play Method (CARM) uses anonymised extracts from authentic conversations, recorded in situ as part of the daily work of the organization, to enable trainees to learn from what actually happens in encounters. Having seen and heard a sequence of turns whose transcript is synchronised with the audio/video recording, trainees discuss possible interactional difficulties, and suggest candidate next turns. The original next turn of the conversation is revealed, and trainees consider its likely effectiveness. Starting from Stokoe's observation that even trainees with extensive experience have problems in predicting what works, as well as articulating 'tacit knowledge of their own practices, despite the fact that "they can do it" in real situations' (2011b), the CARM method appears particularly relevant for the professionalization of Public Service Interpreting (PSI) and for training four possible targets.

First, CARM can be used to train practising PSI interpreters. While they are professionals in their own right, interpreters work across settings in which they are not members (Garfinkel 1967). For example, PSI interpreters may not have equivalent epistemic access to the work of medicine and the interactional actions that comprise it, as argued already in the seventies by Labov and Fanshel (1977). Interpreters may therefore benefit from observing the building blocks of the kinds of medical or other conversations they may interpret, so as to adapt their skills to different 'communities of practice' (Wenger 1998).

Second, CARM may be applied to the training of student-interpreters (Krystallidou 2014; Niemants and Stokoe 2017; Dal Fovo 2016; 2018), allowing them to engage with authentic contexts of a future profession they may have seldom (or never) experienced before, which may make it difficult for them to reliably simulate interactions in traditional role-play exercises. In contrast to role-plays presented by other authors (see for example Dahnberg this volume), which presume trainees already understand the interpreting process and the settings sufficiently to simulate interpreter-mediated encounters and/or are used to train and develop different interpreting skills separately without presuming a thorough understanding of the process as such, CARM uses research-derived materials to help them observe conversations in specific settings and respond to their interactional contingencies. It may therefore augment the kinds of role-plays that are traditionally used in interpreter training (see for example Pöchhacker 2004: 187; Rudvin and Tomassini 2011: 94–109), ideally with some domain-specific terminology in order to prepare them for the greater complexity of authentic interactions in institutional settings, where communication difficulties in, for example, healthcare, may be linked 'not only to language but also to socio-cultural, health literacy and even institutional issues' (Chiarenza 2020: 203) as well as to asymmetries between service users and providers (Gutierrez 2013). CARM has already been used to raise issues that are relevant to asymmetrical institutional talk (Stokoe 2013a) and may be used to observe and exercise interactional practices, such as the simultaneous rendering and coordinating of talk in social interaction (Wadensjö 1998; Baraldi and Gavioli 2012).

If one assumes that PSI is not (just) about the interpreter (Ozolins 2017) but is jointly constructed, its quality and success also depends on service providers and users. While it may be difficult to train the many users (and both sides) of the wide range of public services requiring an interpreter, using CARM to raise service providers' awareness of interpreter-mediated communication is feasible and has been done (for instance, Stokoe has trained providers and users of the same service).

Finally, CARM may be used to train the trainers (Wadensjö 2014). While guiding trainees towards the profession as idealized in codes of ethics and conduct (on ethics in PSI see Phelan et al. 2020;

Valero-Garcés this volume; Skaaden this volume), trainers can explore the tensions between formal guidance and actual practice (the latter can be more effective, see Stokoe and Sikveland 2017), and engage with trainees in responding to interactional and professional dilemmas which can occur in real life. Such dilemmas may be used to make scripted role-plays more authentic (Falbo and Dal Fovo 2019), or brought to the fore through group debates (such as those proposed by Chiarenza 2020) or through CARM and other CA-based activities (see below). But the fact remains that coping with the complexity of PSI, where turns and sequences are neither linear nor predictable, and where decisions on if/when/what to say and translate are jointly negotiated, requires that interpreters are trained 'not only on what they should do in principle' – for instance interpret accurately – 'but also on what such principle actually involves in the complexity of real-life situations' (Chiarenza 2020: 204).

Relevant epistemological/theoretical considerations

PSI training depends on descriptive findings from interpreting studies and related fields, but the question remains of how to bridge the gap between research findings and classroom activities (that is about role-played simulations vs. actual encounters), as well as of how to enable trainees to both observe and participate in institutional interactions they may interpret.

Analysing role-played simulations vs. actual encounters

According to Van Hasselt, Romano and Vecchi role-plays are 'simulations of real-world interpersonal encounters, communications or events' (2008: 251). Role-play methods involve the participants being trained or assessed to interact with actors or other simulated interlocutors, using 'narrative adaptions' of hypothetical or actual scenarios as the basis for the simulated encounter (Van Hasselt, Romano and Vecchi 2008: 254). Role-plays can be carried out in different ways in interpreter training, ranging from 'closed' role-plays where primary speakers are enacted by following a script and trainees interpret their pre-determined turns-at-talk, to more 'open' role-plays making use of cue cards and/or short role descriptions where primary speakers, possibly played by professionals from that field, enact their role according to what they believe they would say in that given situation (see Dahnberg this volume). Irrespective of the method chosen, role-play activity is complex in two ways: as Francis (1989) and Linell and Thunqvist (2003) underline, the *framing activity* involves actors (typically trainers and trainees) pretending to be different characters, and the *framed activity* involves the characters being acted (for instance, a doctor, a patient, and an interpreter). Analyses of simulated encounters have shown that trainees tend to orient more to the framing than to the framed activity

(De la Croix and Skelton 2009). Since trainees primarily design their turns for the purpose of evaluation by the trainers rather than for the purpose of communication between the primary participants (Niemants 2014), it is 'hard to support a claim that participants in role-play are oriented to the same interactional contingencies as they would be in the actual settings' (Stokoe 2011a). Even where role-plays are based on authentic data, or scripts reproduce precise words spoken by real participants, what is at stake to those participants will not be at stake to the trainers and trainees who simulate it, since 'reality does not travel with the text' (Widdowson 2003: 711) and authentic data do not necessarily entail authentic activities (see Seidlhofer 2003; Boulton and Tyne 2014). As shown in Stokoe (2013b), Niemants (2015), and Stokoe et al. (2020), a second level of inauthenticity occurs since the participants in role-plays may use different communicative strategies to the real settings, either with the aim of reproducing assessable talk or by invoking (stereotypical) category-based knowledge of roles (see Francis 1989: 59).

However, empirical studies of authentic (interpreter-mediated) interactions have undermined many of the conventional arguments about role-played interaction, showing that:

- we cannot trust common-sense intuitions since they tend to caricature what really happens (as also pointed out by Schegloff 1996: 166–169 and Speer 2005: 54);
- translations are not necessarily provided on a turn-by-turn basis as 'conversation unfolds through turn-taking, with options at each point' (Hepburn, Wilkinson and Butler 2014: 248), and interpreters may choose to negotiate their own understanding of the talk as well as that of others before attempting to translate (Wadensjö 1998; Bolden 2000; Davidson 2000; 2002; Baraldi and Gavioli 2012);
- interpreters do not only respond to primary speakers' actions but also make 'sequence-initiating actions' (Davitti and Pasquandrea 2014) − and do so at particular 'choice points' (Hepburn, Wilkinson and Butler 2014: 248);
- interpreting is not just about verbal communication but also involves non-verbal communication (Niemants, Ticca and Traverso 2021), whose importance is particularly visible when participants cannot share the same physical space and communicate through telephone (Castagnoli and Niemants 2018; Russo, González Rodríguez and Iglesias Fernández 2019) or through video interpreting platforms (Hansen 2020; Licoppe and Veyrier 2020; Licoppe this volume) that appear on the increase because of the pandemic.

Such studies have started to pay much closer attention to 'how people actually talk (and respond) when interpreting and being interpreted' (Turner and Merrison 2016: 138), thereby questioning

textual evaluations of interpreting as more or less accurate renditions of source text into target texts, and highlighting ways in which apparently imperfect practices (such as breaches of tenets of faithfulness and neutrality) can have effects on the coordination of PSI as a social interaction (Baraldi 2012: 323), be it onsite or remote. As shown by Shaw et al. (2016) and Stokoe et al. (2018), sometimes best practice, as identified by Conversation Analysis (CA) research, contradicts existing guidance for practitioners. The implication is that when people turn guidance into talk, it might not work, and that over-riding objectives and primary speakers' first moves may create unpredictable contingencies of interaction (that is, professional dilemmas or choice points) which call for situated responses.

Observing vs. participating in interpreter-mediated interactions

An increasing number of unpredictable contingences created by primary speakers can be observed in recent studies on PSI, such as doctors communicating with patients directly thereby doing without the interpreter (Anderson 2012), doctors inviting interpreter-mediators to tell and explain delicate issues to patients (Gavioli 2015), or doctors asking for interpreter-mediators' advice (Falbo and Niemants 2020). It can also be observed that patients do not always respond (immediately) to doctors' questions (Niemants 2019), which calls for interpreters' understanding of why that may be the case (for example 'trouble in speaking, hearing and/or understanding the talk', Schegloff 2007: xiv), and for their action in the next turns.

By looking at the transcripts of authentic data analysed in PSI research, trainees can explore the complexity of interpreter-mediated interaction at their own pace, or 'in slow motion', as reported by trainees addressed by Baraldi and Gavioli (2019: 222). But to better prepare trainees to react to interactional contingences of ongoing talk and silence in interaction, which call for quick and turn-by-turn decisions, it may be worth using a training method where trainees can both observe and participate in the interactions themselves. According to Gavioli and Aston, 'while the participant interacts with the text as an intended recipient, the observer views this interaction from the outside, adopting a critical analytical perspective. Observer as well as participant roles can allow learning: observation allows strategies of interaction to be noticed, while participation allows such strategies to be tested' (2001: 241). As we will see in the following section, the CARM method enables learners to *observe* authentic interactions as they unfold as well as to *participate* by responding to participants' ongoing talk, thereby providing two ways of preparing to the complexity of PSI in different settings and language combinations.

We illustrate the technique developed by Stokoe via authentic (interpreter-mediated) healthcare audio data in an Italian hospital and video data of interpreting in Norwegian hospital encounters, with the aim to train both (practising and would be) interpreters and healthcare professionals. However, CARM can readily be adapted to fit other languages, domains, and target audiences, provided that the trainer bases their workshops on conversation analytic research.

Literature overview

Over the last decade, CARM has been used to address some of the shortcomings of closed and open role-plays in different training settings and for different talk-based institutions (Stokoe 2014). CARM prompts workshop participants to analyse naturally occurring talk 'in the wild' (Stokoe 2020: 333) and to investigate why a specific action is accomplished at a particular moment (*why that now?* being the quintessential CA question), then encourages discussion of possible next turns. Although CARM almost always matches the data setting to the participants (mediators see mediation, police see investigative interviews, salespeople see sales calls, and so forth), workshops also include practices from other settings. For example, mediators encounter crisis negotiation and crisis negotiators encounter sales calls, partly to show how the workshop will run via clips from another setting, and also because many (in)effective practices are shared across settings. In Church and Bateman (2019) for instance, trainers are confronted with classroom recordings, and the 'forensic reflection on practice' CARM stimulates can be valuable in informing trainers, that is early childhood teachers, and show that rather than rely on hypothetical scenarios or role-plays, workshop participants can discuss what actually happens in classrooms and how teachers respond to children, thereby stimulating reflection on strategies for intervening in disputes (which are a productive site for learning). So CARM provides them with an opportunity to gradually observe what is happening immediately prior to a teacher intervention, to hypothesize about its likely trajectory, and assess whether the teacher did manage to effectively intervene in the dispute. Halfway between those who advise that children should resolve conflicts themselves and those who encourage direct intervention by teachers, CARM here shows how practices are contingent to prior actions and how teachers can locally respond to the children's needs and concerns on a turn-by-turn basis, rather than aprioristically adopt one position or the other. Quoting Pomerantz and Fehr (1997: 184), the authors argue that this method 'involves moving away from discussing what particular people did on the occasion, to considering what people need to know and do in order to appropriately perform the action in any new situation they encounter'.

The reach of CA, and thus of CARM (Stokoe 2020), is expanded by its openness to work across disciplines and languages and makes of it a perfect candidate to deal with interpreter-mediated interactions in different institutional settings, where just like in any other setting, every word matters.

While CA based activities have been used for about twenty years in interpreter training (for instance by Merlini 2007; Zorzi 2008; Bührig et al. 2012; Davitti and Pasquandrea 2014; Baraldi and Gavioli 2020), to the best of our knowledge the first attempt to use CARM in PSI interpreting dates back to 2011, when, within the framework of her PhD project, Niemants was comparing role-played vs. actual interpreter-mediated encounters in healthcare and had identified CARM as a viable solution to avoid the two layers of inauthenticity she has found in her corpus (see above). Since then, other trainers have used CARM, or variants thereof, in interpreting classes at graduate level (Dal Fovo 2018), in sessions for postgraduate students (Krystallidou 2014; Dal Fovo 2016), as well as in sessions for interpreters' trainers (Wadensjö 2014), and CARM is an entry of the *Dictionary of Education and Assessment in Translation and Interpreting Studies* (Dastyar 2019).

Critical issues and topics

CARM takes CA research findings as a basis for training, so extracts and recordings represent a first critical issue for its use. Trainers who want to test this method need to know how to deal with primary and secondary data together in presentation software, since the transcripts and the associated audio or video recordings are exported into some sort of PowerPoint presentation, and then animated such that the transcribed turns at talk appear synchronously.

As with any work involving use of recordings, training data must conform to the ethical consent permissions with which they were collected. In particular, one must be aware that even with voice pitching and blurred video clips, participants, especially interpreters, may be identifiable based on for instance regional dialects. In general, it is important to encourage trainees to consider respectful treatment of participants whose actions we are discussing before the data are presented, as suggested by Parry et al. (2016: 1281) in their recommendations for good practice in video recording and especially in dissemination, reporting and use of the research findings.

Two CARM workshops

Key to CARM is to identify findings from research 'that are not just of interest to academics but also useful for practitioners' (Stokoe 2020: 338), and then deciding how best to guide trainees through the

complexity of actual encounters by selecting likely discussion points and *trainables*. By trainable we mean an observed conversational practice that can be introduced in an individual slide (see Figure 1 and Figure 7 below), then turned into a take-home message and possibly guidance for effective communication.

In the following subsections, we will propose two alternative training paths, one based on audio data with setting and language specific examples and the other based on video data from various hospital encounters with interpreting in various languages. The practice detailed in both sections, questioning in medicine, has been much studied by conversation analysts (Heritage and Maynard 2006; Heritage 2010). What we aim to show, however, is that this practice is equally interesting for healthcare practitioners and interpreters alike as a methodology for reflective observation and participation in interpreter-mediated interactions they will be jointly constructing. As we will see, CA – and thus CARM training – focuses attention on the interplay between interpreters' actions and those of the primary participants, and on the responsibility they all share to achieve effective communication.

Setting specific training path on onsite interpreting

A first example may serve to get trainees to know the machinery of conversations in a specific medical setting where doctors and patients communicate directly, like a men's health ('andrological') service that has recently been the object of CA research (Niemants 2019; 2021a) and that here involves an Italian physician (ANDm) visiting three male patients (PATm) and asking the same routine question about age.

The first patient is Italian. The slide below may be used to introduce trainees to questioning in consultations about infertility problems, which in the corpus[i] always start with a general question about the couple (any children?) and the partner (any gynaecological problems?), and only then move on to talking about the patient (generally through doctor's prefaces like 'talking about the male part' and the like).

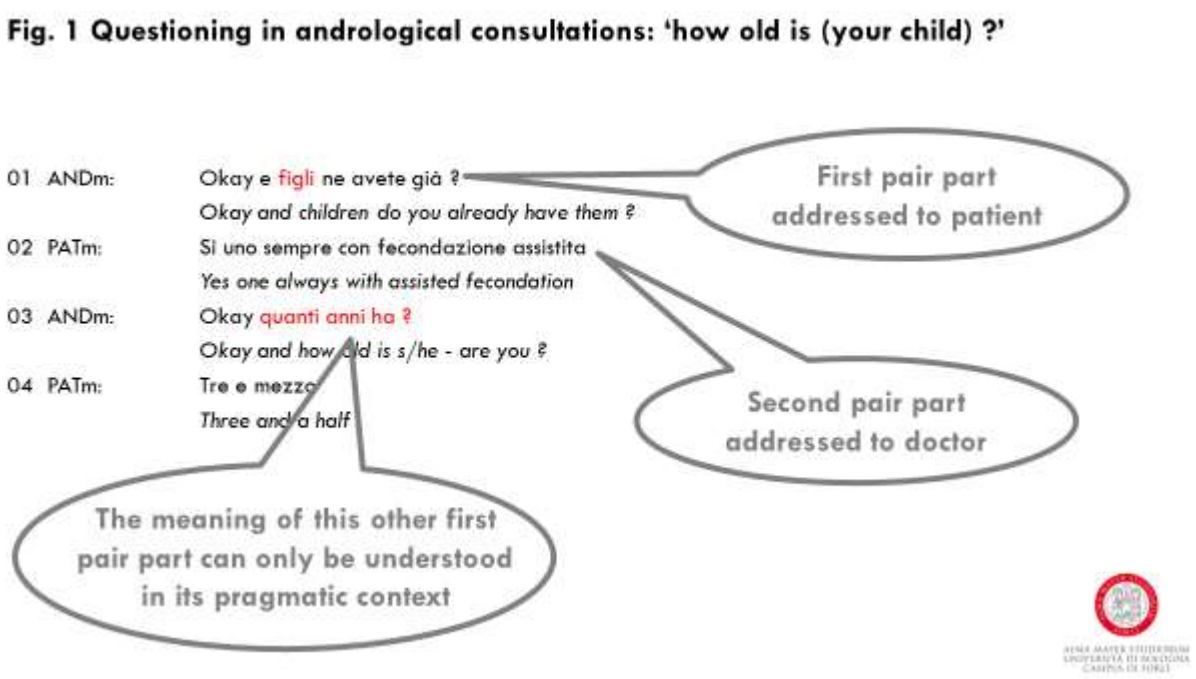

Fig. 1 Slide introducing questioning in men's health consultations with Italian patients

Starting from such a simple introductory excerpt can enable, on the one hand trainers to get acquainted with CARM style and use animations so as to synchronize transcripts with anonymized audios (each line shall appear when it is uttered), and on the other trainees (be them practising and/or would be interpreters or doctors) to progressively enter into the wild of andrological conversations, where the meaning of a simple turn at talk, here *quanti anni ha?* (which can be a formal version of 'how old are you' and/or a question referring to a third person 'how old is s/he/it?'), depends on the pragmatic context in which it is uttered. Here the question is understood (by PATm) as 'how old is s/he?', referring to the child mentioned at turns 1 and 2, but the very same question may also refer to somebody else.

The second patient is a foreign migrant who speaks Italian well enough to communicate with the physician directly. The trainer may start by playing the excerpt in Figure 2, so as to make trainees hear and read what happens before the physician utters the same *quanti anni ha?* question as before.

Fig. 2 Questioning in andrological consultations: 'how old is (your partner) ?' (a)

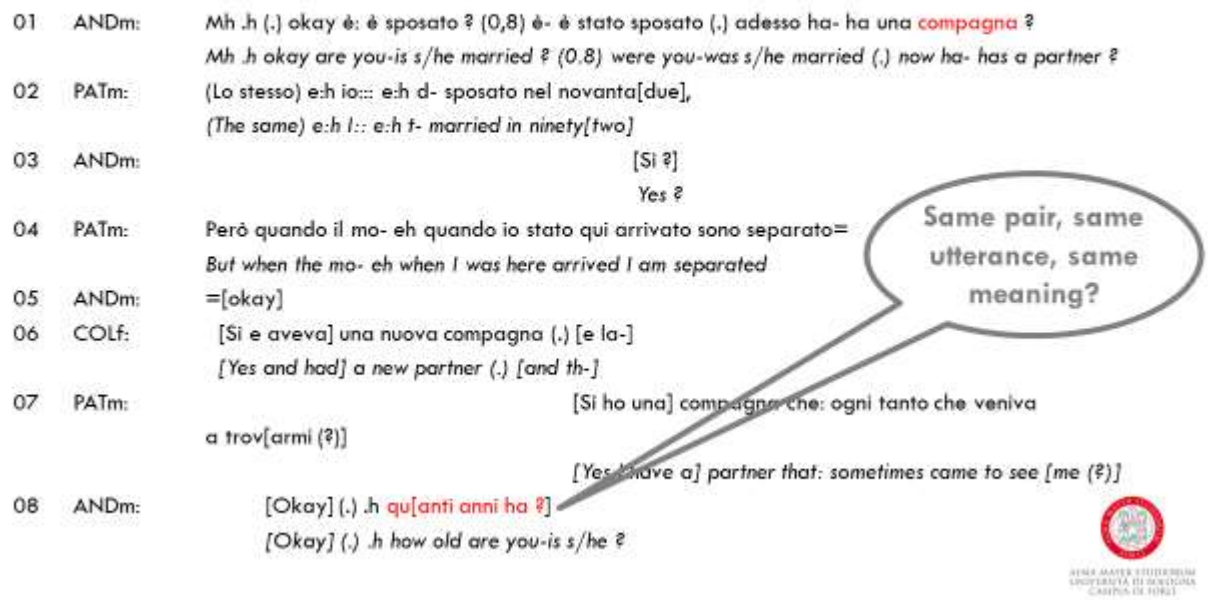

Fig. 2 Example of questioning in men's health consultations with foreign patients (a)

With the help of trainer's comments, trainees can be invited to discuss lines 1 to 8 and raise awareness on the fact that the meaning of the same utterance changes according to the pragmatic context: here it follows a question about the patient's partner (*compagna*, line 1) and is thus referring to her. Trainees are then supposed to produce next turns (interpreters are likely to produce different types of renditions and possibly some requests for clarifications, while doctors will probably produce candidate answers by the patient) and the trainer finally shows what follows.

Fig. 3 Questioning in andrological consultations: 'how old is (your partner) ?' (b)

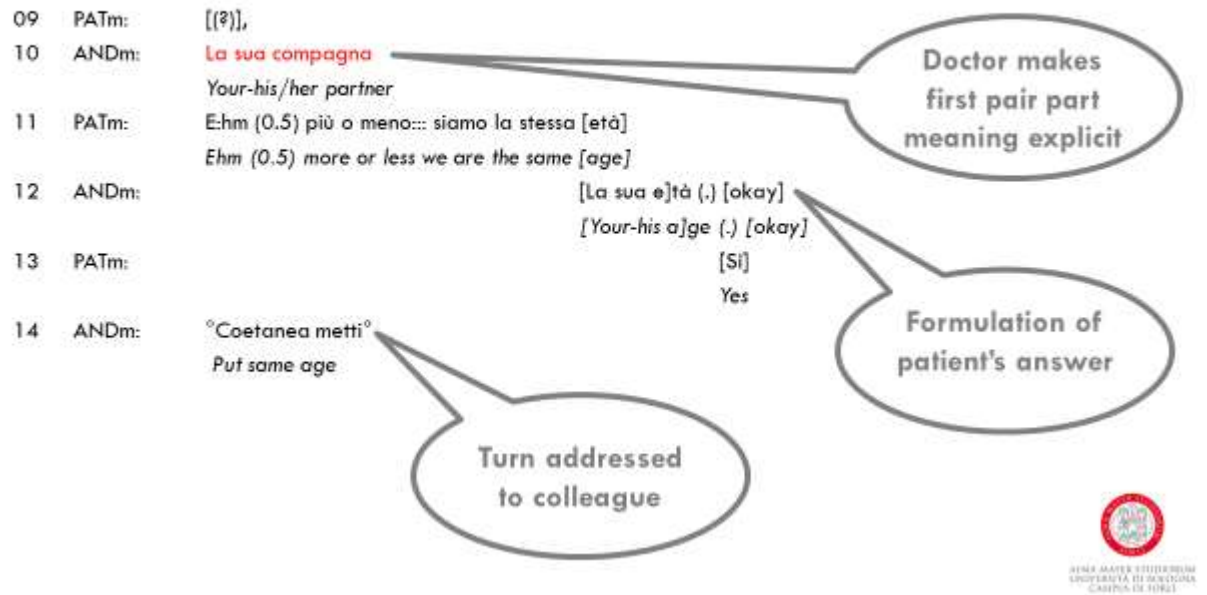

Fig. 3 Example of questioning in men's health consultations with foreign patients (b)

In this second part of the excerpt, participants show that meaning may need clarification even when patients and doctors communicate directly, because it is not in the utterance itself (in this case *quanti anni ha?*) but is the result of a joint construction between speaker and listener who, by reacting, show what they are making of previous turns. As such, this non-mediated interaction may be fruitfully used both with (practising and would be) interpreters and with doctors, to raise their awareness of the machinery and sequential structure of conversation beginnings in this specific medical context. Trainers may possibly comment on the fact that in line 10 ANDm shows he is aware of a possible misunderstanding, then in 12 he shows his own understanding and in 14 he utters something in a low volume, thereby showing he addresses his colleague who is writing down the medical report and transcribing what is jointly negotiated in this excerpt, that is that the patient and his partner are about the same age.

In the CARM workshop focussing on a men's health context, trainers may venture as far as showing what may happen if and when the patient's partner is not only talked about but present in the consultation, which often happens in the case of infertility problems, where partners can react to questions like *quanti anni ha?* and take some interactional space. Once trainees have entered infertility consultations, and realised that initial questions may not be addressed to the patient but to relatives, trainers may move on to an interpreter-mediated consultation where the same *quanti anni ha?* question appears. This final example aims to raise trainees' awareness of how/when interpreters talk in such consultations, demonstrating how the interpreters' participation is locally negotiated in collaboration. From the trainers' viewpoint, there are no added constraints for the use of CARM with interpreter-mediated data, which still make use of anonymized audios and synchronized transcripts. While from the trainees' viewpoint, be they practising or future interpreters and/or doctors, the two Figures below show that mediated interactions are not just the sum of original turns plus their (immediate) renditions into the other language, but a different and co-constructed object, where all participants – and especially doctors and interpreters – contribute on a turn by turn basis.

Fig. 4 Questioning in interpreter-mediated andrological consultations (a)

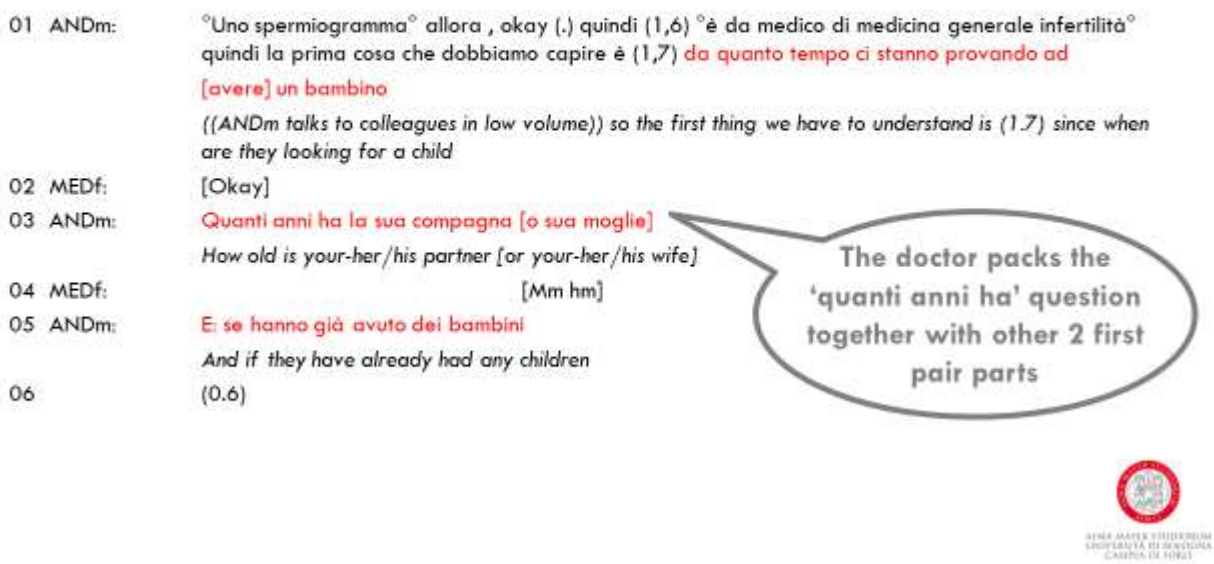

Fig. 4 Example of questioning in interpreter-mediated men's health consultations (a)

In the excerpt above, there is no need for the pragmatic context to disambiguate the *quanti anni ha?* question, since the physician makes the referent explicit in his turn 3. However, the trainer may want to comment on the fact that the doctor does not only produce the routine question about age, as he did when interacting with the patients directly, but he packs it with two other questions (one about how long the couple has been looking for a child and the other about their having other children already). By blocking the transcript synchronised with the audio after the 0.6 silence at line 6, trainers may additionally invite trainees to reflect on its meaning, before asking them to produce candidate next turns and playing what really happened in this authentic consultation, where the English-speaking woman called to interpret shows visible/audible troubles in rendering the series of questions.

Fig. 5 Questioning in interpreter-mediated andrological consultations (b)

Fig. 5 Example of questioning in interpreter-mediated men's health consultations (b)

If used with experienced and in-training interpreters, these last two excerpts can show that PSI is not just about the interpreter, since here it is the doctor himself who changes the way in which he asks the same routine question (as a standalone vs. in a series of questions). This practice is not necessarily functional in interpreter-mediated interactions, where the latency increases after long turns and series of questions, which both seem to project dyadic sequences in the foreign language where the Italian speaking doctor is temporarily excluded. Interpreters may thus be called to reflect on the need to intervene in medical consultations where doctors' first moves may determine non-functional conversational mechanisms, to create some space for their translating and coordinating activities, and to ensure more effective communication.

If used with doctors, the very same excerpt can lead them to conclude that asking questions one at a time, and making their referent explicit, may possibly be more functional in interpreter-mediated interactions, where interpreters need to easily understand and then render jointly constructed meaning. Trainers may show doctors alternative examples of explicit standalone questions present in the corpus (like *la sua compagna quanti anni ha?*, *quanti anni ha sua moglie?*, where the partner and the wife are explicitly referred to) and, in case video recordings were present, let them examine the gazes and gestures that accompany and/or substitute turns at talk or parts thereof, thereby further raising their awareness of non-verbal communication.

Training path on interpreting through video technology

Based on question-answer sequences in hospital encounters where medical professionals and patients do not share a language and interpreting is provided through video technology, this second training path demonstrates how the participants collaboratively organize the activity of interpreting. Furthermore, it shows how the complex interactional space is of import for the participants' interpretation of ongoing activities and relevant next actions. This training path is based on video recordings of video-interpreted hospital encounters,[ii] with the interpreter placed at a different location than the other participants. The first extract, 'do you have any questions Paulina?', serves to provide an example of a (relatively) simple question-answer sequence.

Fig. 6 Interpreting questions: 'do you have any questions Paulina?'

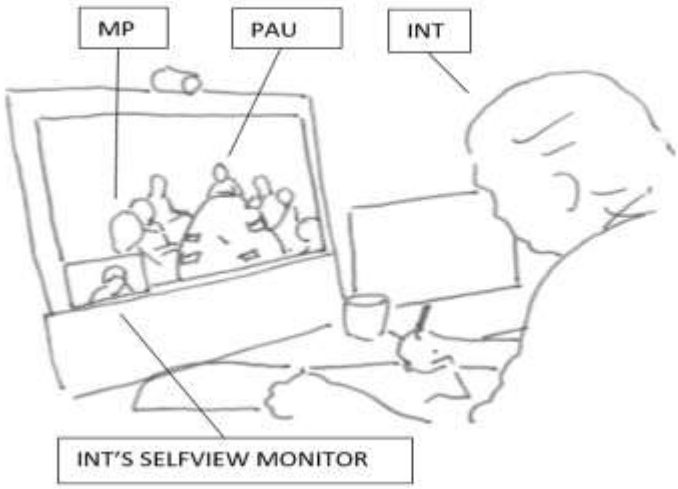

Fig. 6 First slide in training path, image for introduction to the setting

Presenting the situation with an image before playing the video clip (Figure 6), allows the trainer to provide some information about the setting and to guide the trainees' focus of attention. The image shows what the interaction looks like from the interpreter's point of view, where video technology provides the interpreter with visual and auditory access to their co-participants at the hospital ward. While the interactional setting at the ward may seem quite complex with many participants present, the current interaction is mainly between two participants, the Norwegian-speaking medical professional (MP) and the Polish-speaking patient Paulina (PAU), who do not treat the interaction as particularly complex. After an introduction describing the setting and providing a brief outline of what will happen in the extract, the trainer can play the video clip as recorded from the interpreter's point of view (that in Figure 6 above).

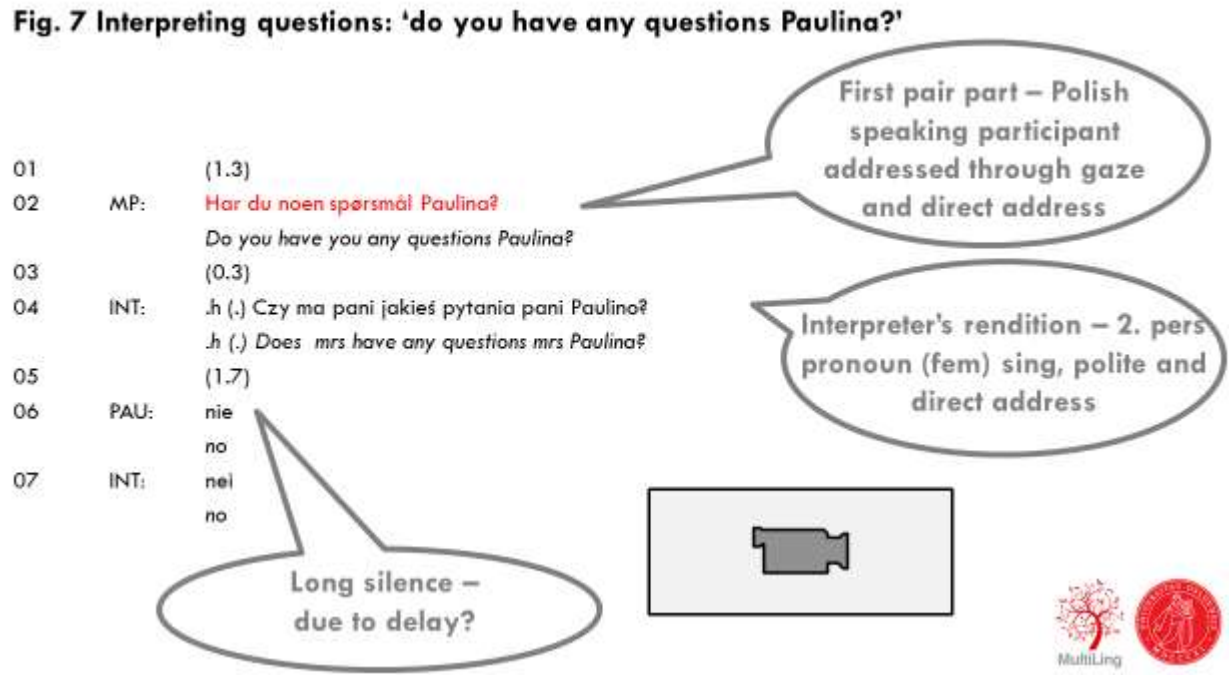

Fig. 7 Second slide in training path, presenting the extract

While this extract is chosen as a (relatively) simple introduction to the interpreter-mediated question-answer sequence, the extract includes a range of possible discussion points. The extract demonstrates how the medical professional poses a question directed to Paulina through physical orientation, gaze and by naming her, and as such explicitly allocates her as the next speaker. Since Paulina and the medical professional do not speak the same language, interpreting is treated as relevant by all participants, and the interpreter produces the next turn. Although the interpreter does not have available all the same resources for directing the utterance to Paulina (interpreter's gaze and bodily orientation from a remote location will not have the same referential meaning for the participants at the ward), the medical professional's use of name makes it possible for the interpreter to direct the utterance in Polish, which in turn makes relevant a response by Paulina. If it was not already clear to all participants who was addressed by the question based on prior speech and local context, the question's design makes it clear to all participants who is addressed. From a conversation analytic point of view, the long silence following the interpreter's rendition (line 4) could indicate trouble responding to the question. However, time lag may occur in video-mediated interaction changing temporality of the interaction (Rusk and Pörn 2019). So, while the extract is seemingly simple and only displays an interpreted extract of a question-answer sequence, it is still rich in discussion points.

The next extract shows a similar learning point, however the example is more complex.

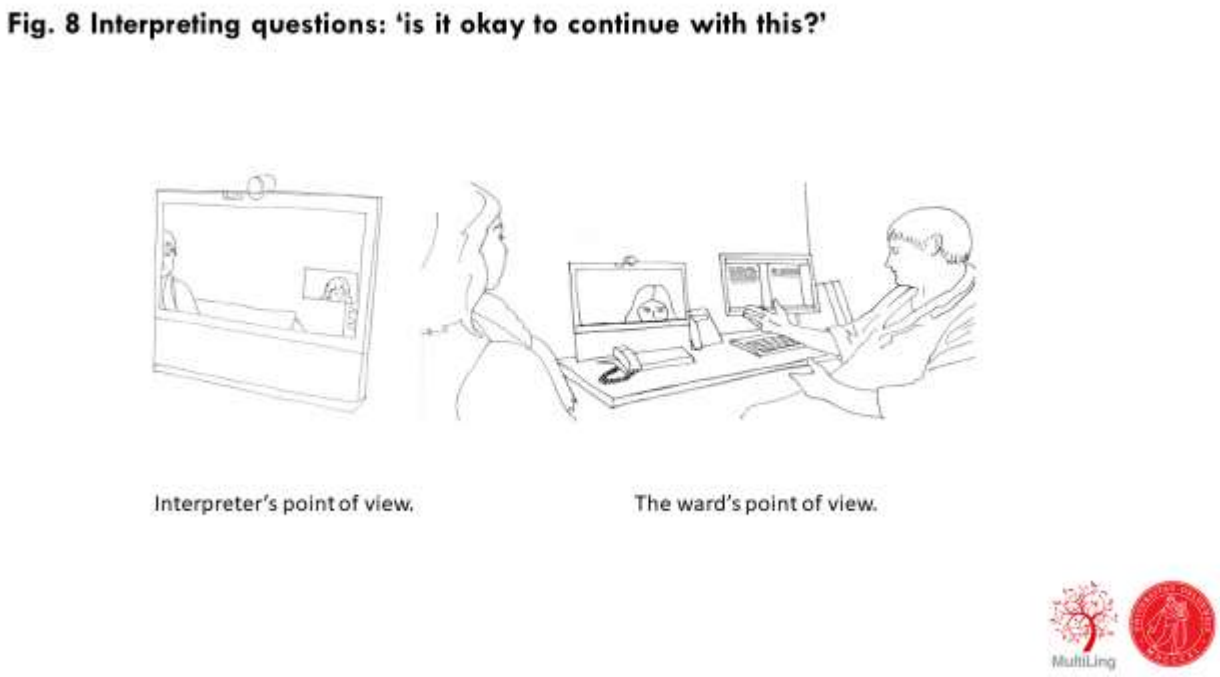

Fig. 8 Slide with images from both sites in the interaction

The slide illustrated in Figure 8 contains images from both sites in the interaction, both the interpreter's point of view (to the left) and the ward's point of view (to the right). The interpreter has only partial visual access to the doctor and cannot see the patient as the patient is seated beyond the scope of the camera. After introducing the seating arrangements and visual affordances to the trainees, trainers may play the first part of the excerpt, where the doctor and patient have begun to speak directly in Norwegian. For this example, we suggest showing the video as recorded from the interpreter's point of view first (that in the left-hand side of Figure 8 above).

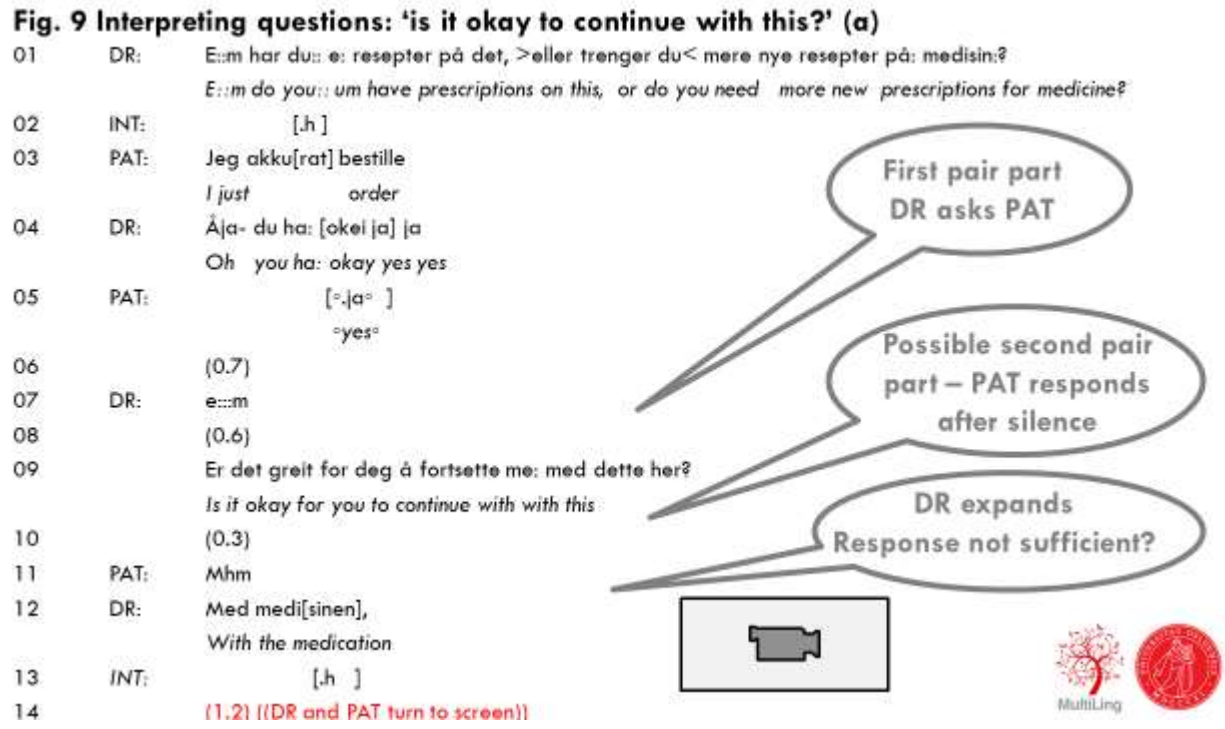

Fig. 9 Slide showing second example in the training path up until focus point

The doctor asks questions and the patient responds without leaving space for interpreting (line 1). The interpreter produces an audible in-breath (line 2), which due to time lag is only audible in the ward during the patient's response (line 3). The doctor treats the patient's response as adequate and moves on to a next question (line 9). After the patient's minimal response (line 11), the doctor expands his question, specifying 'with the medication' (line 12). Again, the interpreter produces an audible in-breath that is only audible in the ward during the doctor's utterance. After the doctor's utterance follows a long silence. This would be a place to stop the video and invite trainees to discuss what the next move would be and why.

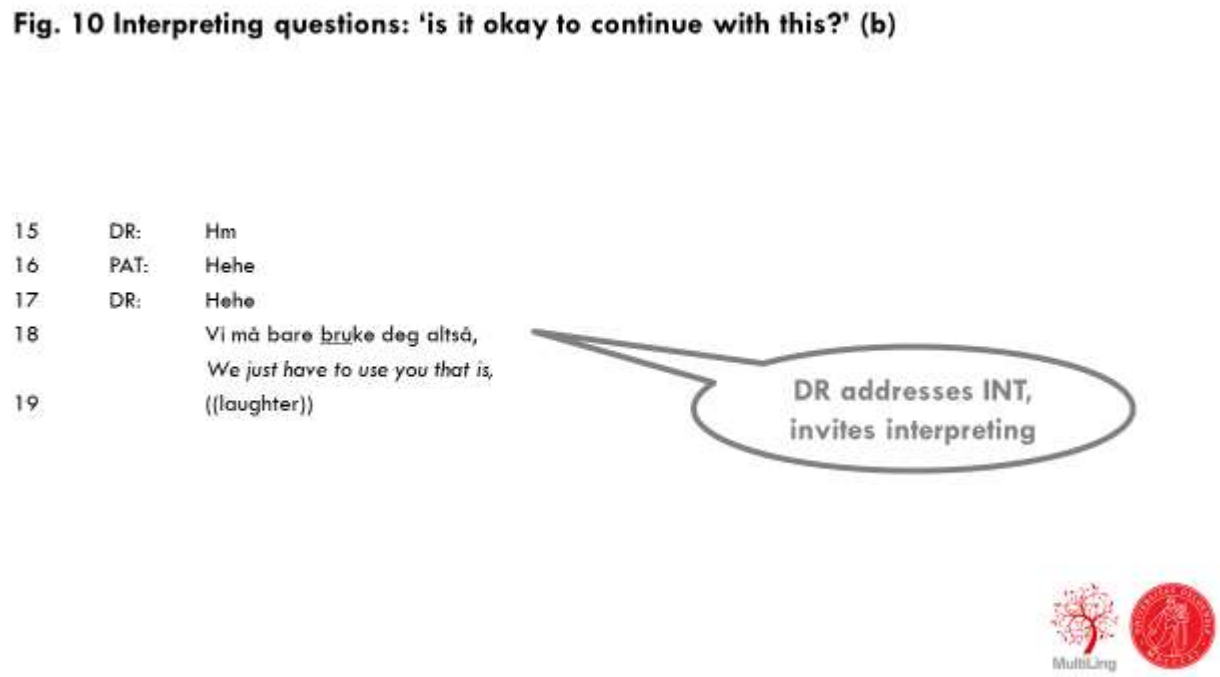

Fig. 10 Slide showing what happens after focus point

What happens next is that the doctor verbally invites the interpreter to interpret (see Hansen 2020 for an in-depth analysis). The example demonstrates how the relevance of interpreting, and thus the interactional trajectory, is locally negotiated by all participants. This last example confirms, although from a different perspective, that translation is jointly negotiated: while in Figure 4 and Figure 5 it was the doctor's first move that affected the interpreter's rendition, here it is the patient responding directly that makes interpreting a matter of negotiation (and again far from the ideal pattern where interpreters closely translate after every single turn at talk).

Showing the same sequence with the video from the ward's point of view will demonstrate to the trainees how participants in interaction may rely on embodied resources in interaction, which are not available to participants at other sites. This training trajectory has demonstrated how both the interactional space afforded by the visual ecology, an interactional space participants-in-interaction create and shape by using the technology, and primary participants' actions may affect interpreters' understanding and actions. This training path, with escalating complexity, enables to observe embodied conduct and how interaction and as such interpreting is organized as a complex set of actions, both verbal and embodied. In their understanding of what is a) the meaning of a primary participants' utterance and b) what is a relevant next action to this, interpreters do not only draw on the verbal conduct, but also on the complex multimodal utterances situated within a specific setting (Hansen 2020).

Trainables, trainees and some further ideas for CARM workshops

Language professionals may need to interpret, both in the sense of understanding and giving meaning to what is said – or unsaid – in the interaction, and in the sense of translating that meaning for the other participants (Seleskovitch and Lederer 2001), so that it can be added to a conversational 'common ground' (Clark and Brennan 1991). Such ground is more complex to build when two languages and 'territories of knowledge' are involved (Heritage 2011, but see also Mason 2006; Raymond 2014) and when interpreting is provided remotely, thus leaving participants with different levels of access to the interaction (Hansen 2020).

Depending on the chosen path, on the type of training in which CARM is used (setting-specific or not?; language-specific or not?; onsite or remote interpreting?), on the target trainees (practising or would be interpreters?; doctors?; trainers?), and on the time available for the workshops (2-hour classes?; half a day?; more?), trainers may vary the number of trainables to be presented. In the case of the training paths we presented above, the final slide may for instance look as follows:

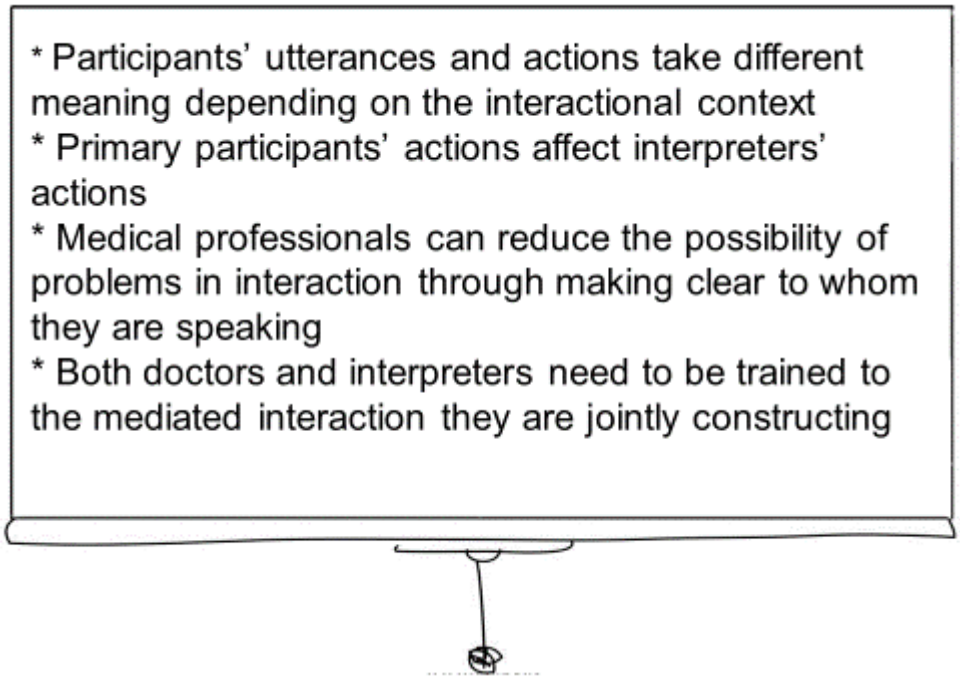

Fig. 11 A sample slide with take-homes

Our suggestion is to include between one and five take home messages that are directly related to the excerpts and conversational practices presented.

For the sake of convenience, the above training paths have been exemplified using authentic (interpreter-mediated) healthcare data and focussing on just one building block of medical encounters (the question-answer pair). However, CARM may readily be adapted to fit any language and PSI

domain (police interviews, asylum interviews, school settings, political interviews, and so forth), provided that the trainer has a) a collection of audio-and/or video-recorded interactions available or can use data collected and analysed by other researchers, and b) a thorough understanding of CA enabling the identification of the same, or other, conversational patterns. A first related topic to this chapter is therefore the problem of data availability. While both text and multimodal corpora are increasingly available through archives, still not much data is available in the area of interpreter-mediated interaction and trainers may find it difficult to obtain the necessary data. When data are available and transcribed, trainers may need support for analysing and presenting them. They may thus benefit from attending a CARM workshop (https://www.carmtraining.org) as well as from reading CA studies applied to interpreting in different institutional settings, possibly becoming a CARM affiliate (https://www.carmtraining.org/affiliate).

A CARM workshop may be carried out with smaller groups of 15–35 participants, which is perhaps more common, to larger groups of as many as 100–150. The workshop may be carried out as a short session of a couple of hours, a series of sessions of a range of time, or longer workshops lasting for a day or two. The CARM trainer chooses a number of 'trainables' and a number of examples to demonstrate the trainable depending on the duration of the session and the purpose of the workshop. The latter can be carried out as a live session with all participants physically co-present at one location, it can take place remotely using video-technologies or it may involve both on-site and remote participants in synchronous blended mode. Irrespective of the mode and of the number of trainables and trainees, each example is framed and introduced for the participants. The extract is played for them using audio or video recordings and synchronized transcripts. The script is stopped at a specific point in the interaction and the participants are invited to discuss what the next move should be. This is then generally discussed in smaller groups of 3–6 participants. The trainer then shows the participants what was the next move in this specific setting. The groups proceed to discuss what the practitioner/s did in the extract. The trainer moves on to a next example, scaffolding the participants to identify effective (and less effective) practice from the evidence laid out to them. Many different topics may be brought up during the workshops depending on the chosen trainables, on the extracts presented, and on the discussions brought up by workshop participants (professional ethics, professional practice or interactional practices, to mention just a few). As exemplified in what follows, the workshops may also possibly prepare the ground for some role-playing, where the trainees can act out the conversations they have observed and participated in.

Although CARM has so far mainly been used in language specific interpreting courses involving single language pairs such as those in the experiences dealt with in this chapter, we would argue that it may also be suitable in general interpreter training. One general course of this type was

experimented in a master interpreting program held at the University of Bologna/Forlì in the academic years 2020/21 and 2021/22. This 30-hour module presented 32 Italian-speaking students having five different language combinations (Italian<>English/French/German/Russian/Spanish) with authentic data recorded in a range of languages and specialised settings. The aim was to foster discussion on relevant theory starting from the practice of interpreters and mediators in, for example, healthcare, asylum-seeking interviews, business meetings, and TV talk-shows (see Niemants 2021b for further details). While dialogue interpreting classes in Forlì are traditionally taught in co-presence by two university trainers at the same time, one for each language, CARM could here make 'a language-specific cohort dependent on one teacher' (Hale and Ozolins 2014: 7), thereby preparing the theoretical ground of all first year students (the module was in blended synchronous mode with most of the students in the classroom and some at home following and interacting via Microsoft Teams) before they started their additional 20-hour traditional role-play exercises per language pair. We would thus venture as far as stating that such a language-independent use of CARM also proved suitable to respond to cost-cutting pressures, which over the last years have affected a number of courses not only at Bologna/Forlì, as well as to address remote teaching/learning needs, such as those required during current pandemics.

Further reading

Baraldi, Claudio, and Laura Gavioli (eds) (2021) *When clinicians and patients do not speak the same language - Interpreting in health care*, special issue of *Health Communication* 36 (9).

The seven papers published in this special issue of Health Communication inquire what happens when a bilingual interpreter and/or mediator participates in talk between health care professionals and patients who speak different languages, thereby providing a good basis to identify some possible trainables in view of a setting-specific CARM workshop.

Hansen, Jessica, and Jan Svennevig (2021) "Creating space for interpreting within extended turns at talk", *Journal of Pragmatics* 182: 144-162.

This article explores multimodal practices employed by medical professionals and interpreters to collaboratively manage the temporary suspension of medical professionals' longer turns in progress, which allows interpreters to begin interpreting. It also addresses how video-technology provides a complex interactional space challenging the fine-tuned moment-by-moment negotiation of turns.

Niemants, Natacha, and Anne Delizée (eds) (2021) *The Interpreters' Newsletter* 26.

This thematic issue of The Interpreters' Newsletter focuses on dialogue interpreting methodology and the eleven contributions it contains are based on authentic data in different communicative contexts, thereby proving useful to identify trainables across languages-cultures and settings, as well as to raise awareness of the wide range of possible analytical lenses.

Stokoe, Elizabeth (2018) *Talk. The Science of Conversation*. London, Little Brown Book Group.

The book describes key domains of conversation analytic research and challenges much of what we think we know about talk, including many communication myths. It was written as a result of the public engagement generated by CARM workshops so that the multiple non-academic stakeholders of CA research, and anyone who is new to this method and approach, could learn about it.

Related topics

General issues of PSI: institutions, codes and norms, professional quality by Carmen Valero-Garcés

Corpus-based studies of PSI by Bernd Meyer

PSI in healthcare by Laura Gavioli and Raffaela Merlini

The professionalization of public service interpreting. Codes of conduct: aid or obstacle? by Hanne Skaaden

Roleplay as a means of training and of testing PSI by Magnus Dahnberg

Public service interpreting; training how to work with interpreters by Tatjana Radanovic Felberg

Training interpreting students to analyse interaction by Elena Davitti

Training student-providers and interpreting students together by Demi Krystallidou

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[i] The data consist of three sub-corpora of men’s health consultations: the first with Italian patients, the second with foreign patients speaking Italian, and the third with foreign patients communicating through an interpreter-mediator. The data were collected as part of an interdisciplinary project financed by the University of Modena and Reggio Emilia and gathering andrologists, sociologists and linguists (FAR 2017, Claudio Baraldi, PI, together with Federico Corradini and Laura Gavioli as linguists, as well as with Antonio Granata, Michela Locaso, Vincenzo Rochira, Daniele Santi, and Giorgia Spaggiari as andrologists).

[ii] This work was partly supported by the Research Council of Norway through its Centres of Excellence funding scheme, project number 223265.