

## **Affiliation in interpreter-mediated therapeutic talk: on the relationship between gaze and head nods**

### **Abstract**

The aim of this article is to explore how affiliation (Stivers 2008) with the patient is displayed and interactionally achieved in the context of an interpreter-mediated therapeutic dialogue. More specifically, we focus on the interplay between affiliative listener responses – especially head nods – and gaze in this setting. Interpreter-mediated therapeutic talk is not only a setting that has received very little systematic scrutiny in the literature, but it is also particularly interesting for the study of listener responses. Drawing on the insights from Conversation Analysis, a naturally occurring interpreter-mediated therapeutic session was analyzed that had been recorded using mobile eye tracking technology. This approach allowed for a detailed analysis of the interlocutors' synchronous gaze behavior in relation to speech and head nods during the interaction. The results reveal differences in the interpreter's and the therapist's affiliative listener responses that are linked to the interactional goals of the encounter and to their social roles. Moreover, we find a strong relationship between mutual gaze and head nods as tokens of affiliation. Thus, these findings provide further argument for the importance of including gaze in the study of interpreter-mediated dialogue and, more broadly, in the study of affiliation in social interaction.

Key words: affiliation – mental healthcare interpreting – listener responses – eye-tracking – gaze - head nods

### **1. Introduction**

Psychotherapy can be defined as a 'talking cure' that takes place within a privileged relationship between therapist and patient (Bot 2005: 5). During the encounter, the therapist is oriented towards the patient in a non-intrusive way in order to provide space for a patient to open out with her telling (Gardner 2001: 34). As previous research has shown, therapists employ verbal listener responses (such as *mm hm, yeah, right*) and nonverbal resources (such as head nods) to affiliate and align with the telling of their patients (Gerhardt & Beyerle 1997; Muntigl et al. 2012; Muntigl & Horvath 2014).

In interpreter-mediated therapeutic encounters, however, the contiguity between the patient's utterance and the therapist's response is disturbed (Englund Dimitrova 1997) and the communicative contact is established with the aid of a mediating third party. Although professional interpreters in mental healthcare are expected to adopt a neutral and objective role, previous studies have shown that the interpreter in face-to-face contexts does not only act as a mere conveyor of the patient's and the therapist's words, but also influences the therapeutic experience. In essence, an interpreter-mediated therapeutic dialogue is a joint action between the therapist, patient and the interpreter (Bot 2005; Wadensjö 2001).

Apart from the studies by Wadensjö (2001) and Bot (2005), very little research has been done on interpreter-mediated therapeutic encounters from a multimodal perspective, that takes both verbal and visual semiotic resources into account. This is partly due to the sensitive nature of psychotherapy, which makes it an extremely difficult task to get permission to video record the sessions. Wadensjö (2001) has shown that the interpreter's placement in relation to the primary parties in the therapeutic interaction (what she refers to as 'the communicative radius') is of great importance for the coordination of the interaction and the advancement of the interpersonal relationship between the primary parties. From an analysis of six interpreter-mediated therapeutic sessions, Bot (2005) concluded that the level of the interpreter's involvement can be projected on a continuum, varying from the interpreter as non-person to the interpreter as equal to both parties. Her analysis also offers new insights into the role of gaze in the display of engagement and in the dynamics of turn-management during the interaction. Yet, systematic research remains to be done on how interpreters in therapeutic context *respond* to a patient's telling. As noted by Stivers et al., "[i]n how recipients respond to actions, they also position themselves relationally vis-à-vis speakers" (2011: 20).

Drawing on the insights from Conversation Analysis (Gardner 2001; Peräkylä 2013; Stivers 2008), this paper provides a fine-grained analysis of how affiliation (as defined by Stivers 2008, see section 2) is displayed and interactively achieved in one therapeutic session by focusing on the interpreter's and the therapist's listener responses during patient's extended turns (cf. Goodwin 1986). More specifically, our interest lies in the interplay between gaze and head nods as tokens of affiliation. As shown in previous research (Bot 2005; Davitti 2013; Krystallidou 2014; Lang 1978; Mason 2012; Pasquandrea 2011, 2012; Wadensjö 2001), gaze direction has an important function in signaling conversational attention and managing the interaction in face-to-face interpreter-mediated dialogue. In order to capture in detail the interlocutors' synchronous gaze behavior during the session, we used mobile eye-tracking devices. By using this new method, we were able to capture detailed gaze information from all interlocutors together with the co-occurring gestures and to analyze the interaction from a unique 'speaker-internal' perspective (Brône & Oben 2015).

For this paper, we examined one naturally occurring therapeutic session at a mental healthcare institution in the Netherlands. Our research questions were as follows: How is affiliation with the patient displayed and interactively achieved? What is the role of gaze direction in displaying and eliciting an affiliative response? And finally, what are the differences in affiliative responses employed by the interpreter and the therapist? At a more general level, we discuss

the implications of these findings for the interpreting practice and for the study of interpreter-mediated psychotherapeutic interaction.

## **2. Affiliation in social interaction**

While listening to a telling (e.g. story or complaint), recipients display their cooperation with the ongoing talk by producing brief listener responses or so-called *backchannels* (Yngve 1970). These include ‘continuers’ (*mm hm, uh huh, yeah*, see also Schegloff 1982), newsmarkers (*Oh!*), assessments (*how nice, great*) and head nods (for an overview, see Gardner 2001). Listener responses reveal something about “how the recipient is engaging in talk as a social action” (Gardner 2001: 8) and at the same time play an important role in the emerging story of the speakers (Mandelbaum 2013; Stivers 2008). Although it has been suggested that listener responses perform various functions in interpreter-mediated talk (Baraldi & Gavioli 2012, Gavioli 2012), they have received little systematic scrutiny in the literature. The focus of this paper is on the interpreter’s and the therapist’s listener responses in the midst of patient’s extended units of talk, through which they display affiliation with the ongoing progression of the patient’s telling.

Stivers (2008, 2011) distinguishes two main levels of cooperation in interaction: the level of structural cooperation (*alignment*) and the level of pro-social and affective cooperation (*affiliation*). *Alignment* involves acknowledging the information provided and supporting the progress of the telling. In the context of storytelling, key resources for alignment are continuers (Schlegloff 1982) such as *mm hm* and *yeah* (Lindström & Sorjonen 2013; Stivers 2008). Continuers merely treat the activity as still in progress and pass on an opportunity to take a full turn of talk (Stivers et al. 2011).

By contrast, *affiliation* involves actions with which a recipient supports and ‘mirrors’ the teller’s evaluative stance towards the events (e.g. as being sad, funny, dreadful etc.), displays empathy and/or cooperates with the preference of the prior action (Stivers et al. 2011: 21). Although the tellers do not always formulate their stance explicitly, various other components of the story will give the recipient an indication of what the teller’s viewpoint is towards the described events, such as story prefaces, marked lexical choices, prosody and context (Stivers 2008). Affiliation is treated as the preferred response in storytelling (Couper-Kuhlen 2012, Peräkylä & Ruusuvuori 2012, Peräkylä et al. 2015). As shown by Peräkylä et al. (2015), the expected affiliative response from the recipient can lead to a teller’s relaxation, whereas the lack of it can increase anxiety and frustration. Moreover, according to Enfield, there is an ‘affiliational

imperative' that compels the interlocutors to maintain a common degree of interpersonal affiliation at each step of the interaction (2006: 399). During the ongoing talk, recipients can display affiliation through various means, including assessments that are congruent with the expressed stance (e.g. *That's great!*) and, in the mid-telling environment, through head nods (Couper-Kuhlen 2012; Stivers 2008). Furthermore, affiliation does not necessarily imply alignment, "as a disaffiliative response such as a disagreement could nonetheless be aligning, moving the sequence forward" (Stivers et al. 2011: 22).

The level of conveyed affect and the resources used for conveying affiliation strongly depend on the sequential placement and the interactional context in which it is produced. Stivers (2008) argues that recipients' head nods in the mid-telling position claim access to and thereby affiliate with the teller's conveyed stance, but at story completion are treated as inadequate and thereby disaffiliating. Institutional contexts, such as doctor-patient interactions, also determine the recipient's expectations concerning the stance that the tellers will be taking (e.g. a complaint) and the level of displayed affiliation (Lee & Tanaka 2014; Lindström & Sorjonen 2013; Stivers 2008).

In traditional, two-person therapeutic sessions, the patient's affective experience is the focus of the attention (Bänninger-Huber 1992) and the therapist's task is to develop and maintain a collaborative relationship with the patient by closely affiliating and aligning with the patient during the treatment (Muntigl et al. 2014) while at the same time controlling his or her own reactions (Bänninger-Huber 1992). Therapists may employ listener responses such as *mhm*, *yeah*, *right* and – in particular - head nods to delicately manage collaboration with their clients (Muntigl et al. 2012, 2014). The differential use of these listener responses reflects various levels of the therapist's involvement and affiliation in the patient's telling (Gerhardt & Beyerle 1997; Muntigl 2012). Psychotherapy is thus particularly interesting for the study of listener responses, as these have been shown to play an important role in establishing and maintaining an effective therapist-patient relationship (Gerhardt & Beyerle 1997; Muntigl et al. 2012, 2014). The question is as to how affiliation is achieved where the therapist and the patient do not share the same language and communicate with the aid of an interpreter. To date, nobody has investigated the use of affiliative responses in the context of interpreter-mediated therapeutic interactions with asylum seekers. In interpreter-mediated therapeutic encounters, it is the interpreter who has the first and primary access to the patient's telling. The therapist, on the other hand, is unable to directly contribute and respond to the emergent story of the patient and has to wait for the interpreter's rendition. The interpreter is thereby expected to adopt a strictly

neutral attitude as defined in most Codes of Conduct<sup>1</sup>. However, the interpreter's role is much more complex than that (see also Wadensjö 1998, Pöchhacker/Schlesinger eds. 2007). Bot (2003, 2005) challenges this ideal of 'neutrality' and argues that the interpreter is an active participant who influences the therapeutic experience through his presence. Still, the interpreter's role as recipient-responder of talk remains a delicate subject (Baraldi & Gavioli 2012; Gavioli 2012). Although interpreters are not supposed to show their own attitude and reactions to the primary speaker's utterances, "they are most often (...) the *first* recipients of the interlocutors' talk; therefore, there must be some way in which they negotiate their 'reciency'" (Gavioli 2012: 201).

In contexts other than psychotherapy, studies have shown that interpreters often act as normal listeners and produce minimal responses to display understanding and to coordinate the ongoing talk (Englund Dimitrova 1997; Baraldi & Gavioli 2012; Gavioli 2012). In therapeutic encounters, interpreters may experience a dilemma as whether to affiliate or not with 'empathic moments' (Heritage 2011, see also Couper-Kuhlen 2012) in the patients' telling. As noted by Wadensjö (2001: 83), interpreters do not receive the same training as therapists:

"While therapists are trained not to take patients' emotions to heart, but rather to make them work for patients' recovery, interpreters do not normally receive such training. While therapists are trained to listen attentively and respond, interpreters are trained mainly to mobilize another mode of listening: to listen attentively, render what they have heard in a new version and avoid direct response."

Avoiding gaze exchange with the patient can be used as a strategy by the interpreters to minimize personal engagement with the patient's telling and consequently, to reduce the emotional load of the assignment. This, however, can have negative consequences for the management of the session (Bot 2005; Wadensjö 2001). On the other hand, some interpreters may find visual contact with the patient a way to "handle temporary tension" (Wadensjö 2001: 83).

As previous research in monolingual contexts has shown, eye contact between interlocutors has an important role in signaling conversational attention, coordinating the talk, eliciting and providing a listener response and conveying (dis)agreement with the ongoing talk (Bavelas et al. 2002; Goodwin 1980, 1981; Jokinen 2010; Kendon 1967; Rossano 2013, Ruusuviori 2001;

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<sup>1</sup> For an example of the Code of Conduct for community interpreters in Belgium, see [http://www.kruispuntmi.be/sites/default/files/bestanden/deontologische\\_code\\_sociaal\\_tolken.pdf](http://www.kruispuntmi.be/sites/default/files/bestanden/deontologische_code_sociaal_tolken.pdf), and in the Netherlands, see <http://www.tvcn.nl/media/157991/gedragscode-voor-tolken-en-vertalers.pdf> [accessed 13/06/2017]

Stivers & Rossano 2010; Vertegaal et al. 2001). With reference to listener responses, Bavelas et al. (2002) have found that recipients are most likely to produce a listener response after a mutual gaze with the speaker. McClave (1998, in Allwood & Cerrato 2003) reports that a higher number of head movements is produced when the interlocutors have eye contact. Therefore, in the following, we wish to explore the interplay between affiliative listener responses and gaze in one interpreter-mediated therapeutic encounter.

### 3. Data and method

The therapeutic session described in this paper was recorded at a mental health institution in the Netherlands. We obtained the permission to record the last session of the patient's treatment. The patient was a Russian-speaking refugee of Armenian descent with a very limited knowledge of Dutch. As he had been in therapy in that institution for several months, he was accustomed to speaking in the presence of an interpreter. The session was conducted by the therapist who had almost no understanding of Russian and rendered by the interpreter who had twenty years of experience in mental health interpreting. All three participants knew each other prior to the recording session and agreed to be recorded by signing a written informed consent, which ensured their anonymity and stated how the data were going to be used and presented.



Figure 1: Three dynamic internalized perspectives the eye-trackers and a side-view on the whole interaction. The dots indicate the gaze direction of each of the participants: the interpreter (left), the patient (middle) and the therapist (right).

As preferred by the therapist, the participants were sitting in a triangular formation around a small table in the consultation room, with the patient in the middle, the interpreter on the right and the therapist on the left side of the patient (Figure 1).

Each participant wore eye-tracking glasses. The patient was wearing the *Pupil Pro Monocular Glasses*, whereas the therapist and the interpreter were wearing the *Arrington Gig-E60*<sup>2</sup>. Mobile eye-tracking enables us to record participant's gaze behavior at any given moment in the conversation, without impeding their freedom of movement<sup>3</sup>. The eye-tracking glasses contain a camera that measures the position of the person's pupil and an integrated scene camera that records what is in the viewing field of the person. In the resulting recording, the visual focus of the person is indicated with a colored dot (or *gaze cursor*), as shown in Figure 1. Mobile eye-tracking is increasingly being used in face-to-face monolingual interaction research to measure interactants' gaze behavior in ongoing face-to-face interactions (Pfeiffer et al. 2013, Oben & Brône 2015). Previous research has shown that, by measuring multiple participants' eye gaze simultaneously, we can get a rich insight into the attention processes and the role of gaze direction as an active communicative signal (e.g. in eliciting or providing feedback in dialogue management). On the basis of a video camera alone, it would not have been possible to get such detailed gaze information (such as rapid gaze shifts) of all participants and at the same time to capture other co-occurring nonverbal behavior, such as gestures, posture and facial expressions. Furthermore, video does not allow a detailed study of interlocutor's mutual gaze in ongoing interaction and errors can occur when making judgements of gaze from video recordings (Argyle & Cook 1976, Mason 2012).

In addition to the eye-trackers, a fixed camera (*Sony HDR-FX1000E*) was placed on the other side of the room to provide a profile shot of the interaction (see also Brône & Oben 2015). During the session, the researchers were waiting in an adjacent room. At the end of the session, a short interview with the participants was conducted, in which they were asked about their background and impressions about the encounter.

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<sup>2</sup> Both eye-tracking systems provide a participant perspective through the scene camera and specific gaze information (with the gaze cursor). For an empirical study using Arrington Gig-E60 in face-to-face dialogue, see Oben & Brône (2015). For information on the Pupil Pro Glasses, see <https://pupil-labs.com/pupil/>.

<sup>3</sup> In the immediate post-interview with the participants, the interpreter and the therapist stated that they were 'fairly aware' of the fact that they were wearing the eye-tracker during the encounter; the patient on the other hand declared that he had 'almost no awareness' of the eye tracker during the conversation. It is thus difficult to establish the level of intrusiveness of the recording equipment in the course of interaction. As it was a naturally occurring therapeutic encounter in a psychotherapeutic institution, each of the participants was there of set purpose: the therapist was oriented toward the realization of specific goals in that therapeutic session, the interpreter was focused on her task of relaying the talk and the patient might also have had his own agenda for his last session.

For the analysis, the four video recordings were synchronized in Adobe Premiere Pro CS4 into one single video (Figure 1), that could be imported into the open-source video annotation tool ELAN (Wittenburg et al. 2006). Then, the interlocutors' speech, gaze and listener responses were annotated on different tiers in ELAN. The continuous gaze information from the eye-trackers was manually annotated on the basis of gaze fixations (with a minimum duration of 120 ms, see Brône & Oben 2015). Once this segmentation was done, each of these gaze fixations was coded for one of the relevant focus points in the interaction: the face of the patient, the face of the counsellor, the wall, etc. Finally, we annotated the interlocutors' mid-telling listener responses in the patient's extended units of talk<sup>4</sup>. The resulting data were then analyzed quantitatively (with the ELAN statistics tool) and qualitatively, by using the micro-analytic approach and insights from Conversation Analysis (CA), which studies interaction in its emerging, co-constructed context (Gardner 2001).

#### **4. Analyses**

In what follows, we first provide an overview of the interpreter's and the therapist's use of listener responses during the patient's extended talk (sections 4.1. and 4.2.). We distinguish the main types of listener responses during the session and their relationship to gaze. Against this backdrop, we focus our attention on head nods as resources to affiliate with the patient's telling (4.3). By combining a quantitative and a qualitative, CA-inspired approach, we reveal the differences in the therapist's and the interpreter's use of affiliative responses in this therapeutic session.

##### **4.1. Interpreter's listener responses**

Given the fact that the interpreter is the first recipient of the patient's telling, we have first measured the absolute and the relative frequencies of interpreter's listener responses during patient's extended units of talk. As shown in Table 1, we have distinguished nonverbal (e.g. head nods and smiles), verbal (e.g. *mm hm, yeah*) and combined<sup>5</sup> listener responses (e.g. a verbal response accompanied by a head nod). In addition, a further distinction was made between listener responses that co-occur with mutual gaze with the patient (during brief periods

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<sup>4</sup> These were defined as units of talk that consist of more than two turn-constructive units (Sacks et al. 1974) in our dataset. The patient produced in total 42 turns, of which 29 involved extended units of talk.

<sup>5</sup> In the literature a distinction is often made between 'verbal' and 'nonverbal' listener responses, whereas – as Allwood & Cerrato (2003) show – they are often produced simultaneously by verbal and nonverbal means (Allwood & Cerrato 2003).



of mutual gaze or the so-called “gaze window”, see Bavelas et al 2002) and those that are produced without eye contact.

Our data show that most of the interpreter’s listener responses were nonverbal (see also Englund Dimitrova 1997). Even though these nonverbal responses were mainly head nods, the interpreter also used few head shakes, smiles, emphatic facial expressions and silent laughs. The latter communicated the interpreter’s friendly and emphatic attitude towards the patient and thus established “affective resonance” between the two (see also Bänninger-Huber 1992: 297).

Interpreter’s listener responses	Mutual gaze	No mutual gaze	Total
Nonverbal	24 (80%)	6 (20%)	30 (48%)
Verbal	7 (54%)	6 (46%)	13 (21%)
Combined	18 (90%)	2 (10%)	20 (32%)
Total	49 (78%)	14 (22%)	<u>63</u>

Table 1: Frequencies of the interpreter’s mid-telling listener responses

Moreover, our results show that a majority of the interpreter’s nonverbal listener responses were generated within the “gaze window” in a statistically significant manner ( $\chi^2=6,122$ ,  $df=2$ ,  $p<0,05$ ). On the other hand, interpreter’s verbal listener responses were used the least and were provided regardless of mutual gaze with the current speaker. They were limited to “continuers” (Schegloff, 1982), such as *mh*, *mm hm* and *okay, ja* (“yeah”), by which the interpreter merely displayed alignment with the patient’s telling. Moreover, the interpreter did not provide any verbal assessments, but instead she used visual resources (e.g. head nods) to display minimal affiliation with the patient’s utterances.

Altogether, the interpreter’s nonverbal listener responses appeared to do all the affiliative work. Verbally or vocally, the interpreter displayed very little affiliation with the ongoing talk and seemed to merely align with the patient’s telling. Nevertheless, using non-intrusive and delicate interactional resources such as continuers (*mh*, *mm hm*) or even remaining silent may be effective in prompting the patient to develop his effectual stance (Muntigl et al., 2014; Stivers 2008; Suchman et al., 1997). This will be discussed further in the qualitative part of the analysis (4.3.1.).

## 4.2. Therapist's listener responses

In expressing a listener response, listeners signal some understanding of the ongoing talk. Therefore, the therapist in this session was found to provide listener responses mainly during the interpreter's turns in Dutch<sup>6</sup>. Table 2 gives the absolute and relative frequencies of the therapist's listener responses during the interpreter's renderings of the patient's extended units of talk<sup>7</sup>.

Therapist's listener responses	Mutual gaze	No mutual gaze	Total
Nonverbal	47 (64%)	27 (36%)	74 (68%)
Verbal	4 (44%)	5 (56%)	9 (8%)
Combined	19 (73%)	7 (27%)	26 (24%)
Total	70 (64%)	39 (36%)	<u>109</u>

Table 2: Frequencies of the therapist's mid-telling listener responses

As shown in Table 2, the therapist produced a total of 109 listener responses, notably more than the interpreter, pointing to a high level of engagement with the patient's story. Most of the therapist's listener responses (68%) were nonverbal, namely head nods, with a few headshakes and smiles. Furthermore, even though the therapist tended to produce listener responses more often during mutual gaze with the current speaker, the correlation between the occurrence of mutual gaze and the therapist's production of listener responses was not significant in this session, as was shown by the Chi-square test ( $\chi^2=2,435$ ,  $df=2$ ,  $p=0,296$ ).

Interestingly, the therapist produced less verbal mid-telling listener responses (8%) than the interpreter (21%). Alignment tokens such as *mm hm*, which signal to the speaker that she may continue speaking, might have been experienced as superfluous, as the interpreter had the task to render everything what the patient had said and only then yield the floor to the next speaker. On the other hand, the therapist's verbal listener responses were more varied than the interpreter's. They ranged from listener responses with minimal semantic content (*mm hm*, *ok*,

<sup>6</sup> The therapist could understand some basic Russian words, such as 'net' (no) or 'da' (yes), but other than that, he did not have any knowledge of the patient's language. However, he sometimes produced a listener response (e.g. a head nod) during the patient's talk in the source language. This was the case when the patient used a familiar word or an iconic gesture to answer the therapist's question. These instances (13 in total) were not taken into account; without understanding of the language, it is not clear which function the therapist's listener responses had in those cases.

<sup>7</sup> Almost all of these extended turns were rendered 'in one go', i.e. as long turns. The interpreter waited until the patient had finished his turn (the patient's longest turn was 1 minute and 4 seconds). Thus, she was able to memorize very long chunks without taking notes.

*yeah*), to newsmarkers (*oh!*) (see Gardner 2001) and assessments, such as *nee precies* ('no exactly'), *dat is mooi* (that's nice'), that marked the therapist's affiliation with the patient's stance.

To summarize, the therapist displayed more active involvement and engagement with the patient's telling than the interpreter, which is apparent from the higher frequency of his listener responses in comparison to the interpreter and the minimal semantic content of the interpreter's listener responses. Moreover, whereas the interpreter appeared to be downplaying her use of listener responses, the therapist, on the other hand, appeared to do the opposite.

### **4.3. Head nods as resources to affiliate**

In this section, we discuss the interpreter's and the therapist's use of head nods as resources to affiliate with the patient. As we have shown, head nods were the most frequently used type of listener response by both the interpreter and the therapist in this session. Head nods relate to increased affect and establishing rapport (Kita & Ide 2007; Stivers 2008) and at the same time do not make any epistemic claims that might 'intimidate' the teller (Muntigl et al. 2014: 41). By taking a qualitative approach, our aim is to examine separately the sequential context of the interpreter's and the therapist's affiliative nods during patient's extended units of talk.

#### **4.3.1. Interpreter's head nods**

##### *Gaze as response inviting cue*

In the following, we focus on the interpreter's affiliative head nods during the patient's telling. A first case is shown in Extract 1. The encoding symbols for gaze in this paper were inspired by Rossano's (2012) system, which was developed for dyadic interactions, and by Davitti's (2013) and Auer's (*forthcoming*) conventions, that adapted Rossano's system to triadic interactions. Note that the beginning and the end of mutual gaze is indicated with curled brackets above the utterance and other nonverbal behavior (such as head nods) below the utterance<sup>8</sup>.

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<sup>8</sup> During the patient's turns in the excerpts 1-3, the patient was oriented with his head (and body) towards the interpreter, while the interpreter was oriented towards the patient. This led to a momentary exclusion of the therapist, or a split of the participation framework (Goffman 1981). Therefore, encoding the gaze behavior of the therapist (who was momentarily excluded from the dyad between the interpreter and the patient) does not contribute to the present analysis.

The therapist asks the patient how he has experienced his stay at the mental health institution. After the interpreter's rendition and a long silence, the patient starts off by expressing his stance with 'it was very bad' (line 4), while looking at the desk in front of him. There is a slight pause, but the interpreter does not produce a response token: there is no display of affiliation with the expressed stance. Instead of producing a continuer or taking the turn to render his utterance, she waits for more information. The absence of a listener response here is thus illustrative of the interpreter's coordinative role; she judges if the patient's telling is sufficient to start rendering.

[1]

1 THER: En en hoe euh: hoe heeft u het hier=euh:: gehad?  
*And and how euh: how was it here euh:: for you?*

2 INT: Как (.) вам сдесь жилось всё это время?  
*How (.) was it for you to live here all this time?*

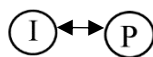
3 (1.6)

4 PAT: → Сначала очень (0.8) плохо был,  
*In the beginning very (0.8) bad it was.*

5 (0.7)

6 Не то что.  
*Not because.*

7 (.)



8 → У меня ситуация был плю+хо.  
*My situation was ba+d.*

int: +double nod -- >>

The patient continues in line 6, but breaks off his talk. He then self-repairs (Schegloff et al. 1977) in line 8 by explicating that his own situation ('my situation') was bad, and not the circumstances at the institution, as he explains later on. While producing the word 'bad' in line 8, he shifts his gaze towards the interpreter, who immediately responds with an affiliative nod. Thus, by orienting his gaze at the interpreter, the patient selects her as the addressee and responder of his telling (cf. Stivers & Rossano 2010). Immediately after her response, he moves his gaze away and continues his talk. This example shows that mutual gaze elicits the interpreter's head nod and thus functions as an affiliation inviting cue (see also Stivers & Rossano 2010, Heath 1992).

In excerpt 2, we find a similar pattern. Prior to this extract, the patient has been telling that he was in shock when he came to the clinic. Here, the patient is asked if this feeling has

disappeared. After a sigh and a long pause, the patient starts responding, while gazing at the desk in front of him. The interpreter is maintaining her gaze at him throughout his turn. Notice that the interpreter produces a head nod only after the patient directs his gaze at her in line 9.

[2]

1 INT Вы сказали, пришли сюда, вы были в шоке;  
*You said, that you came here, you were in shock;*  
 а сейчас остается такое ощущение или ушло состояние шока –  
*and now does that feeling remain or has the state of shock disappeared -*

2 (-)

3 PAT ((sighs))

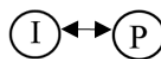
4 (1.4)

5 Почти ушле= ушел (.) но  
*It has almost disappear=disappeared (.) but*

6 (0.7)

7 я говорил, что  
*I have told that*

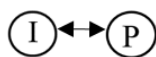
8 (0.5)



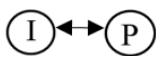
9 → в наше время, я, когда я сплю, во сне +увиджу+.  
*at night, I, when I sleep, in my dreams +I see+.*

int:

+double nod+



10 (0.5)



11 INT Mm [hm

12 PAT [что у меня (.) со мной приходил,  
*[that what my (.) happened to me,*

13 (0.6)

14 я не забываю это  
*I will never forget that*

15 (0.5)

16 до конца моей жизни:= и то  
*until the end of my life:=and that*

17 (0.8)

18 такой было что (.) не забуду.  
*was like that (.) I won't forget.*

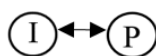
The patient is telling that the initial state of shock has almost disappeared, but in lines 7-19 he repeats (*I have told*) that the bad memories keep coming back in his dreams. By repeating this and becoming more granular (cf. Stivers 2008) in his telling (*at night, when I sleep, in my dreams*), he conveys his stance towards these nightmares as something that still troubles him and that will not go away. It is only when the patient directs his gaze at the interpreter (line 9 ‘I see’) that she immediately displays affiliation with head nods. However, the patient maintains his gaze at her and after a short pause (line 10), she aligns by producing a continuer (‘*Mm hm*’, line 11). ‘*Mm hm*’ is used here to encourage the patient to continue speaking (see Drummond & Hopper 1993, Gardner 2001) and it shows how the interpreter delicately coordinates the interaction. Their mutual gaze ends in line 12 and during the remainder of the patient’s turns, the interpreter does not offer any kind of listener response. On several occasions during the patient’s turn, the interpreter is offered direct access to his stance, but she appears to withhold her response. She is carefully monitoring the patient’s speech and nonverbal behavior and waits for him to develop his stance further (Muntigl et al. 2012). In sum, these two examples reveal a direct relationship between the patient’s gaze and the interpreter’s affiliative responses and illustrate the subtlety of the interpreter’s coordinative role in such an encounter.

### *Sustained mutual gaze and increased affiliative strength*

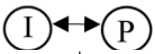
We have found that the average duration of the patient’s gaze towards the interpreter during his extended turns was 4 seconds. In the following example, the patient retains his gaze at the interpreter for 14 seconds. This is strikingly long, as mutual gazes tend to be quite short (Kendon 1967: 28). As we will show, it appears that the patient’s sustained gaze at the interpreter increases the recurrence (and repetitiveness) of interpreter’s nods.

Prior to this excerpt, the patient has been telling that he takes a lot of medicines to regulate his blood pressure, as the traumatic experiences from his past keep coming back in his dreams. Here, the patient is telling that when his blood pressure is measured during the night, it is always high. He cannot forget the past. In contrast to extracts 1 and 2, the interpreter and the patient are engaged in mutual gaze throughout the whole excerpt.

[3]



1 PAT ↑  
\_\_\_\_\_  
всегда, когда мне проверяют  
*always, when (my blood pressure) is checked*

2		(-)
3		утром. <i>in the morning</i>
4		(.)
5	INT →	+Mm
	int	+repeated shallow nods --->
6		(0.7)
7	PAT	нормальное+ давление. <i>normal + blood pressure</i>
	int	-----+
8	PAT	а когда вече+ром. <i>but when in the eve+ning.</i>
	int →	+slow repeated nods --->
9		(.)
10	PAT →	Ночью проверяют, всегда есть да+вление+ <i>At night they check, it's always h+igh +.</i>
	int	-----+ +repeated nods--->
11		(.)
12	INT	(Ja.) <i>(Yeah.)</i>
	int	---->
		
13	PAT	Никогда не забуду.+ <i>I will never forget.+</i>
	int	-----+

The patient starts off by telling “when (blood pressure) is checked”, after which there is a short pause. Then he continues in line 3 by specifying when it is checked (‘in the morning’), which provides extra detail into the situation and projects the contrast with the information that is introduced in line 8 (‘but when in the evening’). By becoming more detailed in his report, the patient “heightens accessibility” (cf. Stivers 2008) of his situation to his recipient. The interpreter responds with the minimal response ‘Mm’ (line 4), augmented with shallow nods that continue into line 7. According to Gardner (2001: 31), ‘Mm’ can be seen as a “a non-intrusive, reserved response to a delicate topic”. The interpreter’s nods continue during the long pause (line 6) well into line 8. By nodding, she is responding to the patient’s sustained gaze at her and is displaying her affiliation with the patient’s situation.

In lines 8-11, the patient introduces a contrast (‘But when in the evening’). He self-repairs by adding that ‘at night’, when his blood pressure is checked, it is always high. All the while the

patient and the interpreter are engaged in mutual gaze. In lines 9-11, the interpreter briefly closes her eyes and starts producing a series of slow nods. Closing of the eyes while nodding adds to the affiliative character of her response (see also Kendon 1967). She appears to be closely affiliating with the patient's story. In line 10, at the point when the interpreter has been given access to the situation through the patient's detailed description, the interpreter starts nodding again. At the possible completion of the patient's turn, the interpreter produces the acknowledgment token 'Yeah', augmented with head nods, which display her heightened level of understanding of the preceding telling and willingness to take the turn (Gardner 2001, Drummond & Hopper 1993). She continues nodding as the patient adds in line 13 "I will never forget". Thus, it appears that the patient's sustained gaze increases the strength of the interpreter's affiliation with the patient's telling.

In this section, we have shown that, although the interpreter seems to adopt a reserved attitude, she still has an important role in displaying affiliation with the patient's talk. Mutual gaze with the patient draws her to produce affiliative head nods to his telling. Also, the duration of her head nods seems to be linked to the sustained mutual gaze with the patient and displays her heightened level of affiliation. In other words, "extended mutual gazes appear to be indicative of an intensifying of the direct relations between the participants" (Kendon 1967: 48).

### 4.3.2. Therapist's head nods

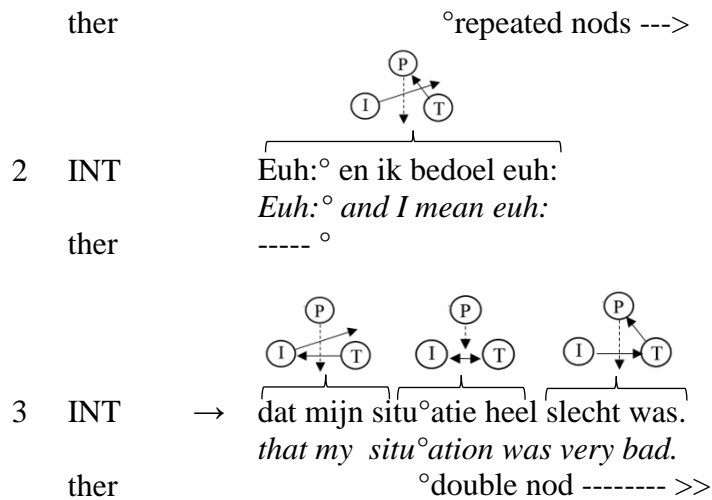
#### *Dual feedback and synchronization with the patient's stance displays*

We now turn to the therapist's use of affiliative head nods to the patient's story. In the following example, which is the continuation of extract 1, the interpreter is rendering the patient's talk into Dutch. The gaze directions of all three interlocutors are transcribed above the utterance. In contrast to the interpreter, the therapist's head nods are synchronized with the renderings of the patient's stance in line 1 ('It was very bad') and line 3 ('my situation was very bad') (see Muntigl et al. 2012):

[4]

1	INT	→	Het was heel s <sup>o</sup> lecht. <i>It was very ba<sup>o</sup>d.</i>





Interestingly, at the beginning of his head nods in line 1, the therapist shifts his gaze to the patient and continues nodding. In line 3 ('was very bad') his nodding is again accompanied by a gaze shift towards the patient. Thus, by shifting his gaze to the patient while nodding, the therapist displays understanding and endorsement of the expressed stance while at the same time indicating with his gaze who he is affiliating with (namely, with the patient). This is what we refer to as *dual feedback*. Dual feedback can be defined as listener responses (in this case, head nods) that are accompanied by gaze shift from one interlocutor to the other and through which the current recipient displays understanding and endorsement of the (jointly) expressed stance. In this context, the stance is expressed in Dutch by the interpreter (who is the 'animator', see Goffman 1981), whereas the 'principal' of the conveyed stance is the patient. By producing *dual feedback* the therapist is simultaneously aligning with the interpreter and affiliating with the patient. Thus, the phenomenon of *dual feedback* clearly shows how the concepts of affiliation and alignment are intertwined. Also, with *dual feedback* the therapist is maintaining the triadic interaction pattern during the encounter<sup>9</sup>.

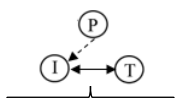
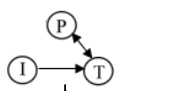
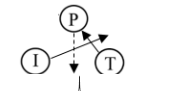
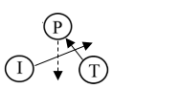
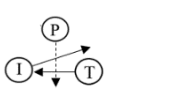
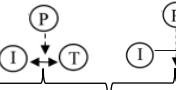
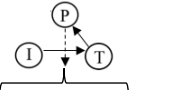
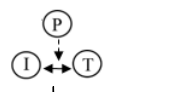
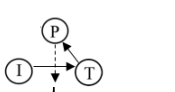
#### *Nodding as a direct response to the client's disagreement*

The therapist produced head nods as a direct response to the patient's disagreement. This is in line with findings by Muntigl et al. (2012), who have shown that head nods are used as a resource for strengthening and for re-establishing affiliation with the patient in contexts of

<sup>9</sup> As commented by the anonymous reviewer, the therapist's affiliative response is delayed in relation to the patient's turn, which means that the patient does not really know which part of the extended narrative the therapist is aligning with. However, this does not diminish the socially inspired function of the therapist's *dual feedback* in this setting.

disagreement. An example is shown in excerpt 5. Prior to this excerpt, the therapist has asked the patient if he has learned to cope with his nightmares during his stay at the clinic, as nightmares are very difficult to control and to reduce. In the following extract we provide the interpreter's rendition of the patient's turn.

[5]

- 1 INT →   
 dat kl<sup>o</sup>opt.  
*that's true.*  
 ther                    °repeated nods --->
- 3 INT   
 euh: daar kan ik ook niks mee:  
*euh I can't do anything with it.*  
 ther ----->
- 5   
 (-)<sup>o</sup>  
 ther                    ---<sup>o</sup>
- 6 INT →    
 en daarom [wil ik] nu eigenlijk liever  
*and that's why I would now actually rather*
- 7 PAT                    [(да)]  
                               (yeah)
- 8    
 over iets anders heb[ben (.)]  
*talk about something else (.)*
- 9 THER                    [°ja°]  
                               [°yeah°]  
 ther                    °nod°
- 10 INT    
 ik wil daar niet meer over heb[ben].  
*I don't want to talk about it anymore.*

11	THER	[°nee precies°] [°no exactly°] °    nod    °
	ther	

In line 1, the therapist's question is ignored, but the interpreter renders the patient's agreement ('that's true') with the therapist's suggestion that nightmares are difficult to control. The therapist starts a series of nods during this affiliating move of the patient (lines 1-5). These head nods appear to reinforce the established positive alliance between them (cf Muntigl 2012:14). However, in lines 6-10 a disaffiliating move is introduced ('I would rather talk about something else, I don't want to talk about it anymore'), that puts the affiliation between the therapist and the patient under pressure. In response to this rejection of the proposed agenda, the therapist immediately produces a head nod augmented with the acknowledgment token 'yeah' (line 9), while briefly shifting his gaze towards the patient. The immediacy of his response indicates no trouble with agreeing with the evaluative position in the patient's talk (cf. Stivers et al. 2011). The therapist is thus maximally affiliating by displaying direct endorsement of the patient's stance. As noted by Muntigl et al., the therapist is seeking to avoid disagreements, as these "may place stress on the therapist-client relationship (...) they may hinder important therapeutic work" (2014: 332). In line 11, the therapist increases his endorsement of the patient's stance by shifting his gaze towards the patient and providing the assessment 'no exactly' in combination with a nod. With his head nods, the therapist is actively working towards maintaining affiliation and alignment with the client "even in the face of outright disagreement" (Muntigl 2012: 10). The sequence in excerpt 5 also expresses a nice example of the way, in which diverging affiliation does not necessarily threaten the interlocutors' structural alignment in a conversation. By indicating in lines 6 and 8 that he 'would rather talk about something else' the patient reaffirms his willingness to continue cooperating in the ongoing conversation.

## 5. Discussion and conclusions

In this paper, we have analyzed the interpreter's and the therapist's use of verbal and nonverbal affiliative responses during the patient's extended units of talk in one therapeutic session. We have shown that the differences in their use of listener responses to the patient's telling may reflect the differences in the interpreter's and the therapist's roles and involvement in the therapeutic process. Although the interpreter in this session appears to be the addressee of the

patient's talk, she produces less listener responses than the therapist. There is a risk of displaying too much affiliation with the patient's telling. As noted by Englund-Dimitrova, "a feedback that is too personal can make the speaker feel that it is the interpreter who is the other interlocutor" (1997: 163). However, through a careful placement of her listener responses during the patient's discourse, the interpreter in this session is discreetly coordinating the talk (see Gavioli 2012) and affiliating with the patient.

This case study shows that both the interpreter and the therapist use head nods to affiliate with the patient, but in slightly different ways. The *interpreter's nods* were strongly linked to the patient's gaze, that functioned as an affiliation inviting cue. Thus, the interpreter seems to respond to her interlocutor's affective expectations (Baraldi & Gavioli 2012). We have also found that mutual gaze with the patient seems to intensify the interpreter's listener responses and her display of affiliation (see also Kendon 1967). According to Merlini & Favaron "a strict adherence to a dry, formal, passive and detached interpreting style (...) is not always the best way to serve one's clients, especially when their intention is to engage in a friendly and cooperative dialogue" (2005: 132). The display of cooperativeness may be especially relevant in the context of therapeutic talks with traumatized asylum seekers. However, the danger of being the responder is that the interpreter may end up doing therapeutic work: "the therapist is not only able to gradually rebuild a positive alignment, but also to elicit an elaborated response from the client" (Muntigl 2012: 24). This means that the interpreter in psychotherapy is constantly working towards maintaining the delicate balance between professional neutrality and cooperativeness. This study has shown that head nods and visual orientation are subtle ways to display affiliation and patient orientation. Thus, as a responder, the interpreter is maintaining and forging the current social relationship at a level of intensity or intimacy that is related to the goals and purposes of the given interaction (cf. Gavioli 2012, Enfield 2008, Merlini & Favaron 2005).

The therapist, on the other hand, is dependent on the interpreter's rendering and involvement in the interaction. His listener responses seem to perform a less coordinative function as the interpreter's do. The therapist is reacting to a product of the interpreter's cognitive effort, whereas the interpreter is responding to the patient's talk-in-production, with all its pauses, hesitations and self-repairs. This becomes clear from the differences in the positioning and structural characteristics of their affiliative responses. As for *the therapist's head nods*, the findings are consistent with what was reported by Muntigl et al. (2012, 2014). His head nods are target-specific: they are sequentially positioned and contiguous to the teller's expressions of stance (cf. Muntigl et al. 2014). Through his use of affiliative head nods, he is actively

working towards managing interpersonal affiliation with the patient. Finally, we have revealed that the therapist's gaze shifts as part of *dual feedback* are a manifestation of a "triadic affective interaction" (Baraldi & Gavioli 2008).

There is much more to be learned about the interactional dynamics of interpreter-mediated psychotherapeutic encounters. Due to its limited scope, our study is of an exploratory nature and does not seek to make generalizations that may hold for every interpreter-mediated psychotherapeutic encounter. Indeed, more data need to be collected in order to gain a broader picture of the interpreter's listener role in therapeutic sessions and its impact on the therapeutic relationship. Our main aim was to provide a multimodal perspective on the analysis of recipient's listener responses in the context of mental health interpreting. The study illustrates the importance of a multimodal approach in gaining a better understanding of the intersubjective relations among the interlocutors and the interpreter's social role in the context of mental health interpreting. Moreover, the observations in this study provide further argument for the importance of including gaze in the analysis of affiliation in social interaction.

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## **Appendix: Transcription conventions**

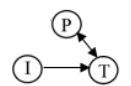
Speech is transcribed according to GAT2 (see Selting et al. 2011). Conventions for the multimodal transcription are adopted from Mondada (2007) and the encoding symbols for gaze are inspired by Rossano's (2012), Davitti's (2013) and Auer's (*forthcoming*) conventions.

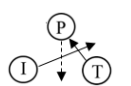
- [ ] simultaneous speech
- (.) micropause (shorter than 0.2 seconds)
- (-) short pause (duration between 0.2. and 0.5 seconds)
- .h in-breath
- (text) unclear or dubious words
- : lengthening or prolongation of a sound (sound stretch)
- ° delimits gestures by the therapist

- + delimits gestures by the interpreter
- °---> the action described continues across subsequent lines
- >° until the same symbol is reached
- >> the action described continues after the excerpt's end

*Examples*

 Mutual gaze between the interpreter and the patient

 The therapist and the patient are gazing at each other, while the interpreter is gazing at the therapist

 The therapist is gazing at the patient, while the patient is gazing in front of him and the interpreter at the wall.