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Through the Looking-Glass:
Reflections of/on Empathy in Healthcare Interpreter Education

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Abstract

The paper investigates empathic conduct in the context of healthcare interpreter education. Drawing on the concepts of dispositional and interactional empathy, activity frames, role-playing vs. role-taking, and situated learning, the study attempts to answer four research questions: How far does (un)empathic disposition correlate with (un)empathic behaviour in simulated interaction? Does the didactic frame have an inhibiting effect on students' expression of empathy? Can empathy be suitably developed in the classroom environment? Is empathic responsivity a desirable educational goal for healthcare interpreters? A research protocol was set up, and implemented on a sample of 15 postgraduate student interpreters. It entailed the administration of a dispositional empathy test, the video-recording of role-play data, and the collection of post-simulation feedback. The role-play script was based on an authentic healthcare encounter addressing the highly sensitive issue of elective abortion. The following are the key findings from the combined analysis of the three data sets. No systematic correlation between the study subjects' dispositional and interactional empathy levels could be established. The influence of the didactic frame, albeit undeniable, did not turn out to be a major obstacle to the subjects' manifestation of empathy. In the classroom environment, empathic skills can be acquired through the combined use of a variety of tools, with reflective and interactive learning activities being fundamental to unravel the complex interplay between rapport-building and other motives for action. Empathic responsivity and, even more significantly, awareness of its effects on interaction may be valuable learning achievements in healthcare interpreter education, as they enable students to contribute to the provision of humane medical care while keeping within the boundaries of professional ethics.

1. Introduction

This paper builds on previous research into empathy in interpreter-mediated healthcare interaction (Merlini, 2015; Merlini and Gatti, 2015;

Merlini, 2017a). The primary interest of these earlier studies was a methodological and descriptive one, entailing a multi-focal qualitative analysis of real-life data; yet, the issue of how empathic behaviour impacts on professional ethics was also addressed. In the absence of centralized educational and accreditation programmes, the contention was that, in the Italian healthcare context, one of the major "zones of uncertainty" accounting for the indefiniteness of "cultural mediation"[1] practice is precisely empathic conduct. Findings seemed to indicate that empathy can be successfully used by both healthcare providers and cultural mediators to fulfil the institutional task at hand, while relating humanely to patients "in search not only of a solution to their problem but also of understanding and compassion" (Ruusuvuori, 2007: 598).

In light of the above, a research protocol was devised to investigate the role of empathy in healthcare interpreter education. Dispositional and interactional empathy have been analysed on the basis of three tools: an empathy test; transcripts of interactional data from a classroom role-play; and students' feedback reports. The study involved 15 subjects belonging to two subsequent cohorts of students attending a 30-hour post-graduate university course on healthcare interpreting. Drawing on such theoretical notions as activity frames, role-playing vs. role-taking, situated learning, and interpreter training vs. interpreter education the following research questions have been asked. First, what is the correlation between students' dispositional empathy and their interactional behavior in classroom practice? Second, are possible discrepancies to be accounted for by the didactic frame? Third, is the simulated environment a suitable context for the development of empathic responsivity? Fourth and lastly, is empathy awareness a desirable learning outcome in healthcare interpreter education?

2. Teaching empathy: Theoretical underpinnings

While referring readers to Merlini (2015) for a discussion of the notion of empathy and its impact on doctor-patient communication as documented in medical literature, a brief summary of major findings concerning interpreters' affiliative behaviour is provided here.

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[1] For the difference between community interpreting and cultural mediation, see Merlini (2009). Reference is made in this paper to "interpreters" (rather than "mediators") as a specific category of academically educated post-graduate students.

Following this, attention is shifted to educational issues, in line with this paper's topic.

Reviewing a wide selection of both generic and sector-specific codes of ethics, Ozolins (2015) notes how their focus on neutrality and invisibility has preserved, over time, the machine-type model as the prescribed form of interpreting conduct. The basic equation between professionalism and emotional detachment, in particular, was placed at the very core of interpreting ethics not only in the field of conference interpreting, but also in the dialogue interpreting one as this was thought to be the best way to professionalize its largely *ad hoc* practice. Gradually, however, the stigmatization of interpreters' agency, along with the practical applicability of codes have been called into question by researchers – Angelelli (2004) being one of the first – as a number of empirical studies on authentic interpreting performances started to reveal the production, by non-professional and professional interpreters alike, of affiliation moves, especially in the healthcare contexts, in open disregard of neutrality prescriptions.

A twofold trend has since been recorded. In her review of nine seminal studies on interpreter-mediated healthcare encounters, Fernandez (2010) found that interpreters' exclusive focus on factual biomedical information coupled with their neglect of the emotional side of the interaction hamper the development of doctor-patient rapport. More specifically, failure to transmit the healthcare providers' display of empathy through verbal and non-verbal cues negatively affect the doctor's ability to provide support and build trust (Rosenberg *et al.*, 2007; Pham *et al.*, 2008). Conversely, evidence of the opposite trend towards a more empathic interpreting conduct is found in the studies of Merlini and Favaron (2005), Baraldi and Gavioli (2007), and Merlini and Gatti (2015). In their data, interpreters are seen to challenge affective neutrality through affiliative responses which treat the patient's manifestation of feelings and worries as conversationally relevant, and, in some cases, further reinforce the healthcare practitioner's empathic model of communication.

On the premise that empathy can be used as an effective clinical tool to promote diagnostic accuracy, therapeutic adherence, and both patient and physician satisfaction, a number of medical educators have started conceptualising it as a set of teachable and learnable communicative skills, which need practising to achieve adequate mastery (Coulehan *et al.,* 2001). This same goal underlies the birth of narrative-based medicine (NBM) (Charon, 2001; Kalitzkus and Matthiessen, 2009), as against evidence-based medicine (EBM) with its

emphasis on scientific objectivity and doctor-centred communication pratice. By educating doctors to attentively listen to and humanely respond to patients' storytelling of illness, NBM enables them to identify the fears and hopes associated with their patients' conditions, as they enter the latter's often chaotic inner world in search for coherent meaning. The narrative approach to medical care is thus one of the latest and most promising avenues for developing doctors' empathic engagement.

Similar attempts at equipping healthcare interpreting students with empathic communication skills are, if anything, very much in their infancy. As Dysart-Gale (2005: 401) observes, it is not surprising that many professional interpreters manifest distress and ethical dilemmas with regard to the expression of affect, given that "[they] are not trained to establish therapeutical rapport with the patient". On the same note, Fernandez (2010: 223) argued for a new turn in training practices:

> Interpreting students should be offered information regarding involvement and rapport, and should be taught strategies to handle verbal rapport and nonverbal rapport, and culturally different ways to relay involvement. […] More informed decisions by student interpreters could be made if students were made aware of the risks posed by seeking for the medical (objective medical information) at the cost of the emotional (subjective personal accounts).

One of the earliest and widest university-level training initiatives in the medical interpreting field is accounted for in Ertl and Pöllabauer (2010). Aimed at developing a targeted curriculum and innovative teaching materials, the EU-funded MedInt project was a response to the inadequate training provision for healthcare interpreters in European countries. Despite its many merits, especially in advancing professionalization and raising stakeholders' awareness, empathic communication needs were not specifically addressed in the curriculum conception and design; moreover, the curriculum itself could be neither implemented nor tested, due to time and financial constraints.

Only very recently have teams of researchers in the United States and Belgium proposed medical interpreting courses featuring empathic skills acquisition as a major learning outcome. Targeting a cohort of 80 bilingual medical students, the Penn State College of Medicine offered regular whole-day interpreting workshops from 2015 to 2017, with the declared aim of enhancing student physicians' communication skills

and empathic sensitivity to vulnerable limited English proficiency patients, potentially resulting in more professionals adopting a "humanistic healthcare" approach. Reporting on the programme results, Vergas Pelaez *et al.* (2018) note that all participants developed proficiency in interpreting – to the extent that those who took the exam were able to successfully become certified medical interpreters – and, even more significantly, that their self-reported measures of empathy increased on completion of the course. The study by Krystallidou *et al.* (2018a) investigates the impact of student interpreters' interactional behavior on doctor-patient empathic communication. Data consist of simulated consultations which were held in 2016 at the University of Antwerp as an additional joint-training activity involving medical students and Master's students in interpreting. 9 video-recorded interactions were coded using the Empathic Communication Coding System (Bylund and Makoul, 2005) to identify empathic opportunities initiated by the patient, and the doctor's responses ranging from 0 (denial of the patient's perspective) up to level 6 (sharing of feelings and experiences). Despite the limitations of the coding model, which does not consider the non-verbal components of empathy, the study is the first quantitative, systematically conducted exploration of interpreter-induced shifts in the levels of patient- and doctor-expressed empathy. The authors conclude suggesting that educational curricula should address the effects that interpreter renditions have on the complex co-construction of empathy.

Coming to the learning and/or testing tools, both medical (Bradley, 2006) and interpreter education (Dubslaff and Martinsen, 2005; Stokoe, 2014; Crezee, 2015; Cirillo and Niemants, 2017) have relied on some form of role-play practice – from more traditional scripted role-plays, to real-life scenario-based improvisations, to conversation analytic role-playing, up to semi-authentic pre-professional simulations. The different varieties have been designed, over time, to increase the authenticity of pedagogical materials while overcoming the limitations of classic role-plays, particularly in terms of interpersonal dynamics. De Pedro Ricoy (2010: 109), for instance, underlines how "genuine distress or aggression on the part of the participants in a […] [real] health-care scenario is considerably more difficult to cope with than 'acted distress/aggression' in role-play situations, in which students feel safe". In medical education literature, despite their reputation as the gold standard practice, Atkins and Roberts (2018: 14) argue against the use of standardized, statistically

analysed role-plays for the assessment of empathy levels in exam settings, on the grounds that

> the frame of showing empathy to a role-playing patient is nested in a frame of displaying competence to an examiner, which in turn is nested in the institutional frame of the overall assessment process. So what matters is not how emotionally and sincerely connected the candidate feels to the role-player but how far they are seen as 'empathic' by the examiner.

The notion of "frame" (Goffman, 1974) bears the utmost relevance for the purposes of the present study. Revising Dubslaff and Martinsen's (2005: 215) diagram of embedded activity frames to accommodate the shift from testing to research/learning setting, the framework of the present study can be represented as shown in Fig.1:
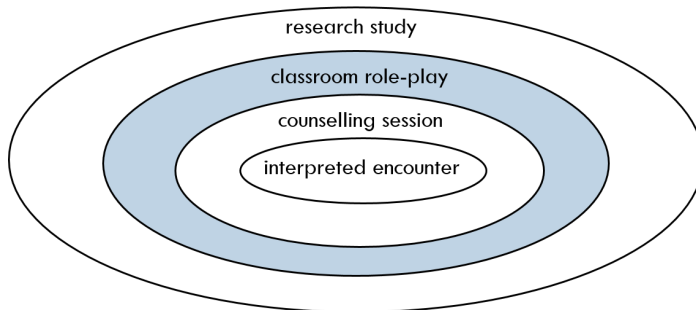

Figure 1: Activity frames

In this configuration, the students do not feel compelled to comply with a standard check-list of acceptable behaviours, as they would in an institutional assessment frame. The possible distortions originating from the outer frame – in our case, the research study one – have also been largely neutralized by the design of the present research protocol, as discussed in Section 3 below. As for the didactic frame – the only remaining one susceptible of significantly affecting the subjects' manifestation of empathy – two may be the inhibiting factors; namely, the inherent distance between student and lecturer statuses prevailing over their simulated roles; and students' orientation towards an "ethics of conviction". Comparing healthcare interpreting role-played interactions with authentic ones, Niemants (2013) identifies a dichotomous orientation to a classroom "ethics of conviction" vs. a

real-life "ethics of responsibility". In other words, whereas in class students tend to adhere to an ideal model of interpreting conduct, interpreters in real-life contexts are seen to take responsibility for the outcome of the interaction, departing from theoretical guidelines when this is deemed necessary to achieve overarching communication goals. Hence, the question raised by Niemants is the following: How can teachers help students overcome the confines of the didactic frame, and bridge the gap between "playing" roles in the classroom and "taking" roles in the real world? One answer may be found in the social constructivist concept of "situated learning" (Kiraly, 2000; González-Davies and Enríquez-Raído 2016), which aims precisely at moving students along the continuum from membership of the community of learners to membership of the community of practice. To this end, the situated learning approach fosters learners' autonomous construction of knowledge, as against mere regurgitation of received notions and passive compliance with normative guidelines. By observing, reflecting, and providing feedback on their own and others' performances (including real-life expert ones), students actively contribute to shaping and transforming the group's competencies.

This process is facilitated by exposure to authentic and/or highly simulated work environments and tasks, both inside and outside the classroom. Focusing specifically on healthcare interpreter education, both Crezee (2015: 56-59) and Krystallidou *et al.* (2018b) report on the benefits of collaborative and interdisciplinary experiences of shared pre-professional practice, whereby student interpreters work through semi-authentic scenarios together with student healthcare practitioners. Their findings point to the successful development of a more insightful, resourceful and reflective approach to contextually dependent communication and relational needs.

Finally, situated learning theories show evident connections with the conceptual transition from "interpreter training" to "interpreter education." Spearheaded by Angelelli (2008), the shift has consolidated into a learner-centred, dialogic-based pedagogical paradigm. Evidence of its currency in Interpreting Studies is the sixth volume of the Critical Link series, which devotes an entire section to the topic (Schäffner *et al.*, 2013: 285-337), as well as the volumes by Furmanek and Tipton (2016) and Cirillo and Niemants (2017). In her contribution to the latter, Merlini (2017b: 156) points to the narrow confines of practical-only training with its focus on instrumental skills, setting it against the wider educational goal of expanding students' capacity of "improvisation" – defined as a reasoned and creative opposition to the

linearity of habit – through a guided process of "reflection on one's art".

3. The research study

The study was implemented within two subsequent healthcare interpreting course editions held in the academic years of 2015-16 and 2017-18. The course is taught in the second year of the MA degree in Modern Languages for International Communication and Cooperation at the University of Macerata, Italy. The programmes and contents of both editions were identical, and aimed at developing the students' ability to autonomously decide what interactional and interpreting behaviours are best suited to achieving the primary participants' healthcare goals, in a number of contextually diverse medical settings. Both in the theoretical and practical components of the course, the focus is on conversational and relational dynamics, the role of empathy in building trust between healthcare provider and patient, and issues of professional ethics.

3.1. Research design and protocol

The protocol envisaged three phases. At the beginning of the very first class of each edition (**phase 1**), prior to any introduction to the topics of medical interpreting and empathy, all attending students were administered Davis' (1980, 1983) **Interpersonal Reactivity Index (IRI) test**. The 28-item questionnaire is a widely used self-report measure of dispositional empathy consisting of four 7-item scales, each tapping a different component of the multidimensional construct of empathy. The fantasy scale (FS) taps the respondents' tendency to imaginatively transpose themselves into the actions and lives of fictitious characters; the perspective taking scale (PT) assesses the tendency to "step outside the self", and adopt another's psychological perspective; empathic concern (EC) measures other-oriented feelings of sympathy and concern for unfortunate others, whereas personal distress (PD) measures self-oriented feelings of anxiety and discomfort in witnessing others' negative experiences. In terms of correlations between the four scales, Davis (1980) posited the following: fantasy scores display moderate to null correlation with the other scales; the perspective-taking scale is positively related to empathic concern, but

somewhat negatively related to personal distress scores – that is, greater perspective-taking ability is associated with greater feelings of empathic concern for others, and with lower personal unease in the face of others' distress. These correlations have been extensively validated in subsequent literature. Konrath *et al.* (2011), among others, observe that the emotional sensitivity and self-control associated with high scores in EC – which is arguably the scale that represents the most prototypical conception of empathy – translate into more prosocial attitudes and behaviors (such as the willingness to do voluntary work, for example). PT high scores are equally related to prosocial outcomes, being associated with high self-esteem and desire to help others. As for the remaining two scales, FS has been found to bear no relation with prosocial behavior, while PD high scores appear to be associated with higher social dysfunction (e.g., shyness, loneliness, social anxiety, verbal aggression). On account of their prototypical salience and documented prosocial association, only the scores of the two central scales (PT and EC) are analysed here for the purpose of describing each subject's empathic disposition. Finally, with reference to the mean scores of Davis' (1980) first study – as derived from a statistically significant sample of over 1000 respondents (579 males and 582 females) – they are as follows: FS, 18.75 for women vs. 15.73 for men; PT, 17.96 vs. 16.78; EC, 21.67 vs. 19.04; and PD, 12.28 vs. 9.46. Thus, women exhibited higher scores than men on all four scales, with the smallest difference obtaining for the perspective taking scale measuring the cognitive dimension of empathy. The generally lower empathic disposition of the male population has also been corroborated by later research.

In the second half of the 10-week course (**phase 2**), students were invited to volunteer for an unspecified research project involving the video-recording of their interpreting performance in a **role-play (RP)**. Participants (here referred to as subjects) authorized the use of their anonymized data. By then, empathy in medical interpreting had been presented only from a theoretical point of view; no purpose-written role-play had yet been used in class to reflect upon the implications of empathic behaviour in terms of professional ethics. Neither the study subjects nor the other students were informed about the aim of the study, prior to the simulations. Each simulation took place before the class, yet in the absence of fellow study subjects. While indications about the role-play were limited to a sketchy description of context and participants, clearly no instruction on how to behave was provided. The volunteer subjects were explicitly told that their performances

would not be subjected to formal evaluation. This procedure was meant to reduce, as far as possible, the impact of the research and didactic frames on subjects' spontaneity.

The role-play script (see Appendix 1) is based on an authentic interaction, discussed in Merlini (2015), addressing the highly sensitive issue of elective abortion. An Estonian undocumented immigrant woman went to a family planning clinic for a voluntary termination of pregnancy. The service provider, an Italian female sociologist, started the encounter enquiring about the woman's personal circumstances, particularly the relationship with her boyfriend. This routine practice of story-telling elicitation, however, annoyed the woman, who did not understand why she was being questioned, and closed up. Though the woman had some knowledge of Italian, a Russian-speaking female mediator was called in "just in case". A crucial part of the encounter was when the service provider engaged in a parallel conversation with another person, and service user and mediator started a dyadic monolingual sequence in Russian. In the role-play version, an English mother-tongue male language assistant played the part of a social worker (SW), and the Italian mother-tongue female lecturer (author of the present study) the part of the pregnant patient (P).[2] Differently from the real-life encounter, where the service provider displayed a markedly empathic attitude throughout, SW was instructed to adopt an affectively neutral behaviour, except for the instances that were structurally built into the script. Clearly, a degree of flexibility had to be envisaged, as departures from the script were sometimes unavoidable to respond realistically to the subjects' interactional moves. As documented in Appendix 1, opportunities for empathy construction were designed to arise from the following occurrences: P's initial attempts to communicate directly with the service provider; SW's joking remark about P's quitting on her partner; his shifting to a more empathic pattern in explaining the goals of the counselling session; and finally, his momentary absence from the conversation.

Following upon each simulation (**phase 3**), both the subject who had role-played it and his/her classmates were asked to individually write down a **feedback report (FR)** on any aspects of the interactional dynamics that they felt might be useful for class discussion. For the purposes of the present investigation, only the reports of the study

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[2] While having fellow students play the parts of service provider and patient would have undoubtedly reduced the evaluative threat as perceived by subjects (despite assurances to the contrary), lecturers were thought to be able to better guarantee uniformity of interactional conduct and consequent comparability of data.

subjects have been analysed. Guided class discussion addressing (un)empathic interactional moves and outcomes was conducted in subsequent weeks on the basis of the students' feedback reports and the subjects' videoed role-play performances. Although, for reasons of length, the detailed contents of the discussions are not accounted for here, this reflective learning activity has yielded additional evidence in support of the conclusions of this paper.

3.2.   Data sets

The study involved 15 students (3 males and 12 females), aged between 23 and 29 (see Appendix 2). All the subjects were starting their second year of the Macerata MA degree course. In the first year of their degree, all the subjects had taken a 60-hour conference interpreting course focusing on the consecutive mode with note-taking, and all had passed the corresponding exam before starting the second-year healthcare interpreting course. The difference in size between the samples of the two cohorts (4 subjects in 2016 vs. 11 in 2017) is due to the smaller number of students who took the then pilot medical interpreting course in the 2015-16 academic year.

The three sets of data referring respectively to dispositional empathy (DE), interactional empathy (IE), and feedback report have been analysed as follows.

The preliminary step has entailed the processing of the subjects' IRI questionnaires. Given the reduced number of male subjects (3 out of 15), sex differences have not been measured, and the following mean scores (and corresponding standard deviation values) have been calculated on the 15-subject sample: FS 18.53, sd 4.838; PT 20.07, sd 4.114; EC 19.87, sd 3.815; PD 13.20, sd 5.158. Comparing these mean scores with Davis' ones for females, the former are higher on three scales, with the smallest difference (0.57) obtaining for the FS scale and the largest (2.11) for the PT one. Our mean score for EC is instead lower by 1.8 points. Each subject's PT and EC scores have subsequently been set against the mean values for the two scales (see line chart in Appendix 3). A subject's empathic disposition has been classified as either high or low if two conditions are met:

1) his/her scores for both scales are either above or below the scales' mean values;
2) at least one score of either scale is 24 points and above, or 16 points and below.

All other instances have been classified as medium (see Fig. 2, second column).

Interactional data from role-plays have been transcribed and subjected to a threefold analysis to identify:

1) verbal perspective-taking and attentive listening devices (e.g. checking understanding, reformulating, expressing approval, reassuring, backchannelling, etc.; see Merlini, 2015);
2) cues of prosodic empathy (reduced speech rate, lower pitch, pausing, intonational and rhythmic matching, etc.; McHenry *et al.*, 2011; Weiste and Peräkylä, 2014);
3) non-verbal empathic displays (e.g. gesturing, touching, facial expressivity, eye-contact, open posture; Haase and Tepper 1972; Riess and Kraft-Todd, 2014).

Based on the analysis, a synthetic assessment of each subject's interactional conduct as exhibiting high, medium or low empathy has been formulated (see Fig.2, third column). Where empathic devices from all three categories featured extensively and in strong mutual interplay with one another, the subject's interactional conduct has been graded as "high". Where displays were less frequent, and devices either belonged predominantly to only one of the above categories or were not employed in synergy, empathy has been classified as "medium". A "low" label indicates either the scarcity or absence of empathy devices. Considering the scope of the present study, no interactional excerpts are shown here; yet, where relevant, observations on the various types of empathic displays have been included in the discussion of findings.

Subject feedback reports were searched for comments about the inhibiting effect of the didactic frame, in terms of either student-lecturer status distance (SD) or "ethics of conviction" orientation (ECO), or both.

The table in Fig. 2 provides a comparative overview of the findings;[3] these will be discussed in the next Section, together with the most indicative and interesting cases.

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[3] Note that "d.c." stands for difficult to classify, and that the empty cells in the FR column indicate that the corresponding feedback reports did not contain any observations concerning the impact of the didactic frame.

SUBJECTS	IRI degree of DE	RP degree of IE	FR ref. to SD/ECO
S1 (male)	medium	low	
S2 (female)	high	high	SD
S3 (female)	medium	d.c.	
S4 (female)	medium	medium	ECO
S5 (female)	medium	low	SD, ECO
S6 (female)	high	high	
S7 (female)	medium	medium	SD, ECO
S8 (female)	medium	high	
S9 (female)	medium	medium	
S10 (male)	high	medium	
S11 (female)	medium	medium	SD
S12 (female)	low	low	
S13 (female)	medium	medium	
S14 (male)	low	low	
S15 (female)	medium	high	

Figure 2: Comparative overview of findings
IRI: Interpersonal Reactivity Index/DE: dispositional empathy
RP: role-play/IE interactional empathy
FR: feedback report/student-lecturer status distance (SD) or ethics
of conviction orientation (ECO).

3.3.   Discussion of findings

The present study aimed to investigate four research questions (see Section 1). The first one concerned the correspondence (or lack thereof) between subjects' dispositional and interactional empathy levels. As illustrated in Fig.2, findings show that the two are aligned in two thirds of cases. Of the five instances of mismatch (S1, S5, S8, S10, S15), three (S1, S5 and S10) entail a decrease in the level of displayed empathy. The hypothesis, as derived from our second research question, was that the didactic frame might inhibit empathic expression. Analysing these three subjects' feedback reports, however, reference was found to both student/lecturer distance and ethics of conviction orientation only in one case (S5: *I had difficulty getting into my part. It was puzzling to see my lecturers perform roles. Probably, I stuck rather to my translator role and did not empathize much with the patient*).

Overall, explicit mention of student-lecturer status distance and/or ethics of conviction as empathy-inhibiting factors is present in one third of cases (5 out of 15). With the above-mentioned exception

of S5, the subjects in question (S2, S4, S7, S11) display a match between IRI test scores and IE levels during role-play performances. The analysis of the four feedback reports has yielded the following results. S2's self-reported inclination towards a highly empathic behaviour was confirmed in the role-play, where she deployed a vast array of verbal, nonverbal and prosodic empathy devices. Yet, she commented: *I had difficulties stepping into my role, getting truly involved in the interaction, and establishing rapport with the patient, since I kept seeing her as my lecturer. I also abstained from any form of physical contact for this same reason, whilst I would have resorted to it in a real interaction.* The didactic frame was clearly perceived as a hindrance, but its impact was of no major consequence in her case. Similar feedback on SD was provided by S11 (whose case is discussed at some length further down) and S7 (*I was conscious that it was a simulation, I was unable to overcome the student-lecturer relationship and get into the part, I felt emotionally uninvolved*). As in S5's case, the latter subject makes an almost identical additional reference to a normatively conceived "translator role", implying a supposed contrast between it and empathy (S7: *I stuck to a translator role and did not manage to establish rapport*). Whereas the very low degree of S5's interactional empathy may have been due to the didactic frame, S7 did in fact empathize with the patient (especially during the dyadic sequence) contrary to her self-assessment, and despite her mentioning both SD and ECO. The only other reference to an ethics of conviction orientation is in S4's FR, where the subject admits that she was aware of the patient's need for comfort (*I saw the patient was quite demoralized and I was tempted to put my hand on her shoulder to encourage her*) but did not act on this drive out of concern for role boundaries, as she herself clarified during class discussion. S4's interactional performance was in any case in line with her IRI scores (just like S7's), and featured attentive listening, as well as nonverbal empathy devices such as eye-contact and smiling. Incidentally, the most eloquent interactional indicators of simulation-related difficulties included inconsistent switching between formal ("lei") and informal ("tu") personal pronouns when addressing the patient, and incorrect selection of language in the renditions of primary speakers' turns (i.e. addressing the Italian-speaking one in English, and vice versa).

Summing up on the impact of the didactic frame, this did not turn out to be a major obstacle to the subjects' manifestation of empathy. The inhibiting effect of the ECO factor, in particular, was diminished in two ways: firstly, through a focused planning of class contents, whereby issues of professional ethics were dealt with later on in the

Course and during post-practice collective assessment and discussion sessions; and, secondly, through the adoption of a learner-centred pedagogical model, fostering reflective and interactive knowledge construction as against passive normative compliance (see for instance S15's comment: *Seeing the woman was distressed and disoriented, I tried to get close to her and understand her situation. I think I departed from the neutrality principle that is required in interpreting, and I instinctively asked some questions on my own initiative*).

Leaving aside the research and didactic frames, what can be the possible causes of the decrease in S1 and S10's interactional compared to their dispositional empathy levels? And, more generally, what difficulties affected the subjects' rapport-building behaviour in interaction? The cross-analysis of role-plays and feedback reports has revealed three critical areas: partiality due to ideological bias on the topic of elective abortion; self-centred discomfort; and need for interactional control.[4]

S1's unempathic attitude (as emblematically evidenced by his keeping silent and leaning back on the chair, arms crossed, throughout the long initial monolingual sequence) was motivated as follows: *Probably, I have not been empathic enough; probably, I felt more inclined to side with the psychologist.* Conversely, resistance against what was felt to be an attempt at restricting the patient's freedom of choice was observed in four cases (S9, S11, S12 and S13). The four female subjects identified so much with the patient as to show manifest annoyance and even contrariness at the social worker's questioning routine. S11's behaviour is taken as a representative example of ideological partiality. Despite the reference to the didactic frame in her feedback report (*I was initially influenced by the academic context, and the classroom environment did not help me get into the role-play*), she soon forgot it was a simulation, and noted: *Seeing P was traumatized by SW's questions, I tried to protect her.* Advocacy characterizes S11's entire performance – on hearing the social worker's joke about the patient quitting on her partner, she first put on an expression of disbelief, and then addressed him on her own initiative saying: "Maybe we should stop asking these questions"; in translating the social worker's explanations about the aim of the counselling session, she distanced herself through the repeated use of hedges ("a quanto pare", so it seems); during the social worker's momentary absence, she went as far as expressing doubts regarding his competence; and finally, she asked him if the patient could see a

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[4] Conclusive evidence in support of these findings emerged from class discussion.

medical doctor. Autonomous contributions were made also by S12 and S13, who told the patient that she should feel free not to answer, and that the counselling session was not compulsory. S9 made explicit reference to abortion in her feedback report: *I was quite rough with SW and, acting in P's interest, I kept asking him the reasons behind his questioning. I told him that P had already decided. I felt awkward; speaking about abortion is never easy.* Subjects' nonverbal signals of self-centred discomfort (i.e. self-touch gestures, such as hair and upper leg stroking or neck scratching, throat clearing, and sighing) were also highly indicative. S12, in particular, provided the following feedback: *When SW started asking personal questions, I saw that P was feeling anxious, and although I tried to make her feel more at ease, I was anxious myself. My voice trembled. When SW moved away, I told P that the decision was only hers. I did not want her to feel judged, as I would not want to feel judged if I were in her situation.*[5] By disaligning themselves, verbally and nonverbally, with the service provider, these subjects hampered the construction of rapport and mutual trust between primary speakers, with the result that their manifestations of empathy towards the patient (where present) were ultimately ineffective.

The last two cases worthy of notice are S10 and S3, with the latter deserving a discussion of its own (hence the d.c., difficult to classify, label). S10 exhibited a degree of empathy which does not reflect his high IRI scores, as he fluctuated between attentive listening and perspective-taking displays on the one hand, and unempathic moves on the other (e.g. he rendered the social worker's joke as a serious question thus puzzling the patient, omitted the former's rapport-building reference to his being aware of the difficult psychological state of women who are in the patient's situation, and prosodically kept a fast speech rate throughout). Highly revealing of S10's "control seeking" concern is this comment: *I wanted to be fully in control of the situation and manage it with self-confidence. I single-handedly decided to put an end to the monolingual sequence and started translating, without consulting P.* An even stronger preoccupation with interactional control was observed in S3's performance. In the initial monolingual sequence, she kept butting in to offer her assistance, despite the patient's willingness to speak directly to the social worker, and the latter's explicit request to refrain from intervening if not strictly necessary. During the dyadic exchanges, she

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[5] Though Personal Distress was not considered for the purposes of this study, S12 had an extremely high score, in line with this scale's correlation to anxiety and self-centredness.

intrusively asked the patient why she wanted to have an abortion, and if it was for economic reasons. It may be hypothesized that her assertive conduct combined with a rather artificial construction of empathy was a self-conscious attempt at aligning with some presumed expectations of interpreter agency which she may have erroneously associated to the research frame.[6] The following comments would seem to support this hypothesis: *When SW invited me to let him speak directly with the patient in Italian, I found this to be a contradiction: 'If they have asked for me to be present then surely I must be of help!' So more than once I did not comply with his instruction. When I was left alone with the patient I sought to understand why she wanted to have an abortion, so as to convey the reasons to SW.*

One final consideration: although the male vs. female empathic differences have not been an object of scrutiny in this study, it is nonetheless interesting to note that, overall, the performances of the three male subjects exhibited comparatively lower levels of interactional empathy. Aside from a generally lower empathic disposition of the male population, the topic of the encounter is likely to have held them back from the patient's emotional sphere.

4. Conclusions: Looking through and looking ahead

> "O Tiger-lily," said Alice, addressing herself to one that was waving gracefully about in the wind, "I wish you could talk!"
> "We can talk," said the Tiger-lily: "when there's anybody worth talking to."
> (Lewis Carroll, *Through the Looking-Glass, and What Alice Found There,* 1871)

The lack of a systematic correlation between dispositional and interactional empathy, as evidenced in our data, provides food for thought on at least three counts: people with a non-empathic disposition may act empathically under specific circumstances, and vice versa; empathy is a context-dependent, interactionally achieved outcome; and empathic skills may be acquired. This concluding section attempts to provide exploratory answers to the following research

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[6] It should be noted that S3 exhibits the highest PT score in the sample, while her EC score is significantly below average, which could also partially explain her intellectualized approach to the task.

questions: whether empathic responsivity can be developed in a simulated learning environment; and whether this is a desirable learning outcome in healthcare interpreter education.

While we cannot say precisely how far the simulated environment impacted on interactional conduct, the cross-analysis of the three data sets seems to indicate that its empathy-inhibiting effect was of only limited relevance, as testified by the manifest emotional involvement of most of the subjects. To reduce the impact of the didactic frame even further, a possible improvement on the research design might have entailed a semi-authentic scenario acted out by a real healthcare service provider, with primary participants speaking mutually unintelligible languages. Although this activity too is envisaged in the Course, for the purposes of the research study the scripted role-play performed by lecturers was thought to guarantee higher uniformity and comparability. In the classroom environment, empathic responsivity can indeed be developed through the combined use of a variety of pedagogical tools, with post-simulation collective assessment and discussion sessions being most fundamental to unravel the complex interplay between rapport-building and other motives for action.

So delicate a topic as elective abortion is bound to raise ideological and personal issues which should not, however, affect interpreting behaviour. Both the role-plays and the feedback reports have instead revealed, in quite a number of cases, the subjects' tendency to violate the principle of impartiality and take sides. By drawing a clear-cut distinction between impartiality and unempathic conduct, student interpreters learn how to build rapport while keeping within the confines of professional ethics. Not only will they come to appreciate that empathy is not at odds with the principles and guidelines of correct practice, but also that empathy work implies the co-construction of rapport by all participants. Interpreters' empathizing with one party while openly disaligning with the other for ideological reasons may seriously jeopardize the outcome of a service encounter. The most successful role-plays were the ones where subjects manifested humane concern for the patient, conveyed the social worker's attempts at empathizing with her, and always involved the service provider back into the relational dynamics. Especially eloquent was the subjects' behaviour in the absence of the service provider and upon his return. Just like the Tiger-lily finds Alice to be a worthwhile conversational partner, and replies: "We can talk […] when there's anybody worth talking to", so the patient opened up to the student interpreter. It was then up to the latter to extend the empathic opportunity to the service

provider enabling him to prove himself as someone equally worth talking to.

Coming to the last research question, developing empathic responsivity awareness through reflection on one's own and others' communicative behaviours can be crucial in helping healthcare student interpreters *Through the Looking-Glass*. Moving beyond one's own reflected image and truly "seeing" the other by entering their own world is the very essence of empathy, as the father of modern empathy research wrote a few decades ago:

> "to be with another in [an empathic] way means that for the time being you lay aside the views and values you hold for yourself in order to enter another world without prejudice". (Rogers 1975: 4)

Finally, looking ahead to the future of interpreter education, once this self- and other-awareness is consolidated, a desirable evolution might entail "reaching beyond a rule-based, legalistic enterprise, toward an individualized and meaning-based practice" (Charon, 2001: 1901), as is happening in medical education.

Acknowledgments

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Appendix 1: Role-play script

Setting:	A publicly funded clinic, where pregnancy options counselling sessions are compulsory prior to any medical course of action.
Scenario:	The Italian-speaking patient (P) goes to the clinic for a voluntary termination of pregnancy, and is not aware that a preliminary counselling session is required. An English-speaking male social worker (SW) meets her for the counselling session. Knowing no Italian, he has required an Italian-English interpreter to be present. P initially thinks SW is a medical doctor, and starts speaking to him in poor English.
SW:	Hi, welcome, come in, please.
P:	Hi. You doctor?
SW:	No, I'm not a medical doctor, but I work here at the clinic. How can I help you?
P:	I pregnant. Don't want baby. They say I come here.
SW:	So, you do not want to carry on with your pregnancy. This means you are here to ask for a voluntary termination, am I right?
P:	I want no baby.
SW:	And what about your partner, does he agree? Are you married?
P:	No, not married.
SW:	Do you live with the baby's father?
P:	No.
SW:	Did he split up with you when you got pregnant?
P:	No, I left.
SW:	You quit on him?! ((smiling)) Well done! Good for you! No, seriously, why did you part?
P:	Now, over.
SW:	So, it's over, you say. Was it love?
P:	Yes, for me.
SW:	Did he not love you?
P:	I don't know. He bad things to me.
SW:	((looking at the student interpreter)) Shall we continue in Italian, so maybe she relaxes a bit?
P:	Perché tutte queste domande? A che servono? Io pensavo che sarei venuta qui e che un dottore mi avrebbe semplicemente fatto una visita e che poi avrei fatto quel che devo fare e me ne sarei tornata a casa [*Why all of these questions? What's their purpose? I thought I would come here, and that a medical doctor would simply examine me, and I would do what I have to do, and then I would go back home*]
SW:	Well, it is not as simple as that. I'm a social worker, and when you come to a place like this there's an initial consultation, where I have to ask you some questions, some personal questions. Now, when you don't understand ask her/him ((referring to the student interpreter)), okay?
P:	Okay.
SW:	Before you terminate a pregnancy, you have to talk with someone like me, because when you want to have abortion it's no easy decision for a woman; ((in a softer and more empathic tone of voice)) so we give women the possibility to talk with someone, to let their pain out, because women who decide not to carry on with their pregnancy are desperate, aren't they? So, do not take it as if I were prying into your personal life, as if you were being interrogated. Do not close up and be on the defensive. See this as a chance to let everything out, to cry even, to let your pain out
((Someone knocks at the door, gets into the room and asks to talk with SW. SW stands up, moves away and the two start talking. P is left alone with the student interpreter. After 5 minutes SW comes back))
SW:	What I was saying was that we are trying to understand your situation, your psychological condition, to be able to then help you as best as we can, so that you may take the best decision for you, for your life. Whether you decide to interrupt or carry on with your pregnancy, we are here to help you.
P:	Capito.

Appendix 2: Summary overview of data

Subjects	Sex	Date of IRI test	Date of RP and FR
S1	male	11/02/2016	12/05/2016
S2	female	11/02/2016	12/05/2016
S3	female	11/02/2016	12/05/2016
S4	female	11/02/2016	12/05/2016
S5	female	5/10/2017	7/12/2017
S6	female	5/10/2017	7/12/2017
S7	female	5/10/2017	7/12/2017
S8	female	5/10/2017	7/12/2017
S9	female	5/10/2017	7/12/2017
S10	male	5/10/2017	7/12/2017
S11	female	5/10/2017	7/12/2017
S12	female	5/10/2017	7/12/2017
S13	female	5/10/2017	7/12/2017
S14	male	5/10/2017	7/12/2017
S15	female	5/10/2017	7/12/2017

Appendix 3: Line chart of subjects' PT and EC scores