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Verbal and nonverbal concomitants of rapport in health care encounters: implications for interpreters
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ABSTRACT

This article examines verbal and nonverbal rapport in mediated healthcare encounters. A review of nine studies reveals the interpreters' tendency to editorialise non medical facts, repetitions, variation, emphasis and verbal and nonverbal back-channelling as they seem to regard this information as non medically relevant. Medical rapport, however, is mostly relayed through these verbal and nonverbal behaviours, and thus the development of doctor-patient involvement in the interaction can be compromised. Doctors' and interpreters' views on rapport are analysed, and implications for training and research are extracted.

KEYWORDS

Nonverbal mediation, medical interpreting, verbal behaviours, nonverbal behaviours

1. Verbal and nonverbal rapport in medical encounters

An impressive body of literature on medical interpersonal communication suggests that doctor-patient rapport is central to effective medical care delivery (Cooper & Tauber 2005; Kurz et al. 2003; Hall et al. 1995; Friedman 1979). The importance of doctor-patient rapport has long been recognised (cf. Hippocrates 1923), as patients' physical wellbeing and healing are largely dependent on effective technical knowledge supplemented with affective interpersonal communication (Kurz et al. 2003, Ambady et al. 2002, Beck et al. 2002). Research findings have revealed that the interpersonal quality of the doctor-patient relationship can actually influence the patient's course of recovery, since supportive communication can decrease the patient's anxiety, which is a basic concomitant of illness (DiMatteo & Taranta 1979). Affect and empathy in medical encounters is thought to be especially linked to nonverbal behaviour, and its emotion-related skills: coding and encoding nonverbal information, and emotional self-awareness (Roter et al. 2006, Beck et al. 2002, Hall et al. 1995, DiMatteo & Taranta 1979).

Nonverbal behaviour is defined as a variety of communicative behaviours that do not carry linguistic content (Knapp & Hall 2007). These include facial expression, smiling, eye gaze, head nods, postural position, back-channelling, interruptions, overlapping speech, and paralinguistic speech characteristics such as speech rate, intonation, fluency, voice quality, pitch, loudness, and speech disfluencies. Nonverbal communication also plays a major role in the organisation of turn-taking in conversation. The nonverbal dimension of speech overlaps with the verbal messages, and in so doing it provides meaning in context, by reinforcing or contradicting the verbal content.

Definitions of rapport highlight a high level of mutual understanding, a high level of positivity or warmth, and a high level of behavioural coordination, i.e., a more synchronised behaviour both in terms of form and timing (Tickle-Degnen & Rosenthal 1992). We can distinguish between speech-unrelated nonverbal rapport, speech-related nonverbal rapport and verbal rapport. The first is conveyed through facial expressivity, more gestures, body movements involving more forward lean, direct body orientation, more head nodding and smiling, direct eye-contact, closer interpersonal distance, and a softer tone of voice (Ambady et al. 2002, Hall et al. 1995). Verbal rapport in the form of back-channelling ("um," "I see," "Is that right?"), emphases, repetitions as well as small talk is communication aimed at building relationships rather than establishing medical facts (Street & Buller 1987, Aranguri et al. 2006: 626).

Patients are particularly alert to doctors' nonverbal behaviour, because they are anxious and feel uncertain, so they try to discern the doctor's feelings about them or their condition. In turn, doctors use patient's nonverbal cues to assess the clinical progress, gauge the degree of pain, as well as to reassure and support patients. We are very accurate when we judge another persons' emotions, and in most cases we do better than chance level (van Bezooijen 1984; Scherer et al. 2001), using very small and short displays of emotion (Ambady et al. 2001). It is not surprising that patients tend to be more satisfied with doctors who are good at expressing and correctly interpreting their patients' nonverbal behaviour than with those who are not adept at conveying affect in their practice (Flores 2005; Im et al. 2004; Elderkin-Thompson et al. 2001; DiMatteo et al. 1986). An affective tone of voice (Schmid et al. 2007), facial expressivity (the combination of smiling, frowning and nodding), open body posture, spontaneous style, and a slow pace of delivery have been positively correlated with perceptions of doctors' warmth, empathy and concern (Beck et al. 2002; Elderkin-Thomson et al. 2001; Hall et al. 1995).

Emotions as expressed by nonverbal behaviour can also exert a profound influence on cognitive processes such as information storing, recall, decision making, information processing and interpersonal attitudes (Gray 2001; Oatley & Jenkins 1996). The emotional nature of the interaction affects patients in an array of different ways, from satisfaction and recall to adherence to treatment and a better quality of life (Beck et al. 2002; DiMatteo et al. 1986). Doctors' detachment and distancing behaviour (absence of smiling and direct eye-gaze) has been found to relate to decreased patient's physical and cognitive functioning (Ambady et al. 2002). Contrarily, doctors' empathic nonverbal cues, such as head nodding, forward lean, direct body orientation (Beck et al. 2002), affective tone of voice and greater expressiveness (more forward lean, more nodding, more gestures, closer physical proximity, and more gazing)

(Griffith et al. 2003; Hall et al. 1995) have been positively associated with higher patient satisfaction and higher patient outcomes.

2. Verbal and nonverbal rapport in mediated medical encounters

The establishment of trust with the parties, and the communication of affect alongside the message have been viewed by interpreters as an intrinsic part of their role (Angelelli 2001: 26), particularly in medical settings, where they see themselves as more visible than in other professional environments (*ibid.*: 24). In fact, empathy and the ability to establish rapport are seen as prerequisites in interpreted doctor-patient interaction (Bot 2005: 90).

Interpreting scholars have highlighted the central role of interpreters' verbal and nonverbal features in the management of turn-taking: eye-contact and gaze withdrawal, interruptions, back-channelling, hedges, pauses and gestures (Mason 2009; Bot 2005; Wadensjö 1998, 1999; Tebble 1999; Englund Dimitrova 1995), and how they serve a coordinating as well as a cooperative function.

Interpreting rapport in the form of verbal and nonverbal feedback can be fraught with problems. As each interlocutor has to listen to every message twice, feedback is often incorporated to the following utterance in the conversational turn. As a result, it may not be clear whether it is the interlocutors' feedback or the interpreters' feedback (Englund Dimitrova 1995: 159). Feedback can serve various purposes. It can convey understanding, perception and cooperation, thus contributing to the building of rapport, but it can simply convey the interlocutor's wish to uphold or take the floor. Additionally, many verbal and nonverbal forms of feedback are culture bound, and can pose misunderstandings (Bernstein et al. 2002).

A review of various codes of ethics and practice that articulate the role of medical interpreters (Beltran Avery 2001; Kaufert & Putsch 1997), and the literature on doctors-patient interaction with interpreters (Silverman et al. 2005; Davidson 2000) show an emphasis on the value of interpreters performing as neutral parties to the consultation, and a neglect of the emotional side of the interaction (Hsieh et al. 2009; Leanza 2005; Dysart-Gale 2005). Scholars have addressed the inadequacy of the conduit role in medical encounters (Angelelli 2004; Davidson 2000; Cambridge 1999; Tebble 1999; Kaufert & Koolage 1984), and have shown that interpreters perform beyond the conduit role, thus influencing the process and the content of the medical exchange (Bot 2005; Angelelli 2004; Davidson 2000). But additional extensions to the role of the interpreter as a clarifier, a cultural broker, and patient's advocate do not seem to have solved the conflict, as codes of conduct seem to offer little guidance as to when and how to perform these additional roles (Kaufert & Putsch 1997). Consequently, interpreters often face ethical strains in their

practice as regards the expression rapport (Hsieh et al. 2009, Kaufert & Putsch 1997).

There seem to be mismatches with regard to the parties' expectations about the interpreter's role in mediated medical encounters. On the one hand, interpreters' and doctors' codes of ethics emphasise the conduit role, largely based on verbatim rendering of the linguistic information (Dysart-Gale 2005; Leanza 2005; Angelelli 2001, Davidson 2000). This contrasts sharply with some doctor's expectations, as shown in studies by Pöchhacker (2001), Rosenberg et al. (2007) and Hsieh et al. (2009), but not so much with others, particularly in mental health settings (Hsieh, Ju & Kong 2009: 6). Doctors' expectations as to interpreters' engaging in rapport seem to vary according to individual preferences as well as their domain of specialty (Hsieh et al. 2009). In mental health care, there are doctors who do not approve of interpreters engaging in small talk with their patients, let alone provide emotional support, but others see it as serving therapeutical purposes, and oncologist seem to believe is helpful (ibid.: 6-7). On the other hand, patients seem to see interpreters as listeners, sympathisers, friends (Bot 2001: 31), and some have referred to them as "anchors," particularly in refugee settings (Rosenberg et al. 2007: 288).

Another mismatch can be found in the different approaches that the parties take to affect. Doctors and service providers are expected to develop an empathetic, supportive relationship with the clients (Kurz et al. 2003; Hall et al. 1995; DiMatteo & Taranta 1979, Friedman 1979), whereas "interpreters are not trained to establish therapeutical rapport with the patient" (Dysart-Gale 2005: 401). It is not surprising that many professional interpreters have expressed distress, and ethical dilemmas with regard to the expression of affect (Hsieh 2006: 925, Dysart-Gale 2005: 92), as the boundaries between what is medical, social and emotional are not clear-cut.

3. Interpreting rapport

The nine studies reviewed in this article share a core of common elements, and a similar methodological approach. They are all concerned with interpreted-mediated healthcare encounters, and interested in the medical and social impact of interpreter performance. In particular they all share an interest in analysing what guides interpreters in their decisions as to what is and what is not relevant at the various stages of the medical interview, and the clinical, social and emotional side effects of these practices. Materials consisted of corpora of recorded mediated healthcare encounters between providers, patients and both professional and *ad hoc* interpreters. Professional interpreters were described as having received training from local, regional or national associations, having passed a test or having had supervised experienced, and being paid for their professional activity. In general, the reviewed authors' views on

interpreters are broader than other studies of mediated medical encounters found in the medical literature which conceive of interpreters as 'translation machines' performing the conduit role. Researches seemed to be aware of the conflict between the roles expected from the different parties, and how these roles very often collide.

The studies found that the interpreters working in medical settings tend to focus on factual information, neglecting other communicative goals at play in the encounter, which could have a negative effect on the doctor-patient relationship, challenging the development of rapport.

Bolden's (2000) study of an on-staff interpreter who had some training reveals his tendency to attend to and topicalise biomedical facts. The interpreter structured the interview using yes/no questions, and interrogation tags in pursue of the relevant diagnostically relevant information. Information regarded as diagnostically irrelevant was summarised. This limited the possibility of the patients establishing a more personal relationship with the doctor, and the doctors' chances to actually hear what their patients wanted to tell them. Davidson (2000) conducted a study of professional interpreters at a hospital. The interpreters were professional in the sense that they were paid for their services, but had no formal training in interpretation or translation. Interpreters appeared to be taking on the role of co-diagnostician, seeking and offering information and running the interview. Hispanic patients' detailed accounts of their medical difficulties in the handling of their ailment were deemed irrelevant, and were editorialised in order to keep patients 'on track' (Davidson 2000: 390). Patients' self was misrepresented, their portrayal being that of passive agents, which resulted in misdiagnosis. In a similar vein, the study by Leanza (2005) shows doctors' expectations of the role of the interpreter as getting the biomedical message across to the patient, and acting as cultural informants only when interpreting to the patient. Interpreters were seen to do precisely that, aligning themselves with the institution rather than acting as cultural facilitators. Both providers and interpreters seemed to have lost sight of the relational dimension of the interaction. Dysart-Gale (2005) explored professional interpreters' views on codes of ethics, and whether they were effective in guiding them through their practice. Interpreters claimed that anxiety and confusion were felt particularly when providers' translation culture recommended a type of practice that, to their minds, might lead to inappropriate action. This was seen in instances when the interpreter did not know whether to verbalise questions that patients would not pose themselves out of cultural differences, but that their nonverbal behaviour leaked as relevant: "You can see from their body language that they don't understand, but they just nod, and I all I can do is stand there" (*ibid.*: 98) or in anecdotes where interpreters dithered to offer personal condolences to relatives who they knew personally:

There was just this woman who lost her baby. I know her from before from church...she lost her baby today, and everyone, the doctor and nurses and all, were standing around and saying they were sorry, and I was interpreting, fine, no problem, and then they all just left the room and I was standing alone with her and I didn't know what to do. I don't know. Am I allowed to say I'm sorry? I mean, there's nobody to interpret for, and if I see her at church, it would be like breaking confidentiality to talk about it. What should we do then? ... I felt so bad for her (Dysart-Gale 2005: 98).

Aranguri et al. (2006) noted differences in rapport in monolingual medical encounters as compared to medical encounters mediated by staff and family members. The data revealed that verbal reinforcement, repetition and affect, which are responsible for conveying rapport, were substantially reduced in comparison with the monolingual interviews (*ibid.*: 626). In her study of interpreter's role as co-diagnostician, Hsieh (2007: 925) observed that the interpreters (certified professionals who had undergone an 80-hour training course) assumed doctors' communicative goals and did so editorialising information which was thought to be medically irrelevant. While interpreters repeated requests for medical information in order to comply with the doctors' communicative goal of diagnosis, they largely did not render doctors' emphasis and repetitions which were not related to medical facts, and were aimed at conveying reassurance and warmth. In some instances, doctors' prosodic performance (a caring and animated tone of voice) was changed into a more direct, authoritative style (*ibid.*: 928-929). Equally, verbal rapport was compromised when face-threat reduction strategies, and comments that required no answer were not translated (*ibid.*: 929). Doctors' perception of interpreters (both professional and *ad hoc*) was analysed by Rosenberg et al. (2007) who show that doctors were anxious that their rapport was not relayed by the interpreter:

The ability of the interpreter to transmit the physician's expressions of emotion, empathy etc. through paralinguistic cues, such as tone of voice, gestures, and encouragement was uncommon, but when it occurred, as beneficial to the creation of a good patient-physician relationship (Rosenberg et al. 2007: 289).

Kiemanh et al. (2008) had interpretations by family members analysed by research interpreters, and the results are much in keeping with Rosenberg et al.'s (2007) in that interpretations negatively affected the doctors' ability to provide emotional support and rapport, and decreased their degree of empathy (*ibid.*: 115). In a recent study by Hsieh et al. (2009) interested in exploring interpreters' views on their roles, the authors analysed the dimensions involved in the building of trust. Two clashing views emerged. As regards the dimension of 'competence,' doctors emphasised that an exact and literal interpretation was central to the credibility of an interpreters' performance (*ibid.*: 4), however, interpreters were expected to provide emotional support and rapport with the patients if they were to comply with the 'shared goals' dimension:

If I walk in and I like my patient's shoes, I'd say, "Oh, I love your shoes! They are so cute" [high, cheery tone]. . . . And some of [the interpreters] go like, "Yeah, ha-ha." I'm like, "No! Tell her! I like her shoes!" "Tell her I love her baby!" We are an emotional group (Hsieh, Ju & Kong 2009: 6).

Discussion

A review of codes of ethics in interpreting reveals that they leave no space for rapport in the interaction between doctor and patient. Rapport, however, lies at the heart of the quality of medical care delivery. Repetition, variation, emphasis, feedback, detail imagery, back-channelling are means to build personal involvement, and thus enable understanding and rapport (Tannen 2007: 134). The studies reviewed in this article show that by editorialising repetitions, emphasis and patients' detailed accounts, and not relying questions that required no answer the interpreters could be excluding patients from the interaction, misrepresenting their self. At the same time, not rendering doctors' repetitions, emphasis and non medical facts can portray an authoritative, distant image of the provider, contrary to the providers' attempt to build a personal relationship with his/her patient.

These practices could be due to various factors. Doctors have contradictory views on the role of interpreters as co-providers of support and encouragement. On the one hand, they see interpreter competence in terms of neutrality and linguistic accuracy, and on the other hand they expect interpreters to adhere to shared goals and diagnostic efficacy, which imply the development of rapport. Diverging views also stem from different medical specialties, being mental health providers more reluctant to interpreters' conveying rapport than practitioners in other domains.

Lack of training (*ad hoc* interpreters), insufficient guidance by codes of ethics (professional interpreters), and providers' varying expectations as to the interpreter's role, together with interpreters' preconception of the social hierarchy of healthcare settings could have lead interpreters to strive towards diagnostic efficacy, ignoring other communicative goals of the interaction, such as the building of rapport as conveyed by verbal and nonverbal feedback, small talk, and low medical content talk. Most interpreters seemed to assume the doctor's communicative goals, and editorialised feedback and non medical information. Although many of these strategies can be attributed to interpreters' effort to maximise doctors' time in medical institutions with a chronic shortage of time, most of the editorialising strategies were taken rather subjectively, and posed risks to doctor-patient relationships.

Conclusion

Understanding is facilitated by doctors and patients experiencing emotional involvement. In conversation, involvement and rapport building result from the appropriate inference of the goal of the interaction. As pointed out by Gumperz (1982), involvement can be seriously compromised in cross-cultural communication, and the studies reviewed in this article show that rapport can be challenged when interpreters remain silent, editorialise, and summarise what they regard as non biomedical information. This has implications for training. 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. Nonverbal sensitivity tests, such as PONS (Rosenthal *et al* 1979) or DANVA (Nowicki & Duke 2001) could be used in the classroom to raise students' awareness of the role of the nonverbal dimension in the development of the doctor-patient relationship. 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). Adopting a more global approach to the encounter could help interpreters better decide how best they can take an active role in deciding what is relevant and important for the ongoing activity and relationship and how it is displayed verbally and nonverbally.

Implications for research include taking on an interdisciplinary approach to the study of the verbal and nonverbal concomitants of mediated medical rapport. Much can be gained if social psychology models such as the Brunswick's lens model (Scherer 1982) were used to explore the role of emotional rapport in the medical interview, and how the nonverbal dimension of rapport can help compensate the challenges involved in the relaying of verbal rapport. At the same time, doctors' and patients' expectations as to rapport should be probed in various domains of specialism to ascertain whether doctors and patients vary in their priorities. The findings resulting from the interdisciplinary study of rapport and the expectations survey should inform both the training of medical interpreters, providers, and the codes of ethics that articulate their practice.

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Biography

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