Forms of Participation in a Mental Health Care Consultation with a Nonpresent Interpreter

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Abstract (87 words)

Interpreter-mediated interactions via phone are becoming increasingly frequent, especially in medical settings. I examine one case of a mental care consultation with a non-present interpreter. My aim is to explore how the three participants – mental health practitioner, client and non-present interpreter – use multimodal resources to manage the possible interactional relations among themselves. I will show how, at certain points, they use gaze and body orientation to integrate into the overall triadic interaction a series of exchanges between practitioner and client. The data are in Arabic and French, with an English translation.

Key words

Telephone interpreting, Participation, Multimodality, Mental health care, Dyadic and triadic participation frameworks.

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Interpreter-mediated interactions have attracted increasing attention in recent years, not only in the field of translation studies, but also with regard to interactional issues, such as sequentiality or participation. Interpreting via the telephone, on the other hand, although becoming a widespread form of interpreting in many professional areas, has as yet been discussed in only a limited number of studies. In this paper, I briefly review the main characteristics that have been identified concerning telephone interpreting and then focus on the forms of participation it makes possible.

It is a generally shared view today that an interpreter is not a mere "language conduit", but a full-fledged participant in a triadic interaction, assuming an important responsibility in co-constructing the interaction (Wadensjö, 1998; Bolden, 2000; Angelelli, 2004; Baraldi & Gavioli, 2012, among numerous others). In the field of medical consultations, this conception has led to questioning of the roles, places and specificities of the different participants' contributions in the interpreter–patient–doctor triad. These concern, for instance, the issue of the doctor's or the interpreter's own skills and expertise, the issue of the interpreter's types of contributions connected to the ongoing activities in the consultation (history taking,

examination, etc.) and the question of the audibility of the patient's own talk. One way of studying these issues in sequential terms is to examine the presence of sequences among only two out of the three participants in the situation. Some studies have been devoted to dyadic patient–interpreter sequences that are not translations and that could be considered to exclude the doctor (Gavioli, 2014, 2015). In this paper, I examine this issue of dyadic communication within the triadic situation with a focus on doctor–patient communication.

Interpreting via telephone puts the issue in yet another light. Since the interpreter is not physically present, the organization of participation clearly differs from when s/he is on-site, and the coordination role s/he assumes also differs. The main point that is made in many studies of telephone interpreting relates to how this condition limits the participants' access to what is going on in the consultation, creates asymmetries between them and consequently limits the opportunity for the interpreter to coordinate the talk. In this paper, on the basis of a multimodal analysis, I outline a more complex picture of the situation considering the following characteristics. First of all, I show that in the data under study, the interpreter *does* play an important coordinating role. I also show that the two on-site participants deal differently with the remote interpreter's contributions. This participant is thus present in the situation, not with one unique status but with different participatory statuses. Then, I focus on a phenomenon observed in the data: the emergence of dyadic participation frameworks within the overall triadic one. Following the work of Goffman, I use the term "participation framework" to refer to the way in which the persons involved in a conversation display, through their contributions, how they organize participation, in terms of recipientship and speakership, on a moment by moment basis.

The paper is based on a single case analysis of a mental care consultation with a female Syrian refugee in France and including a telephone interpreter.

1. Telephone interpreting[1] and participation

Participation is a core issue in interactional approaches to interpreting (see, in particular, Wadensjö's seminal work on "interpreting as interaction", 1998; and the papers gathered in Baraldi & Gavioli's book on "coordinating participation", 2012). It is studied through examining the question of the interpreter's status/place (person or non-person, full-fledged participant or not, etc.) and the sequential organization of the triadic sequences arising from the interpreter's mediation (Wadensjö, 1998; Bolden, 2000). In the last few decades, research has been regenerated by the development of multimodal studies (see Davitti, in press, for a review of this evolution; and a series of research papers on interpreted interaction in different settings gathered in Biagini, Davitti & Sandrelli, 2017). Researchers have specifically proposed detailed studies of phenomena such as switches in the participation framework (Wadensjö, 2008), the role of gaze in turn-taking organization, transition between turns (Pasquandrea, 2011, 2012; Ticca, 2010, 2017; Traverso, in press) and participants' positioning (Mason, 2012), changes in voice to organize the participation framework (Ticca & Traverso, 2015), spatial organization of the participants (Wadensjö, 2001), impact of the use of documents or computers on participation frameworks (Traverso, 2017; Ticca & Traverso, 2017) and construction of the interpreter's (in)visibility in video-mediated interpreted communication (Licoppe & Veyrier, 2017).

In this paper, I focus on a consultation interpreted via telephone. This type of interpreting has mainly been studied through quantitative approaches, generally based on questionnaires and interviews and leading to results in terms of advantages and drawbacks. Among the advantages, the convenience of this form of interpreting is often mentioned:

[1] Some papers address telephone interpreting using the term "remote interpreting".

interpreters are more easily available (Phillips, 2013) and a wider range of languages is offered (Kelly, 2008; Phillips, 2013). Another point is that telephone interpreting is seen as increasing privacy (Wadensjö, 1999; Kelly, 2007; Rosenberg, 2004). Phillips for instance considers that it creates an anonymous and disembodied interpreter, who can thus be experienced as "an imagined other, rather than a specific person" (2013: 518).

The negative aspects of telephone interpreting generally mentioned are rather the reverse picture of its advantages. The most often quoted drawback is the lack of visual cues, which prevents the interpreter from seeing the parties' facial expressions, gestures and gaze (Wadensjö, 1999; Mikkelson, 2003, among others). The risk of poor sound quality is another difficulty recurrently mentioned and specifically the impossibility of having voices overlap in some telephone systems. This can be particularly troublesome because it prevents hearing of the co-participant's continuers ("hmm", …, etc.), frequently uttered in overlap. Although telephone interpreting can provide a sense of privacy (as mentioned above), it may also be experienced as a threat to privacy, since one cannot see whether the interpreter is in a public or private space, alone or within earshot of other people, etc. (Kelly, 2008; Ozolins, 2011).

Wadensjö's (1999) paper provides one of the rare qualitative analyses of naturally occurring data from telephone-interpreted interaction, focused on turn-taking and participation. On the basis of a comparison of telephone and on-site interpreting, she speaks of the loss of "the sense of immediacy inherent to face-to-face interaction" (1999: 269) in telephone interpreting and stresses the consequence this has for the interpreter's ability to organize talk. She shows that the transitions between the participants' turns are smoother in situations including an on-site interpreter, i.e. there is no gap between the successive turns and even frequently short overlaps or latching, similarly to what is the case in ordinary exchanges (Schegloff, 2000; Jefferson, 2004). This displays a better rhythmic synchrony between the turns, based on prosodic patterns indicating the end of the ongoing turn. In contrast, she observes that in telephone-interpreted encounters, transitions between participants' turns are mostly longer.

In the following analysis, I mainly focus on changes in the participation configurations according to the temporal and sequential development of the interaction and the type of ongoing interactional activities, such as question/answer sequences, storytelling, complaints, etc. I follow the approach to participation presented in Goodwin C. (1981; 2000), Goodwin M.H. (1980) and Goodwin & Goodwin (2004), based on a very-fine grained examination of how the participants involved in social situations display shared and mutual engagement in the activities. This view of participation is basically multimodal and considers all the relevant semiotic fields for the participants' actions, as well as the material environment (space, objects) in which the interaction takes place. Within this perspective, I propose a case study of the construction of participation at different moments of the interaction, based on verbal forms, vocal cues, gaze, body orientation and gesture.

2. The data

The data are part of a large corpus of interactions recorded in healthcare settings receiving refugees and migrants in France.[2] The interaction for the case study is a consultation between

[2] The data were collected for the REMILAS, *Refugees, migrants and their languages in healthcare services*, research project, funded by the French National Research Agency (2016–2019). This deals with obstacles to communication in refugees' health and mental care consultations in France. All the data collected for this project were recorded with all the participants' informed consent and a set of ethical precautions, established in agreement with the legal services and ethical committees of the academic and healthcare institutions concerned, were respected in the collection, analysis, storage and publication of excerpts of the data. See http://www.icar.cnrs.fr/sites/projet-remilas/corpus/.

a psychologist and a Syrian migrant woman, who has obtained the status of subsidiary protection. The consultation takes place in an asylum seekers' centre, where the patient lives with her two daughters and where the psychologist holds consultations once a week. The interaction is part of a psychological follow-up; therefore, the two participants know each other well. The interpreter is a professional and she is also used to working with these two persons. She translates from French to Arabic and vice versa. This interaction is interesting because it is a smooth and fluid psychological consultation, in spite of the complex framework in which it takes place, a framework often described by the interpreters we have interviewed in the REMILAS project as second best, resorted to essentially for economic reasons.

The consultation was followed by an interview with the psychologist, in which she explained to the researchers[3] that the patient was in the process of learning French and that she herself understood some Arabic. What emanates from the data in this regard does not give a clear idea of the patient's understanding of French. At the end of the consultation, some exchanges in French take place, which show that her French remains very basic. Similarly, her attitude during the consultation suggests that she understands rather little of the psychologist's talk. Nonetheless, from time to time, she displays an understanding that enables her to react relevantly during the translation and she also utters a few words in French (see §4). The psychologist, in contrast, gives no cues at all of her understanding of any turn or word in Arabic.

During the consultation, the on-site participants are sitting across from each other at a table, with the speakerphone on the table between them, as shown in figure 1.

#1. Basic configuration of the encounter

The data include only the video recording of the on-site participants; we have no video of the interpreter in her own site.

In the interaction considered here, the interpreter provides consecutive interpreting.[4] Many of the features or problems reviewed above are not found in this interaction. The sound quality is not perfect, but good enough to assure mutual understanding. Only briefly, at two moments, do audibility problems occur and these are quickly solved by repairs. Nor do we

[3] Data were collected by Anna Claudia Ticca and Emilie Jouin-Chardon.

[4] This type of interpreting taking place in social situations is called "dialogue interpreting". Its main features, as defined in Baker (1998), are that it is bi-directional, carried out consecutively and occurs turn by turn, or at least small unit by small unit.

observe difficulties in turn organization. This is partly due to the fact that the patient is a very talkative woman, who tends to produce very long turns at talk (most of them between 30 s and 1 min), and that the professional interpreter works through taking notes of these very long stretches of talk and then translates. This is mentioned by the psychologist in the interview as a very positive feature. All the three participants also give clear cues on the structure of their turns at talk, regularly indicating their starting, with markers such as “donc euh” (so uh), “naʃam ʔizan” (yes so), and their closing with prosodic cues (see §3).

The consultation is one hour long and develops in two main phases. The first, about 22 min in duration, is devoted to the patient's health problems with her feet; the second concerns her morale. In this second part, the patient talks about the problems of cohabitation in the centre. She reports at length violent actions that have been committed by some residents and asks that the centre's director organizes a meeting devoted to this issue. In this phase, she mainly tells stories and complains.

3. Participation configurations

The most recurring address and recipient behaviours of the patient and the psychologist during the interaction differ. The following excerpt shows how each of them organizes the participation framework in which she speaks and specifically how they display the place they attribute to the remote interpreter. During the whole excerpt, the psychologist looks at the patient in front of her in a continuous manner. This is the reason why I have not described her gaze in the multimodal transcription, but only her head movements and facial expressions.

1) REMILAS_ 170719_PYE_1_0609_pas expliqué
PYE: Emiline, the psychologist; ENM: Enam, the patient; IPT: the telephone interpreter

```
1     PYE  ◊d'accord\◊ (.) donc euh: ◊i vous◊ a pas expliqué euh: hm
            okay            so uh he didn't explain to you uh mh
      pye  ◊nod      ◊              ◊H. left—right◊
      enm  >>stares at PYE, arms on the table ->

2 #         ◊le #2 résultat de la radio//◊ (.) ↓°quand vous êtes allée l` voir°/\
            the X-ray result                  when you went to see him
      pye  ◊hand gesture, raises eyebrows◊

3           (0.5) + (0.9)
      enm         +... turns her gaze towards the phone->

4 #   IPT   tam+ām\ #3 izan huwa ma fassarlik natāʔiʒ əṣṣūra://
            fine       so he didn't  explain to you the results of the photo
      enm      +--- head oriented toward the phone ->

5           .h ʔø ṣūret lʔaʃeʔa\ °lamman ʔenti rəħti ʃūfti la ṭṭabīb°/
            .h uh the X-ray photo when you went to see the doctor

6           (0.8)

7     ENM   +ah/ laʔ+ ma: fassar ʃē bass ʔø: katabli fawran/
            oh no he explained nothing just uh: he wrote me immediately
      enm   +H. left—right+

8           katab elø: wasfije jaʕni ma qālli ʔenno nafs ħālet lø:
            he wrote the uh: prescription I mean he did not tell me that it is
            the same case as::

9           rəkbet ljasā:r wala ɣēr ħāle (0.5) .h ø: bass katable
            the left foot or another case (0.5) .h uh: he only wrote me

10          wasfe miʃān  elø: ʔø: (0.3) əddawa ʒe- ʒībo:
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          a prescription for the: uh:  (0.3) the medecine that I {must} take

11        men ʕend l:- w ʔaʕṭīla waṣfet əṭṭabīb\
          from th-    and give it the doctor's prescription

12        (1.9)

13   IPT  euh: non il m'a pas expliqué: il m'a ◊pas [dit]+◊ si: c'était le
          uh no he didn't explain to me he didn't tell me if it was the

14   PYE                                              [hm]
     pye                                          ◊series of nods◊
     enm                                                +body+G twd.PYE->

15   IPT  même cas+ que: le pied: gauche/ ◊[(.) .h i◊] m'a juste donné
          same case as the left foot      (.) .h he just gave me
     enm          +G twd. phone ---------------------------------->

16   PYE                                  [d'accord\]
                                           okay
     pye                                  ◊strong nod◊

17   IPT   +une prescrip◊tion:/◊ [.h] +euh:: donc+ pour un+ médicament)
          xpa prescription        .h:  uh::  then for a medicine    (0.9)
     enmG  >+G twd. PYE ---------------------------------->+G twd. phone->>
     enmEB                            +raises EB+
     pye                ◊raises shoulders◊

18   PYE                         [°bon°]
                                  well

19   IPT  (0.9) que j` dois pren:dre et: l'emm`ner avec moi °chez
          that I must take and take with me to

20        l` médecin\°
          the doctor

21   PYE  ◊d'accord\◊
          okay\
     pye  ◊strong nod◊
```

The excerpt starts with a question uttered by the psychologist elaborating on the patient's previous answer to her question about her encounter with the radiologist. The sequential development corresponds to a format related to consecutive interpreted interactions, with the original question in French (lines 1–2), followed by the translation of the question into Arabic (4–5), then the patient's answer in Arabic (7–11), the translation of the answer into French (13–19) and finally the doctor's receipt token (line 20). This format is the most frequently found in the consultation.[5]

I comment hereafter in more detail on the development of the excerpt at the sequential and participatory levels, showing that the participants give clear cues on how they organize their talk sequentially and how they re-organize the participation framework.

First, we can notice, in line 1, the acknowledgement token uttered by the psychologist at the beginning of her turn, expressing her reception of the interpreter's previous talk (rendering of a previous patient's turn). This is a very clear structuration device. It is followed by a short pause, then by the initiation of the next question. The psychologist requests confirmation of an inference she made based on the patient's previous talk, stating that the doctor did not give her an explanation of the X-ray result. The syntactic and prosodic formats of the psychologist's turn give interesting sequential cues. The question is composed of two units.

[5] Nevertheless, it is far from being the most frequent in all the interpreted consultations, as many papers have shown (see among others Wadensjö 1998, Bolden 2000, Traverso 2002, Gavioli 2015).

The questioning part itself (up to line 2, "... the X-ray result") ends with a highly rising pitch before the pause. At this moment, the question is semantically complete. During this turn constructional unit (TCU) the psychologist gazes at the patient, as indeed she does for the whole excerpt. Here she also performs a series of gestures. First, in line 1, she makes a head movement from left to right immediately before the negation ("◊i vous◊ a pas expliqué", as in "◊he you◊ did not explain"), performing a sort of gestural version of the negation. Then, in line 2, she makes an iconic hand gesture (Figure 2), moving her hand twice as if going from the bottom to the top of a document, before putting her arm back on the table just before the pause. Along with this gesture, she slightly tilts her head to the right and raises her eyebrows, while staring at the patient, thereby performing an embodied posture of questioning her interlocutor. During the whole TCU, the patient stares at the psychologist, motionless, her arms on the table (as shown in figures 1 and 2).

#2. The psychologist mimicking going through a document

After the pause, the second part of the question is a sort of appendix (Mertens 2006), uttered at a low pitch and with decreased intensity. This prosodic contour is a clear cue of the end of the turn, at least for the interpreter (for we cannot assume that the patient is able to grasp this type of cue in a discourse in French).

The psychologist's communicative behaviour during her turn builds a participation framework that includes her two interlocutors by different means. She addresses the patient as her direct interlocutor, verbally through the use of "you" (line 1 "he didn't explain to **you**", line 2 "when **you** went to see him") and gesturally through gazing at her throughout her turn and embodying her questioning. She addresses the interpreter in a more indirect way through discourse markers (such as the "okay" in line 1) and prosodic cues.[6]

During the pause in line 3, the participation framework starts to be transformed. This pause is rather long, which could be interpreted as indicating the patient's lack of understanding of the psychologist's question in French. During this pause, the patient remains for a short while staring at the psychologist, who has stopped talking. Then, after 0.5 s., she moves her gaze in the direction of the phone, showing that she is awaiting the interpreter's translation. The patient then maintains this same position during the entirety of the

[6] See Ticca & Traverso (2015) for an analysis of the use of prosodic cues in an interaction with an interpreter who works without seeing the doctor's actions accompanying her talk (while examining a patient in a medical consultation).

interpreter's turn, mainly looking into the distance, while the psychologist continues to look at her.

The interpreter's turn in lines 4–5 starts with the marker “fine”. This is not a translation, but a structuration marker (unlike the second marker at the beginning of the turn “so”, which is a rendition). This cue is merely produced for the patient (since the psychologist cannot understand it), as a sort of pre-beginning (see Gavioli 2012). We can also notice that the interpreter uses the same turn structure as the psychologist in lines 1–2 (a two-unit turn), with the same type of prosodic contrast for the second unit.

After the translation and a pause in line 6, the patient answers the question, with her body oriented to the phone, whereas the psychologist continues looking at her (Figure 3).

#3. The patient answering the psychologist's question, oriented towards the phone

In line 13, the interpreter starts rendering the patient's answer. Unlike in her first turn of translation (lines 4–5), she does not start here with a discourse marker, but rather adheres to the patient's turn structure (patient's turn “oh no” in line 7 rendered with her “uh no” in line 13). The end of her turn is marked with a falling intonation, decreased intensity and creaky voice. We can also mention that she reorganizes the patient's talk (the patient speaks twice of the prescription, once in lines 7–8 and then in line 9, whereas the interpreter provides all the information on this point at once, at the end of her turn, in lines 14–16).

During the interpreter's talk, the on-site participants' behaviour differs. At the beginning of the turn, the patient is totally oriented towards the phone, while the psychologist looks at her (Figure 3). Very quickly, in line 14, after the first part of the translation of the answer (“he didn't explain to me”), the psychologist produces continuers (“hm” and a series of nods). This display of recipientship entails a change in the patient's attitude: she sits up and looks at the psychologist for a short while. This sequencing of actions (the psychologist uttering a receipt token and the patient looking at her) also recurs in line 16, after the psychologist's “okay” and nod, acknowledging the second piece of information.

During the third part of the interpreter's turn, the patient is still looking at the psychologist – the two on-site participants are thus looking at each other (as in Figure 1). During the pause after “he just gave me a prescription”, the psychologist grimaces and raises her shoulders, which receives a very slight facial expression in response from the patient (not visible in the blurred pictures), as in a sort of silent fleeting exchange. At the very end of the excerpt, in line 21, the psychologist utters a final receipt token.

To sum up, we can say that the two on-site participants construct the participation framework in which they produce their turns at talk very differently. When she talks, the psychologist gives numerous cues on her direct address to the recipient in front of her (pronouns, continuous gaze and expressive gestures, such as nods and hand gestures). She never orients her gaze to the phone when talking, but remains focused on the patient. The patient, on the other hand, when speaking is mainly oriented to the phone, and only from time to time gazes at the psychologist. She uses direct address pronouns ("you") only for the interpreter and addresses the psychologist in an indirect way (for instance, one of the rare requests she makes to the psychologist in the interaction comes in the form: "maybe you say to the madam here...", i.e. the request is addressed to the interpreter, "you say", and the psychologist is designated as "the madam here"). These configurations are observed on an almost systematic basis in the consultation.

During the interpreter's turns, the on-site participants' behaviour also differs. When the interpreter translates the psychologist's talk, the patient, who is the main addressee, is oriented to the phone. She stays motionless while listening. At the same time, the psychologist looks at her. When the interpreter translates the patient's talk, the main addressee (the psychologist) looks at the patient, she makes expressive faces and adopts expressive body postures (like raising her shoulders), maintaining direct communicative contact with the patient in front of her. She also provides regular audible receipt tokens, which signal her recipientship to the remote interpreter, while also often triggering the patient to look at her.

At the end of the excerpt, we observe a fleeting and silent dual exchange between the two on-site participants, mainly in a gestural mode. The next section focuses on this type of exchange, through which a dyadic participation framework is set up in parallel to the main triadic one.

4. Dyadic and triadic participation frameworks

The construction of a dyadic participation framework in parallel with the triadic one takes place during the interpreter's talk, noticeably when she is translating the patient's talk. The dyadic participation framework is constructed as secondary to the triadic, whereas the triadic framework remains the primary one for the on-site participants and is the only one for the interpreter. Characteristically, the short sequences developed in the dyadic participation framework by the patient and the psychologist are sequentially and topically connected to the progression of the interaction developed at the main framework level; they are of a gestural and/or vocal nature and they are produced so as not to disturb the interpreter's talk in the main participation framework.

This phenomenon could be described in terms of footing, since, in Goffman's terms, it is the result of "changes in the alignment we take up to ourselves and the others present" (1981: 128), changes in "our frame for events" (*ibid*.). Still following Goffman, it could also be referred to as a form of "byplay" ("subordinated communication of a subset of ratified participants" 1981: 128), such as the case described by M. Goodwin in storytelling as "a complex conversational floor which is simultaneous yet subordinate to the main floor being managed by story-teller and principal addressed recipient(s)" (1991: 156).

This phenomenon is a form of duplication of the participation framework, provoked by a change in footing. The sense of footing here is not that the participants "change the alignment they take up to themselves", in terms of the different voices they make audible in their own talk (see Goffman's deconstruction of the "production format", 1981). It is not either connected to the dialogic organization of talk (see Goodwin, 2007, in line with Voloshinov/Bakhtin, 1973). The change in footing concerned here is that they align

differently to their recipients, distinguishing between two categories: the whole group vs one. They provide different information, through different means, in these two frameworks.

The triadic participation framework in the cases we examine hereafter is constructed as follows: the interpreter is in the process of translating the patient's story and the psychologist and the patient are listening to her. Within this main participation framework, the two on-site participants set up from time to time a dyadic participation framework, providing additional information to each other tightly related to that delivered by the interpreter. In contrast to the cases described in M. Goodwin (1991), here the emergence of a parallel participation framework is not a practice by which the on-site participants distance themselves from the ongoing speaker's talk (as jokes or ironic comments would do). It appears much more as a practice through which they add pieces of information to those provided by the interpreter and establish a direct contact between them based on the interpreter's mediation. This last aspect distinguishes this phenomenon of "side sequences" (Jefferson, 1972), in that it does not correspond to an interruption of the on-going activity.

The case examined in excerpt 1 takes place in the first part of the consultation and mainly comprises question-answer sequences. In the second part of the consultation, when long stretches of talk occur, the phenomenon becomes more salient. Here, the specific interlocutory situation in place when the interpreter talks is striking. At these moments, within the consultation office the voice that comes out of the phone is a disembodied voice, telling a second version of one of the on-site participants' previous talk. This voice is listened to while the participants are sitting in front of – and sometimes staring at – the original speaker. When the psychologist listens to the interpreter's voice, rendering in French what the patient in front of her has just said, she looks at the original speaker, addressing several attention signals to her. Facing her, the patient, whose translated talk is being uttered, gazes at the psychologist, the recipient of her own talk (produced via another voice, in a language that she does not understand). Although this situation could broadly be seen as similar to those including an on-site interpreter, the absence of the interpreter's body as the source of the translating voice imparts to it a sense of discrepancy and even of strangeness (see Wadensjö, "loss of the sense of immediacy" in telephone interpreting, 1999).

In excerpt 2, the secondary participation framework is opened up at a moment in which the interpreter is translating the patient's report of serious violent incidents concerning children that happened in the centre.

2) REMILAS_ 170719_PYE_1_2430_Verre jeté_Traduction

```
1    IPT  euh:+ ◊ donc par exemple\ euh:◊ avec mes ◊enfants/ moi + j` leur
          uh      so for instance uh with my children        I
     enm      + G.twd. PYE-------------------------------------> +
     pye        ◊ smile---------------- ◊          ◊series of small nods->

2         apprends qu'i faut dis◊cuter des choses\ ◊(0.3)     ◊
          teach to them that they must discuss about issues (0.3)
   ->pye  ->                    ◊                  ◊strong nod◊

3    IPT   [et pas] fra[pper les +autres\] (0.4) euh: mais:: ici: euh:
             and not hit the others       (0.4)  uh but  here uh

4    PYE  ◊[hm +hm ]   [°très bien°      ]◊+
            hm hm        very well
     pye  ◊series of small nods------->  ◊
     enm      + G.twd. PYE--------------> +

5    IPT  les gens euh:: (0.6) donc euh parfois fonctionnent ◊autrement\◊
          people uh      (0.6) well uh sometimes function differently
     pye                                                  ◊small grimace◊
```

```
6          (0.3)

7     PYE  °hmhm°
           hmhm

8     IPT  ◊et euh:: pas comme j'ai appris à mes◊ enfants de: ne pas:
           and uh  not as I taught to my children not to
     pye   ◊series of small nods->              ◊

9     IPT  frapper les uns les autres/ mais:: ◊de se parler\    ◊
           hit each other             but to talk to each other
     pye                                      ◊series small nods◊

10    IPT  (0.5) pa`ce que le foyer donc y a des gens de partout/
           (0.5) because the centre well there are people from
           everywhere

11         ◊qui sont là\◊ (0.4)
           who are there
     pye   ◊nods->->    ◊
```

From lines 1 to 11, the "usual" participative configuration we have described in excerpt 1 is in place. The psychologist produces numerous attention devices in the form of receipt tokens, nods – either strong single nods or series of small nods – and facial expressions, such as grimaces, and the patient alternates between gazing at the psychologist (the psychologist's receipt token triggers the focus of the patient's gaze on her, line 4) and looking into the distance, head oriented towards the phone. In line 12 (excerpt 3 below), the interpreter starts rendering an event that the patient has just reported:

3) REMILAS_ 170719_PYE_1_2430_Verre jeté_Traduction

```
12    IPT  par exemple ma fille aînée feyrouz/ (0.5) euh:: elle
           for instance my eldest daughter feyrouz (0.5) uh she
     enm   >>looks in the distance-->

13         était v`nue y a quelques jours et: elle avait
           came a few days ago            and she had

14         euh: (0.6) donc elle était: euh: ◊blessée/ sous son oeil/◊
           uh  (0.6) so she was uh        injured under her eye
     pye                                    ◊small grimace          ◊

15         ◊c'était une amie [à] elle◊ (0.4) euh ◊donc euh: qui l'a◊
           it was a friend of her    (0.4) uh  well uh who has
16    PYE                    [x]
     pye   ◊   small grimace          ◊            ◊small nods->     ◊

17 #  IPT  +blessée/ (0.5) ◊euh:: + #4 [après #5 y a d'autres  ◊&
           injured her (0.5) uh    after there are others
18    ENM                             [°°°xxxxxxxxxxxxxxxxxxxxx
     pye                       ◊.........--points R then L eyes--,,,◊
     enm   +G->PYE                    +.........---------points R eye-->
```

#4

#5

#4, #5. The psychologist and the patient exchanging gesturally

```
19   IPT  &aussi qui sont dans le bâtiment\]+ (.) donc A+ (0.3)
          also who are in the building            well A

20   ENM  xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx°°°]
     enm  ----------------------,,,,,,,,,,,+          +gaze away->

21   IPT  °mais pas B\° (0.5)
          and not B

22   PYE  HMHM
          HMHM
```

While listening to the interpreter's talk, the participants start setting up a parallel participation framework, in which they communicate through gesture. We can observe its very progressive emergence. In line 14, the psychologist acknowledges one important piece of information provided in the interpreter's rendering (“so she was uh injured under her eye”) with a small grimace. In line 16, she again makes a small grimace (during the interpreter's “it was a friend of her”), while uttering in a low voice one short syllable (inaudible). During this second instance, the psychologist stares intensely at the patient, but at this moment, the patient is looking away and does not react at all. Then, during the expansion of the TCU in lines 15–17,

after the pause (“uh well uh who has injured her”), the patient turns her gaze to the psychologist. At this moment, they look at each other. Then, in line 18, the psychologist points to her right eye (Figure 4) then left eye (Figure 5). She gets the patient's response in the form of a mirror gesture to her own right eye (Figure 5). Along with this gesture, the patient also adds (inaudible) information in a very low voice (lines 18–20).

This embodied activity provides additional information (i.e. which eye has been injured). It is subordinated to the interpreter's talk, depends on the information being delivered and is sequentially coordinated to the slow production of the interpreter's TCUs. We can observe that this exchange is mainly silent and that the patient's turn at talk (in lines 18–20) is uttered in such a low voice that it is not understandable in the recording. We can hypothesize that the interpreter does not hear it either. At least she does not display any cue on hearing it. At the end of it, the patient returns to looking away. Another example occurs during the next step of the story:

4) REMILAS_ 170719_PYE_1_2430_Verre jeté_Traduction

```
23   IPT  qui: euh:: (0.6) euh:: qui font aussi euh: des choses de
          who uh    (0.6) uh who also do uh things of

24        ce genre/ ils jettent +du: verre\ [(0.5)    ils
          this sort they throw   glass       (0.5)    they
     enm                        +gaze toward PYE->

25 #  PYE                                    [◊((°°°ah oui°°°))#6
                                                °°°oh yes°°°
     pye                                     ◊tilts head left->
```

#6. The psychologist displaying attentiveness (head tilted to the right)

```
26   IPT  +boi::vent [dans des: euh] (0.4)] ◊verres euh: du: euh:◊
          drink in uh                 (0.4)   glasses uh of uh
     enm  +nod

27 #  ENM         #7 [+≤°trosième étage°] +
                       ≤°third floor° ((FR))≥
     enm              +hand gesture 3    +
     pye                                    ◊shakes head       ◊
```

#7. The patient giving additional information through gesture

28 IPT (0.4) donc en verre\
(0.4) well in glass

29 PYE ◊hmmh◊
hmmh
pye ◊*nod* ◊

The second reported event is the fact that some of the centre residents throw glass bottles from the top of the building. Here again the two on-site participants build a participation framework in duo, subordinated to the interpreter's talk. In line 24, the patient orients her gaze towards the psychologist, just before the occurrence of the word “glass” in the interpreter's talk. In line 25, the psychologist acknowledges the new information that has been given, with a receipt token expressing her astonishment (a form of change of state token, in line with Heritage, 1984, °°°oh yes°°°), uttered in a very low voice. This opens up the subordinated participation framework. Simultaneously, she slightly tilts her head to the right, staring at the patient, in a posture displaying her recipientship (Figure 6). The patient confirms the information in line 26 with a nod and then, in line 27, utters in overlap “third floor”, in a low voice, making the gesture “3” with her left hand[7] (Figure 7). This additional information on the secondary participation framework is sequentially coordinated with the interpreter's talk: after the psychologist's receipt token (line 25) acknowledging the interpreter's information (“they throw glass”), the patient reacts in line 26, first with a nod, then by providing the additional information. This precise sequencing indicates that she has a certain understanding of the interpreter's talk in French (at least of recurring key words in the story, such as “glass” in line 24), which enables her to synchronize her contribution with the sequential progression of the ongoing talk. Interestingly, she utters her additional information in French, thus clearly addressing the psychologist, since the language choice makes the translation dispensable. In addition, her very low voice makes her production inaudible to the remote interpreter. This exchange falls down when the interpreter is starting a detailed version of the same story and it is produced so as not to disturb her. Then, during the second expanded version of the story, the secondary participation framework is maintained, as shown in excerpt 5:

5) REMILAS_ 170719_PYE_1_2430_Verre jeté_Traduction

30 IPT et vers onze heures/ vers vingt trois heures minuit/

[7] Counting on one's hand in Syria is done starting with the little finger (not the thumb), so to display "3", one shows the three fingers from the little one.

around eleven o'clock around eleven o'clock midnight

31 (0.4) ils euh jettent/ depuis tout en haut/ (.) pour euh
(0.4) they uh throw from the very top (.) for uh

32 casser ◊les verres en +bas\◊ (0.5) et: euh: ◊y avait aussi
breaking the glasses down (0.5) and uh there was also
pye ◊grimace ◊ ◊series of nods->
enm +gaze towards PYE ->

33 IPT un enfant◊ qui a été blessé\ [(0.5) eu]h:: +[donc+ euh]
a child who has been injured (0.5) uh well uh
pye -> ◊

34 PYE [◊°°°ah oui°°°]◊
°°°oh yes°°°
pye -> ◊raises eyebrows◊

35 # ENM +[oui:+]#8
yes
enm +nod +....

36 # IPT par euh: [une#9 bou]teille\#10+
by uh a bottle
emn ...----------,,,,,,,,,,,+

37 ENM [puft]
puft

38 ENM tombé
≤fallen ((FR))≥


#8


#9

 #10

#9, 10, 11. The patient mimicking the throwing of an object away

39 PYE ◊hm [hm::◊
hm hm
pye ◊*grimace* ◊

40 IPT [+concernant son amie donc: euh à: (.) à feyrouz/ j'ai
concerning her friend well uh to (.) to feyrouz I
enm *+gaze in the distance ->*

41 réglé le pro[blème/+ (0.4)]
fixed the problem (0.4)
enm *+gaze to PYE ->*

42 PYE [◊°°°très +bien+°°°◊]
°°°very well°°°
pye ◊*nods* ◊
enm *+nod +*

43 IPT ◊mais::: euh:◊ ces gens donc +euh du troisième étage\ **(.)**
but uh these people well uh of the third floor
pye ◊*nods->* ◊
enm *+gaze away ->*
44 [dans le bâ]timent A qui jettent euh: ces verres
in the A building who throw uh these glasses

45 PYE [hmhm]
hmhm

46 IPT à ◊minuit/◊ (0.4) et aussi des couteaux/ +alors là
at midnight (0.4) and also knives well there
pye *◊nod, grimace◊*
enm *+gaze to PYE ->*

47 IPT ◊je suis [prête ◊+à] dire+ [des:: noms (0.3) pour [vous/]
I'm ready to tell names for you
pye *◊grimace->* ◊

48 PYE [°ah bon°] ◊[hmhm]◊
oh really **hmhm**
enm *+nods +*

49 PYE hmhm
hmhm

During this expanded version of the story, the psychologist continues to gaze at the patient and produces various cues showing her attentiveness (grimaces, nods, raising eyebrows, etc.).

After the mention of a child having been injured (line 33), she expresses her surprise with a change-of-state token ("oh yes" line 34). The patient then confirms (line 35) and immediately starts a gesture mimicking the throwing of an object away (Figures 8, 9, 10), while she also imitates the whisper of a flying object (line 37). As in the previous case, she also utters a word in French, here the word "fallen" (line 38). The psychologist acknowledges this multimodal version of the action, in line 39, with a verbal acknowledgement and a grimace.

A last dyadic exchange also takes place in lines 46–49. It starts when the patient turns her gaze to the psychologist after the mention of the knives. She may recognize the word "knives", or be reacting to the psychologist's receipt token uttered in line 45. In line 47, the psychologist makes a grimace reacting to the mention of knives being thrown and utters, in line 48, a change-of-state token ("oh really"). This triggers the patient's nod in line 48. At this point, the interpreter starts reporting what the patient has requested be done in reaction to these violent actions. The patient stops adding information and returns to her "ordinary" way of listening, remaining still with only small nods from time to time, whereas the psychologist continues to produce recipientship cues, as she commonly does.

The setting up of a secondary participation framework is not a very frequent phenomenon in the interaction. It seems to be connected to the activity of storytelling and emerges when major elements in the stories are produced (here the mention of people being injured), or at least elements presented as emotionally charged, even if in an implicit way (as in "he just gave me a prescription", excerpt 1, line 15, implicitly regretting not having been given an explanation).

The sequences taking place in these secondary frameworks are produced so as not to disturb the interpreter's activity, i.e. the participants do not engage in what would appear to be disconnected productions with respect to the interpreter's talk, nor do they produce talk that could be heard by the remote interpreter. These frameworks emerge when the participants gaze at each other, either as the result of a receipt token produced by the psychologist, prompting the patient's gaze to turn to her, or on the patient's own initiative. Differences nevertheless exist in the different examples.

A first category concerns excerpts 3 and 4, excerpt 5 case 2, as well as – to a certain extent – excerpt 1. In these cases, the interaction in the secondary participation framework is mainly silent, or includes very rare words uttered in a very low and inaudible manner. In the first example, what occurs in this second participation framework is the sharing of an assessment of what the interpreter is saying (disappointment or criticism that the doctor did not explain). In excerpts 3 and 4, the participants share punctual information added to the interpreter's talk (which eye, which floor). Case 2 in excerpt 5 is also a way of sharing an assessment of information presented as severe and astonishing (throwing knives). Excerpt 5, case 1, is different and seems to constitute another category, in that more than adding new information to what the interpreter is saying, the participants provide a second version of it. All the cases, however, share the characteristics of emphasizing certain aspects of the story.

Concerning language, the setting up of such a secondary participation framework depends on the patient's capacity to understand some French. On the basis of the data, one cannot evaluate whether she can grasp some sentences, or if she only relies on certain recurring key words in the stories (such as "bottle", "glass", "eye", "injured", "knives") which she perhaps heard repeatedly at the time of the events and which she uses as sorts of "pointers" to the stage of the story being reached in the interpreter's rendering. Her skills in French nevertheless enable her to use this language to contrast her participation in the overall participation framework (in Arabic) and in the dyadic framework (in French and through gestures and facial expressions). In addition to this competence on the patient's side, we can assume that the setting up of such secondary participation frameworks is also strongly

connected to the psychologist's conduct, such as initiating gestural exchanges when the patient looks at her at crucial moments, or gaining the patient's gaze with her receipt tokens.

5. Conclusion

In this paper we have seen that telephone-interpreted interactions cannot simply be described as missing the multimodal dimensions of interaction. Not only do two of the participants have access to these multimodal dimensions, but also several other aspects of the situation become significant as soon as the detailed unfolding of interaction is considered. We have seen that the way in which interaction functions in this case is more complex than most previous studies have underlined.

In the case study, probably due to the fact that the participants know each other well, they communicate in a very smooth way: their turn-taking is fluid and the patient even succeeds in initiating topics or exchanges (as in excerpt 4). In her interview, the psychologist says that she very much appreciates working with this interpreter, who, according to her, is very skilled and very professional. Indeed, the analysis shows that the interpreter assumes an important role in coordinating the triadic interaction, in particular through the use of different types of markers. Furthermore, the analysis also reveals that all three participants are very attentive in their management of the mediated interaction. Specifically, they avoid overlapping the others' talk and they clearly indicate when their turn is starting or finishing with prosodic cues and discourse markers. They also take into consideration these same cues when produced by their interlocutors. This attention to the way in which talk is delivered is very helpful for each of them in managing turn taking.

With respect to the issue of how to maintain a sense of health practitioner – patient communication within the mediated situation, the analysis shows a case in which this is done mainly via embodied conducts. The psychologist uses nods, gaze and facial expressions in order to establish a continuous face-to-face communication with the patient, even if – in front of her – the patient tends to retain a motionless posture, with her gaze and body oriented towards the phone. The opening up of a parallel participation framework is another means by which the on-site participants maintain a dual communication. The on-site participants manage the two parallel frameworks based on the following characteristics. They clearly remain attentive in a continuous manner to what goes on in the main framework, in which the interpreter's talk is uttered. They display this attentiveness differently: the psychologist by regular receipt tokens and the patient by her body orientation. They open up the secondary framework in a progressive manner, beginning with the same devices used to display attention to the interpreter. Hence the recurrently observed sequence that launches the second participation framework is the psychologist's receipt token, triggering a reorientation in the patient's gaze and body. Many of the psychologist's receipt tokens thus have the double function of continuers for the interpreter and signals that trigger a reorientation of the patient's body posture enabling visibility. What goes on in the dyadic participation framework is sequentially and topically connected to the interaction in the triadic framework. In this respect, it is noticeable that even when resorting to vocal or verbal productions in their exchanges in this dyadic framework, the participants keep them very low so as not to disturb the ongoing interpreter's translation.[8] This specific organization of participation enables the patient to provide in a direct manner elements such as assessments and pieces of information

[8] We assume that this form of duplication of the participation framework is different from what can happen with an on-site interpreter when the patient and the doctor have dual exchanges in parallel with the translator's talk. In this latter case, were exchanges such as those we have described to occur, they would necessarily affect the interpreter's conduct, since s/he would have visual access to them.

for the psychologist and even to express other versions of parts of the story being rendered by the interpreter, enriched with emphasis on emotional moments. This two-party communication is made possible by the presence of the third party, whose talk leads the different levels of communication.

To go beyond the case study, we can assume that the way in which the participants deal with the situation here is not specific to this interaction (as a case), but represents a possible, or even common way of doing in the context of telephone-interpreted interaction. It appears then that considering telephone-interpreted interactions as characterized above all by a lack of multimodality is an interpreter-oriented view, which gives only a part of the picture. Gaze, body posture and facial expressions play an important role in maintaining the health practitioner – patient communication on site and in opening up and stopping the dyadic framework. Hand and arm gestures are also used as a means of providing additional parts or parallel versions of the story being told by the interpreter. Interestingly, these are of speaker's gestures type, but are produced in connection – semantically and sequentially – with the talk of another speaker.

At a more general level, the analysis shows the need to consider complex and constraining settings (such as interpreted interactions with a remote interpreter) on a temporal and sequential basis, rather than as a given and constraining protocol, since the way in which participants adjust their conduct to the context changes with the unfolding interaction. They transform the participation framework in which they communicate according to the ongoing activity and their local communicative needs. Moreover, they manage to transform a complex and constraining setting into resources for their interaction.

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Transcript Conventions

Talk and other multimodal resources have been transcribed according to the orthographic conventions developed by the ICOR group (ICAR lab, Lyon, http://icar.univ-lyon2.fr/projets/ICOR/ICAR_Conventions_ICOR.pdf). For Arabic IPA is used. An indicative translation is provided line per line.

≤ ≥	indicates a part of talk in another language (ex. French in a turn in Arabic).
/ \	rising or falling intonation of the preceding segment.
(.)	short pause (< 0.2s).
(1.5)	timed pause in seconds and tenths of seconds.
[ ]	beginning and end of overlap.
xxx	inaudible segment.
((home))	transcriber's comments.
=	contiguous utterances.
°home°	low volume.
:	stretching of prior syllable.
par-	cut-off.
#	shows the moment in the transcription at which the screen shot has been taken.
◊ ◊, + +	gesture delimitation (psychologist, patient). The gesture is described in the following line in italics.
. . . --„	gesture or gaze preparation, apex and retractation (see Mondada, 2007)
>>	movement or gaze having started before the beginning of the excerpt.
->	movement or gaze continuing in the next lines.
H	head.
G	gaze.
EB	eyebrow.