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ICONESOFT EDIZIONI - GRUPPO RADIVO HOLDING
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ICONESOFT EDIZIONI – RADIVO HOLDING
BOLOGNA

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Interpreting Distress Narratives in Italian Reception Centres: The need for caution when negotiating empathy [1]

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Abstract

Based on first-hand data collected by the authors this paper examines how public service interpreters (known as "language mediators" in the Italian setting) negotiate empathic stress. The paper seeks to demonstrate how empathy can be beneficial in building a constructive relationship but can also negatively impact the interpreter. Following a description of the Italian setting, the authors analyse recorded mediated interactions and in-depth interviews in Italian migrant reception centres, illustrating how language mediators are pro-actively engaged during the mediated sessions in a mutually supportive relationship. As a result of the high level of distress in the narrative content, they struggle to position themselves professionally (impartiality) and personally (empathic alignment) vis-a-vis the migrant, especially when they themselves have similar migratory backgrounds. We suggest that although empathy is useful in the overall communication process to maximize cognitive and pragmatic comprehension, to build a relationship of trust and to provide an optimal rendition, it is crucial to be aware of the risks for the interpreter's self-care. This is especially important in a country like Italy where language mediators are encouraged to engage pro-actively and empathically in the communication.

Keywords: PSI, empathy, refugees and migrants, reception centres, narratives of distress

[1] Whilst both authors have worked closely together to write this paper, M. Rudvin is responsible for part 1 and A. Carfagnini for the majority of part 2 (except for 2.2 which was analysed and written by both authors), including the data collection and transcription. The data are being analysed by Carfagnini from an interactional perspective for her PhD at the University of Mons.

1. Bonding and empathy

A number of disciplines in the humanities and in the hard sciences acknowledge the importance of soft skills, not only as a humanitarian value but because they optimize financial, medical, or other results. In this paper, we have chosen to focus specifically on one such soft skill that has come into the public arena in a broad range of disciplines over the last decade, namely empathy. Loosely seen as "putting oneself in another person's shoes" and generally perceived as a positive value, it underpins the human ability to cooperate and collaborate in groups – an "other-oriented" ability upon which human civilization depends. Empathy has been hailed as a crucial relationship-building skill across a range of disciplines and professions (see e.g. Betzler 2019), and more recently also in interpreting studies.[2]

1.1 Disambiguating empathy

By virtue of having a predominantly positive connotation, it may seem self-evident that showing empathy is desirable, especially when dealing with persons in distress. A broadly used layman's understanding of "empathy" contains multiple sub-sets and states of being that are often categorized, and therefore perceived, as uniform. Rather, empathy as a broad concept encompasses cognitive, affect-based and moral-ideological aspects. Among the many studies disambiguating empathy is Davis' IRI index constructed around the four scales of perspective taking, fantasy, empathic concern and personal distress, and adopted by Merlini (2019) in her experimental study on empathy in interpreter education. In their 2013 study, Gleichgerrcht and Decety, further elucidate the multidimensional nature of empathy:

> There is now a converging agreement that empathy is not a single ability but a complex socio-emotional competency that encompasses different interacting components. **Empathic**

[2] See e.g. Mercer and Reynolds (2002); Hojat *et al.* (2002, 2017). For empathic communication in interpreting, see Merlini and Gatti (2015) Merlini (2019). See also the KU Leuven project *Empathiccare4all* (Salaets, Wermuth, Pype, Krystallidou) focusing on integrating empathy into the interpreter training curriculum: https://www.arts.kuleuven.be/english/rg_interpreting_studies/research-projects/empathiccare4all/index. Çoban and Albiz Telci (2106) suggest integrating emotional intelligence into translation and interpreter training.

> **arousal**, the first element of empathy to appear during ontogeny, refers to the contagious sharing of the affective state of another. **Empathic understanding** entails the formation of an explicit mental representation of the emotional state of another person. **Empathic concern** refers to other-oriented emotion felt for someone in need, which produces a motivational state of increasing the other's welfare. Finally, **emotion regulation** enables the control of emotion, affect, drive, and motivation. Even though these components are intertwined and not independent of one another, it is helpful to dissociate them, as each contributes to various aspects of the experience of empathy. (Gleichgerrcht and Decety 2013: 2; our emphasis)

In a translation or interpreting setting, the very act of translation rests upon what we might broadly call *cognitive empathy* (a pre-affect state): having a mental representation of the writer's/speaker's intentionality (to the extent this is possible).[3] Whereas translators or conference interpreters can rely primarily on cognitive empathy, public service interpreters are frequently confronted with the need to understand and relate directly to people recounting distress narratives, potentially triggering *empathic concern*. Being able to distinguish states of empathy (cognitive, moral, ideological, psychological, and emotional) can help *emotion regulation* and counter potential empathy-related stress.

1.2 The medical field: empathy enhances treatment

Many disciplines and professions encourage empathy as a constructive skill, but it is the medical literature (in both physical and mental health) that is particularly robust. "Entering into" the patient's experience by listening attentively and by verbally and non-verbally communicating an empathic bond, can help the clinician reach a more accurate diagnosis, provide better treatment, and obtain better patient compliance.[4] The

[3] The distinction between cognitive vs affective empathy is not however clearcut. Hojat *et al.* (2017), for example, distinguish between cognitive and affective empathy, but regard affective empathy as "sympathy". For simplicity, we choose to regard cognitive empathy as propositional and as pragmatic comprehension, and affective empathy as engagement.

[4] There is by now a great wealth of literature on this in the medical sciences (e.g. Gleichgerrcht and Decety, 2013). There is also a growing field of popular literature available on the internet on the therapeutic impact of a constructive

medical literature thus suggests that empathy not only furthers cognitive understanding, but is therapeutic in and of itself. However, the (positive) empathic bond created between clinician and patient can create an emotional overload that can be difficult to regulate, jeopardizing self-care. Although empathy and trust are instrumental to therapeutic success, they may add another potential stressor for the clinician not least in the mental health setting and in settings involving trauma.[5] Impacting factors are both intrinsic to the information content (distress narratives of profound trauma, violence, abuse, etc.) and extrinsic to it (the therapist's own identification and involvement, as perceived personally by him- or herself).

In interpreter-mediated patient-clinician communication, if the interpreter is party to the empathic communication and is able to re-present – to the extent that is possible – the clinician's propositional and pragmatic message in his/her rendition, this will further mutual comprehension. Furthermore, in the same way that an empathic bond helps to establish trust between patient and clinician (optimizing patient compliance), it can crucially help the interpreter establish a relationship of *trust*, especially in situations involving intense emotions or physical danger. Results such as these are useful in order to understand how listening to distress narratives is processed by interpreters in a broader array of settings, including the refugee setting.

patient-clinician relationship (e.g. https://greatergood.berkeley.edu/article/item/should_we_train_clinicians_for_empathy).

[5] Communicative events involving refugees and victims of violence (torture, domestic violence, abuse, etc.) are particularly pertinent settings; research examining interpreters and trauma narratives has been increasing, such as the EU funded SOS-VICS project on interpreting and gender-based violence. See Valero-Garcés (2005) and Rudvin and Pesare's 2015 study from a migrant identification centre. See also Ndongo-Keller (2015) for a more recent study of interpreters and vicarious trauma. Zancanaro's excellent unpublished 2019 MA thesis is a valuable insight into the work of interpreters and mediators working with victims of torture, and contains an in-depth discussion of situational, professional and psychological issues. For research relating specifically to interpreting and clinicians see Hlavac (2017) and Krystallidou et al. (2018). Research on Sign Language Interpreting (e.g. Harvey, 2003) began to address empathy and self-care quite early on. Gallaudet University Press has published many excellent studies; for an early study see Metzger (1999). See also Robyn Dean's work, and the more recent work she has done with Robert Pollard on the Demand control schema perspective (Dean and Pollard, 2011).

1.3 Potentially harmful effects of empathy

Although empathy is important for human moral and social organization, un-regulated empathy can also be a cause of distress if it leads to an internalization of the other person's pain (known as vicarious, or secondary trauma). Rauvola *et al.* (2019: 298) define empathy-based stress as "a process of trauma exposure (i.e., a stressor) combined with the experience of empathy (i.e., an individually- and contextually-driven affective reaction) that results in empathy-based strain, adverse occupational health reactions, and other work-relevant outcomes." They define secondary traumatic stress as "the stress reaction induced in caregivers following exposure to clients' traumatic material" (Rauvola *et al.*, 2019: 303). The authoritative British Medical Association (BMA) gives the following definition of vicarious trauma:

> Vicarious trauma is a process of change resulting from empathetic engagement with trauma survivors. Anyone who engages empathetically with survivors of traumatic incidents, torture, and material relating to their trauma, is potentially affected, including doctors and other health professionals.[6]

1.4 Potential negative impact of empathy on interpreter

The work of scholars such as Beverly Costa and Marjorie Bancroft have thrown light on how interpreters listening to distress narratives and becoming deeply involved in the event, are particularly susceptible to vicarious trauma: "Although we know that many survivors experience trauma, most people don't realize how often interpreters experience vicarious trauma. … It's a dirty secret that many interpreters are affected by VT, yet few are trained to manage it."[7]

[6] https://www.bma.org.uk/advice-and-support/your-wellbeing/vicarious-trauma/vicarious-trauma-signs-and-strategies-for-coping.

[7] https://www.ata-chronicle.online/cover-feature/breaking-silence-what-interpreters-need-to-know-about-victim%E2%80%A8services-interpreting/.%20See%20also%20Bancroft%E2%80%99s%20Access2Interpreters%20website%20at%20https:/www.access2intepreters.com/breaking-silence-what-interpreters-need-to-know-about-victim-services-interpreting/

As early as 1999, the psychologist Karen Baistow reported on interpreter stress related to traumatic content at one of the first international conferences on community interpreting. Her findings (295 respondents) showed that more than 66% were sometimes upset by the material they had to interpret, and 49% experienced mood or behavioral changes related to their work. Lai *et al.*'s large-scale 2015 study (271 respondents), examined interpreter stress related to emotional involvement and issues of self-care, reporting a high level of emotional stress and vicarious trauma. Like Lai *et al.*, Costa *et al.* (2020) also address the "tug-of-war" between emotions and a "neutral code of ethics", as does Costa in a previous study:

> They would hear and relay clients' harrowing stories. But their ethical code binds them to strict confidentiality and requires them to take no action beyond the transfer of meaning between speakers of different languages. Interpreters cannot offer a solution to the problems they hear, nor can they talk to anyone about the impact the stories have on them. They are left without any means of relief.[8]

Polat's (2020: 697) most recent paper perfectly captures the frustration regarding role boundaries through the notion of "restricted agency", her respondents expressing alignment to a professional code of conduct. The author provides numerous examples illustrating the emotion-impartiality dilemma in her data from interpreters in refugee settings. Her interviewees confirm that they try to control their emotions and maintain "emotional stamina" during the mediation session; the majority are strongly committed to their impartiality guidelines stating that "an interpreter who shares the same culture or the same traumatic past may lose neutrality by causing emotionality in their own behavior. In such cases, the interpreter should show emotional maturity and stamina, and avoid behaviors that may adversely affect the interview" (*ibid.*: 695).

Emotional stress adds to an already intense real-time cognitive processing during the interpreting session, potentially compromising the quality of the interpreting rendition. As Lai *et al.* (2015: 15) state "any additional load caused by the cognitive shifts described above will divert the brain's finite resources away from the task of rendering one language comprehensibly into another and cause a decline in the interpreting performance, either in accuracy, fluency, or completeness."

[8] https://research.reading.ac.uk/exploring-archives/2019/10/29/dr-costa-on-around-the-well/ See also Costa 2020.

Lastly, where service providers "enter into" a distress narrative in order to understand, diagnose and treat – which could feel cathartic when successfully resolved – interpreters' role-boundary limitation (Polat's "restrictive agency") excludes them from the benefits of positive "closure". Thus, where service providers in many professions can pro-actively provide solutions to the narrator's distress, the interpreter cannot, a situation which may lead to feelings of paralysis, inertia and powerlessness.

The picture that emerges from the works mentioned above is the need to include emotional stress management in interpreter training (and by the same token the need to use professional rather than ad-hoc interpreters), provide clear-cut guidelines on role boundaries, and support groups (such as that of Costa's *Mothertongue* or the online support groups she describes in Costa *et al.*, 2020).

1.5 PSI and language mediation. Balancing empathy and self-care

Based on numerous interactions, interviews and surveys with managers, trainers, language mediators and mediation students over the last two decades, and confirmed in the data-sets described here, a clear picture has emerged for us as researchers and interpreter trainers: language mediators in Italy are encouraged to be more pro-active in their interactions with clients than what is expected of interpreters in most English-speaking and European countries in those same settings. There is by now ample literature describing how the role of the "language mediator"[9] (IM) is

[9] https://www.cies.it/mediazione-interculturale/. The CNEL guidelines also provide an indication of job descriptions. UNI has recently provided standards for community interpreters (available at http://store.uni.com/catalogo/iso-13611-2014/?josso_back_to=http://store.uni.com/josso-security-check.php&josso_cmd=login_optional&josso_partnerapp_host=store.uni.com#) For further details on the Italian situation see e.g Rudvin and Spinzi (2014); Merlini and Gatti (2015); Zancanaro(2019).
The international literature on Community- and Public Service Interpreting provides ample examples of codes of ethics, especially as they pertain to specific sectors: the National Association of Legal Interpreters (https://najit.org/) provides a much-used code of ethics; the Californian Standards for Healthcare Interpreters.
(http://www.chiaonline.org/Resources/Documents/CHIA%20Standards/standards_chia.pdf. Sandra Hale (2007) provides an overview of codes of ethics from around the world, from which three recurrent tenets emerge that we consider to be central to the interpreting profession: accuracy, impartiality and confidentiality.

highly agentive as a result of both training and job description. In this paper, solely for the purposes of brevity, we will be using the terms "public service interpreter" and "language mediator" in the Italian sense of the term synonymously; when referring to the Italian setting, we will use an abbreviated form of Interpreter-Mediator, namely IM (see e.g. Rudvin and Spinzi, 2014). Due to the lack of professional, organizational, institutional and juridical structure surrounding "language mediation" in Italy, there is no consolidated national code of ethics, although some of the larger NGOs such as CIES have ethical guidelines. Many Italian organizations prefer to hire mediators from the same countries as the non-Italian speaker precisely because they expect a pro-active intervention (by the mediator) that will also take on board – also pre-emptively – cultural aspects that an "outsider" might not be able to provide. An example of this is the code of ethics provided by the cultural organization CIES above, that actively promotes empathic bonding between IM and migrant whilst requiring the IM to be impartial and to provide an accurate (but summary) translation as well as cultural decoding. An important caveat here is that many IMs do not receive training (due to lack of organization and/or funding) and are hired on the basis of language and cultural compatibility. The provision or lack of training impacts deeply both on interpreter self-care and performance.

In Italy, both the role (tending towards an "assistance-based approach") and the terminology ("mediation" rather than "interpreting") reflect and shape the Italian approach. This is relevant to the present discussion because the real and perceived self-participation and agency of the IM could strengthen the bond and the degree of perceived empathy. If the IM belongs to the same ethnic group as the migrant (or are themselves victims of trauma[10]), the likelihood of bonding and identification taking place is – we claim – increased; likewise, in settings involving narratives of severe trauma, the engaged approach will likely trigger stress-inducing empathic bonds. Our data suggest that IMs are forced to balance various sets of professional and personal ethics. We suggest that in this "struggle", affect-based empathy may run deeper and prevail over professional distancing ethics, unless previously addressed (i.e. in training).

In our data, there were multiple cases of IMs struggling to negotiate complex empathic bonds against baseline injunctions of not taking sides and maintaining distance. Reflecting the Italian "mediated approach", the IMs were at times actively advising migrants on how to proceed in order

[10] See Ahlberg's in-depth 2008 study on her experience as a clinical psychologist working with victims of torture; the book contains many reflections on the therapist-interpreter-patient relationship.

for their application to be successful. Indeed, they were frequently encouraged to "take over" the event, with no clear boundaries regarding professional mandate. This lack of clarity triggers a shift of focus from cognition-empathy (understanding and translating) to affect-empathy (or possibly antipathy), an extra stressor in the already complex task at hand. The further the IM is drawn into the situation as an active decision-maker in terms of content, information exchange and procedure, the more difficult it will be to manage affect-based empathy, we suggest.

In the previous paragraphs we have looked at both beneficial and potentially harmful effects of empathy, arguing that the interest in empathy as an interpreting skill is important, but should be treated with caution. This is even more so for a setting that by definition involves high-impact distress narratives, namely the refugee setting.

2. Data-Sets and analysis

2.1 Description

Data consist of first-hand material collected by Carfagnini at two reception centres in Italy. CARA (Centro di accoglienza per richiedenti asilo), a reception centre for asylum seekers operating under the supervision of the Ministry of the Interior, was hosting asylum seekers. The second centre, under the auspices of an international Catholic organization, assists refugees and forced migrants.[11]

These data were collected between October 2013 and March 2014 while in-depth interviews were carried out between September and October 2019.

There are three data-sets:

- 19 audio-recorded mediated interactions of medical consultations (involving French and English as lingua franca);
- 16 hours of recorded semi-structured interviews involving: 9 IMs, 5 doctors and psychotherapists, 3 legal assistants, 1 social

[11] Data were also collected by the authors in two additional CIE (Centro di identificazione ed espulsione) centres, in two different cities, hosting undocumented migrants. Further data from the CIE in Bologna were collected by Rudvin in 2014 (Rudvin and Pesare, 2015).

assistant, 1 humanitarian assistant and 1 social assistant dealing with victims of trafficking;[12]
- contextual data collected *in situ* through ethnographic methods such as direct observation of 20 IMs, 7 doctors, 3 social assistants, and 3 legal assistants.

The transcription format is inspired by Gallez's PHD thesis (2014). Although space-consuming, it has the advantage of clearly visualizing the turn progression in the triadic interaction. This format is therefore a useful visual tool to analyze the IM's moves from an interactionist perspective. The interviews provide clear evidence of negotiation of empathic bonds. The excerpts illustrate the IM's attempt to find a balance between engagement and self-protection.

Whereas the mediated interactions (see excerpts in 2.3 below) provide data that attest to the IMs' positive empathic engagement, it was the *in situ* contextual data and the semi-structured interviews that clearly illustrated the inner struggle of the IMs regarding their empathic positioning. Thus, the first data set provides examples of positive empathic engagement, whilst the other two data-sets – supported by examples from an ongoing survey – illustrate how empathic engagement can play out negatively for IMs.

2.2 Ongoing on-line survey on empathy and stress among IMs

A fourth source of data, an online survey conducted by the authors, specifically probing issues of empathy and stress among IMs in Italy, supports the data-sets. Although the survey is still ongoing and the results too few to warrant its inclusion as a separate data-set (14 respondents to date, 11 of whom work in the health sector and/or with refugees), the responses clearly demonstrate that empathy can be a powerful potential stressor. The majority of the respondents stated that it is important to establish a rapport with the non-Italian speaking migrant; "helping" and "giving a voice to" the migrant is overwhelmingly seen as a positive feature.

The following comments show how much importance the respondents give to an empathic interpersonal relationship with the migrant, and how deeply they are driven by their own sense of solidarity and/or

[12] We refer to the situation in effect during our data collection. At the time of writing, the latest decree Law 113/2018 has brought significant changes to the structure of the Italian reception system.

responsibility; at times the empathic bond is strengthened by their own migratory experiences. Here are some examples from the survey (translated from Italian by the authors):

> I would say that each of them has their own story and their own way of dealing with things. But the bond I had with them remained a bond of fraternity.
>
> After the interview I always kept in touch with my friends because I am young, only 22 years old, and most of the people I meet are either the same age or a little older. For me it is important because I always try to help, not materially, but with advice. I have been an undocumented migrant, so I always try to share my experience.
>
> For me it is important to create a bond, even if they are about to leave, because usually the migrant is wary of the other person and to open up he will need reassurance otherwise he closes up inside and won't say anything else. It's really important not to let yourself get carried away by the feelings that result from those bonds; you have to put limits, so that you can interpret well without taking sides.
>
> Sometimes even just a kind word or a piece of advice showing empathy can be of great help for those who are really desperate.
>
> It's nice to help those in need.

The second part of the survey aimed to probe for potential negative effects of the migrant-IM bond. The following are some of the results that emerged (questions in italics, followed by response). *The bond with the migrant can be negative because* … (options provided). A third of the respondents answered "it renders the IM less impartial" and "it makes the IM seem less professional in the eyes of the service provider"; just under a third answered "it gives the IM too much responsibility"; and "it can be painful if 'sad stories' are involved"; over a third answered "I keep thinking about it after the interpreting session". *Do you ever find yourself re-living the migrant's problems as if it were your own experience*? Over a third answered "yes". *Do you ever re-live past traumas or difficult situations that you have experienced in the past as a result of what you are listening to during the*

mediated session? A third answered "yes", and a small minority "don't know". *Do you ever feel bad because of what you are listening to?* Over two thirds answered "yes". A spontaneous comment in response to the last question was the following: "I felt like reliving the death of my mother and then I had to ask them to stop the session and I asked my colleague to replace me, as I was no longer able to continue."

Interestingly, when asked if they used any coping strategies to deal with the stress resulting from the session, 13 replied that they either: "try not to think about it", "talk about it with the family", "participate in sports or other activities" or "other". Only three said that they "didn't need any strategies as such"[13]. (There were 13 responses; several answers were possible). Our results strongly suggest that empathic bonds were being created during contact with migrants and that IMs were struggling to negotiate these bonds. Indeed, such bonds were seen as positive and appropriate, but at the same time a source of inner conflict.

2.3 Identifying areas of conflict and tension in the data-sets

The interview format in the second data-set was designed after careful examination of patterns observed during the four weeks spent inside the centres by Carfagnini[14]. The questions mainly focused on the way the IM's communicative strategies were influenced by and interconnected with the different services and service providers in the centers. Research strands that emerged during the semi-structured interviews and further interactions include: How do the IMs experience empathic pressure? How does it impact on the communicative situation? Do they draw back to protect themselves? Do they align more closely with the asylum applicant, or with the institution? Do they prioritize the ultimate goal of the communicative event (a successful asylum application) and actively help the migrant, thus activating "deep", rather than "surface", ethics? Is an empathic bond felt to be an added stressor?

[13] These answers might reflect a reluctance to admit difficulties in managing or regulating emotional engagement to save professional and personal face – or simply the strong desire to do a good job while showing humanity (as indeed cultural/linguistic-mediation training in Italy encourages). The data must also be seen in the light of occupational conditions – lack of pre- or continuous training, lack of clear guidelines, lack of professional prestige and certainly lack of adequate pay. All such factors compromise professional motivation.

[14] Semi-structured interviews based on a 58-item questionnaire (open and closed questions).

Respondent 1: Malinke IM from the Ivory Coast, with Italian-Malinke/French/Bambara/English language combinations[15]. When asked about coping strategies, he replies[16]:

> So to tell you the truth, when I started to work as a mediator, the first few months were difficult. I was also a refugee, having experienced some of the problems, not all of them, so at the beginning **I found myself inside the patients' stories**. I had **difficulty in detaching myself** from these problems and it made me feel bad and I also had difficulties at home to sleep, because I was always thinking about these bad stories.
>
> It doesn't mean that a mediator isn't a person, we have a heart, emotions, but he **mustn't show these emotions, you have to control them. But often it's not easy**, someone who starts crying for 30 minutes, you're a bit confused as a mediator, because **you start to live again the difficulties.** Because **we mediators are refugees too**. Some of us have also crossed the desert, have passed through these experiences, and they come to tell you about them in front of you. And from the beginning it reminds you of all the difficulties. But it is your job. **You have to make the difference between the work, the mediator, your role as mediator, and your life.** You're here to support, to help this young man, not to cry.

Respondent 2: Tunisian IM with Italian-Arabic/French language combinations. In the following excerpt he was describing a particularly complex emotional situation:

> Even if now I have less difficulty than before, the difficulty is **when the patient is too emotionally charged**, when an emotion that is too strong emerges from the patient and even

[15] Respondent 1 did not only work for the centre where Carfagnini met him, but had also worked for and was still working for many centres dealing with migrants in the first reception phase.

[16] Transcriptions and translations of interactions and interviews by Carfagnini. Emphasis added. All translations have been adapted as little as possible to ensure readability and comprehension but at the same time maintain the oral nature and sometimes stylistic incongruencies.

> you, as a human being, the mediator is also often **in difficulty, emotionally implicated, affected by the words**. So, often, for us, emotions can emerge that can make you feel sad. It's true that **I try to resist my emotions**, **but there is still some sympathy** when confronted with a difficult story.

Respondent 3: IM from Mali with the following language combinations: Italian – Bambara/French/English/Wolof/Mandingo[17]. In the following excerpt he specifically addresses alignment issues:

> As far as the positive aspects are concerned, in my opinion it is very **important to create trust between the three partie**s involved in the interaction because **if there is no such bond of trust, you go nowhere.** …Well, let's not forget that most of the migrants have been persecuted in their country, so one who runs away from a difficult, dramatic situation, **always sees the doctor or the mediator as the boss**. So they already come with an idea that they always feel persecuted so it is very **important to create this trust**, to confide in you to allow them to speak, **to bring out the problem by themselves**. So that's the positive aspect, it is important in my opinion. The negative aspect, if there is one, is however the **risk of not being able to put a barrier between the professional bond and what we can call the heart bond.** And it's a little more nuanced in that case. We're human beings.

In the patient-clinician interactions we find recurrent alignment patterns. In the excerpt below, the participants are a 40-45 year old Italian female GP; a 40-45 year old male patient from Mauritania (P); and a 35-40 year old female IM of Ivorian origin. To the doctor's (GP) question "What is the reason for your visit?" the patient (P) replies that he has a date for the hearing, and that they have requested a medical report. The doctor (GP) shows the IM this part of the report as illustrated in the following sequence:[18]

[17] Respondent 3 had worked for more the 50 reception centres in one specific region of Italy and had more than 8 years of experience.

[18] In transcribing the original utterances, the following conventions were adopted:
[ ] overlapping utterances
= latched utterances

N°	Doctor – GP	Mediator - IM	Patient - P
89	Do you understand? ((GP shows IM the medical records))		
90		mhm	
91	((GP looks IM in the eye)) so try to find out how he got those scars(.) well (.) he does have scars(.) bu:t		
92		how'd you get those scars?	
93			but now (.) I've come to Italy now
94		where are you from?	
95			e: (.) until after a month (.) I've got through the forest=
96		=>>no no no no no >> (.) I said (.) where are you from? Where do you come from? (.) Your country? What country are you from?	
97			Mauritania
98		Mauritania	
99			ye:s
100		where'd you get those scars? How'd you get them?	
101			li:ste:n to me ca:refully (1)
102		mhm	
103			I (.) look after animals

(.) brief pause
(2) pause of 2 seconds
(+) pause of more than 2 seconds
↑ rising intonation
°text° decreased volume
te::xt stretched sound
TEXT louder volume
>text> increased pace
<text< decreased pace
(xxx) inaudible
((text)) analyst comments or descriptions

104		mhm	
105			in the forest
106		mhm	
107			now until a month (.) I went through the trees (2)
108		mhm (+) I'm listening eh sir?	
109			the (xxx) kept the animals >the animals they made me fall> (.) and there is a lot of torture (.) now I went to Marocco
110		did the animals do this to you?	
111			yes
112		>>HOW ?>>	
113			eh:::- my boss↑
114		>>GET dressed please >>	
115			what are you saying?
116		>please get dressed> (.) ((IM turns and looks at GP)) °very confused°=	
117			=NOW I have [a
118	[confused? ((GP and IM look at each other while P speaks))		
119		mhm	

The doctor gives the IM the floor, telling her: "so try to find out how he got those scars". The IM is very straightforward, adopts a peremptory tone and seeks to impose her professional authority; in an interview that took place after the consultation, she explained that as an African woman her prior experience with African men had led her to feel that she was not being treated as a professional, and that the interpersonal dynamic was crucial between them. As the interaction unfolds, her willingness to encourage communication increases. The IM's communicative tone becomes more and more friendly, encouraging the patient to tell her as much as possible about his health problems. Four times the IM takes the initiative to interject questions: "Do you have any other problems besides that? Do you have other health problems?" (line 145), "Other than that?" (line 174), "Yes (.) apart from that (.) is everything physically all right? (line 178)", "Apart from that, are you all right? I (.) speak to you (.) on a (.) physical level. You don't have any health problems apart from the foot

and there?" (line 205). The IM's proactive, engaged approach is meant to establish rapport, strongly signaling empathy and a desire to help the patient.

Other examples of empathic IM-migrant bonds that are successfully dealt with by the IM in the first data-set are the following. In one interaction, an asylum seeker from the Ivory Coast is afraid that providing a blood sample could lead to him losing all his blood. But the interpreter understands this and continues to converse with the patient to reassure him. In another interaction, a woman from Mauritania has been a victim of abuse for 10 years, the perpetrator being a man for whom she did domestic chores. When asked "Where do you sleep?", the patient responded "It's him, the one who helped me here". The IM hearing "him" is afraid that "him" refers to the same man who had been hurting her for 10 years, so she decides on her own initiative to continue asking questions, as if to reassure herself that the patient is in safe hands.

Although we observed IMs engaging empathically with migrants when listening to their traumatic narratives in our interactional data, we did not witness first-hand any triadic interactions characterized by conflicting empathic behaviors. However, in the contextual data and in the informal interviews, IMs frequently reported negotiating empathic stress, and one of their main concerns was indeed struggling to negotiate an empathically engaged approach. Many IMs stressed that keeping the right distance on an emotional level was paramount in order not to "lose control". In the words of an Eritrean IM:

> It's really a job that you have to do, it's really a job that you have to do in your head; when you leave home, eh::: **you have to have two pairs of shoes**. Two pairs of shoes. When you come into the house, you have to leave your shoes behind you; that's what they say. Especially with the refugee boats; it isn't easy, it's hard, it isn't easy; there should be a psychologist for the mediator; yes, yes.

This also reflected the preliminary results from the online survey as described above, and from both authors' previous work with IMs in Italy.
An example from the second data-set – the interviews – illustrates the IM's acute struggle to negotiate empathy, putting at risk their own self-care. In our data we see that this last aspect, self-care, usually kicks in later, after the session. Although the IMs seemed to handle empathic stress well during the session itself, it is impossible to say how this might affect them in the long run. The dilemmas and feelings of intense stress observed in

both the online survey and the recorded sessions are strongly supported by the *in situ* observations and the informal conversations Carfagnini had with the IMs during her research period. A Tunisian IM who arrived in Italy in 2011 in the wake of the Arab Spring, tells the researcher how he finds it difficult to negotiate certain situations. He gives the example of two young boys who had just come off the refugee boats, and had lost both mother and father during the sea voyage. It was very difficult, he says. During the mediation sessions he tries to exercise self-control and not cry, but afterwards, in the evening, he vents his frustration with others or goes out to get drunk.

> It's the kind of thing that makes your hair go grey or makes you stay awake till four in the morning, but while you're with that person, **you try to avoid it [crying]. It's really really hard**. For me personally it's the most difficult thing there is, maintaining a distance from the stories they tell. And:: often I hear such painful stories and I feel like crying, **but it's not the right time, at all,** and so one has to try to stay strong until after the session, **and then go alone to get drunk**.

An Eritrean IM still remembers the arrival of a group of Eritreans and, perceiving their suffering, she still remembers their smell – associated with the suffering:

> I remember an episode, in Crotone. They called me at three in the morning, some boats had arrived, **some boats had arrived from Lampedusa**; instead of taking the migrants from Lampedusa to Crotone, **they kept them for three days** [in another city].[19] Can you believe that? Can you believe that I was feeling unwell, I was unwell for 15 days, I was unwell because for 24 hours I could smell their smell. For 24 hours **I could smell their smell, that stayed with me for 15 days**. I went back, I went there for 15 days, but I came back, I couldn't do it; I was in the shower the whole time. **These are traumas**; maybe when I tell these stories, they're hard to even believe; d'you understand? **Only those people who have experienced this can understand certain things; oh well; bad, eh… Really awful.**

Carfagnini heard numerous similar narratives during her research period. What emerged was a clear picture of how IMs attempted to negotiate emotionally highly complex interactions with very few tools for support.

[19] Added by the authors in order to omit the city for reasons of privacy.

They negotiated as best as they could, trying to "be strong" and not getting carried away by their emotions. It was afterwards however, after the sessions, in their daily lives, that they felt the true emotional impact of the empathic bond. This could take the form of insomnia, recurrent anxious thoughts, crying, alcohol consumption or lingering smells.

3. Concluding remarks

Showing concern for a person in need – empathy – is a valuable human quality, and triggers the desire to help, which is a fundamental drive for human survival. We have argued above that empathy can help professionals to better understand their interlocutors, encourage cooperation and trigger positive treatment reactions. Both cognitive and emotional empathy can be a useful part of the interpreter's tool-kit in many ways. However, although encouraging interpreters and language mediators to demonstrate emotional empathy when listening to narratives of distress seems both natural and moral, the consequences of not managing potential stress resulting from that very same empathic bond can be harmful. It is crucial that the interpreter or language mediator is made aware of the dangers of empathic bonding to him/herself, and is given the tools and resources to pre-empt and/or manage any resulting trauma, especially in those countries where interpreters are encouraged to engage pro-actively with the interlocutors.

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