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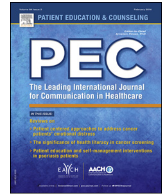

Review article

Conceptualizing emotion in healthcare interpreting: A normative approach to interpreters' emotion work

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ABSTRACT

Objectives: By juxtaposing literature in signed language interpreting with that of spoken language interpreting, we provide a narrative review to explore the complexity of emotion management in interpreter-mediated medical encounters.
Methods: We conduct literature search through library databases and Google Scholar using varied combinations of search terms, including interpreter, emotion, culture, and health care.
Results: We first examine (a) interpreters' management and performance of others' emotions, (b) interpreters' management and performance of their own emotions, and (c) impacts of emotion work for healthcare interpreters.
Conclusion: By problematizing the roles and functions of emotion and emotion work in interpreter-mediated medical encounters, we propose a normative model to guide future research and practices of interpreters' emotion management in cross-cultural care.
Practice implications: Quality and equality of care should serve as the guiding principle for interpreters' decision-making about their emotions and emotion work. Rather than adopting a predetermined practice, interpreters should evaluate and prioritize the various clinical, interpersonal, and therapeutic objectives as they consider the best practice in managing their own and other speakers' emotions.

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1. Introduction

The medical community has placed increasing significance on the interpersonal and relational aspects of healthcare delivery [1–3]. Numerous studies have demonstrated that healthcare professionals' emotional management and emotion work can have an important impact on patients' quality of care and health outcomes [4–6]. However, such emotion labor also can be draining, often resulting in individuals' experiences of stress and burnout [7–10].

Interpreters are a unique type of healthcare professionals who often are viewed as the solution when providers and patients do not share the same language. In interpreter-mediated medical encounters, interpreters' emotional management can entail emotional display of their own and/or other speakers' emotions. As such, their performances can have important interpersonal and clinical consequences to the shifting boundaries of task, identities, and relationships in provider–patient interactions [11,12].

We define healthcare interpreters as professionals who provide interpreting services in healthcare settings [13], including spoken and signed language interpreters. Despite interpreters' central role in mediating provider–patient interactions, many healthcare providers continue to conceptualize and expect interpreters to assume a neutral *conduit* role, transferring information from one language to another in a word-for-word, machine-like fashion [14–16]. In this view, an interpreter-mediated medical encounter is not recognized as a dynamic process that is co-constructed by all participants. Interpreters are passive tools to be wielded by other participants [17]. Researchers debated about: "Is it necessary for the interpreter to mimic the emotional tone and content of messages? If the emotional tone and content is not understood or is misunderstood, is it the responsibility of the interpreter to verbalize them?" [18] Recent literature has addressed these issues and highlighted the complexity of interpreter-mediated medical encounters [19,20], challenging the effectiveness and appropriateness of interpreter-as-conduit model [21].

In this review, our goal is to extend this line of research by examining the roles and functions of emotion and emotion work in healthcare interpreting. We first examine (a) interpreters' management of others' emotions, (b) interpreters' management of their own emotions, and (c) impacts of emotion work for healthcare interpreters. By problematizing the roles and functions of emotion in interpreter-mediated medical encounters, we propose a normative model to guide future research and practices of interpreters' emotion management. In addition, by juxtaposing literature in signed and spoken language interpreting, we offer one of the first studies to explore the complex functions and meanings of emotion and emotion display across all interpreter-mediated interactions.

2. Methods

Due to the limited number of studies that address this issue directly, we conducted a narrative review [22], which is particularly useful for examining complicated issues across various disciplines and developing a theoretical model for best practices and future research directions [23,24]. We conducted literature search through library databases (e.g., Medline, PsycInfo, ERIC, and JSTOR) and Google Scholar, using combinations of varied search terms, including interpreter (e.g., medical/healthcare/community interpreters), emotion (e.g., empathy, emotion management/work/display, and vicarious trauma), culture (e.g., cultural norms/displays), and health care (e.g., provider–patient communication/relationship). We focused on how emotions have been conceptualized and examined in interpreter-mediated medical encounters across different disciplines. We limited our review to professional interpreters because other types of interpreters' (e.g., family interpreters) emotional performances may confound with their other social roles. We also excluded publications written in languages other than English.

3. Results

We follow previous studies by acknowledging healthcare professionals' experience and performances of emotions are not necessarily limited to their felt emotions but also reflect their understanding about their professional roles. For example, a review of the nursing literature concluded that empathy has been conceptualized in five distinct categories: (a) a human trait; (b) a learned communication skill; (c) a communication process; (d) an act of caring; and (e) a reciprocal relationship developed over time [25]. Such variations highlight the complexity of emotion and emotion work in healthcare settings as professionals balance their intuitive human condition with their professional roles *and* organizational goals [26].

Unlike the nursing literature, few studies have directly addressed the issue of empathy and emotion in healthcare interpreting. This lack of research may be attributable to the traditional and prevalent ideology of interpreters-as-conduit [27], a machine-like, passive interpreting style [14–16]. Interpreters have been found to have internalized such an expectation, noting that the conduit role requires them to be detached, to be emotionless, and to avoid interactions with others [28–30]. Providers also have argued that emotion expressions (e.g., angry tone and agitated movement) are noticeable to others in medical encounters and universally understood and thus, do not require interpreters' relay [11,31]. As a result, expressions of emotion have not been a central issue to the theories and practice of healthcare interpreting. There has been little evidence-based guidance for healthcare interpreters' management of emotions. In fact, there are few studies that examine the clinical consequences of interpreters' (mis)management of emotions.

Nevertheless, failure in recognizing the complexity of emotional performances in cross-cultural healthcare has undoubtedly led to miscommunication, and even problematic diagnoses. For example, in American Sign Language (ASL), language production involves articulation of the hands, face, and body. Unfortunately, non-signing physicians have been reported misdiagnosing "an expressive Deaf person as having tics, inappropriate affection, and personality and mood disorder" [32], resulting in Deaf patients' negative experiences and avoidance behaviors [33]. Miscommunication can arise when different cultures do not share the same understanding about the appropriateness and meanings of emotional displays [34–37]. For example, although it may be appropriate for an oncologist to tease or joke with a patient with cancer in the U.S. to develop rapport, people from Japan or France would find it inappropriate or offensive to use humorous talk in such a context [38]. In short, it may be necessary for interpreters to communicate the emotion expressions and affective content to ensure successful provider–patient interactions [18,20].

3.1. Interpreters' management and performance of others' emotions

Due to the influence of the conduit model, interpreters' "appropriate" expression and performances of emotions is often conceptualized to be the original speakers' emotional or affective state rather than their own emotions [39]. However, there remain questions about how interpreters should relay such information (e.g., mimicking speakers' emotional display or providing metalinguistic comments that describe their perception of the affective content) [18]. The choice of how interpreters express other speakers' emotion is a complicated issue, involving concerns about

interpreter visibility, content authenticity, communicative efficiency, communicative goals, and therapeutic objectives.

Embedding emotional and affective content in interpreters' non-verbal communication (i.e., mimicking original speaker) can minimize interpreters' visibility and create a smooth flow of interactions. However, other speakers who are not familiar with interpreters' performance in first-person style may be startled by interpreters' emotional display of anger or frustration, confusing interpreters' emotion expressions as their own attitudes and resulting in problematic attributions [31,40]. In addition, whereas others may appreciate interpreters' dramatic performance of others' positive emotions (e.g., congratulating a mother about her beautiful newborn in an exaggerated tone that mimics that of the speaker) [39], it is questionable if interpreters' reenactment of others' negative emotion (e.g., frustration and anger targeting healthcare professionals or patients) would be equally appreciated and readily accepted. Positive emotions may facilitate interpersonal interactions and bonding; however, interpreters may feel obligated to diffuse or prevent conflict between a patient and a clinician by "cover[ing] up the words of the doctor" [41]. From this perspective, interpreters' assessment of communicative goals (e.g., enhance provider–patient bonding) may influence their decision on whether and to what extent to relay others' emotion expressions.

Healthcare interpreters' reenactment of others' emotion in cross-cultural contexts can be particularly challenging for the following reasons. First, cultural differences in emotion display can be very subtle, with diverging cultural and clinical meanings [35,37]. It can be difficult for an interpreter to master the various hidden cultural display rules for a wide variety of emotions *and* to have the non-verbal skills to reenact them effectively [42]. In addition, because emotions in healthcare settings can entail therapeutic objectives and/or clinical consequences, interpreters may face challenges in managing the multilayered and multidimensional meanings of individuals' emotions. For example, it may be difficult, if not impossible, to reenact a mental health patient's emotions in a way that is both culturally appropriate and clinically meaningful [43]. Although sadness and suffering may be diagnosed as a symptom of depression in western cultures, people from non-western cultures may view these emotions as an empowerment to their cultural identities rather than an illness condition [44,45]. A study found mental health providers hold paradoxical attitudes about interpreters' role, describing "the interpreter as both an obstacle and a facilitator of the empathic process, helping them to develop, and at times inhibiting, a sense of empathic connectivity with the client" [46]. The complexity of cross-cultural implications and clinical meanings of individuals' emotions has been a challenging issue for healthcare professionals [6]. Without adequate clinical knowledge and cross-cultural training, an interpreter may inadvertently heighten, minimize, or overlook a patient's or a provider's emotions and emotion work, contributing to compromised care.

Second, because different cultures/languages may have different encoding and decoding rules [35,47,48], the same non-verbal display may entail different meanings in different cultures. For example, although eye contact has semantic and syntactic functions in both spoken and signed languages [49], eye gaze patterns in ASL contribute to specific grammatical and pragmatic meanings [50]. For example, when a Deaf storyteller maintains eye gaze with an audience, s/he assumes the role of narrator; in contrast, when the storyteller gazes away from the audience and signs, s/he assumes the role of story character. When a Deaf storyteller's eye gaze is fixed on his/her hands, the behavior serves the function of marking emphasis in the narrative. However, non-signing providers may find Deaf patient's or ASL-English interpreter's lack of mutual eye gaze as suggesting a lack of interest or avoidance behaviors [49].

Third, modifying individuals' emotional display can be challenging in a triadic, cross-cultural interactions. For example, Matsumoto [51] found that Americans tend to believe that people show a higher intensity in their affective displays than their subjective experience (e.g., individuals are not as excited as they appear to be); in contrast, Japanese inferred greater intensity of subjective experience (e.g., individuals are more excited than they appear to be). It is unclear if other participants, after observing the original speakers' non-verbal expressions, would be able to understand that the interpreter has modified the emotion display for reasons of cross-cultural equivalence rather than to modify the original speakers' emotion. There also can be a confounding effect with the repeated exposure to the speaker's and the interpreter's (different) emotion display.

Fourth, the clinical settings present unique considerations for interpreters' management and performance of others' emotions. Successful provider–patient communication can be therapeutic (e.g., providing comfort and reducing suffering) and strengthen interpersonal relationships (e.g., provider–patient trust and rapport) [4]. As a result, a patient may prefer to establish direct communication with a physician (vice versa) when they prioritize interpersonal bonding over potential risks of miscommunication, despite their limited language proficiencies [52,53]. In these situations, an interpreter may choose to maintain a silent presence, only to intervene when they observed significant misunderstanding or when the participants failed to resolve misunderstanding on their own [28]. However, an interpreter may become aware of the communicative challenges but uncertain about the appropriate interventions. For example, Deaf people whose speech is not readily intelligible have been reported being judged as being less intelligent (and even mentally compromised) than Deaf people whose voice is intelligible [54]. A patient with limited English proficiency (LEP) or a healthcare provider with limited medical Spanish may not realize that his/her comments or emotion display were confusing to others. In these situations, an interpreter may feel motivated to repeat the speaker's talk to ensure appropriate understanding; nevertheless, such practices (i.e., repeating a person's speech) may be perceived as condescending for individuals who wish to establish direct communication with each other. In short, healthcare interpreters often need to consider other potential communicative goals (e.g., interpersonal goals) at play when they manage others' emotions and emotional display in medical encounters.

Finally, it is important to recognize that not all emotion expressions in healthcare settings are appropriate. Researchers have long recognized the imbalance of power in provider–patient relationship [55]. Minority patients (e.g., hearing and Deaf patients with limited English proficiency) are particularly vulnerable to structural injustice or social stigma in healthcare settings [56]. If a provider's communicative behaviors and emotion expressions (e.g., patronizing or impatient attitudes) facilitate such injustice or oppression, an interpreter may find it unethical to maintain such attitudes through their reenactment of others' emotions [43,57]. From this perspective, researchers have noted interpreters' role in serving as organizational gatekeepers [28,58,59]. However, it is also important to note that interpreters may not have accurate assessment about others' emotion work. An interpreter who offers emotional support to a patient may mistakably compromise a mental healthcare providers' effort to adopt a more confrontational attitude as part of a therapeutic process [60].

3.2. Empathy as emotion work in healthcare interpreting

Like nurses in clinical care, interpreters cannot escape from a patient's experiences of suffering. Unlike nurses who are in a position of being responsible for alleviating the suffering,

interpreters often feel frustrated and powerless in the communicative process [61,62]. This is because professional interpreters often feel restrained by their professional codes to maintain neutrality by avoiding active intervention, including building rapport or offering emotional support, even when they perceive the need for interventions [17,28,30,63]. This is a tension unique to healthcare interpreters.

One of the unique conceptualizations of interpreters' emotion work as a result of such tensions is the objectification of interpreters and their emotion work. For example, some providers argued that emotional support is implied through interpreters' physical presence and that "on-site interpreters' physical presence is symbolic, representing a caring gesture from the providers" [60]. In addition, providers were found to conceptualize interpreters' emotional support for and relationship with patients as resources to be exploited for their therapeutic objectives and institutional needs [17,64]. Because interpreters' private interactions with patients may yield valuable diagnostic and persuasive resources for providers [65], providers may expect interpreters to use their emotional support for and bonds with patients to actively pursue providers' agenda [17]. On the other hand, some interpreters were found to view non-interference as respect for patient autonomy in face of problematic provider–patient interactions. One interpreter commented, "Because you have patients who are very submissive, very afraid, depending on what they went through. So, the interpreter thinks that he or she has a right to advocate. *But were you asked to do so?*" [66]. Similarly, a signed language interpreter stated, "I've been beaten over the head that we don't get to say anything – that the boundaries are like cement walls" [67]. Interpreters' professionalism is reflected in their ability to deny their urge to offer emotion support. From this perspective, interpreters, as well as their emotion work, become resources to be managed, exploited, distributed, or withheld. Interpreters' agency and role as an active member in the healthcare team to ensure the quality of care are overlooked.

However, evidence-based research on interpreter-mediated medical encounters has repeatedly demonstrated that interpreters' active management of the process and content of provider–patient communication is necessary to ensure the quality of care [65,68]. Researchers have argued that interpreters' emotion work has a direct impact on the quality and process of care. For example, when interpreters' interpreting style incorporates strategies to build rapport and trust with the patient (as opposed to be emotionally detached), patients are more likely to accept providers' recommended treatment [69]. A neutral/slightly cheerful interpreter can act as a buffer for the patient against the negative mood expressed by a despondent therapist [70]. Interpreters' side interactions with patients may allow patients to feel more comfortable to reveal sensitive information (e.g., HIV diagnosis) when interacting with providers [65]. Interpreters actively provide emotional support and minimize negative attitudes/emotions during medical encounters by noting the needs to bridge cultural differences, enhance provider–patient bonding, and ensure quality care [28,40,60,71]. A recent study found that nurses highly value interpreters' function as patient ally [72], which echoes with the general tasks of nurses in which they often help patients to voice their concerns, address their information needs, and provide emotional support [26,73].

One may question the appropriateness for interpreters to make other speakers to appear friendlier, nicer, or more polite than they really are. Such a concern highlights the tensions in normative expectations for interpreter-mediated medical encounters, such as maintaining interpreter neutrality, honoring participants' voices, facilitating provider–patient interactions, ensuring the quality of care, and creating conditions in which patients can make judgments about their own healthcare providers.

Interpreters are aware of the normative expectations for interpersonal social interactions. For example, studies have consistently identified interpreters' desire to connect with patients, noting that it would be rude, uncaring, or insensitive if they do not have some direct interpersonal interactions with the patients [40]. However, the normative rules for everyday social interactions may differ significantly in clinical contexts. Whereas it may be appropriate to offer emotional support to a patient with cancer, mental health providers have expressed concerns about how small talk (e.g., "Where are you from? Do you have children?") can trigger traumatic episodes for refugees who have experienced devastating events in their home country or how interpreter–patient bonding may compromise providers' therapeutic relationship and treatment process with the patient [60,74]. As a result, interpreters' understanding and expression of their own empathy and emotion work in clinical care are likely to take a more subtle performance and complex management, balancing the prevalent, ideological expectations of a neutral interpreter while providing active interventions to address patients' emotional needs and providers' therapeutic objectives in healthcare settings.

3.3. Emotion contagion and vicarious trauma in healthcare interpreting

The literature on interpreters' occupational hazards and self-care first emerged in the late 1980s in the literature for signed language interpreters, focusing on interpreters' upper extremity cumulative trauma disorders (e.g., tendonitis and carpal tunnel syndrome) as a result of repeated movement of arms, hands, and wrists [75,76]. The analytical focus is reinforced by the interpreter-as-conduit model and the utilitarian approach to healthcare interpreters, treating interpreters' body as a tool to be protected and maintained. Although the research community has been aware of the negative consequences (e.g., emotional exhaustion, compassion fatigue, and burnout) of healthcare professionals' emotion work since early 1980s [77,78], few had paid attention to interpreters' experiences until early 2000s. This may be because interpreters have traditionally been trained to adopt an emotionless, passive, and robot-like style of interpreting [28]; as a result, researchers overlooked issues related to interpreters' emotion work as well as its corresponding impacts.

However, because interpreters adopt a first-person speech style (i.e., talking or signing as if they were the original speaker) during interpreter-mediated interactions, they can be particularly vulnerable to emotion contagion (e.g., experiencing the exact emotion of others) and vicarious trauma, both of which have been identified as important predictors of burnout for health professionals [10,78–80]. In fact, the majority of work on interpreters' vicarious trauma emerged from studies on European interpreters who work with war refugees, asylum seekers, and torture survivors [81–83]. It is important to note that despite their success in surviving in the host society, many interpreters were once refugees themselves, subjected to various forms of oppression and trauma (e.g., witnessing family members being assaulted or even slaughtered) [84,85]. Similarly, interpreters who have Deaf family members may have witnessed the repeated marginalization of their loved ones by the mainstream society [86]. Interpreters' close identification with these patients' shared cultural, sociopolitical, ethnic, geopolitical, or life histories can contribute to feeling overwhelmed by the emotional impacts of their interpreting tasks [84,87,88]. One study found 20% of interpreters for refugees experienced some level of posttraumatic stress disorders [81].

It is disturbing that despite the well-established training and institutional support to assist mental health providers' secondary trauma stress, there are few structured resources in either organizational settings or the industry for interpreters to cope

with their experiences of emotional exhaustion or vicarious trauma. Interpreter self-care is often treated as a caveat in interpreter training rather than a topic that is essential to interpreters' professionalism or well-being.

4. Discussion and conclusion

4.1. Discussion

Researchers have consistently demonstrated the limitations of the conduit model in guiding interpreters' practices [21,65,68], including emotional management, as it fails to consider the emergent nature of provider–patient communication. In response, we propose to adopt a normative approach to the study of healthcare interpreters' emotions and emotion work as such a theoretical approach is particularly useful to accommodate cross-cultural differences in applied contexts [89]. By normative, we mean a theoretical account designed to predict and explain the meanings and evaluations of interpreters' emotions and emotion work to be more or less appropriate or effective. Our objective is to offer a general framework that looks across disciplines and different levels of social and cultural norms in cross-cultural care.

Within a normative approach, we adopt following assumptions. First, emotions are inherent in and enacted through social interactions, with implications for the particular task, identities, and relationships involved [90,91]. Second, because emotions are socially constructed in and through social relationships, the meanings of emotion lie in the "rules" which guide behavior at particular points in time and place [92,93]. Third, the normative rules exist in the larger sociocultural contexts, which shape individuals' expectations and interpretations of emotions and emotional display [94].

We recognize that interpreter-mediated medical encounters are by definition cross-cultural, involving norms from multiple sociocultural systems (e.g., the patient's and the provider's culture, organizational culture, and medical culture). We also acknowledge that not all sociocultural norms are of equal footing (e.g., Deaf or LEP patients may feel that their norms are marginalized as a minority group). However, regardless of the patients' and providers' own sociocultural norms, all interpreter-mediated medical encounters still take place within healthcare settings.

Healthcare institutions are constructed for a specific purpose, to treat ill people. A medical encounter is considered unsuccessful when a patient does not receive quality care, does not experience better health outcomes, and/or experiences health disparities at any stage of their illness experiences. In this applied context, interpreting serves a greater purpose than fulfilling patients' or providers' individual communicative goals. Interpreting, as well as provider–patient interactions, is a goal-oriented activity. The goal is to ensure that the patient receives quality and equality in care (QEC), with improved health outcomes and minimal health disparities. In other words, QEC should serve as the guiding principle for all interpreter-mediated medical encounters. It is from this perspective, we echo Goldsmith's [89] notion of a normative theory as it allows generalization across sociocultural contexts due to its universalities (e.g., healthcare contexts and its goals for QEC) but also provides flexibility for variations specific to a particular sociocultural contexts (e.g., Deaf or Hispanic cultures).

We do not wish to present prescriptive behavioral guidelines (e.g., specific behavioral strategies) to regulate interpreters' behaviors. For example, within the conduit model, some argued that interpreters should remain emotionless and detached because others can see the speakers' emotion (i.e., focus on words) [11,31], others argued that interpreters should convey others' emotion (i.e., talk as the original speaker) [39]. These two approaches, however, are incompatible. It is also unclear when and how an interpreter should switch between these approaches. By imposing standardized behavioral guidelines irrespective of contexts, the conduit model can compromise QEC by overlooking the complexity and emergent nature of provider–patient interactions [28,40,60,71].

In contrast, we appeal to QEC as the guiding principle for interpreters' decision-making about their emotions and emotion work. This approach is acknowledges that interpreter-as-conduit is one of the many norms in healthcare settings [27], allowing interpreters follow the conduit model as they see fit. For example, most people may feel that it is appropriate and effective for interpreters to reenact other speakers' exaggerated performance of positive emotions [39], because it facilitates QEC. As a result, our normative model would predict that interpreters are likely to relay positive emotions, which would also be evaluated positively by other participants.

Whereas the conduit model have been found to create interpreters' frustration about how to best manage others' negative emotions [31,40,41], our theoretical approach can explain and address concerns related to such practices. First, we argue that the conflicts arise from competing components of QEC. In addition to "do no harm" (i.e., beneficence), patient autonomy and informed decision making are also important components of QEC [21,95]. Although not disclosing a provider's prejudicial attitude may satisfy the values of beneficence, it also deprives a patient from making informed, autonomous decision about the quality of their provider. Similarly, an interpreter may feel reluctant to relay a patient's negative attitudes for fear of compromising provider–patient relationship. As a result, interpreters are faced with the competing values within a healthcare system.

Second, the issue can become more complicated in cross-cultural care due to competing sociocultural norms regarding what constitutes QEC. For example, whereas patient autonomy and informed decision making are common values in the West, not all healthcare systems share the same expectations. For example, whereas 65% of U.S. physicians reported to always tell children about their cancer diagnoses, only 9.5% of Japanese physicians reported the same [96]. In a more paternalistic healthcare system, healthcare professionals may be expected to protect patients from additional harms. In this instance, Japanese-English healthcare interpreter may find it difficult to reconcile the conflicting norms of the two cultures.

So, whether and how should interpreter relay the negative emotions of others? A normative approach does not offer a predetermined answer. Rather, it encourages participants to identify and prioritize the various sociocultural norms that are relevant to the specific communicative event. Although QEC is a guiding principle for all healthcare deliveries, we argue that the meanings of QEC are not fixed or predetermined but are socially constructed at particular points in time and place. The challenge faced by interpreters then is to identify and prioritize the various components that may constitute the definitions of QEC in that particular interaction.

For example, cultural differences in values placed on medical paternalism and patient autonomy [97] may dictate whether and how an interpreter should block an individual's negative attitude. Whereas having the ability to assess a physician's appropriate emotion display may be an important aspect of QEC for an American patient, Japanese norms may favor a harmonious medical encounter even if the emotional content is modified by an interpreter [98]. In addition, even when the goal is to achieve QEC by protecting patient autonomy, an interpreter's response can be shaped by the extent of a normative violation [99]. For example, an interpreter may choose to embed a mildly irritated tone in his/her interpretation but openly refuse to relay prejudicial comments (while informing the patient about providers' problematic behaviors). From this perspective, an interpreter actively

evaluates the best strategy to achieve QEC by prioritizing and balancing other important values relevant to the medical encounter (e.g., beneficence, provider–patient trust, speakers' control over the communicative event). Such practices are consistent with recent findings of interpreters' active and critical role in maintaining and contributing to QEC [28,40,60,71].

Similarly, an interpreter may have other considerations when relaying a patient's negative attitudes or abusive behaviors (e.g., clinical relevance, interpreter visibility, and provider–patient relationships). For example, an interpreter may choose to reenact the negative attitudes during talk therapy to minimize his/her visibility and disruption to provider–patient interactions; in contrast, if the patient is frustrated during physical therapy, an interpreter may choose to offer a summary report of the patient's emotion without providing verbatim performance of the abusive comments to minimize face threats. In both situations, the interpreter treated the patient's negative attitudes to be clinically relevant (and thus, necessary to be relayed to achieve QEC) but prioritized different communicative goals resulting in different choice of strategies. It is also conceivable that an interpreter may block a patient's expression of negative attitudes because it is not clinically relevant and does not facilitate any components of QEC.

Finally, a normative model is also applicable to interpreters' management of their own emotions. For example, when an interpreter believes that expressing empathy toward patients can facilitates QEC, we predict that they are likely to do so. However, because providers from different specialties may hold different expectations about the needed interpreter behaviors to achieve QEC, they may hold divergent evaluations about such practices [60,72].

4.2. Conclusion

Goldsmith [89] explained, ''One important goal of a normative theory is to provide a basis for recommendations about how communicators can achieve desirable outcomes.'' Our goal with a normative approach is to explain and predict their emotion work by understanding the normative rules that guides their understanding and practices of emotions in cross-cultural care. This new approach allows researchers to ask interesting questions regarding: (a) the meanings and functions of emotions and emotion work in interpreter-mediated medical encounters within specific contexts and the potentially conflicting goals speakers may have as they seek to honor competing values; (b) the interrelationships among communicative behaviors related to individuals' management of emotions and the ways in which these form meaningful practices, and (c) the ways in which the meanings and functions of emotion displays in interpreter-mediated medical encounters provide an account for why certain behaviors/displays are judged to be more appropriate and effective than others.

4.3. Practice implications

Quality and equality of care should serve as the guiding principle for interpreter-mediated medical encounters [100]. Rather than adopting a predetermined practice, interpreters should evaluate and prioritize the various clinical, interpersonal, and therapeutic objectives as they consider the best practice in managing their own and other speakers' emotions. Participants can best respond to the normative values specific to the communicative event when providers and interpreters (a) are familiar with the different criteria for and components of QEC in different contexts, (b) maintain a large repertoire of perspective-taking and problem-solving skills, and (c) can collaborate on the QEC goals (e.g., holding pre/post-consultation meetings between interpreters and providers/patients to identify and negotiate specific goals).

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