

John Benjamins Publishing Company



This is a contribution from *Multilingual Individuals and Multilingual Societies*.

Edited by Kurt Braunmüller and Christoph Gabriel.

© 2012. John Benjamins Publishing Company

This electronic file may not be altered in any way.

The author(s) of this article is/are permitted to use this PDF file to generate printed copies to be used by way of offprints, for their personal use only.

Permission is granted by the publishers to post this file on a closed server which is accessible to members (students and staff) only of the author's/s' institute, it is not permitted to post this PDF on the open internet.

For any other use of this material prior written permission should be obtained from the publishers or through the Copyright Clearance Center (for USA: www.copyright.com).

Please contact rights@benjamins.nl or consult our website: www.benjamins.com

Tables of Contents, abstracts and guidelines are available at www.benjamins.com

Explaining the interpreter's unease

Conflicts and contradictions in bilingual communication in clinical settings

Kristin Bührig¹, Ortrun Kliche¹, Bernd Meyer²
and Birte Pawlack¹

¹University of Hamburg, Germany; ²University of Mainz/Germersheim, Germany

This article builds on previous research on ad-hoc interpreting in German hospitals. It discusses the concept of interpreters as “interventive beings” and its consequences for interpreter training. Although the concept seems to be descriptively adequate, it disregards difficulties of interpreters with their active engagement in communication of others. After discussing two types of active engagement, the article makes suggestions for interpreter training.

Keywords: German, Turkish, Portuguese, community interpreting, doctor-patient communication, interpreter training, discourse analysis

1. Introduction

Research on different types of interpreting has shown that dialogue-interpreters are not just conduits (Reddy 1979) who decode and encode two languages (Weber 1984) when interpreting. Rather, interpreters become involved in the communication process and become co-participants by e.g. coordinating and structuring conversation (Apfelbaum 2004, Bolden 2000, Wadensjö 1998), by changing the illocutionary quality of speech actions (Rehbein 1985), or by explaining technical terms (Angelelli 2003). In fact, they are no longer seen as neutral or invisible, but rather as “interventive beings” (Maier 2007, Munday 2007) who interact in the communication of others, for example by mediating between discrepant cultural backgrounds (Pöschhacker 2004: 59). In terms of Goffman's well known speaker role categories, they are not only animators (“bod[ies] engaged in acoustic activity”), but also authors that “select the sentiments that are being expressed”, or even principals who are “committed to what the words say” (see Goffman 1981: 144). Nowadays, scholars working in the field of translation studies usually

consider many of these interventions to be normal and necessary practice in order to enable understanding and to keep the flow of conversation going. Although this view of interpreters (and translators) is widely shared in current research on translation and intercultural communication (House 1981, House & Rehbein 2004, Rehbein 2006), we will discuss this matter with regard to the basic principles of verbal interaction. The reason for this is that the concept of intervention, despite its descriptive power, widely ignores the subjective stance of ad-hoc interpreters towards interventions – how do they feel about intervening in the communication between primary parties?

During the development and evaluation of an interpreter training program for bilingual hospital employees, we interviewed six nurses acting as ad-hoc interpreters about their communicative practice in the context of doctor-patient communication. Interviewees explained that in certain cases, they felt uncomfortable engaging in the communication process; e.g. when acting in place of the doctor or when disrupting the conversation in order to clarify their own questions or to address other difficulties associated with the task. Thus, the focus of this paper lies on what we call “the interpreter’s unease” that may result from intervening in certain situations. This unease of ad-hoc interpreters in medical settings seems to be based on the impression that their behavior has in some way negative consequences for the conversation and/ or for themselves. Our question is the source of this unease. We argue that it is not the result of individual characteristics such as weak language abilities or low self-confidence, but is rather caused by communicative challenges that are systematically linked to interpreter-mediated interaction. These challenges are associated with the level of verbal planning that is required of interpreters in different constellations, as well as with the handling of basic communicative principles such as turn-taking and conditional relevance. Two different types of interventions, namely “other-initiated interventions” and “self-initiated interventions”, will be identified and analyzed with regard to verbal planning and communicative principles. These two types, which in some way lead interpreters to become involved in the communication, can be identified in excerpts from interviews with ad-hoc interpreters and also on the basis of transcripts of authentic discourse data (Bührig & Meyer 2004).¹ Before we go into the data analysis in Section 3, we shall give some information on our theoretical framework in Section 2.

2. Theoretical background

To understand the communicative challenges that can contribute to an interpreter’s unease, it is helpful to look at the constellation of participants in interpreter-mediated

1. The corpus “DiK” can be accessed online at <http://www.corpora.uni-hamburg.de/sfb538/en_overview.html> (16 March 2012). It encompasses about 90 transcripts of audio-recorded doctor-patient communication. Half of the interactions are mediated by ad-hoc-interpreters such as nurses or family members. The languages used are German, Spanish, Turkish and Portuguese.

communication from the perspective of linguistic action theory. The central term that may allow systematic access to the different forms of participation on the part of an interpreter is the concept of “planning” an utterance. In accordance with Miller, Galanter & Pribram (1973) and Austin's (1986) seminal work on the complexity of linguistic action, linguistic action theory (Rehbein 1977, Redder 2008) considers any action that a human performs to be preceded by a “pre-history” and followed by the effects an action has on the hearer, the “post-history”. During the history of an action, an interlocutor will develop an utterance-plan, which contains a “focus” (considering what is to be said) and a “scheme” (the way in which something is to be said to a given listener). The object of this planning can range from a single utterance to a complete turn or an entire speech, for instance in planning a presentation etc. Sometimes, the process of planning takes on the character of a collaborative activity, as in the case of collaborative storytelling (see Quasthoff 1980).

In the case of interpreting, planning activities can oscillate between a single and a joint venture: the man or woman in the middle can be involved in the planning activities of the primary parties to different degrees, and they may even employ planning activities that are not at all based on the contributions of co-participants. However, being involved in the primary parties' planning activities involves, among other things, the process of establishing a relation between source language elements and target language elements. By following the original speaker's plan, the interpreter adopts the speaker's focus and looks in the target language for linguistic means that are in some respect equivalent to those expressions the original speaker has chosen.

These mental processes of the interpreter can be understood as “reproducing” a source-language-utterance (Bührig & Rehbein 2000, Bührig 2005). Reproducing is a creative activity that requires an understanding of all formal and functional dimensions of an utterance in the source language, and moreover, its intended effect on the hearer. Thus, in reproducing, the interpreter shares both the role of a listener as well as the role of a speaker whilst performing the given source-language-utterance in the target language. The difference compared to the target-language listener concerns the post-history, i.e. the interpreter is not subject to the effects that the respective utterance may have, in our case the effects that the medical doctor's utterance could have on the patient.

To sum up, the participant status of an interpreter partly depends on the level of verbal planning that becomes necessary in the process of reproducing a source language utterance within the target language. The independent planning of an utterance requires an independent focus-formation, while in the case of adopting the original plan of the speaker, the interpreter only modulates the scheme of the original plan, for example with regard to the grammatical constraints of the target language. Thus, interventions may oscillate between necessary grammatical changes and planning processes in which the interpreter acts more or less autonomously. We shall argue that unease in the context of interpreting is associated especially with situations in which interpreters go through such autonomous planning processes without being equipped with the necessary institutional knowledge or status to do so.

3. Sources of unease

In the following sections, we will empirically analyse some sources of unease on the basis of data from semi-structured interviews and interpreter-mediated doctor-patient communication. Our aim is to identify and describe situations that systematically lead interpreters to go beyond what is usually expected from them. The interviews were recorded in the context of a project on interpreter training for bilingual nursing staff. The project aimed at developing a training module for nurses who frequently act as ad-hoc interpreters at their workplaces. A group of six nurses participated in the training and gave feedback on their previous experiences as interpreters in the medical context. The transcripts of interpreter-mediated doctor-patient interaction are from an earlier project ad-hoc interpreting in German hospitals.²

3.1 Other-initiated interventions

It was disconcerting for our interviewees when primary speakers, i.e. the physicians, asked them to perform certain communicative tasks in their place. The nurses told us about situations in which – directly or indirectly – they were asked to carry out rather unpleasant jobs that normally the physicians are responsible for.

The nurse Tanja reported on a conversation in which she was made responsible for addressing the non-compliance of a mother who refused to let her ill child stay in the hospital. The child had burn injuries and was supposed to stay in the hospital so that the wounds would not become infected. Although the pediatrician and surgeons tried to convince the mother to let her child stay, the mother still wanted to take her child home. When the conversation refused to progress beyond this conflict, a surgeon turned to the interpreter. As she explained in the interview, “Well, I was standing between the surgeons, because we were in our examination room. And the pediatrician looks at me and then I say something, because she [the mother] doesn’t want to. And the surgeon looks at me again. And/ well, this was really a little bit ((laughs, 1s)) not so nice.”

As Tanja reported, the surgeon did not react to the mother’s reluctance with any sort of verbal or nonverbal action directed at the mother herself. Instead, he continued to look at the interpreter Tanja as if she were responsible for the situation and expected her to come up with a solution to the stalemate.

Another nurse, Meryem, described a situation in which a doctor asked her to convince an aggressive Turkish-speaking patient to adhere to the hospital rules. The patient had been involved in a stabbing, was injured and had been transported to the hospital. He insisted on keeping a knife in his closet because he felt threatened, and spoke in an aggressive manner to other patients in the same ward: “He [the patient] did not threaten the other patients with his knife or anything, but he directly talked

2. The data can be accessed online via <http://www.corpora.uni-hamburg.de/sfb538/en_overview.html> (16 March 2012).

back, in his way, loud, perhaps a little bit aggressive. And it was about me/ about the patient sticking to the rules of conduct for the hospital. I was supposed to make that clear to him. The physician told me to do so.”

The only point of reference given to her by the physician was the intended outcome of the conversation, to convince the patient to behave appropriately. In order to be able to follow this instruction, she partly had to complete a planning process of her own. Normally, an interpreter can base his or her translations on the speaker's original utterances. But in the present case, the nurse had no such original draft and was charged with acting in place of the doctor. One could legitimately claim that the task of talking to an aggressive patient is only a borderline case of interpreting. However, she saw herself as the interpreter in this situation. She told us that she was afraid the patient would get the impression that she sided with the doctor and was not merely interpreting. She perceived the position she was put in as very unpleasant and difficult. The only way out of this situation would have been to resist the doctor's request.

In the incident described by Meryem, another phenomenon becomes apparent that needs to be highlighted in the context of “other-initiated interventions”. The interviewees stated that they often interpreted in situations when only one of the primary speakers was present. This occurs when, for example, a non-proficient patient has something to ask a doctor who is not present in the given moment. Frequently, the patients then turn to the bilingual nurses who are around more often. The patients ask them their questions, which later, after finding the doctor, will be reproduced in the other language. The doctor then answers the question, which the interpreter remembers and reproduces to the patient when they meet again in the ward. We called this special form of communication *Streckendolmetschen* (‘distance interpreting’). Here, the break in the speech situation between doctor and patient is not just based on a language barrier but also on time and space. Distance interpreting, in this way, may generally be considered a specific case of “other-initiated intervention”: reception and reproduction of the perceived message no longer take place at the same time, making it difficult to distinguish between message and messenger – the messenger appears to be acting on his or her own account.

Of course, the episodes illustrated by Tanja and Meryem are only the tip of the iceberg. Ad-hoc interpreters change the underlying plan of the original utterance or begin planning autonomously, even in less drastic situations. This can be shown by looking at discourse data.

In the following example (Excerpt 1), we look at a briefing for informed consent in which a patient is prepared for a surgery of his hip joint. The German doctor is a female anaesthesiologist. The patient is a retired Portuguese worker with limited German proficiency. A Portuguese nurse who has lived in Germany for 30 years serves as an ad-hoc interpreter in this conversation; her mother language is Portuguese and she speaks German as a second language. The doctor briefs the patient for anaesthesia and surgery. Then she asks a battery of questions about the patient's medical history in order to fill out the consent form for the anaesthesia. In the course of these questions, she asks about his teeth.

Excerpt 1: “May I have a look at your teeth?”

Briefing for informed consent, treatment: surgery of hip joint

Transcript no. 17 from the Corpus “DiK”

DOC: German anaesthesiologist (f), INT: Portuguese nurse (f), PAT: Portuguese patient (m)

101	DOC	Darf ich Ihre Zähne mal sehen?	May I have a look at your teeth?
102	INT	Ehm b/ vá lá mostrar os dentes a ela, se faz favor.	Uhm b/ go ahead and show her your teeth, please.
103	DOC	– Ja, die sind aber katastrophal!	– Oh, they are catastrophic!
104	PAT	É de tanto fumo.	It ‘s because of smoking so much.
105	PAT	((1s)) Ou keine Ahne.	((1s)) Or keine Ahne ³ .
106	DOC	((browses through files 3s)) Sagen Sie ihm bitte, dass wir nicht ausschließen können, dass bei diesen schlechten Zähnen – im Rahmen der Vollnarkose – Zähne abbrechen.	((3s)) Please tell him, that we cannot rule out, that with these bad teeth – during the anaesthesia – teeth break.
107	INT	Disse ehm que o perigo de voc/ como os seus dentes não estão em condições, que tem a, tem a boca – num estado um bocadito/ eh não a condizer com, com o coiso da operação pode acontecer que algum dos dentes que você tem na boca, e que estão assim um bocado podres, – que se partam.	She said uhm that there is the risk of you/ because your teeth are not in a good condition, that you have, have the mouth – in a condition a little bit/ uh not conforming to, to the thing of the surgery, it can happen that some of the teeth you have in your mouth, that are a little bit bad, that they break.

Let us first summarize Excerpt 1. The doctor asks the patient to show his teeth (101) and the interpreter translates the doctor’s utterance, whereupon the patient complies. The doctor evaluates the condition of the teeth with an exclamation (103), which is not translated. However, the patient seems to understand what the doctor said because he reacts by giving an excuse in Portuguese (104), which is not interpreted and which he himself subsequently mitigates (105). The doctor then peruses the consent form. It is very likely that she makes a note about the teeth in order to protect herself legally in case teeth are actually broken. Then she asks the nurse to tell the patient that teeth can break during the anaesthesia (106). The interpreter subsequently mitigates the information about the risks in (107).

Our focus for this short passage lies on the last two utterances. After the doctor evaluates the condition of the patient’s teeth, she follows the routine plan of telling the patient about the risks. Here, she changes the form of address: she does not address the patient directly as she had during the rest of the previous conversation. Instead, she turns to the interpreter and addresses her directly with a request: “Sagen Sie ihm bitte,

3. ‘Keine Ahne’ stands for the German expression ‘keine Ahnung’, ‘no idea’.

dass ...” (‘Please tell him, that ...’). With this shift, she distances herself from the communication, the duty of reproducing the speech action is explicitly passed on to the interpreter. The doctor does not bother to make her utterance less face-threatening by mitigating the drastic evaluation of the patient’s teeth. Considering the evaluative stance of her utterance, it seems that she tries to refuse taking any responsibility for the patients’ well-being, especially for his teeth, by blaming him for their condition. It is now up to the nurse to formulate the statement appropriately. In doing this, she fails to follow the original plan of the doctor and instead makes some modifications in her own utterance planning. Obviously, this is difficult for her. She reformulates and aborts her utterance several times. However, in the end her translation is less face-threatening than the doctor’s original remark. She mitigates the doctor’s evaluation of the patient’s teeth: *schlechte Zähne* (‘bad teeth’) turns into *um bocado podres* (‘a little bit bad’). Furthermore, she also mitigates the possibility of the risk. Whereas the doctor says that they, the medical authorities, cannot rule out (“nicht ausschließen können”) the possibility that teeth may break, the interpreter says that it “could happen” that teeth break (“pode acontecer”) by using an impersonal construction. The intervention of mitigating the evaluative statement of the physician and presenting it as a matter of fact rather than a medical judgment linked to an expert was the result of the aggressive and evaluative tone used by the anesthesiologist. In our opinion, it is plausible that the nurse would not have felt obliged to change the original statement if the doctor herself had formulated it more appropriately. The trigger for intervention in Excerpt 1 is obviously more subtle than in the situation with Meryem, who was explicitly requested to convince a difficult patient of something. However, in both incidents presented here, overt or subtle, the ad-hoc interpreters were induced by others to intervene into the interaction.

3.2 Self-initiated interventions

Another source of unease pointed out in the interviews were those situations in which the nurses themselves decided to intervene in the conversation and change or add elements. The ad-hoc interpreter Alicja describes how she feels about this practice: “Because partially I don’t know ... if I may, can, should say something in between. ((1,5s)) Should I really just translate what the doctor says, what the patient says? Should I add my two cents?” It seems that Alicja does not know whether she may intervene or whether this may even be expected of her. She is torn between different assumptions and lacks guidelines for the extent to which she may or should bring herself into the conversation. In our discourse data, we found incidents of such self-initiated interventions in which ad-hoc interpreters “add their two cents”, as Alicja formulated it. The example we look at is from a briefing for informed consent in which a German anaesthesiologist briefs a Portuguese patient for a puncture behind the liver; a Portuguese-speaking nurse interprets for them. In the following excerpt, the doctor informs the patient that because he takes the medicament heparin, he has a higher risk of bleeding. The example shows that such interventions may take place rather unnoticed by other participants, and that they are not without risk for the interpreters.

Excerpt 2: “Inside? No, outside.”

Briefing for informed consent, treatment: puncture

Transcript no. 22 from the Corpus ‘DiK’

DOC: German anesthesiologist (m, 35), INT: Portuguese nurse (f, 25), PAT: Portuguese patient (m, 40)

52	DOC	– An Risiken – birgt so eine Punktion immer – die Blutung.	– Such a puncture always – bears the risk of bleeding.
53	DOC	– Und zwar insbesondere deshalb, weil Sie ja durch das ähm ((1s)) Heparin, was Sie bis heute morgen bekommen haben, künstlicher Bluter sind.	– And in particular, because with uhm the heparin, that you got until this morning, you are an artificial bleeder.
54	INT	Complicações que pode acontecer: eh durante assim uma/ quando picarem eh pode t/ ter sangue/ pode deitar sangue, – pode perder sangue, como tee/ teve até hoje de manhã – – o medicamento que põe o sangue fino.	Complications that can happen: uh during such a/ when they puncture eh you can h/ have blood/ can put blood/ you can lose blood, because you go/ got this morning a medicament that makes the blood thin.
55	PAT	Pois´	Yes´
56	INT	Pode ser que deit/ eh prontos, que continue sangue (a) correr – mais – do que normal.	It can be that bleed/ uh, that it continues to bleed more than normal.
57	PAT	Hmhm´	Hmhm´
58	DOC	Deswegen haben wir ...	For this reason we have ...
59	PAT	Para, para dentro?	In/, inside?
60	INT	Não, para fora, para fora.	No, outside, outside.
61	DOC	Deswegen haben wir das Heparin heute ausgestellt, damit – die Blutgerinnung jetzt normal wird.	For this reason we have discontinued the heparin, so that – the blood clotting now gets normal.

The doctor talks about the risks of a bleeding (52), which could be problematic for the patient, since he became an artificial bleeder (53). In the following sections, the nurse interprets the doctor’s utterances and expands upon them by explaining the effect of the medicine more explicitly (54, 56); the patient signals that he understands (55, 57). When the doctor wishes to continue with the briefing, the patient interrupts and asks if the possible bleeding would be (on the) “inside” (59). The nurse does not translate his question and answers it herself (60); she states that the bleeding would be on the outside. After this sequence in Portuguese, the doctor continues in German.

By answering the patients’ question herself, the nurse carries out an action with an autonomous focus-formation which is not initiated by the doctor or the patient. Rather, her intervention is rooted in the sequential power of the question and in the fact that she believes that she knows the answer. The patient’s question causes a “conditional relevance” (Schegloff 1968, 1978), an expectation for a certain type of follow-up utterance,

namely an answer. Question (first part) and answer (second part) together form an “adjacency pair” (Schegloff & Sacks 1973: 295). The nurse does what is preferable and expected in dyadic communication and answers the question herself. This procedure does not seem to disturb the conversation, and neither the patient nor the doctor complains. It saved time and the conversation continues without any notable break.

However, this form of intervention may result in severe negative consequences. It might be the case that interpreters overestimate their competence and do not give the right answer, which occurs in the present example. The nurse states that the bleeding would be “on the outside”, but actually the risk the doctor is talking about is internal bleeding. Since the nurse did not inform the doctor about the question-answer sequence, he had no chance to adjust his contributions. Furthermore, the hidden intervention makes it more difficult for him to monitor the extent to which the patient understands what he is trying to explain. In light of the potentially negative consequences of such interventions, it is not surprising that interpreters feel uncomfortable with them.

4. Conclusion: Consequences for ad-hoc interpreter training in hospitals

In our paper, we have discussed different types of interventions on the part of ad-hoc interpreters in interpreter-mediated doctor-patient communication. Our aim was to enhance our understanding of how certain tasks and constellations evoke unease in ad-hoc interpreters with respect to their own performance. The background of the study was a project for the development of an interpreter training program for bilingual hospital employees. The basic approach to this project entails that the training contents should be developed in a bottom-up fashion, from the perspective of the trainees and in accordance with what they themselves perceive as relevant. Therefore, interviews were carried out before the project started to elucidate the perspective and the needs of trainees. One of the topics addressed in these interviews was the unease of ad-hoc interpreters about how and to what degree it is useful or even desirable for them to intervene in the communicative exchange between primary parties. In accordance with previous research, it was clear that interventions in general are necessary to facilitate communication between doctor and patient, and that some of them need to be accepted as a natural part of the interpreters' footing. On the other hand, it also turned out that in certain cases, physicians and nurses themselves overestimated their own abilities in terms of the performance of specific speech actions. These cases range from seemingly simple speech actions such as spontaneously answering a question that seems easy to answer, as in the case of internal or external bleeding, to complex and large communicative projects such as admonishing an aggressive patient for failing to adhere to hospital rules. All incidents have in common that interpreters become involved in the communication without being prepared to do so. A nurse that answers questions about possible risks or convinces a mother to let her baby stay in the hospital is often not necessarily equipped with the relevant knowledge or the institutional status

to complete these tasks. However, we do not take such case studies as warning signs indicating a road block. Rather, we use them as examples that serve to mirror communicative practices and which can be reflected on by participants. Thus, within our approach to interpreter training, sources of unease are interesting objects of study because they may tell us something about the hidden conflicts and contradictions in multilingual communication in institutions.

References

- Angelelli, C. 2003. The visible co-participant: The interpreter's role in doctor-patient encounters. In *From Topic Boundaries to Omission: New Research on Interpretation*, eds. M. Metzger, S. Collins, V. Dively & R. Shaw, 3–26. Washington DC: Gallaudet University Press.
- Apfelbaum, B. 2004. *Gesprächsdynamik in Dolmetsch-Interaktionen*. Radolfzell: Verlag für Gesprächsforschung.
- Austin, J. L. 1986. *How to Do Things with Words*, 2nd edn. Oxford: OUP.
- Bolden, G. 2000. Toward understanding practices of medical interpreting: Interpreters' involvement in history taking. *Discourse Studies* 4: 387–419.
- Bührig, K. 2005. 'Speech action patterns' and 'discourse types'. *Folia Linguistica* 39: 143–171.
- Bührig, K. & B. Meyer. 2004. Ad hoc interpreting and achievement of communicative purposes in briefings for informed consent. In *Multilingual Communication* (Hamburg Studies on Multilingualism 3), eds. J. House & J. Rehbein, 43–62. Amsterdam: John Benjamins.
- Bührig, K. & J. Rehbein. 2000. *Reproduzierendes Handeln: Übersetzen, simultanes und konsekutives Dolmetschen im diskursanalytischen Vergleich* (Arbeiten zur Mehrsprachigkeit 9). Hamburg: Universität Hamburg.
- Goffman, E. 1981. Footing. In *Forms of Talk*, ed. E. Goffman, 124–159. Philadelphia PA: University of Pennsylvania Press.
- House, J. 1981. *A Model for Translation Quality Assessment*, 2nd edn. Tübingen: Narr.
- House, J. & J. Rehbein. 2004. What is multilingual communication? In *Multilingual Communication* (Hamburg Studies on Multilingualism 3), eds. J. House & J. Rehbein, 1–17. Amsterdam: John Benjamins.
- Maier, C. 2007. The translator as an intervenient being. In *Translation as Intervention*, ed. J. Munday, 1–17. London: Continuum.
- Miller, G. A., E. Galanter & K. H. Pribram. 1973. *Strategien des Handelns: Pläne und Strukturen des Verhaltens*. Stuttgart: Klett.
- Munday, J., ed. 2007. *Translation as Intervention*. London: Continuum.
- Pöschhacker, F. 2004. *Introducing Interpreting Studies*. London: Routledge.
- Quasthoff, U. M. 1980. Gemeinsames Erzählen als Form und Mittel im sozialen Konflikt oder Ein Ehepaar erzählt eine Geschichte. In *Erzählen im Alltag*, ed. K. Ehlich, 109–141. Frankfurt: Suhrkamp.
- Redder, A. 2008. Functional pragmatics. In *Interpersonal Communication: Handbook of Applied Linguistics*, Vol. 2, eds. G. Antos & E. Ventola, 133–178. Berlin: Mouton de Gruyter.
- Reddy, M. 1979. *The Conduit Metaphor: A Case of Frame Conflict in our Language about Language*. Cambridge: CUP.

- Rehbein, J. 1977. *Komplexes Handeln: Elemente zur Handlungstheorie der Sprache*. Stuttgart: Metzler.
- Rehbein, J. 1985. Ein ungleiches Paar – Verfahren des Sprachmittels in der medizinischen Beratung. In *Interkulturelle Kommunikation*, ed. J. Rehbein, 420–448. Tübingen: Narr.
- Rehbein, J. 2006. The cultural apparatus: Thoughts on the relationship between language, culture, and society. In *Beyond Misunderstanding: Linguistic Analyses of Intercultural Communication* (Pragmatics & Beyond New Series 144), eds. K. Bührig & J. D. ten Thije, 43–96. Amsterdam: John Benjamins.
- Schegloff, E. A. 1968. Sequencing in conversational openings. *American Anthropologist* 70: 1075–1095.
- Schegloff, E. A. 1978. On some questions and ambiguities in conversation. In *Current Trends in Text Linguistics*, ed. W. Dressler, 81–102. Berlin: Mouton de Gruyter.
- Schegloff, E. A. & H. Sacks. 1973. Opening up closings. *Semiotica* 8: 289–327.
- Wadensjö, C. 1998. *Interpreting as Interaction*. London: Longman.
- Weber, W. 1984. *Training Translators and Conference Interpreters*. New York NY: Harcourt Brace Jovanovich.