ISSN 1974-4382

TRANSLATION AND BEYOND: ADDRESSING THE EMOTIONAL LABOR AND WELL-BEING OF HEALTHCARE MEDIATORS

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Citation: Ardizzoni, Sabrina (2026) "Translation and Beyond: Addressing the Emotional Labor and Well-Being of Healthcare Mediators", in Ardizzoni, Sabrina, Marta Aurora, Claudia Buffagni, Anna Di Toro, Imsuk Jung and Andrea Scibetta (eds) *Advanced Technologies, Methods and Materials for Human Health and Well-Being: A Transcultural and Interdisciplinary Perspective*, *mediAzioni* 50: A8–A29, 10.60923/issn.1974-4382/24461, ISSN 1974-4382.

Abstract: Language and cultural barriers can compromise the quality of healthcare by generating misunderstandings that affect diagnosis, treatment, and patient satisfaction. As societies become increasingly multilingual, the need for professional language and cultural mediation is growing (Angelelli 2004; Gattiglia and Morelli 2022). Research has shown that emotional well-being is crucial to both mediator performance and care quality (Baraldi and Gavioli 2016; Curi *et al.* 2020). Both professional interpreters – though trained to maintain neutrality and emotional distance (Hsieh 2008) – and non-professional interpreters – e.g. family members or community brokers – tend to be deeply emotionally engaged. In both cases, exposure to patients' suffering may lead to vicarious trauma, particularly in healthcare contexts (Du 2024). When mediators focus solely on meaning transfer, patients' emotions risk being silenced, weakening empathic communication (Krystallidou *et al.* 2020). Drawing on multimodal ethnography, discourse analysis, and data from the THE (Tuscany Health Ecosystem) project, this article examines the emotional labor of language and cultural mediators within broader sociopolitical frameworks. Findings highlight the interplay of motivation, frustration, ethical dilemmas, and burnout in mediation work, emphasizing the need for targeted training that integrates medical language, AI-assisted tools, and emotional resilience, alongside institutional recognition of the mediators' role and well-being.

Keywords: emotional burden; public service interpreting; healthcare interpreting; translanguaging; intercultural mediation.

1. Introduction

The role of Public Service Interpreters (PSI) in healthcare must be situated within the broader context of the doctor–patient communication. According to Heritage and Maynard (2006), medical encounters are structured forms of institutional talk in which participants co-construct knowledge and social roles through interaction. Communication unfolds in recurrent sequential phases, namely opening, problem presentation, anamnesis (history-taking), physical examination, diagnosis, treatment recommendation, and closing. In this inherently asymmetric encounter, physicians hold epistemic authority over clinical knowledge, while patients contribute experiential knowledge of illness, leading to ongoing negotiation of understanding and responsibility. Overall, doctor–patient communication emerges as a socially and institutionally embedded activity rather than a neutral exchange of information. Consolandi *et al.* (2024) highlight the centrality of categories like "trust and truth", "uncertainty/certainty" in doctor-patient communication and their role in the construction of a successful clinical interaction. In Italy, these features have been formally codified through the Code of Medical Ethics in FNOMCeO (2019) [2014 and subsequent amendments].

The interpreter plays a central role in medical settings, not merely as a conduit for replacing words from one language with another, but, as Wadensjö (2014[1998]) argues, as a key coordinator of the interaction itself. Unlike consecutive conference interpreting, medical interpreting involves the co-construction of spoken discourse, where the dialogue unfolds and is negotiated in the *hic et nunc* (Gavioli 2020: 630). Empathy and alignment are discursively achieved through formulations, mitigations, and displays of understanding. This process is characterized by overlapping speech, frequent turn-taking, and context-dependent meaning, all of which require the interpreter to actively manage the flow of communication.

By facilitating mutual understanding and legitimizing the patient's voice, the linguistic and cultural mediator (LCM) helps to clarify the power relations that define many medical interactions, particularly in contexts of migration and intercultural contact. These dynamics shape the emotional labor required, as interpreters constantly navigate hierarchical structures while managing their own affective responses. Even if, starting from Hsieh (2008), the metaphor of the PSI as a "robot" has been already widely debunked by numerous studies, nevertheless the conduit model is still commonly considered a priority in interpreters' training, and a resistant parameter for evaluating the interpreting service, while emotional labor is seldom taken into consideration. This challenging scenario requires intensive emotional demands, due to the urgency of clinical interactions, the vulnerability of patients, and various physical and ethical issues.

Crucially, this study addresses the language and culture mediation labor from the point of view of the LCMs, as professional – or non-professional – workers in an institutional setting, that of the healthcare facilities, in a part of Italy where a high presence of allophones and a significant mobility of foreign residents call for a frequent use of translingual mediation. We adopt here the conceptual distinction

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between “labor” and “work” as outlined by Hannah Arendt in *The Human Condition* (1958) and further elaborated by Judith Butler in *Frames of War* (2009). In line with Arendt's distinction between “labor” and “work”, the emotional labor performed by healthcare interpreters is often perceived merely as a “normal”, necessary activity tied to the immediate demands of patient care, rather than being recognized as “work”: that is, as the creation of lasting, meaningful contributions to the healthcare environment. However, drawing on Butler’s reflections on precarity and the relational dimensions of labor, one may safely conclude that the work of interpreters is fundamentally situated within networks of interdependence and vulnerability. Rather than being recognized as durable “work”, their contributions remain exposed to systemic invisibility, mirroring the broader socio-political conditions that render certain forms of labor less valued or even dispensable.

2. Emotional burden in healthcare interpreting: some previous studies

Since the 50s, great attention was dedicated to the linguistic and paralinguistic aspects of the dialogic medical encounters. The intersection between culture, illness, and care in cross-cultural clinical encounter was addressed within the anthropologist discourse as early as 1978 by Kleinman (1978). More than two decades ago, Hsieh (2008) brought to the front the widely discussed paradigm of “interpreters’ invisibility”, emphasizing the interpreter’s agency and dialogic positioning in healthcare encounters (Angelelli 2004; 2019; Amato 2012; Pöchhacker 2021, among others). Angelelli (2004) introduced the concept of the interpreter as a “visible co-participant” who constructs meaning collaboratively with both patients and healthcare providers. Similarly, Heritage and Maynard (2006) explored how interpreters influence the sequencing and interpretation of medical questions, diagnoses, and instructions, thus shaping the clinical encounter. In Italy, many studies have highlighted how, in the ongoing negotiation between two speakers from different socio-cultural backgrounds, the language and cultural mediator (LCM) plays the role of empowering the patient’s position within a communicative setting that is inherently asymmetric, due to disparities in language, knowledge, and social positionality (Orletti 2011; Orletti and Fatigante 2013; Orletti and Iovino, 2018; Gavioli 2018; Piacentini *et al.* 2019; Baraldi and Gavioli 2007; 2019; Gavioli 2018; Ardizzoni 2025).

These perspectives align with a broader discourse in the field of PSI, which increasingly emphasizes the importance of sociolinguistic and pragmatic competence in interpreters, beyond bilingualism (Wadensjö 2014[1998]; Benucci and Grosso 2021; Gavioli and Wadensjö 2023). In this view, the interpreter is no longer regarded as a neutral conduit, but as a cultural and communicative agent who engages with power dynamics, institutional discourse, and patient vulnerability.

Sarangi (2024) introduces the notion of “communicative vulnerability”, which affects all participants: the care recipient, the healthcare provider, and the

interpreter. He highlights the interpreter's constant shifting between the role of a mere linguistic conduit and that of a strategic communicative mediator, or broker, capable of influencing both the processes and the outcomes of the clinical encounter.

The emotional impact of interpreters' involvement in mediated consultations is a relatively recent but growing area of academic inquiry. According to Herring and Walczyński (2024), acting as language and cultural bridges, healthcare interpreters are regularly exposed to emotionally complex and high-stress situations. The same researchers, Rachel Herring (Century College) and Marcin Walczyński (University of Wrocław) edited a special issue in FITISPos entirely dedicated to emotions and stress in PSI, aimed at providing recommendation for translator training. In between, many inquiries have been focused on this issue: Valero Garcés (2015), drawing from surveys carried on in Spain, highlights the relationship between the task of translation in a healthcare setting, and the psychological well-being of PSI interpreters. All the surveys show that the risk, for interpreters in healthcare services, of encountering distress and emotional burnout is greater than for other PSI interpreters. Hsieh and Nicodemus (2015) argue for a normative approach to interpreters' emotional work, proposing that emotional engagement should be seen as an essential part of professional practice rather than as an individual weakness. Similarly, Zwischenberger and Alexa (2022) introduce the concept of "translaboration" to emphasize that translation and interpreting are embedded forms of labor entangled with broader socio-political and emotional relations. Chen *et al.* (2023) analyze emotional labor, emotional exhaustion and physical and mental health among health professionals, showing that these directly affect the quality of patient care and the occurrence of medical negligence. Their study is based on a particular hospital, and it shows various responses from different professionals in the same premises. Antonini *et al.* (2017) edited a volume on non-professional interpreting and translation (NPIT), in which great attention was given to the emotional impact of children and adolescents acting as language brokers for their families and friends. Moreover, Antonini (2010), Bucaria and Rossato (2010), Angelelli (2016), Ceccoli (2022), among others, dedicated much attention to the emotional burden of children who are frequently asked to act as interpreters, (child language brokering), deriving both from the technicalities they are asked to broker, and their social position in the triadic interaction. Many of these studies highlighted the sense of pride and satisfaction young brokers felt in the mediation practice, but some of them focused on the emotional stress of young and adult interpreters in medical settings.

Du's (2024) contribution addresses the impact of routine translation work in healthcare services on interpreters' psychological well-being in UK, and questions whether a training program can be developed to better prepare them for the emotional challenges they face. The six professional interpreters participating in the focus group in her study show sympathy and empathy toward their users, especially asylum seekers and refugees; but, on the other hand, they express negative distressing emotions such as sadness, embarrassment, shock, and horror for themselves. (Du 2024:117).

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3. This research

This research is based on LCM practices in healthcare facilities in Tuscany, Italy. It explores the intersection of healthcare LCM) and emotional burden, adopting an eclectic and interdisciplinary research framework grounded in sociology, anthropology, and critical theory.

My enquiry tackles a problem that is self-evident among LCM service providers, namely the frequent abandonment of the healthcare field by PSIs, and the ensuing challenge faced by agencies and hospitals in maintaining a consistent and efficient body of LCM professionals within healthcare facilities. Relevant to this issue, the study posits the following research questions (RQ):

> RQ1: Why do many LCMs, after a long, or, more often, short period of engagement in healthcare, abandon the field?
> RQ2: What are the heaviest burdens that lead healthcare LCMs to migrate towards other interpreting settings?
> RQ3: Is it possible to provide an emotionally healthier environment for LCMs?

To address these topics, we draw on Hochschild's (2012[2008]) concept of "emotional labor", which refers to the regulation and management of emotions in professional settings, where individuals are required to modulate their feelings as part of their job performance. Following Hochschild's framework, we analyze the cognitive, bodily, and psychological dimensions that profoundly shape the actual experiences of professionals operating in emotionally charged environments.

3.1 Research context and design

As a part of THE (Tuscany Health Ecosystem) – Spoke 3 Project, the primary area of investigation for this study is Tuscany, with a focus on healthcare interpreters active within facilities participating in the project, namely AUSL Toscana Centro (AUSLTC) and Hospital "Le Scotte" in Siena. The data therefore primarily concern mediators affiliated with LCM service providers operating in these two locations.

However, the study also includes interviews with non-professional/informal mediators who occasionally assist hospitals, either independently or on behalf of patients. These individuals are often family members, acquaintances, or community members of the patients, and may offer interpreting services for a fee. Although they lack formal qualifications, they enjoy social recognition within the local community.

The lengthy preparatory phase of the project was mainly dedicated to completing the formal procedures required to activate all the areas of investigation across the research territory, i.e. not only LCMs, but also the linguistic analysis of dialogic doctor–patient interpreting and narrative medicine. This process was

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significantly delayed by the strict regulations imposed by European Community privacy legislation, and the drafting and signing of formal agreements, which demanded considerable time and coordination. Nevertheless, the mediators enthusiastically welcomed the opportunity to participate, demonstrating an immediate willingness to complete the questionnaires that will be described in the next section, and engage in face-to-face interviews. As a result, around 50 mediators were contacted overall, the majority of whom were women, and 28 in-depth semi-structured interviews were collected. Approximately 90% of the participants worked primarily in Italian–Chinese translation and mediation. The majority of informants came from migrant family backgrounds, and some were of Italian origin. They are active in multiple fields, such as obstetrics and gynecology, infertility clinics, pediatric neuropsychiatry, cardiology, oncology, and general health services.

3.2. Methodology and data acquisition

The research adopted a qualitative approach, in order to capture the complexity of emotional burden during interpreting practice in healthcare settings. Data collection was based on two primary tools: structured questionnaires and semi-structured interviews.

An online questionnaire designed to gather information from LCMs on their knowledge, opinions, attitudes, beliefs, and behavior was distributed via weblink or QR code through social apps, such as WhatsApp and WeChat, and by email, to a specific group, asking to collaborate in the distribution. This method is particularly effective for collecting standardized data across a target population, facilitating both quantitative and qualitative analyses, and it is often used in addition to other instruments (Benaglia 2024: 47; Mei and Brown 2018), as in our case. A 35-question questionnaire was administered to LCMs, including individuals of Chinese, Italian, or other backgrounds, who were either currently or formerly active in healthcare services. Questionnaires include various types of questions, such as closed-ended, open-ended, Likert-scale, and multiple-choice items, for addressing the research objectives. In the context of this study, the questionnaires were meticulously developed to explore the experiences of healthcare interpreters and mediators. They encompassed sections on personal and professional background, motivations, emotional experiences, and coping strategies. We also included several open-ended questions, allowing respondents to answer in their own words and provide more personal and detailed information. This enabled the collection of a broad range of perspectives regarding their professional or non-professional experiences. To ensure the reliability and validity of the questionnaires, a pilot test was conducted with a subset of a designated group of participants. Feedback from this phase informed revisions to question wording and format, enhancing clarity and relevance. As of May 30, 2025, the final version of the questionnaire has been completed by 28 mediators, the majority of whom were women. Approximately 90% reported working primarily in Italian–Chinese translation and mediation.

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Alongside the questionnaires, we prepared a script for one-to-one in-depth interviews, designed to better explore the topics either through face-to-face meetings or online sessions. As defined in Bernard (2017: 108), in-depth interviews, or semi-structured interviews "may be described as a conversation with a purpose". A semi-structured interview is a qualitative data collection method commonly used in social research, where the interviewer follows a flexible interview guide composed of open-ended questions, allowing for the exploration of specific themes while also giving space for participants to introduce new topics and elaborate on their experiences (Natali 2024: 19–44). According to Bernard (2017: 162), semi-structured interviews are "best used when you want data that are both comparable across respondents and rich in detail". In this research, 27 semi-structured interviews were conducted with mediators – 25 women and 2 men – using a multimodal approach that included face-to-face meetings, as well as exchanges via email, WhatsApp, and WeChat. The purpose of the interviews was to explore the interpreters' emotional experiences in greater depth. The interviews followed a narrative methodology, encouraging participants to share their personal experiences in detail. Interview questions focused on participants' motivation, perception of emotional burden, their strategies for emotional regulation, institutional support received (or lacking), and the broader impact of their work on personal well-being and professional identity. A key question guiding the interviews was: "Can you describe a case which had an important emotional impact on you?" This open-ended prompt enabled participants to reflect on significant episodes in their careers, providing valuable insights into the emotional dimensions of their work. Interviews, in Italian and Chinese, were audio recorded and digitized, to allow the data to be anonymized and analyzed, then qualitative analysis was processed using NVivo, a software widely employed in qualitative research within the social sciences. Nevertheless, some interviews were not recorded, for technical reasons. In these instances, personal notes were used.

Through this methodology, the research questions were addressed comprehensively, leading to a deeper understanding of the socio-emotional dimensions of healthcare interpreting.

4. Analysis

Of the 28 in-depth semi-structured interviewees, the majority were women, of Chinese, Italian, but also Somalian, Pakistani, Bangladeshi, Moroccan, Albanian, and USA family background.[1]

[1] The anonymised respondents have been recorded as RW (respondent, woman) and RM (Respondant, male) and a progressive number.

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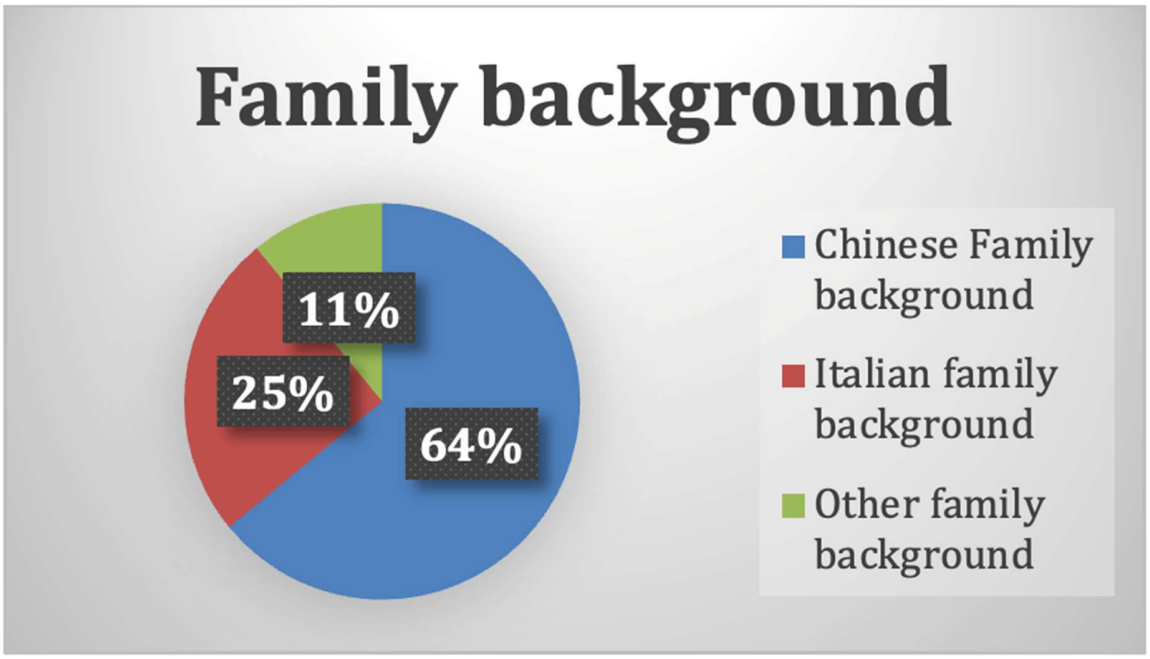

Figure 1. Family background of the respondents

Some LCMs with migrant backgrounds engage not only with their heritage languages, but also with other language pairs that do not correspond to their own linguistic or cultural backgrounds, e.g., Arabic native speakers may provide interpretation for Chinese-speaking or French-speaking patients from Africa. This exemplifies the fluid and dynamic nature of their professional practice, which can be situated within the emerging field of Translanguaging Studies (Li 2018), and suggests a promising direction for future research.

The analysis of the questionnaires and interviews revealed a complex set of themes regarding the emotional burden of healthcare LCMs in interpreting in Tuscan facilities.

4.1 Motivation

Most LCMs are motivated by a sense of solidarity, social engagement, activism, and advocacy, rather than by economic incentives. Their participation in healthcare interpreting is deeply rooted in a strong sense of social responsibility and emotional commitment to supporting vulnerable populations. For many LCMs with migrant backgrounds, this engagement is perceived as a personal mission to assist members from their own communities, driven more by empathy and solidarity than by professional ambition.

> **RW3**: "We're second generation and Italian speakers, and if a fellow countryman doesn't understand Italian, we're the ones who have to help them. We need to do them a favor, as we must be responsible" (Chinese, professional).

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In some cases, this involvement also responds to family expectations and is embedded in informal networks of reciprocity, where interpreting becomes a way to build and maintain social capital within migrant communities. As one informant explained:

> **RW13**: "My mother asked me to help a man from our village who needed surgery, even though I didn't know him. She said that if we do them a favor, they'll be kind to us, too" (Chinese, informal).

Italian LCMs state they are willing to help people whose language and culture they have studied, either in Italy or abroad. They show a high social motivation, stronger than the economic one:

> **RW18:** "I have also worked in business translation, which is more rewarding in terms of income; however, I prefer working with migrant women in healthcare settings, as it gives me the sense of doing something truly meaningful" (Italian, professional).

Just a very small percentage deals with LCM as a source of income, even those who defined themselves as professionals.

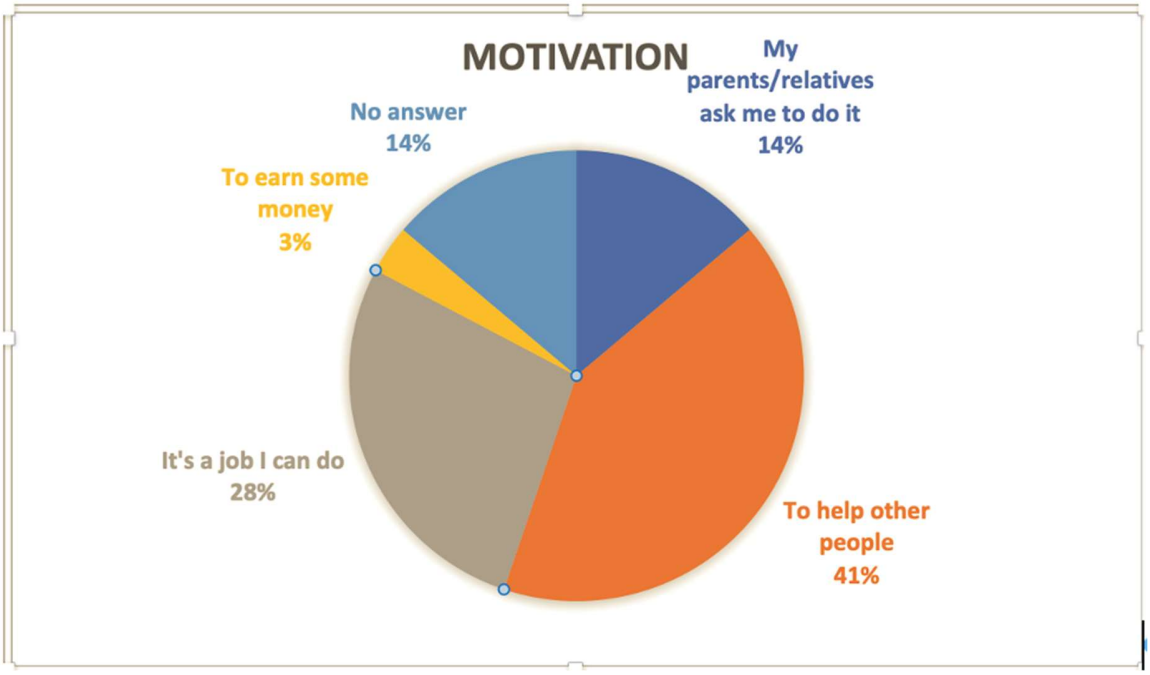

Figure 2. Motivation.

Nevertheless, many interpreters leave the profession after a relatively short period, often continuing to work only occasionally. Although we do not have precise figures regarding the number of LCMs who have chosen to pursue different career paths, interviews with mediation agency coordinators confirm that maintaining a

stable group of professional interpreters is challenging, largely due to the high turnover rate. Among our interviewees, 20% abandoned the job, for both economic and psychological reasons.

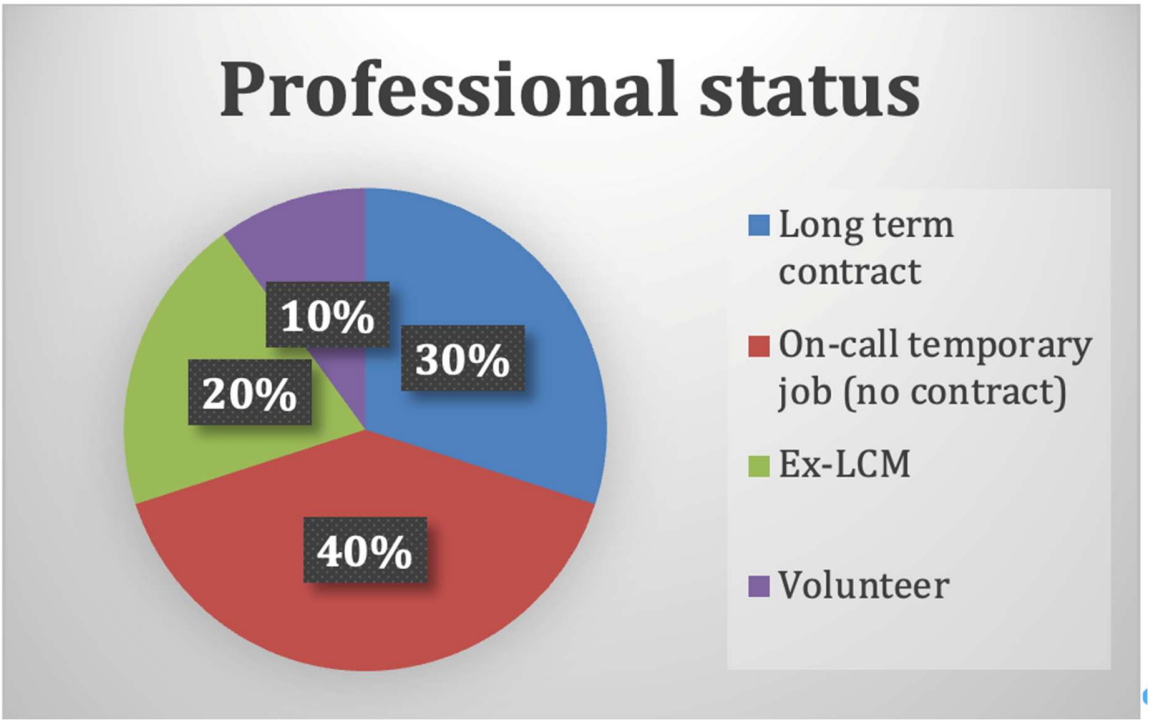

Figure 3. Professional status of the LCM interviewed

Following are some of the answers collected from ex-LCMs:

> **RW6**: "Over the course of about ten years, the reason that led me to slow down my work pace and gradually reduce my collaboration – until I eventually stopped altogether – was undoubtedly the emotional burden of the assignments. The situations involving pediatric patients were the most emotionally impactful for me" (Italian, ex-LCM).
> **RW8:** "I like to be a healthcare interpreter, in order to help people. But now I found a real job, so I don't do it anymore, unless my family needs it" (Somali, ex-LCM).

It is noticed that, more in a face-to-face interview than in the questionnaires, they tend to manifest distress, both for the professional treatment, and for the daily routine they are asked to do. Sometimes it has to do with the lack of institutional recognition:

> **RW8:** "It is very frustrating: what happened to me was that I was forgotten in the corridor: I had hurried to get to the clinic, driven a long way, once there, they totally forgot about me and left me out of the room".

Some of them resist, but the emotional burden is heavy. Some complain that their presence is requested merely as a formal act:

> **RW2**: "We are often involved for bureaucracy processing, mostly for informed consent, often when it is too late. By then, the patient has gone all the way without understanding what is happening to him/her. Sometimes the patient has not understood why he – or she – had surgery!" (Italian, professional).

Some feel frustrated, unheard:

> **RW12:** "I feel helpless because I see how much work would need to be done, like training, planning, establishing a relationship with patients simply with time and being there, but I can't do more than the mediation I am asked to do" (Chinese, professional)

And, facing the digital threat, disposable:

> **RW2:** "We mediators, unfortunately ... are seen sometimes as a help, sometimes, you feel they [=medical staff] would prefer phone or online translation more; of course, it depends on who you find; it's faster, there's less hassle, it's done sooner. ... They give you the impression that for them, we mediators are not people, but rather something they call for with a form; we come and go".
> **RW23:** "They normally rely on Google Translate and only contact us when something goes wrong – typically to resolve issues that arose after previous encounters in which the relative, usually the husband, acted as the main translator, even though he understood only about 70%, if that" (Albanian professional).

All these statements should also be interpreted in light of the objective data regarding average remuneration for the service, which typically amounts to approximately 13 euros average per hour.

4.2 Emotional burden: three categories

Following sociologist Hochschild's (2012[1983]) categories, the first key dimension of the work we want to analyze here is cognitive burden. The cognitive aspect of emotional burden involves interpreters actively managing mental processes to comprehend, reformulate, and convey meaning across linguistic and cultural boundaries. They must suppress personal biases, modulate their emotional tone, and maintain neutrality while fostering empathetic communication.

According to LCMs' own narratives, the medical field is perceived as "serious", "difficult", "precise", "challenging", and there is a high sense of responsibility in the interpreting job.

> **RW14:** "You also need to prepare before going over there, especially over to the hospital, because if you do not understand the terminology, you might even harm someone" (Chinese, temporary).

The cognitive burden is strictly linked to the self-perception of their role and positionality within the doctor–patient interaction. The "mirror" and "bridge" metaphors are frequently interiorized.

> **RW2:** "I am the mirror of patients' requests and emotions. Whatever they express, I transfer it to the doctor".

Primarily, the linguistic task is that of getting acquainted with a specialized terminology. In the absence of adequate resources, professional LCMs build their own working glossaries:

> **RW14:** "Well, I also know that the medical field is more serious about translating, and you can't be sloppy about it. Therefore, I created a document in my computer, dedicated to the medical field, assigning a section to each specialty. For example, for ENT, I collected specific terms and finally recorded them. Some rarer terms, or those I was not previously familiar with, were annotated with explanations, so that I could understand and remember them in the future".

This task is effectively managed in both languages, especially considering that most mediators do not have a formal medical background.

Secondarily, medical terminology is highly stratified: alongside the specialized language used by healthcare professionals, there are popular variants employed by patients to describe symptoms, illnesses, and treatments. These everyday expressions are often colloquial and differ significantly from the official medical lexicon. This means that the mediator must be proficient in a wide range of linguistic registers, must constantly adapt language to patients' different educational backgrounds and cultural frames of reference. The LCM, therefore, must be able to navigate this linguistic stratification in both languages, ensuring that communication is bilaterally fluid.

> **RW2:** "We cannot rely on dictionaries or official materials, because patients do not use technical terms".
> **RM15:** "You have to be able to adapt the terms to the patient's personal culture. You cannot use the same register with an unschooled patient and with a college graduate" (Ethiopia, professional).

In the current digital era, the Internet and a range of applications are employed to mitigate the cognitive demands associated with technical translation. The interviewees predominantly utilized general online translation platforms, such as Pleco and Google Translate, while some also incorporated AI-based tools, including ChatGPT. Although these resources are generally regarded as valuable, they

frequently prove inadequate for addressing more complex translation tasks. Consequently, users often resort to Wikipedia or specialized health-related websites to obtain more comprehensive and nuanced explanations.

Regarding the linguistic complexity of interpreting in this setting, all mediators agree that a conduit translation is not sufficient in medical encounters, and that their task cannot be fully accomplished without carefully decoding the hidden messages implied by the speakers. As stated also by The Lancet Commission: Culture and Health: "Intercultural health communication is not only about language translation, but also situated beliefs and practices about causation, local views on what constitutes effective provision of health care, and attitudes about agency and advocacy" (Napier *et al.* 2014: 1614).

Communication in healthcare settings is shaped by cultural norms, emotional states, power dynamics, and unspoken expectations, which require LCMs to pay attention not only to verbal, but also to non-verbal semiotic resources, such as body language, gestures, eye-contact, proximity, contextual subtleties, and culturally specific forms of expression, in order to facilitate truly effective and empathetic communication and co-construct patient–doctor relationship (See also Vargas-Urpi: 2013). This interpretive dimension of the task often requires them to navigate complex interpersonal dynamics and to act as cultural brokers, not just linguistic intermediaries.

Emotion management involves, on the one hand, the suppression of the LCMs' own feelings and, on the other, the decoding and bidirectional transmission of the speakers' emotions.

> **RW2:** "In Chinese patients, emotions are not always identifiable, especially in the presence of a doctor; they are very restrained. Even women who have just given birth do not display any joy at the birth of their child".

Beach and Dixson (2001) note that patients rarely articulate their emotions explicitly; instead, they tend to offer indirect cues about their feelings, thereby creating what the authors term "potential empathic opportunities" for both healthcare professionals and mediators (*ibid.*: 39). Similarly, Gavioli and Merlini (2023: 193) emphasize the collaborative role of healthcare professionals and LCMs in ensuring that patients are given the interactional space to express their emotions and concerns. In line with prior researchers, such as Hiesh and Nicodemus (2015), and Consolandi *et al.* (2024), we agree that emotion mismanagement can have a significant impact on the therapeutic interaction, particularly in the context of divergent socio-cultural systems; this issue therefore needs further research.

As part of the cognitive labor involved, some mediators highlighted the necessity of acquiring knowledge about local healthcare services. Although this aspect does not explicitly emerge in discussions concerning cognitive labor, it is frequently mentioned in relation to the training programs they aspire to undertake. Indeed, such training is incorporated in the programs of certain agencies outside

Tuscany – notably in regions such as Lombardy and Emilia-Romagna – but is scarce in the area under investigation.

Another key dimension emerged as a recurrent theme in the narratives: bodily labor.

Bodily labor manifests in the careful regulation of gestures, posture, and facial expressions, aligning with the emotional norms of professional healthcare settings. As demonstrated by Hochschild (2012[1983]), professional roles often demand the suppression of personal feelings and the active modulation of emotional and bodily expressions to align with institutional expectations. In healthcare settings, this form of emotional and bodily labor is explicitly required by many codes of ethics and professional guidelines for LCMs, yet it remains largely unrecognized despite being central to perceptions of professional interpreting.

Furthermore, mediators without a background in medicine or healthcare may find themselves facing aspects of human experience for which they are not adequately prepared: distressing and overwhelming sights, odors, and the chaotic nature of emergency situations (Ardizzoni 2025). In one case, a mediator was involved in a mediation session in the operating room while the patient, who was awake, was undergoing brain surgery.

These dimensions of their work are rarely, if ever, addressed in standard language or cultural mediation training programs. As a result, mediators are often required to manage intense sensory and emotional experiences without the benefit of specific preparation, thereby adding another layer of complexity to their professional responsibilities.

Physical exhaustion and logistical challenges are also a routine part of interpreters' daily experiences, as illustrated by the account of a respondent who described having to personally transport a pregnant woman from one hospital to another.

> **RW9**: "During the pre-partum visit to the clinic in … (small town), the gynecologist changed her expression and ... well, there was no more blood flow between mother and baby, so the lady had to be taken to the hospital in … (city). I ended up having to take them because they didn't have a car. I don't know why an ambulance was not arranged" (Italian, professional).

In addition to cognitive and bodily demands, interpreters reported confronting psychological labor of considerable intensity. The psychological dimension is particularly profound, as interpreters internalize professional roles while bearing cumulative emotional burdens. Repeated exposure to trauma, suffering, death and systemic inequalities generates emotional dissonance, leading to compassion fatigue, burnout, and even moral injury. They face vicarious trauma, especially when mediating in emotionally charged contexts such as pediatric oncology, ICU, terminal illnesses, or cases of abuse. One particularly telling experience involved a mediator who was tasked with delivering a devastating diagnosis to a young patient:

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> **RW1**: "I remember that I had to tell a boy, about 18 years old, that he had cancer and could never have children. It was very hard for me. How could you tell a boy something like that? It was not easy for me, but that boy reacted very well, though, I mean, it's not easy to have to translate a diagnosis like that, right? Both for the diagnosis itself, plus the fact that he could not have children; maybe he could have even saved his sperm, for the future" (Chinese, professional).

The psychological burden associated with navigating medical situations that overlap with ethical dilemmas constitutes a further dimension of complexity in the mediators' work. Many women LCMs report feeling a strong sense of responsibility when translating for other women. Several female respondents to the questionnaire highlighted, for example, the morally sensitive issue of decisions regarding abortion based on the sex of the fetus. In such instances, mediators are expected to adopt a neutral and non-judgmental stance, for which they must suppress their own emotions. Nevertheless, they feel a personal distress coping with these morally sensitive issues. Moreover, some LCMs report experiencing an extension of their responsibilities beyond the clinical setting, as they are often drawn into complex ethical and emotional dynamics that transcend the boundaries of their professional role.

> **RW6:** "The situations involving pediatric patients were the heaviest for me: the child was born and schooled in Italy so he had the language tools to understand, but he was still a minor, and could not be told how serious his illness was while asking him to explain it to mom and dad. Therefore, the parents would cling to me in the hope of receiving continuous updates".

Facing a psychologically challenging situation, the LCM tends to act out of his/her official field of action:

> **RW2:** "I had to tell a woman that her husband had a very short life expectancy, and at first she didn't believe me. It struck me how calm she was. I helped her take her husband home, to China".

Cases involving gender-based violence and domestic abuse are particularly challenging and difficult to manage. Such scenarios not only demand a solid grasp of medical terminology and procedures, but also require mediators to confront profound moral, cultural, and emotional challenges, often without the benefit of specialized ethical or psychological training.

> **RW23:** "One of the most difficult cases I encountered was when I was asked to interpret for a young woman who had been severely abused – at the time, I was about to give birth myself".
> **RW1**: "I had to deal with a case of abused mother and daughter, and that was very difficult because it involves things about Chinese tradition, the man-woman role, the social hierarchy between children and parents, ... and so on, so it also made me think a lot".

To cope with the psychological burden of their work, some interpreters adopt personal strategies, such as avoiding emotionally overwhelming cases altogether. As another respondent explained:

> **RW12:** "Usually, if I understand that they are cases dealing with pedophilia or children who are dying, I don't take them".

When asked about access to professional training and participation in focus groups, the results show reported that such opportunities are limited. Nevertheless, some associations or cooperatives do provide refresher courses or facilitate focus groups, particularly on the topic of gender-based violence. These accounts reveal that the segregation and sexual or psychological abuse of migrant women is not confined to a specific ethnic group, but rather cuts across all social strata. Within the migratory context, such forms of violence remain a critical and urgent issue – one that cultural mediators are not professionally equipped to address, yet frequently internalize as a form of personal trauma.

Taken together, these findings reveal a highly demanding emotional landscape for LCMs operating in healthcare, characterized by precarious working conditions, emotional overload, and a profound need for institutional recognition and support.

5. Conclusions

Although scholarly attention has been increasingly devoted to the emotional burden experienced in healthcare settings, numerous critical issues related to emotional labor within everyday clinical practice remain insufficiently addressed. The consequences of neglecting the emotional labor extend beyond the scope of individual well-being, impacting broader organizational and systemic outcomes. Emotional exhaustion can impair communication, undermine trust between patients and healthcare providers, exacerbate existing healthcare disparities, and ultimately contribute to the attrition of LCMs, thereby leaving critical aspects of social and medical inclusion of migrant patients unaddressed. Effective transcultural communication depends not only on linguistic fidelity but also on emotional resilience and attunement. Thus, promoting interpreter well-being is not merely a matter of occupational health but a fundamental aspect of quality care delivery.

This study revealed how emotional labor constitutes a central, though often invisible, aspect of healthcare interpreting. Understanding its multiple dimensions allows for a richer conceptualization of interpreters' professional realities and challenges reductive narratives that frame interpreting as mere information transfer. Recognizing emotional labor as a structural rather than an individual issue is crucial for understanding the systemic barriers that contribute to attrition among healthcare interpreters.

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Situating emotional labor within a broader interdisciplinary framework enables a critical rethinking of interpreter education, institutional policy, and healthcare practice. Future research and policy initiatives must recognize emotional labor not as an ancillary phenomenon but as a constitutive element of healthcare delivery, essential for promoting equity, empathy, and effective communication in increasingly diverse societies.

Drawing on a multimodal ethnographic approach informed by translation studies, sociology, anthropology, and critical theory, this research shows how the cognitive, bodily, and affective dimensions of emotional labor intertwine with broader structures of precarity, institutional invisibility, and systemic inequity. It further reflects on how these entanglements shape interpreters' professional trajectories and embodied experiences of care, revealing the ethical and emotional stakes of mediation work.

As far as the three RQ questions are concerned, RQ1 (Why do many LCMs, after a long or, more often, short period of engagement in healthcare, abandon the field?) is addressed through the observation that, despite high expectations placed upon them, LCMs' heavy emotional, cognitive, and bodily labor seldom receives formal recognition. As perceived "outgroup" members within healthcare institutions, LCMs often experience a deep sense of powerlessness, helplessness, and frustration, ultimately leading many to abandon the field. In response to RQ2 (What are the heaviest burdens that lead healthcare LCMs to migrate towards other interpreting settings?), the study identifies the heaviest burdens as the intense responsibility involved in the interpretation task (cognitive labor), the frequent additional requests outside formal medical encounters (bodily labor), and the significant difficulty of managing and coping with patients' emotions in sensitive cases (psychological labor). These pressures are cumulative and subjective, creating highly individualized vulnerabilities that further complicate the professional life of healthcare interpreters. Addressing RQ3 (Is it possible to provide an emotionally healthier environment for LCMs?), the creation of emotionally healthier environments for LCMs requires systemic changes. Interpreter education programs must go beyond linguistic training to include emotional competence, ethical reflexivity, and resilience-building strategies. Institutions must implement support systems such as regular supervision, debriefing opportunities, peer support groups, and access to mental health services. Acknowledging the emotional dimension of interpreting is not merely symbolic; it constitutes an act of epistemic and institutional recognition that restores visibility and legitimacy to interpreters' labor.

Addressing this issue, our research points to actionable strategies to create an emotionally healthier environment for LCMs:

- professional LCM training programs must give more visibility to the specificities of healthcare interpreting as a linguistic and cultural mediation task;
- specialized courses on Chinese–Italian healthcare language, focusing on diamesic, diastratic, and diatopic variations, are urgently needed.

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- trainees must be systematically informed about the emotional challenges inherent in healthcare settings and trained in strategies for managing both their own and others' emotions.

Moreover, ongoing training should incorporate focus groups and case study analyses to provide peer support mechanisms for coping with vicarious trauma and emotional stress.

There is a powerful need to work in collaboration with healthcare institutions and staff in order to reposition LCMs not as peripheral auxiliaries, but as integral ingroup professionals whose competences deserve recognition and support.

Emotional labor must be brought "out of hiding and into the public realm", as a critical and legitimate aspect of healthcare interpreting practice.

In conclusion, healthcare interpreters are not mere linguistic intermediaries; they are workers with a vital emotional burden. Recognizing and supporting this dimension is crucial for building equitable, empathetic, and sustainable healthcare systems. Future research should explore how different institutional models succeed or fail in recognizing and managing interpreters' emotional labor. Longitudinal studies would be particularly valuable in assessing the long-term emotional impacts on interpreters and in identifying best practices for sustainable and emotionally supportive professional environments. In sum, this study calls for a paradigm shift in the way healthcare systems view and support their interpreters: recognizing them not only as language facilitators but also as essential emotional workers, whose well-being is vital for the provision of truly equitable and humane healthcare services. Bringing emotional labor out of hiding and into the public realm may ensure that interpreters' emotional contributions are formally recognized.

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10.60923/issn.1974-4382/24461