Communication & Medicine

Sheffield
http://equinoxpub.com
https://doi.org/10.1558/cam.20385

Submitted: 18 June 2021
Accepted: 16 August 2022

Language brokering between deaf signing parents and healthcare professionals: The experience of young hearing people in the UK

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Abstract

Language brokering refers to the informal interpreting performed by children and young people, typically in migrant families. Hearing heritage signers are typically individuals who grow up using a sign language at home with deaf parents. As most of them are hearing, they often broker between their signing deaf parent(s) and hearing non-signers. Brokering has been found to occur in varied contexts, including healthcare settings. Using semi-structured interviews, this study aimed specifically to explore the experiences of hearing heritage signers brokering between their parents and healthcare professionals using British Sign Language.

Hearing heritage signers' experiences of brokering in healthcare settings were found to be varied, as were their attitudes, feelings and views towards brokering. Key themes were identified: pride and pressure; insider and outsider status; conflicting roles; autonomy, dependence and independence; choice and expectation; and perceptions of high- or low-stakes brokering. Based on these findings, recommendations for healthcare providers include increasing awareness of deaf people's rights and access, recognition of children's developmental needs in these contexts and the ability to signpost hearing heritage signers to appropriate support networks.

Keywords: deaf parents; healthcare; heritage signers; language brokering; mediated communication; sign language

1. Introduction

Deaf people who use sign languages constitute linguistic and cultural minority communities (Ladd 2003; Batterbury *et al.* 2007). Although Grosjean (2001) suggests that deaf people have a linguistic human right to grow up with full access to the opportunities to learn signed and/or spoken languages alongside written language, we know that this does not always come to fruition despite the prevalence of language rights frameworks (Snoddon and Underwood 2017).

It is thought that approximately 88% of children born to deaf parents are hearing (Schein and Delk 1974). Many of these children grow up as bimodal-bilinguals using the sign language of their local deaf communities and the spoken/written language of the wider population and assimilate the cultural values of both the deaf communities and the wider phonocentric society.

A term commonly used to describe hearing individuals with deaf parents who grow up using sign language is *Coda* (Children of deaf adults) (Bishop and Hicks 2008). Drawing on the concept of *heritage speakers* (coined by Valdés [2001]) and recognising sign languages as heritage languages (Compton 2014), Napier (2021) alternatively refers to *heritage signers* for those who grow up using a sign language at home with deaf parents – foregrounding the sign language use and that they can be deaf or hearing. This study focuses specifically on *hearing* heritage signers.

Heritage signers can be compared to other bilingual populations, particularly second-generation immigrants (Pyers and Emmorey 2008; Napier 2021), and they may act as intercultural mediators imparting information between their deaf parent(s) and hearing people through a process that Tse (1995) terms *child language brokering*. In the context of deaf communities this activity is referred to as *sign language brokering* (Napier 2021), hereafter referred to as brokering.

This paper focuses on a qualitative study of heritage signers' experiences of brokering using British Sign Language (BSL) and English between their deaf parents and healthcare professionals. Our study sought to address the following questions and sub-questions:

1. *What are heritage signers' experiences of brokering in healthcare settings?*
   a. *What are their attitudes, feelings and views towards brokering?*
   b. *What impacts do they perceive brokering has/had on them?*
2. *What are the differences in the brokering experiences of heritage signers in healthcare settings?*
   a. *What are the factors that influence these differences?*
3. *How can healthcare providers better address the needs of deaf patients and their hearing children?*

2. Literature review

Research on interpreting in healthcare settings confirms the challenges of mediating highly important, technical and emotional information in this context (see Angelelli 2010), especially when it is carried out by non-professional or 'lay' interpreters (Flores *et al*. 2012; Roberts and Sarangi 2018). The term *brokering*, rather than *interpreting*, is used to highlight that it is an informal bilingual-bicultural practice often performed by children and young people, who are not trained or qualified interpreters. Brokering occurs in a range of settings (Valdés 2003; Hall and Guéry 2010), including healthcare (Green *et al*. 2005; Banas *et al*. 2017) and could be considered non-professional role performance; this goes against expectations in the healthcare context, where interlocutors perform set roles (Sarangi 2010). Anguiano (2018) distinguishes between *low-stakes contexts* (e.g., house callers or televisions programmes), *everyday contexts* (e.g., translating correspondence from the school or in shops) and *high-stakes contexts*, where accurate interpretation may be crucial (e.g., medical or legal contexts).

It has been evidenced that young brokers, adult brokers and parents in migrant families have differing beliefs and feelings about brokering. These feelings often change depending on the age of the broker, the nature of the brokering, perceived brokering ability and the relationship between brokers and parents (Angelelli 2010; Weisskirch 2013; Bauer 2016). Brokering is complex and multi-dimensional (Cline *et al*. 2010): engaging in this practice can be a linguistic, cognitive and socioemotional asset for young people (Valdés 2003), but can also be felt as a burden (Angelelli 2016). Filer and Filer (2011) have questioned the developmental appropriateness of heritage signers brokering in counselling settings, because of risks of 'role reversal' where children take on roles that are typically parental.

The seminal study with this population involved interviews with 150 hearing adults with deaf parents in the United States and focused on their cultural identity and affiliation with the American Deaf community (Preston 1994). Aside from this study and other studies of heritage signers' general perceptions of growing up in deaf-hearing families that touch on brokering practices as part of that life experience (e.g., Knight 2018; Lynch 2020), there are only a few studies that specifically focus on heritage signers' experiences of brokering (Buchino 1993; Napier 2017, 2021; Moroe and de Andrade 2018a, 2018b). Consequently, heritage signers' stories have been largely invisible in the general brokering literature.

There have been significant changes that may have impacted brokering experiences in the UK, including the introduction of officially registered BSL/English interpreters and legislation that makes it unlawful to discriminate against individuals based on protected characteristics, including disability (Stone 2013). Advances in technology have provided increased access to captions, in-vision interpreting, video-telephone relay and remote interpreting services (Napier 2021). Despite this, access to healthcare for deaf BSL users remains restricted (Rogers *et al.* 2018), with particular challenges in mental health contexts (Ackroyd and Wright 2018). Issues include a lack of health literacy or access to information in sign language, a lack of professional interpreters, doctors being unfamiliar in interacting with deaf people or working with interpreters (Napier and Kidd 2013) and heritage signers still brokering for their parents in healthcare environments (Napier 2017).

We could find no existing studies designed specifically to explore heritage signers' experiences of brokering in healthcare consultations, so this study is an attempt to fill this gap.

3. Data and methodology

Data were collected qualitatively through one-to-one semi-structured interviews – face-to-face or by video call – with 12 young hearing people with deaf parents who use BSL. The participants were aged between 16 and 25, and were recruited through network, purposive and snowball sampling. Advertisements were shared though organisations including deaf groups, the 'CODA UK and Ireland' organisation and BSL interpreter networks. The interviews were conducted until we reached the data saturation point. All interviews were conducted in English (by Gee) and were audio and video recorded. The interview duration was determined by the participant (mean 48 mins, range 35–62 mins). The study received ethical approval from the Health Sciences Research Governance Committee (HSRGC) at the University of York (HSRC/2019/364/A).

Eleven of the 12 participants were female and all were white, having grown up in a range of different environments (Table 1). The participants were employed full-time or were students. Five participants had professional or voluntary roles involving the use of sign language, including being school assistants at a deaf school and sign language interpreter trainees.

Table 1. *Participant demographics*

	Mean (SD)	**Range**
Age	**20 (1.82)**	**17-23**
	Frequency (*n* = 12)	**Percentage (%)**
Female	11	91.7
White	12	100.0
Employment status		
Employed full-time	7	58.3
Student	5	41.7
Area grew up		
Inner City	3	25.0
Suburbs	3	25.0
Town	5	41.7
Village	2	16.7
Not answered	1	8.3

Seven participants identified spoken English as their first language. Six participants reported that both their parents were deaf. Of the remaining participants, three reported having one deaf and one partially deaf parent, and three reported having one deaf and one hearing parent. Most participants reported starting language brokering at a young age, with three stating they began as young as two to three years old. The participants were asked to rate their language abilities in BSL and English on a Likert Scale (1 = poor, 5 = extremely fluent). On average they reported higher competence in English compared to BSL (see Figure 1).

Brokering took place in a range of healthcare settings (Table 2). All participants reported being involved in telephone-based brokering.

The interviews were conducted using a topic guide (see Appendix), which was developed drawing on a comprehensive review of relevant literature and previous sign language brokering research (Napier 2017, 2021), and the positionality

Figure 1. *Self-reported language abilities for British Sign Language (blue) and spoken English (yellow), rated on a scale of 1–5 (1 = poor, 5= extremely fluent)*

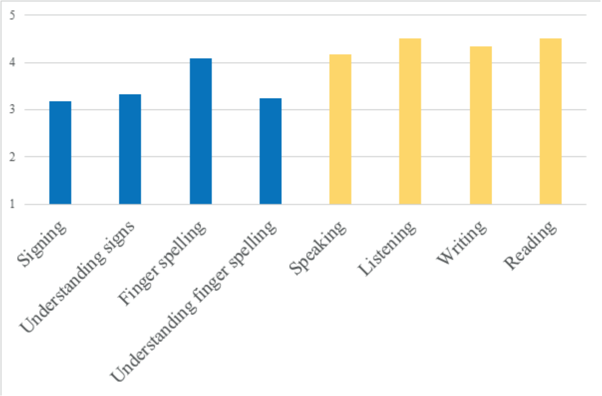

Table 2. *Self-reported healthcare-brokering settings*

Healthcare setting	'Yes' response (*n* = 11)	Response percentage (%)
Hospital ward	5	45.4
Outpatient doctor appointment	4	36.3
General practice	7	63.6
Emergency department	4	36.3
Dentist	6	54.5
Audiologist	2	18.2
Opticians	7	63.6
Pharmacy	9	81.8
Telephone (e.g. making appointments)	11	100.0

Note- One participant did not complete this question

and expertise of the team, which covered several areas: deaf child mental health; sign language interpreting; lived deaf experience; lived experience of being hearing heritage signers; qualitative interviewing; and research methodology with deaf signers.

3.1. Analytical procedure

For our analytical purposes, the recordings were transcribed verbatim by Gee (who is not a BSL user) to include pauses, hesitations and exclamations. The interviews were reviewed and annotated by an independent qualified BSL–English interpreter who noted non-verbal gestures or BSL. This was to avoid loss of information, as heritage signers often switch between or blend languages (Bishop and Hicks 2008).

We approached the data from the perspective of framework analysis, which was developed as a method for applied policy research (Ritchie and Spencer 2002) and is used commonly within healthcare research (Gale *et al.* 2013). This methodology was used to interpret the interview data, allowing for incorporation of both *a priori* and emerging themes. The structured m ethod for summarising the data was suited to this study, where multiple researchers with different backgrounds worked collectively on the analysis (Gale *et al.* 2013). Preliminary coding was carried out independently by Gee and Napier. Discrepancies were then discussed. Further coding and indexing were performed iteratively across the research team to further develop and redefine the thematic framework. The data were indexed according to themes and subthemes using NVivo. Relevant data were then extracted to create thematic maps to further explore connections and achieve a broader view of the overarching themes.

4. Findings

We present four overarching themes and embedded subthemes that are illustrated using direct quotations from interviewees. When the views of several interviewees aligned, we provide an illustrative quote from one interviewee that best captures the comments from several participants.

4.1. Attitudes, feelings and views

A range of powerful and sometimes conflicting emotions towards brokering were described.

4.1.1. Pride and responsibility

Many participants identified the importance of the brokering role (Extract 1).

Extract 1

I understand it to be really important. Necessary for communication and like relationships and things like that. (P2)

Some participants experienced a sense of pride from feeling that they were helping their parents by facilitating communication, which in several instances was reinforced by external praise from parents (Extracts 2–3).

Extract 2

I was helping my parents and that was a nice thing for me as well as them because I felt like I was doing something useful. (P1)

Extract 3

My Dad always said it's just a way of us looking after him and being grown up so it was, you know we should kind of be proud of ourselves. (P9)

Praise was also received from healthcare professionals but in retrospect many participants identified this as inappropriate (Extract 4).

Extract 4

> [E]specially when I was younger, they would just say, 'Oh aren't you really good, you're so clever you know these two languages and you're being really helpful' and when I was younger, I was like, 'Oh wow, that's lovely, I'm being called clever'. Whereas now it's like, 'Well, you know, I shouldn't be here, I'm not qualified to do this, I just know the language'. (P1)

Some described feeling pressure due to the demands of brokering (Extract 5).

Extract 5

> I would just say more of like the personal and emotional side of it. Just kind of being pressured. You can feel a little bit stressed out without them realising. (P8)

Some participants also recalled a fear of making mistakes. For instance, one participant (P3) was concerned about the 'major confusion and major problems' that might occur due to a mistake. For some the responsibility brought a sense of pride but this was accompanied by the weight of a perceived pressure to broker successfully.

4.1.1. Normality or difference

Many participants described that they did not realise brokering was anything but a normal part of life when they were younger (Extract 6).

Extract 6

> I think everything has just been part of me. I'm like 'Oh there's no question to it, that's just how everything is'. (P8)

They compared brokering to other chores, for instance 'tidying my bedroom' (P2). They described being unaware that other children may have had different experiences, and of coming to realise that their peers did not do brokering and did not have the same responsibilities (Extracts 7–8).

Extract 7

> I just thought it was something that I assumed everyone had to do. (P2)

Extract 8

> [H]earing from friends about the kind of things that they used to do and stuff like that and actually realising, oh we had completely different experiences. (P11)

This sense of feeling different was heightened for some by the realisation of things they were missing out on and by peers who did not understand their experiences. Some described feeling 'singled out' (P10) and wanting to be like the other children (Extract 9 – dots indicate a pause).

Extract 9

> I remember there was like a bit of resentment towards my parents because I… I was like 'oh all I want to do is like be like a "normal" kid and not have to do this thing that I shouldn't have to do'. (P2)

Some participants described their discovering later that other heritage signers had similar experiences (Extract 10).

Extract 10

> Speaking to people who have grown up in the same situation, that it wasn't just me… I used to think 'why is it just me, why have I got do this' but you know being part of that group I understood it wasn't just me and it wasn't just my parents. It was a lot of people really. (P1)

They had some comfort from knowing they were 'not the only one' (P4) and found it useful to have peer support. The CODA UK & Ireland organisation was identified as one of the sources for this support. Some participants described how meeting others with the same experiences legitimised the role (Extract 11).

Extract 11

> It never felt wrong because everyone else was doing it as well. (P1)

However, in other instances this was a perceived pressure (Extract 12).

Extract 12

> They say 'so and so's daughter does it' and 'so and so's son does it' and I'm like 'that doesn't make it right'. (P1)

4.2. *Impacts of brokering*

Some participants described a conflict developing in their self-perception as they took on multiple roles within the family and the wider community.

4.2.1. Conflicting roles

Many participants recalled attempting to balance different roles while brokering. At their own medical appointments they had to negotiate being the patient, while also brokering for their parents, and as such enacted within the consultation. Some felt this took them away from their own 'access' (P11) to the appointment (Extract 13).

Extract 13

It feels a bit annoying because it kind of takes up the time that you would spend discussing about your own health to kind of keep someone else in the loop. (P10)

One participant recalled feeling that their parent had been struggling to support them during a distressing experience in a healthcare setting due to lack of communication ability (Extract 14).

Extract 14

I mean I hated it because I was absolutely terrified 'cos I didn't know it was appendicitis and I didn't know what was going on. And then my Mum she was trying to calm me down and you know I needed the reassurance from her but she didn't really know what was going on as well so. (P12)

Several participants discussed the challenges of taking on the roles of family member and language broker simultaneously, and identified a need for a clear distinction (Extract 15).

Extract 15

They need like the division between being a family member and being the interpreter. 'Cos sometimes the family just needs support themselves. (P3)

Particularly in situations with sensitive information and emotional content, the roles were incompatible (Extract 16).

Extract 16

[T]rying to be emotionally invested but then taking a role of someone who shouldn't be emotionally invested at all. (P10)

4.2.2. Autonomy, interdependence and dependence

Many participants discussed how brokering had increased their levels of maturity and independence.

Through brokering the participants gained experience communicating with adults in a variety of settings from a young age (Extract 17).

Extract 17

I'm used to talking to adults so it doesn't stress me out as much. (P4)

Some identified how confidence in their communication skills led to a more generalised self-confidence, although others described the pressure of brokering making them more anxious (Extracts 18–19).

Extract 18

I think it made me more confident growing up because I was confident in expressing myself. (P9)

Extract 19

I wouldn't say it helped with my confidence because I was really shy and I hated doing it. (P12)

Some participants described 'growing up really quickly' (P2) and feeling they 'matured a lot faster than everyone else' (P4). Some identified specific aspects of childhood they had missed out on (Extract 20).

Extract 20

I would have to take time out of my life to go and interpret for them. I'd have to not spend time with my friends because I had to go do this and do that. And like it took time out of my revision when I was revising for exams. (P1)

Others described their increased maturity leading them to take on a more caring or even 'parental' role with their friends or siblings (Extract 21)

Extract 21

Everyone calls me like the 'mum friend' 'cos I'm always the one looking after everyone else. (P4)

One participant described a reversal in the normal parenting role (Extract 22).

Extract 22

I don't know, it felt like I had to like play this kind of role and almost like, this might be a bit much, but like I was the parent and my Mum was the child. (P2)

Several participants compared the helping role they provided with young carers, although this was not always perceived this way by their parents (Extract 23).

Extract 23

My school got me in touch with like a young carers association and I went home and told my parents and they say, 'well you're not a carer so you don't need to speak to them.' (P1)

For one participant fulfilling this role reduced her sense of identity, although in contrast others described a reinforced sense of identity (Extracts 24–25).

Extract 24

You kind of lose your identity in a sense to…, the fact that you provide like a caring role. (P10)

Extract 25

[A]lmost like affirming identify, it's like okay like I know sign and my parents are deaf and that's who I am and that's okay. (P2)

4.2.3. Support and guidance

The need for greater understanding of the impact of brokering was identified by several participants (Extract 26).

Extract 26

100% there is nowhere near the amount of understanding that there needs to be and not just of, you know, how appropriate it is but also the long-term effects that it has on that child too. (P11)

Some identified a need for greater support and guidance for hearing children with deaf parents (Extract 27 – dots in square brackets indicate an ellipsis).

Extract 27

I think it is a good thing that you are doing this, because the message needs to be put out there. Because it's not about slating anyone or saying that deaf parents are awful because they expect their children to do this, this and this. […] I don't think they are aware of the impacts that it has. I think, you know, there needs to be more awareness I would say. (P1)

Recognition of the impacts of brokering was seen as an important foundation for getting greater support and guidance.

4.3. Differences in experiences

4.3.1. Choice or expectation

All participants described the different ways they became the broker in a given situation. Some recalled offering to broker and often described it as an automatic process (Extract 28).

Extract 28

You just do it. It's a bit like a knee-jerk reaction kind of thing. (P4)

Sometimes they were asked by parents or by health professionals, often in an indirect manner that lacked a clear opportunity for consent, and some recalled health professionals assuming they would take on the role (Extracts 29–30).

Extract 29

They never really said 'Oh can you come and be an interpreter for me?' or anything like that. (P6)

Extract 30

[I]t was never like 'will you do this?', it was always like 'oh you are here to do this.' (P1)

When health professionals asked, they felt it was hard to refuse due to the perceived pressure, or health professionals did not accept their refusal (Extract 31–32).

Extract 31

I guess if that pressure was put on me by other professionals, I wouldn't be able to say no to them. (P11)

Extract 32

[I]t was irritating because he wouldn't... he was asking me to do it, he wouldn't take no for an answer for like the first three, four times. (P3)

Several participants described how, because they were able to communicate in both languages, it was 'the next step' (P6) or the 'natural thing' (P2).

Most participants felt it was unfair for professionals to assume they would take on the role of broker, and said that they preferred to be asked directly and honestly (Extracts 33–34).

Extract 33

I think it's a bit rude like I don't know like, just to assume especially when it's someone younger than you that's basically kinda like a child. (P8)

Extract 34

[W]hen they do ask I'm like thanks for appreciating to ask. (P8)

Many participants felt that they were the only person there who could bridge the communication gap and 'make language accessible' (P7) for their parents.

Some felt they 'couldn't say no' (P1, P6) because 'the appointment wouldn't go ahead' (P1) and they would feel guilty if they did not fulfil the role (Extract 35).

Extract 35

[I]f I didn't help them I'd feel so guilty thinking 'Oh my god, I'm such a bad daughter'. (P6)

Often, refusal was not seen as an option given the pressure of the expectation to fulfil the role. There was overriding concern that their parents would be left without access to communication, hence the resulting guilt.

4.3.2. High- or low-stakes

A distinction was made between situations which were trivial in content and those which were more serious. In general, the participants were willing to broker in 'simple' (P1) situations with 'basic communication' (P7). Many participants had a clear distinction for which situations were 'acceptable' (P3) (Extract 36).

Extract 36

I think I've just kind of got it as doctor's appointments are fine for booking them, pharmacy pick-ups are fine but not the actual going in and sitting there and doing the full communication. That's just like the line. (P3)

They identified brokering in serious situations with sensitive information or high emotional content as inappropriate (Extracts 37–38).

Extract 37

I feel like if it's a bit more of a bigger or more of like a professional sort of situation or too serious then I feel like a bit wary like I don't really think I should be doing this. (P8)

Extract 38

[I]f it was really like emotional like something like that then I would say no. (P6)

4.4. Recognising and meeting the needs of deaf parents and heritage signers

4.4.1. Communication adaptation

Many participants identified a lack of communication adaptation by health professionals, describing how some did not give them time to explain information to their parents (Extract 39).

Extract 39

They just constantly bring it all out and then I'm just trying to translate it all but they don't slow down, they just carry on. (P6)

They also described a lack of awareness of the BSL needs of a deaf person (Extract 40).

Extract 40

I tried to explain to the dentist lady that, you know, she needed to tell me what she was going to do before she sort of lay him down. So, I could explain it to him. But she just didn't do it and she was like trying to lie him down and I was trying to explain like over him what she was saying. (P1)

Several participants described feeling annoyed when health professionals spoke to them without keeping eye contact with the parent (Extract 41).

Extract 41

[M]y Mum is like looking at them and they're just like talking straight at me and I'm like 'no I'm meant to be interpreting here, you're meant to be looking at her, you're having a conversation with her'. (P4)

One participant described professionals as unfamiliar with interacting with deaf people (Extract 42).

Extract 42

I'm not sure how often they deal with situations like that so a lot of the time they just seem a bit flustered and they don't know how to deal with it. (P5)

The participants appreciated efforts to communicate without using a language broker (Extract 43).

Extract 43

[T]ry and communicate with the deaf person as much as you possibly can. And make a bit more of an effort as well like say straight away going to write down on some paper rather than relying on me just because it's easier. (P12)

4.4.2. Deaf people's rights and access

Many participants commented on a lack of awareness amongst healthcare workers about deaf people (Extract 44).

Extract 44

If anything, I would just say get deaf awareness [...]. Know how they feel, how they communicate and what the barriers are because they can't hear. (P6)

A better understanding of these barriers was identified as an important step in professionals improving their communication and increasing their knowledge of deaf people's rights. Many participants thought it should be the health professional's responsibility to book a qualified interpreter (Extract 45).

Extract 45

I think it should be compulsory for professionals, you know, if there is a child there or a young person or the child of that person whether they're an adult or not, I think they should refuse to go ahead with the appointment. (P1)

Equally, many participants described their parents not being aware of their own rights to an interpreter (Extract 46).

Extract 46

[I]f they are trying to use their children it might just... they might not know that they've got a right to an interpreter or how to book one or anything like that. (P11)

Improving healthcare professionals' knowledge of deaf people's rights was highlighted as key to improving access to interpreters and reducing reliance on heritage signers as brokers.

5. Discussion

This study suggests that, despite increased recognition of the rights of deaf people to access professional interpreters, heritage signers continue to act as brokers in healthcare consultations, often starting at a young age. This points to a widespread lack of awareness amongst health professionals of the appropriateness of allowing children to broker for their parents in high-stakes situations.

In keeping with Napier's (2017, 2021) findings, several themes are presented as dichotomies, either because our participants perceived them as positive and negative, or because they presented dilemmas and opposing concepts. Some of the identified themes signalled fluctuating feelings, such as the complex impact brokering had on the participants' levels of independence and autonomy. Increased experience in communicating and navigating situations independently gave some a sense of pride and often led to a greater sense of maturity and confidence. However, taking on responsibilities not normally expected of children sometimes placed them in stressful situations beyond their years and changed the dynamic of the parent–child relationship. This resulted in a conflict with other commitments and a sense of taking on a more 'parental' role.

The concept of 'role reversal' is well established in the brokering literature (Dorner *et al.* 2008; Hua and Costigan 2012) and suggests that reversal of role-set in this context (Sarangi 2010) may have negative impacts on the child as they take on responsibility typically held by parents (McQuillan and Tse 1995; Rainey *et al.* 2014). This can lead to parental disempowerment, which may affect the parent–child relationship, leading to parental frustration and family conflict (Hua and Costigan 2012). Cline *et al.* (2010), comparing the roles of young carers and brokers, found that both engaged in roles usually viewed as 'adult' and take on additional responsibility compared to the western construction of 'normal' childhood. Our participants' descriptions of role reversal align with those of other brokers and heritage signers (Singleton and Tittle 2000; Moroe and de Andrade 2018b).

During adolescence, language brokers often have an improved capability to broker with increased language abilities and psychological maturation, but also a greater desire for independence. There is a potential for conflict between their own interests and family expectations (Rainey *et al.* 2014). Our participants discussed this conflict particularly in situations where they balanced dual roles of patient/broker or family member/broker. In each of these roles there are competing demands, which leads to role conflict (Sarangi 2010). For instance, the participants felt that they had to repress their own needs and emotions to facilitate the healthcare interaction.

In his study of 150 heritage signers, Preston (1994: 151) found that they described their family obligations using terms such as 'premature duties' and 'overly responsible'. Napier (2021), however, argues that heritage signers are socialised into low-stakes brokering from a young age as a cooperative responsibility in the family equivalent to other chores taken up by children in the home and often have a lot of agency in this role.

Some participants explained that their childhood responsibility had to be understood in the specific social context and that the role reversal was reinforced by the wider culture as the hearing child 'inevitably assumed roles denied to their parents' (Preston 1994: 153). Preston (1994) suggests that interdependence could be a route to independence. Brokers take on more responsibility and develop 'more concern for others', which may increase their sense of belonging to the family and reinforce their identity (Dorner *et al.* 2008). Several of our participants described feelings of pride and that brokering reinforced their role within the family. However, their positive experience of responsibility and the process of identity reinforcement seemed to be contingent on the role of broker being recognised and valued.

Napier (2021) has identified that heritage signers feel that becoming a broker is often a perceived normal expectation. Despite our participants appreciating recognition of the role in the family, praise from healthcare professionals was seen retrospectively to be inappropriate given the context of the interaction.

A distinction was also made between high-stakes interactions, such as brokering highly emotional content, sensitive information or complex content, and low-stakes interactions. As noted in Section 1, this distinction has been recognised in the literature (Anguiano 2018; Napier 2021). Several versions of Tse's (1995) Language Brokering Measure (LBM) have been adapted to assess the prevalence of brokering among immigrant communities and heritage signers (Napier 2017), and the more recent ones also incorporate this high-/low-stakes distinction. Anguiano's (2018) study found that increased frequency of high-stakes brokering was associated with prolonged inversion of parent–child roles and lower academic achievement, and that greater levels of 'family obligation' reduced the negative effects of high-stakes brokering. In healthcare settings many interactions fall under the bracket of 'high-stakes', given the complex medical terminology, sensitive information and high emotional content. Our participants gave examples of such high-stakes scenarios and the often-stressful impact they experienced. However, the participants also identified how low-stakes interactions, such as ordering prescriptions and making appointments, had more simplistic content and a perceived lower risk of serious consequences from errors.

Preston (1994) identified that heritage signers were dependent on others to determine which situations were appropriate for them to broker. Our study suggests this often does not happen. Many participants reflected that without such guidance they were unable to identify what was unacceptable until they considered brokering retrospectively from an adult perspective. Several participants identified encounters with health practitioners who did not appear to be aware that brokering by heritage signers was inappropriate and who did not take responsibility to arrange for a qualified interpreter, even though healthcare professionals have reported positive collaborative working relationships with qualified BSL/English interpreters (Schofield and Mapson 2014). Our participants also stated that their parents were unaware of their own rights to access an interpreter.

6. Conclusions

This study contributes to the interpreting studies and intercultural communication literature by confirming that heritage signers continue to function as 'lay' interpreters in healthcare settings. Our findings also correspond with the wider brokering literature evidencing that heritage signers' experiences of brokering in healthcare settings are varied, as are their attitudes, feelings and views about brokering. Clear recommendations can be made to healthcare providers for training and improvements to practice, which will better address the needs of deaf people and their hearing children. National Health Service (NHS) accessibility standards state that health professionals have a duty to meet individuals' 'information and/or communication support needs' (Marsay 2017). Health professionals should therefore be aware of specific interpreter services available in their area, how to book an interpreter and the availability of online remote BSL interpreting services for urgent situations.

Increased awareness by health professionals about how to adapt their communication would also benefit both deaf parents and their children, including not doing other tasks simultaneously, making eye contact with the deaf person when speaking to them, not using unnecessarily complex medical terminology and clearly explaining before proceeding. Accessible training for health professionals is a clear recommendation that emerges from this study.[1]

The participants wanted the impacts of brokering to be more widely recognised and to see specific support for young heritage signers. Organisations such as CODA UK & Ireland already strive to provide this support but it could come from other organisations such as deaf parent groups and young carers groups. Healthcare professionals should be equipped to signpost children and their parents to these networks. Nevertheless, several complex obstacles remain, including limitations in professional interpreter provision and support network funding.

The sample was limited, in that it was entirely white and mostly female. The lack of participants (and researchers) from different ethnic backgrounds limits the scope of this study. Research has shown that many service providers do not consider the 'cultural, religious and social needs' of deaf people from different ethnicities (Ali *et al.* 2008) and that interpreters are not always familiar with the culture and customs of these individuals (Waqar *et al.* 1998). Given the experiences of deaf individuals from different ethnic backgrounds it would be valuable to explore the experiences of their hearing children. For future studies it will be important to design recruitment methods that identify a more diverse sample and involve a more diverse research team.

Previous studies have suggested that female heritage signers are more likely to have brokered as a child and continued as an adult (Preston 1994; Napier 2017; Moroe and de Andrade 2018a), which would explain the high proportion in this study. Women dominate the BSL/English interpreting profession (Napier *et al.* 2022). However, Napier (2021) identified that brokering is not necessarily dominated by females. This study does not have enough male participants to reliably comment on gender differences.

The team has worked with patient and public involvement engagement (PPIE) groups and does recognise that our preconceptions and personal/professional characteristics may have influenced the research questions, data analysis and interpretation. Future research should involve more participants with a wider range of intersectional characteristics. It would be useful to sample families where brokering has not occurred and explore what alternatives occur and the relative consequences. It would also be helpful to establish a co-design strategy to engage deaf parents with medical experts, to systematically marshal the existing evidence and to develop a set of best practice guidelines.

Appendix: Topic guide questions

Topic	Guiding questions	Possible follow up questions
Demographics	Can you tell me a little bit about yourself and your family?	Age?
		One or both parents deaf?
		Do your parents use BSL?
		Any siblings? Are they hearing or deaf? Did they use BSL?
		Other members of family deaf?
		Job role?
Participant understanding of the brokering role	What is your understanding of the language brokering role now?	
	How did you understand your role as a language broker when you were younger?	Did your understanding or beliefs change as you got older?
	How did you feel about being in this role?	Were there some situations you can describe when it was a satisfying experience? Can you describe these?
		Were there some situations when it was challenging? Can you describe these?
Parental understanding of the brokering role	Did your parents understand the language brokering role when you were a child/young person?	Did they discuss this with you at the time?
		Did this change as you got older?
	Did they understand your feelings of being in the brokering role?	Did they ask you how you felt about it?
	Given different developmental ages did they ever express concern about you being in this role?	Did they ever acknowledge it was challenging or difficult?
		How did this feel?
Professional understanding of the role	Did healthcare professionals seem to understand the role of language broker?	Did they ever discuss the role with you?
		Did they ever ask you to fill this role? Can you give examples?
Details of brokering experiences	During childhood and as a young person, can you give me some examples of when you acted as a language broker in a healthcare setting?	In what setting? – clinics, hospital, GP surgery, opticians, dentists, pharmacy
		In what situations?
		Who was involved?
		What age were you?
		Any memories that stand out?
		Can you talk me through some more examples?
	Did you ever broker for your parents when you were the patient? How did that feel?	
	If you think of an appointment, can you talk me through the whole process?	Involvement in other aspects: – reading letters, leaflets or other written information – arranging appointments on the phone – telling other family members outcomes of appointment

Topic	Guiding questions	Possible follow up questions
Taking the role of broker	How did you become the broker in these situations?	Were you asked? Who asked you? Professionals or parent/carer?
		Did you volunteer?
		How did it feel for this role to be assumed?
	Why do you think this happened?	Lack of awareness?
		Family preference? Why did they prefer you to act as an interpreter?
	How did that make you feel at the time?	
	Did your parents ask for information to be delivered in a different format to help them understand?	When were interpreters offered?
		When were they not available?
		Why?
		Did they ask for letters and leaflets to be delivered in BSL?
		Did they ask for email and text messages?
	Who in the family most frequently took on the brokering role?	Why do you think this was?
	Did you ever refuse to take on the role of language broker?	Can you tell me about a specific example?
		What was the situation?
		Why did you refuse in this situation?
		How did this make you feel?
		How old were you when you refused?
	Are there some situations you felt that you could refuse to broker more than other situations?	What made refusal easier?
		What made refusal more difficult?
	If a family came forward to you now and they were in the same situation as you had been in with your family and they were genuinely seeking open advice, what advice would you give them about brokering?	If you could give advice to your past family now without hurting anyone's feelings, what would it be?
	If you could give advice to healthcare professionals about language brokering, what would you say?	
Impact of brokering	Do you think there were any positive impacts of brokering at the time?	Do you have any examples?
		Any effect on: – family dynamics – working life – independence
	Do you think there are any positive impacts of brokering now?	
	Do you think there were any negative impacts of brokering at the time?	
	Do you think there are any negative impacts of brokering now?	
Concluding comments	Is there anything else you'd like to tell us?	

Note

1. See http://www.medisignsproject.eu/MEDISIGNS/CPD_VET_Training.html for examples of training and resources.

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