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Child language brokering in healthcare settings

Rachele Antonini and Ira Torresi

This chapter focuses on non- professional interpreting and translation performed by children from migrant backgrounds, between healthcare providers who speak the host country's language(s), and their own families and/or communities who may lack the necessary proficiency in these language(s). We will first offer a definition of this type of interpreting and translation, called Child Language Brokering (henceforth, CLB) in general (Section 1). We will then review the legal frameworks (Section 2) and the literature on CLB, specifically within the healthcare sector (Section 3). Finally, before reflecting on future directions, we will present some of the findings of our own research on CLB in Italy, with special reference to healthcare (Section 4).

1 Child language brokering: a definition

CLB is an umbrella term for all non-professional interpreting and translation practices performed by children and adolescents (for the purposes of this chapter, we will set the age limit of CLB at 18). Such practices range from describing TV programmes at home to sight-translating bank documents (i.e. translating them orally from a written text). The term became widespread in the 1990s (Shannon 1990; Tse 1995, 1996). Until this point, brokering children and adults were grouped together under various terms such as 'natural translators' (Harris 1976, 1980), 'para-phrasers' (Orellana, Dorner and Pulido 2003; Orellana et al. 2003), 'family interpreters' (Valdés 2003) or just 'bilinguals' (Malakoff and Hakuta 1991); some of this terminology is still in use. Within interpreting studies, occurrences of CLB have traditionally been dealt with only when they emerged in larger studies of ad hoc, family, or non-professional interpreting (e.g. Meyer, Pawlack and Kliche 2010; Pöchhacker 2008) rather than being awarded separate attention.

Typically, child language brokers come from migrant families and have attended school in the host country; they thus participate in both the host country's and their family's languages and cultures. For this reason, their families or communities may call upon them to serve as linguistic and cultural facilitators whenever a professional interpreter or translator is not available, or not desirable because it is easier to rely on a family member

than seeking out professional interpreting services. Similarly, host country institutions, including healthcare providers, may accept CLB as a 'lesser evil', particularly because it is free and because it saves the time and effort of arranging for professional interpreting services (Cirillo, Torresi and Valentini 2010; Antonini 2015: 100). Additionally, in certain settings such as schools or other educational institutions, CLB may be a way to ensure migrant children's inclusion through their active participation in the community, at first as beneficiaries of other children's brokering and later, when they master their new language, as providers of CLB (Rossato 2014; Cirillo 2017: 307).

As is the case with all non- professional translation and interpreting, child language brokering is seldom covered in translation and interpreting handbooks, because it lies outside the boundaries of professional practice that translation and interpreting students are usually trained in. CLB is frequently considered inappropriate particularly in the healthcare sector, as the kind of interpreting and translation required in these settings may be too demanding for a child, both in terms of the medical vocabulary and the emotional strain involved in the process (See Section 3 for a detailed discussion and references). Above all, it is generally understood that personal involvement with the patient receiving treatment is best avoided when providing healthcare services (La Puma *et al.* 1991: 1290). Regardless of such perceptions, however, CLB does occur in real-life healthcare settings, particularly within the context of the recent rise in immigration and the refugee crisis, as will be described in the following sections.

2 Legal frameworks

The provision of interpreting and translation services in healthcare differs widely across countries. Generally speaking, in countries where there is more experience in dealing with multilingualism and superdiversity, there is also greater awareness of the risks posed by non-professionals providing language services. The general provision of language services depends on whether a government will take action by devising and implementing specific policies (Ozolins 2010). In countries with a historically higher migration rates (e.g. Australia, Sweden and the UK), a range of policies has been put into place to help immigrants and minority language speakers in overcoming their language and cultural barriers, such as the use of printed material and interpreters (Hall and Sham 2007: 18). Unfortunately, a systematic implementation of similar language policies is an exception rather than the rule in other parts of the world. In many countries grappling with the more recent influx of migrants such as Italy, Spain or France, the provision of language services in healthcare is based on *ad hoc* measures and random initiatives (Rudvin 2006). The constantly growing demand for language services is not met by an adequate provision of professional interpreting and translation services; instead, the task of interpreting is relegated to family members (including children), friends, untrained members of support staff, and even strangers found in waiting rooms or on the street (Flores 2006).

Countries that actively oppose the use of non- professional interpreters in healthcare settings, and CLB in particular, attempt to limit these practices through a number of guidelines and measures that aim to ensure accessibility with the use of professional interpreters (Rice 2014). In the United States, for instance, the use of bilingual children and family members is opposed on the grounds that their health literacy is not adequate for undertaking this task, since they are put in a position where they try 'to absorb information and transmit it while emotionally upset' (Levetown 2008: e1448). The use of

hospital employees is likewise opposed, because 'their educational levels, even in their own country, may be low, and they […] will be assaulted emotionally with confidential and difficult information' (Levetown 2008: e1448). More recently, the US Department of Health and Human Services ruled with Section 1557 of the Patient Protection and Affordable Care Act that:

> In many circumstances family members, friends, and especially children, are not competent to provide quality, accurate oral interpretation. For communications of particularly sensitive information, oral interpretation by an individual's family or friend often also implicates issues of appropriateness, confidentiality, privacy, and conflict of interest. Thus, covered entities may not rely on family members, friends, or other informal interpreters to provide language access services.
>
> *Department of Health and Human Services 2016: 31417– 31418*

Despite these regulations, children continue to language broker in healthcare settings in the United States, as will be illustrated in Section 3. This can be partly ascribed to a lack of political will to take the legislative debate all the way to final implementation. For instance, the bill banning CLB from California hospitals, discussed by the California Assembly and Senate in 2003/04 (Yee, Diaz and Spitzer 2003), and mentioned by Angelelli (2010), was never lifted from appropriations suspense, meaning that the measures contained in it were never funded, and therefore the bill never came into effective force.

Across the EU, the problem does not seem to be the infringement of regulations on CLB, but the lack of any regulations that would limit this practice or in other ways ensure that patients' language rights are respected. As Yubo Liu and Wei Zhang observe, 'while the US is widely acknowledged as the country most proactive in state and federal efforts in ensuring the rights and interests of patients with limited English proficiency to access interpreting services in healthcare settings, European countries have experienced more fluctuations in the level of government support' (Liu and Zhang 2019: 1–2).

Studies have demonstrated that the lack of provision of professional interpreting and translation services and the ensuing use of minor or adult non-professionals can lead to unequal access to healthcare services and discrimination. The European Union Agency for Fundamental Rights' report (2013), based on qualitative social research and legal analysis in five EU Member States, reveals 'the operation of multiple grounds of discrimination, particularly concerning healthcare' (European Union Agency for Fundamental Rights 2013: 3). The report shows that '[l]anguage was the most relevant communication barrier mentioned by migrants in all the EU Member States surveyed' (European Union Agency for Fundamental Rights 2013: 47). The report also shows that informal interpretation and CLB are reported as one of the most common forms of mediation use in healthcare in Austria, the Czech Republic and Italy (European Union Agency for Fundamental Rights 2013: 50). As these insights into the situation in the United States and the EU show, CLB is still frequently considered to be either the only viable alternative to professional interpreting or the most convenient way to deal with language barriers in the health sector, despite the nascent legal framework and the broad acknowledgement of the possible negative effects of this practice. We will explore this issue in more depth in the following two sections devoted to research on CLB in healthcare, and to our own case study of the phenomenon in Italy.

3 Literature review

As indicated in Section 1, the existence and occurrence of CLB in healthcare settings are typically mentioned in studies that focus on other research areas, such as informal interpreting and medical practice. More recently, the discussion started appearing in works focusing on discriminatory practices within the theoretical framework of human rights, equality and quality of care, and medical ethics. Studies from these areas usually describe CLB as a practice which should be discouraged and prevented (e.g. European Union Agency for Fundamental Rights 2013; Juckett and Unger 2014).

The few studies that have investigated CLB in healthcare as their main focus have highlighted the cognitive, psychological, relational and sociological impact of CLB on children and their families through qualitative methodologies, primarily interviews. The existing research has developed along two main lines: (1) the views of healthcare professionals and, more recently, (2) the views of children (and parents/guardians in a more limited manner). A qualitative study that assessed the reasons for the limited use of professional interpreters by US physicians (Diamond *et al.* 2008: 258) identified four recurrent themes: (1) a general acknowledgement of the underuse of professional interpreting services, which the physicians described as a need to 'get by'; (2) the perceived value of the benefits of using a professional interpreter against their own time constraints and workload; (3) the convenience of relying on family members, including children, or on the physician's second language skills; (4) the normalisation of the underuse of professional interpreting services, despite acknowledging that this situation prevents patients with limited English proficiency from receiving equal care. Another study, which involved 77 bilingual young people in the UK (Free *et al.* 2003), identified the main healthcare settings in which children are likely to interpret/translate. These include: 'translating instructions on medicines, helping complete surgery registration forms, and interpreting in hospital, dental and general practice settings' (Free *et al.* 2003: 531). Their research also shows that:

> While some young people reported that they were sometimes used for interpreting because of deficiencies in formal interpreting services, others reported situations in which they were used by choice. Young people were used for preference, either because the family trusted their interpreting skills or because they had a particularly good understanding of their parent's illness and how it affected their life.
>
> *Free et al. 2003: 531*

Most studies focusing on CLB in healthcare detect the contingent and unplanned nature of this phenomenon and ascribe the involvement of children to the lack of funding or to a missing legal framework preventing the practice. However, they all show that CLB in healthcare is ultimately considered to be more convenient than professional alternatives (perceived as missing or more difficult to arrange) to help families with an immigrant background in overcoming communication barriers.

One of the most cited studies on CLB in healthcare by Cohen, Moran-Ellis and Smaje (1999) shows that for general practitioners (GPs) in the UK, CLB is often the only viable and contingent option. However, GPs also express their opposition to this practice by arguing that children should be protected from 'taboo' subjects for which they are not mentally prepared, and that might be part of the consultation. They state that they accepted children as informal interpreters, provided that the consultation was

'straightforward' (Cohen, Moran- Ellis and Smaje 1999: 173), but they were less willing to have children translate in those consultations that they deemed 'complex' (Cohen, Moran-Ellis and Smaje 1999: 173) or 'sensitive' (Cohen, Moran-Ellis and Smaje 1999: 175). Free *et al.* (2003) analysed young people's accounts of interpreting for family or friends in primary care settings in the UK and confirmed the necessity of having child language brokers due to deficiencies in services, but also because patients prefer to have their children interpret for them.

In terms of prevalence, the data available have been collected by focusing on specific ethnic and linguistic groups and from different populations (e.g. GPs, immigrant adults, children) and thus cannot be considered as representative of the diverse nature of the population with an immigrant background residing in different countries. One of the few exceptions is a US-wide survey aimed at assessing resident physicians' use of professional and non- professional interpreters, showing that 22 per cent of resident physicians in the United States use children as interpreters (Lee *et al.* 2006). Likewise, in 2011, the TRICC Project (Training in Intercultural and Bilingual Competencies in Health and Social Care) surveyed the official policy on interpreting in healthcare in its five European partners (Germany, Italy, the Netherlands, Turkey and the UK) and found that the use of *ad hoc* and informal interpreters (including children) is widespread in all five countries, even though these countries' policies make the use of professional interpreters mandatory (Meeuwesen and Twilt 2011). In a more recent study (Banas *et al.* 2016), 54.1 per cent of the sample comprising 159 adolescents of Hispanic/Latino origin, all attending the same high school in the Midwest of the United States, indicated that they assist family members with healthcare tasks, which included 'talking to the doctor or nurse, reading prescription labels, looking up health information on the Internet, talking to the pharmacist, and filling in medical insurance forms. Less common were talking to the insurance company or finding a doctor' (Banas *et al.* 2016: 900). These studies, although limited to a few specific countries, give an idea of the attitude towards a phenomenon that is generally frowned upon but still tolerated and which, in the absence of more stringent regulations, is becoming normalised.

The review of literature on CLB in healthcare settings shows that researchers have identified advantages and disadvantages associated with having children interpret/translate in this specific context, with the cons far outweighing the pros. The advantages include the fact that child language brokers develop health knowledge and linguistic abilities (Angelelli 2010), as they are exposed to advanced vocabulary and health-related concepts when interpreting (Valdés 2003). They also learn to work together with their parents to contribute to the success of language brokered interactions with healthcare professionals, so that they can actively team up to understand and comprehend health information (Katz 2014). Other advantages include the 'emotional benefits in enjoying helping the family, and benefits to self-esteem in being able to take on a responsible role' (Free *et al.* 2003: 531) as well as an opportunity for young people 'to speak their own language and demonstrate and practice their skills' (Free *et al.* 2003: 531).

The main disadvantages can be subsumed under three main issues: (1) children may not translate information in an accurate way; (2) the translation of legal and medical information may have a negative effect on the parent-child relationship; and (3) the child may be traumatised by the delivery of information about a serious medical condition concerning the child or a person they love. According to the general practitioners involved in Cohen *et al.*'s study, children in their role as language brokers may acquire precocious knowledge of sensitive and delicate topics that may negatively impact on their psychological stability;

the regular dynamics of the family may also be impacted, contributing to the reversal of the traditional adult- child distribution of knowledge and authority (Cohen, Moran-Ellis and Smaje 1999: 183–184). Other studies (e.g. Corona *et al.* 2012; Free *et al.* 2003; Hsieh 2006) describe issues linked to the fact that child language brokers are untrained as interpreters in general and as medical interpreters in particular. Their ages vary. They may not have the necessary linguistic competence in one or both languages involved, and they are also likely to lack the necessary health literacy and the relevant vocabulary (Green *et al.* 2005). All of these could lead the children to 'alter or selectively interpret information instead of interpreting all aspects of the conversation verbatim' (Guntzviller, Jakob and Carreno 2017: 144). Some child language brokers in the Free *et al.* study (2003) also described interpreting in healthcare settings as 'bothering and boring', and noted that it 'could be hard work and could take time away from preferred activities' (Free *et al.* 2003: 531) as well as from school commitments.

One of the dimensions that has recently been the focus of research is the emotional experience of CLB in healthcare. Studies on feelings associated with CLB have yielded mixed or contradictory results and have shown that children are likely to experience varying degrees of stress, and that the feelings attached to their role as language brokers can be both positive and negative (Hall and Guéry 2010), especially depending on the setting (Banas *et al.* 2016). In their study with 76 young bilingual individuals, Green *et al.* (2005) showed that they associated healthcare interpreting with feelings of pride but also unease. For instance, one adolescent explained that he was embarrassed when he had to talk about intimate topics: 'If it's a woman's problem then I can't speak, and it's difficult for my mother and for me, because I feel bad inside that I can't speak for that problem. I am the son, so it's like embarrassment' (Green *et al.* 2005: 2106). However, this study also emphasised how the interviewees 'rarely saw themselves as "inadequate translators" or exploited children, but as skilled mediators, helping to bridge misunderstandings between family members and the public sector' (Green *et al.* 2005: 2108).

However, when CLB occurs in healthcare settings, studies seem to point more towards negative emotional consequences. More specifically, children associated their language brokering activities with feeling awkward and angry when they were caught in the crossfire of disagreements, and by the frustration of not being able to interpret properly. Moreover, they also described feeling embarrassed when they acquired sensitive information about their parents or had to tell parents what to do, and the difficulty of accepting and repeating bad news about their relatives (Free *et al.* 2003: 532).

Antonini's 2015 research demonstrated dramatic differences between how GPs and children perceive CLB situations. While Italian doctors described children as 'natural', 'spontaneous', 'at ease' and 'in their element' when interpreting during a consultation, children more often described that they were embarrassed, scared and worried. Some studies have confirmed that interpreting in situations involving sensitive issues and/ or situations with a heavy emotional load due to the broker's attachment to the patients may be traumatic for the child (Meeuwesen and Twilt 2011). As Jacobs *et al.* (1995) report, a 10- year- old girl who interpreted between the medical staff and her parents when her baby brother was being treated later suffered an emotional trauma when her brother died. According to the authors, this trauma was caused by 'the very close involvement that this young child had in the care of her dying younger brother, including her being used as interpreter between her family and the medical staff' (Meeuwesen and Twilt 2011: 474). These studies show that while the communicative challenges of adult discourse may improve children's linguistic and cognitive abilities, the children also run the risk of being overwhelmed by

painful experiences and sensitive matters that are inappropriate for them, particularly in highly challenging or emotionally charged situations. The following case study of the In MedIO PUER(I) research group describes both the healthcare professionals' perception of CLB and the personal experiences of children who broker in healthcare (similar to Cohen, Moran- Ellis and Smaje 1999), and as such provides a detailed example of a multimethod research project into the specific matter of CLB and healthcare.

4 Case study: In MedIO PUER(I) research group in Italy

In MedIO PUER(I) was a multi- method study that pioneered CLB research in Italy (described in Antonini 2010: 8–10 and Antonini 2015: 97–98). Aimed at investigating child- mediated exchanges between migrants and the host country, the project gave visibility to a variety of institutions as active participants in triadic exchanges between two monolingual speakers and a bilingual speaker. Previous CLB research mainly dealt with the impact of brokering practices on the psychology and development of children and adolescents, relegating institutions to the background and equating them with the contextual variable of 'setting' (with a few notable exceptions, such as Cohen, Moran- Ellis and Smaje 1999 mentioned in Section 3). The In MedIO PUER(I) study sought to address this imbalance by collecting institutional perceptions, opinions and perspectives on CLB alongside those of children and their families.

During its initial stage, In MedIO PUER(I) focused on the collection of interviews in the Italian city of Forlì in the Emilia- Romagna region. The first goal of that early part of the research was to confirm whether CLB occurred during encounters between migrants and Italian institutions. Second, it aimed to explore whether civil servants or community service providers had, or were aware of, any formal or informal guidelines on how to conduct child-mediated encounters. The third purpose was to collect the service providers' perceptions and impressions about CLB, including any first- or second-hand anecdotes of events that had occurred within their institutions. These questions were asked in the form of in-depth semi-structured interviews and addressed to 10 senior officers from various public institutions or community services that might be approached by migrant citizens in their daily lives, including two schools, two social cooperatives, a trade union, a charity, the municipal registry, a municipal family support centre, and the police office that issued residence permits. In the following paragraphs, we will summarise the data collected specifically from one senior manager of the local hospital, whom we interviewed in the first stage of the project. We will then discuss the results of later interviews with 10 medical practitioners and nurses, and brokering children's perceptions specifically connected with CLB in healthcare settings (collected through questionnaires and a contest).

The interviewed senior manager was part of the Forlì local health unit (*AUSL)* (Cirillo, Torresi and Valentini 2010, Torresi 2014). Contrary to what was reported by all other interviewees working in institutions unrelated to healthcare, the Forlì local health unit could rely on professional interpreting services provided by a local cooperative through a special convention funded by the region Emilia-Romagna. At the time of the interview (2007), the convention covered 2,200 hours of interpreting per year that could be used by all facilities of the Forlì health unit (including general practitioners' offices) according to their needs. Additionally, the local health unit had commissioned a multilingual phrasebook with common questions and answers (such as 'where does it hurt' or 'when did it start'), and GPs and hospital staff could locate the phrase they needed in Italian and then point to the translation in the relevant language. Another significant difference

between the interview with the local health unit manager and the rest of the sample of senior service providers was that the health unit manager was not aware of any cases of CLB happening within the local health unit, while acknowledging that the phenomenon probably did occur and could be 'on the increase' (as was later confirmed by interviews with GPs and hospital staff, all of them working for the local health unit).

Spurred by the above-mentioned differences between the healthcare senior officer and the other respondents to the first interviews, the In MedIO PUER(I) group decided to conduct a second round of 10 semi-structured interviews, more specifically aimed at general practitioners and emergency room staff working in the Forlì and Cesena area (Cirillo and Torresi 2013; Cirillo 2014; Antonini 2015: 103–106). The second study focused on the opinions of the GPs and the emergency staff and its aims were as follows: (1) to confirm whether they were aware of the tools mentioned by the local health unit manager (i.e. the free professional interpreting services and the phrasebook); (2) explore their opinions about whether, and to what extent, brokering children contributed to the success of medical encounters with non-Italian-speakers; (3) identify areas or situations in which they thought children should not act as language brokers; and (4) to compare their expectations about professional interpreting versus child language brokering during medical consultations.

After the interview with the local health unit manager, it came as a surprise that the GPs and emergency staff members were evenly split between those who ignored both the option to request professional interpreters and the phrasebook altogether, and those who knew only about the phrasebook (but one of them stated that they had never seen it). Only one GP and one emergency room nurse were aware of the possibility of requesting professional interpreting services through the cooperative mentioned above. However, they both mentioned that such an option was usually neglected because the interpreters were never available on site – they were not supposed to wait on call physically at the hospital, let alone at individual practices, but took appointments that had to be arranged in advance (real-time telephone interpreting was never mentioned as a possibility). The other interviewees seemed to be simply unaware of the convention.

All of the interviewees had witnessed CLB in their own medical practice or hospital ward. Their approach to CLB was generally a pragmatic one. Similar to the doctors who participated in the study by Cohen, Moran-Ellis and Smaje (1999) mentioned in the previous section, they seemed to accept it as a necessary evil, and most highlighted how well child brokers performed, given their young age and lack of training. Three of them considered children and adolescents to be more accurate and trustworthy than adult *ad hoc* interpreters. Those who expressed negative opinions about CLB did not refer to issues related to the brokers' age, but rather to issues related to dialogue interpreting in general, such as 'I'm never sure whether they report what I actually said', or 'it is very time consuming to have them repeat everything I say'.

When asked about particular cases or situations in which they thought CLB should not happen, three interviewees mentioned 'serious illnesses', and another four the sexual and reproductive sphere. One further respondent offered a generic answer that 'it depends on the kind of medical problem'. Interestingly, the remaining two mentioned situations depending on the child's surroundings or subjectivity rather than the nature of the information to be conveyed. One said that children might not understand certain 'nuances' of the medical encounter; the last one stated that CLB should be avoided altogether if the practitioner perceives the child's family to be unsupportive or unable to protect the child from experiences that could prove traumatic.

All 10 interviewees seemed to have higher expectations about professional interpreters than child *ad hoc* brokers, especially in terms of terminological precision and loyalty to the original message. Those values, however, were not acknowledged as the sole or the most important qualities of a medical interpreter – some medical knowledge was also universally mentioned as desirable, perhaps the most important difference between children and professionals. One interviewee stated that she would rather have a child interpret than an adult professional without any training in medicine. Most interviewees mentioned various situations where CLB was preferable to professional interpreting. One interviewee noted that patients might not accept the presence of an unknown adult during the consultation. Another one complained about the additional administrative burden for the doctor whenever a professional is called ('I have to get a special form signed by the patient'), whereas family interpreters are brought in by patients themselves and are their own responsibility. Most interviewees also highlighted the ease, precision and maturity with which child brokers approach their task.

In addition to interviewing the service providers, we also collected children's voices through two main methods – a questionnaire given to young brokers in junior high schools (ages 11-14), and an art contest among primary and junior high school students (ages 6-14). It should be mentioned that the contest was not part of the original design of the In MedIO PUER(I) project, and that its later editions were outside of the project's timeline. However, the research group decided to continue their research after the funded project's official completion, with the idea of progressively expanding and completing the picture on how CLB is practised and perceived in selected Italian locales. In this respect, the data collected through the contest (and all other data collected through the group's subsequent CLB studies) should be considered as a coherent whole.

Although the healthcare setting was not the focus of these parts of the study, several respondents of the questionnaire and participants in the contest did report or recount mediating in healthcare settings or for health emergencies. The broker questionnaire (Cirillo 2017: 297–301) was given in years 2011–2012 to children with a migrant background in seven junior high schools, five of which were in the province of Forlì-Cesena, and two in the nearby city of Bologna. Of the pupils who self-selected as brokers and returned the 277 valid questionnaires of the study, 31 per cent reported having brokered at the doctor's practice or at the hospital, and 27 per cent stated that they had translated doctors' prescriptions and/ or medication leaflets.

A deeper insight was provided by the qualitative and subjective data collected through the *Traduttori in Erba* ('Budding translators/ interpreters') contest for the best short essay or drawing illustrating the author's experience of brokering (Antonini 2017: 322–324). The first three rounds of the contest, open to all local primary and junior high school students regardless of heritage, were held in 2010, 2011 and 2017. Healthcare-related verbal narratives from the first two editions have already been discussed at length elsewhere (Antonini 2015: 106–109; Antonini 2017), but the overall results suggest that children's first-hand subjective accounts of brokering in medical settings are more adamantly negative than GPs seem to perceive. When children write about their brokering experiences in healthcare, they almost invariably mention feelings of anxiety (mainly for their relatives' health), confusion, inadequacy and fear that the relative's health could get worse due to their poor interpreting. One child reported having to call the emergency number when his grandmother had a heart attack with no one else around. The main feeling associated with that experience – 'scared' – was understandably not focused on the interpreting between his non-Italian-speaking grandmother and the Italian operator,

but only on his grandmother's health. Notably, such negative feelings are reported much less frequently in connection with settings unrelated to healthcare. Similarly, of all the drawings submitted for the competition, only two did not depict brokering in bright colours. One of those two portrayed a boy beside a building labelled as the local city hospital, with an ambulance in the background. The drawing is dominated by desaturated cold colours, mainly greys and blues, which are usually associated with sadness and might denote emotional detachment or withdrawal (Torresi 2017: 349–350).

In conclusion, results from the studies conducted by the In MedIO PUER(I) group highlight a dichotomy in the perceptions of CLB in the healthcare setting. Healthcare providers would usually prefer to avoid the practice, but at the same time admit that it can have benefits in certain circumstances and provided that the child is not exposed to harmful or awkward topics. For children who experience CLB in various domains, the healthcare sphere is usually connected with high levels of anxiety and fear that the brokering might be inadequate and lead to serious consequences. This difference in perception highlights the need for more research in order to inform a political and legal framework that is capable of regulating CLB in healthcare settings.

5 Future directions

As illustrated above, brokering children and institutional representatives seem to hold different views and feelings about CLB, especially in the healthcare setting. The very fact that children and adolescents are asked to mediate during medical consultations by their own relatives (most often parents) can create tension between the concerns for the children's wellbeing and the overriding need for medical consultations. In order to explore this aspect, further research focusing on the perception of families with special regard to healthcare settings is needed. So far, data from families are very limited and emerge from studies with a broader scope on CLB in general.

In those rare cases where such data emerge, they seem to confirm the extremely problematic application of CLB whenever a close relative's health is at stake. When parents have been interviewed alongside their children (Ceccoli 2019: 197), their perceived frequency of CLB occurring at a medical practice or hospital tended to be the reverse of their children's. While 69 per cent of children reported having brokered 'always/ often/ sometimes' in such contexts (and the remaining 31 per cent 'rarely' or 'never'), 75 per cent of parents reported that the very same children had 'rarely' or 'never' performed CLB in the healthcare settings. It would be useful to replicate Ceccoli's survey with a more specific focus on CLB in healthcare, so as to explore whether the difference in parents' and their children's subjective memories may in any way be related to the phenomena of parent-child role reversal, often referred to in terms of 'adultification' or 'parentification' (Trickett and Jones 2007; Guske 2010; Orellana 2009). One particularly telling case study, and thus far the only one that acknowledges a parent's feelings and perceptions about CLB's parentification in healthcare, can be found in Vivaldi (2019). Vivaldi interviewed 6 Albanian parents residing in Italy, who had benefited from their own children's brokering at some point of their lives. Healthcare issues emerged only in one account, and were once again associated with strongly negative feelings. The interviewee, an Albanian mother whose baby son had been hospitalised in the local neonatal intensive care unit (NIC), regularly brought her older daughter to the hospital to broker for her. Eventually, the doctors of the NIC ward called a social worker to relieve the girl of some of the full-time brokering she was providing. The social worker assigned the

interviewee a professional interpreter, but the mother reported that she still felt dependent on her daughter, psychologically if not linguistically, despite feeling guilty and inadequate as a result of this very dependence. Of course only one interview is not particularly informative, and more ethnographic data needs to be collected among child brokers' families to further explore their experience of CLB in medical and healthcare settings, especially in connection with adultification and parentification issues that have so far been explored from the children's point of view.

Another area where action, rather than research, is urgently necessary is the development of national or super-national guidelines, as well as codes of ethics for healthcare providers working with patients accompanied by children and adolescents acting as brokers. The current legal frameworks described in Section 2 are too often left unheeded, and do not reach beyond the borders of a few countries. Even in those parts of the world where such guidelines are in place, there seems to be little awareness about them and they are frequently obstructed by political decisions. At present, therefore, the decision on whether to accept untrained minors as interpreters in healthcare interactions seems to be universally as unregulated as CLB in all other settings. In this respect, the method of Action Research – a 'collaborative approach to inquiry' that 'seeks to change the social and personal dynamics of the research situation so that the research process enhances the lives of all who participate' (Stringer 2007: 20) would seem particularly promising in terms of both scientific rigour and practical results.

Further Reading

Antonini, R. (2015) 'Unseen Forms of Interpreting: Child Language Brokering in Italy', *Cultus: The Journal of Intercultural Mediation and Communication,* 8, pp. 96–112.

The article contains several examples of children's narratives about CLB in healthcare settings, submitted for the *Traduttori in Erba* ('Budding translators/interpreters') school contest briefly described in Section 4.

Cohen, S., Moran- Ellis, J. and Smaje, C. (1999) 'Children as Informal Interpreters in GP Consultations: Pragmatics and Ideology', *Sociology of Health and Illness,* 21 (2), pp. 163–186.

The study that broke ground on CLB in healthcare settings, embracing both practical aspects and subjective perceptions. It was also among the first papers to collect the views of institutional representatives on CLB.

Related topics

Healthcare Interpreting Ethics, Dialogue Interpreting in Mental Healthcare, Remote (Telephone) Interpreting in Healthcare Settings

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