Children as Brokers of Their Immigrant Families' Health-Care Connections

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In an era of ever-increasing population diversity, bilingual intermediaries have become critical to health-care provision in the United States and elsewhere. Professional interpreters fulfill these roles in many cases, but family members frequently do as well. This article focuses on children of immigrants as brokers of language, culture, and media content who facilitate their families' connections to health-care providers and health-related resources. Children broker in order to compensate for the limited (or nonexistent) accommodations available to their immigrant families when they interact with health-care providers and institutions. As such, children's brokering constitutes an important, often overlooked, linkage between research on immigrant family dynamics and immigrants' interactions with host country institutions. Children's brokering also has implications for their own social, moral, and educational trajectories, which are deeply influenced by their responsibilities to their families. Data collected through field observations and interviews with Latino immigrant parents, their child brokers, and local health-care providers revealed how children's brokering influences these interactions. This article explores providers' perceptions of and interactions with child brokers and their families, taken in context of the institutions in which they work and of the intrafamily dynamics that can facilitate or constrain children's efforts. Keywords: brokering; children of immigrants; health care; immigration; interpreting.

A constellation of structural factors including socioeconomic status, immigration status, and lack of health insurance coverage have been identified as constraints to U.S. Latinos' health-care access (e.g., Documét and Sharma 2004; Doty and Holmgren 2006; Leduc and Proulx 2004; Mohanty et al. 2005; Siegal et al. 2006). Limited familiarity with English and the vagaries of the U.S. medical system can further challenge the quality of immigrants' communication with health-care providers, even when they do manage to access care. For example, miscommunicated or incomplete information exchanges between patients and providers have been linked with treatment noncompliance and with general resistance to and fear of returning for subsequent visits (Perloff et al. 2006; Post, Cegala, and Miser 2002; Riyadeneyra et al. 2000; Street 2003).

Researchers have documented how professional interpreters can facilitate patient-provider interactions when linguistic and cultural differences constrain direct communication (Butow et al. 2011; Hsieh 2007; Willen 2011). These intermediary roles are not only enacted by professionals. Family members—including children—often perform these services informally, particularly when professional alternatives are unavailable (Cohen, Moran-Ellis, and Smaje1999).

In this article, I explore how children of immigrants broker their families' health-care experiences by, for example, facilitating interactions with providers, finding treatment information online, and filling prescriptions. Professional interpreters' responsibilities are usually limited to formal consultations between providers and patients; children's brokering in health-care settings

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involves a wider range of activities and is embedded in a broader set of family responsibilities (García-Sánchez 2014; Katz 2014). Children's positioning is distinct from adult interpreters—whether they are professionals or not—because they live with and are cared for by the people for whom they perform these tasks. Their positioning as children in adult situations also complicates their perceived and actual abilities to enact these roles. Their brokering efforts serve their families, but also the institutions and providers they interact with. Effectively, children broker to compensate for the limited (or nonexistent) accommodations institutions make for diverse populations. As such, children's brokering constitutes an important, often overlooked, linkage between research on immigrant family dynamics and on immigrants' interactions with host country institutions (García-Sánchez 2014; Katz 2014).

Interest in children's brokering has increased in recent years, with scholars in the United States, United Kingdom, and Europe finding that children enact these roles in schools, parents' workplaces, local businesses, health-care settings, and at home (e.g., Cline et al. 2010; Orellana 2009; Park 2002; Song 1999). Children's brokering also alerts parents to opportunities for social incorporation, including workers' rights and compensation (Valenzuela 1999), rights to peaceable assembly, and naturalization (Félix, González, and Ramírez 2008; Wong and Tseng 2008).

The accumulating literature reveals that children's brokering is an enduring feature of immigrant family life and an important dimension of the second generation's social, moral, and intellectual development. Nancy Foner and Joanna Dreby (2011) noted that children have actively contributed to their families' integration strategies since the first waves of U.S. immigration. They argue, however, that "The strains associated with demands on children to translate for non-English-speaking parents also have become more of a problem [today], given the expansion of government and private bureaucracies and services in which young people's translating skills are required" (Foner and Dreby 2011:555). The increasing bureaucratization of modern life certainly requires immigrant families to navigate ever-increasing requirements, documentation, and formal procedures to address their everyday needs. Health-care facilities are among the most bureaucratic settings that immigrant families encounter and their children are often the primary resource available to parents as they navigate these encounters. However, like Marjorie Orellana (2009) and Inmaculada García-Sánchez (2010), I caution against presuming that brokering is a "strain" or a "problem" for children (Katz 2014).

While increased attention has been paid to children's brokering in recent years, studies have been spread across many disciplines and remain fragmented in terms of terminology, methodology, and theory (Cline et al. 2010; García-Sánchez 2010). This has hindered development of a cohesive research field and deeper consideration of how children's brokering is tied to broader fields of study on immigrant families' social integration and second-generation trajectories (Foner and Dreby 2011; Portes 2010; Portes and Fernández-Kelly 2008). I briefly overview these issues and situate the current project's contribution to addressing these concerns.

Defining Child Brokering

Children's brokering activities have been described by many terms.[1] The two most enduring have been "language brokering," which Lucy Tse (1995) defined as children and teens who act as "intermediaries between linguistically and culturally different parties . . . [who] influence the content and nature of the message they convey, and ultimately affect the perceptions and decisions of the agents for whom they act" (p. 180). The second is "culture brokering," which Edison Trickett and associates (Jones and Trickett 2005; Tricket, Sorani, and Birman 2010) feel more appropriately emphasizes the cultural dimensions of brokering over the linguistic ones.

1. For a comprehensive summary of terms that have been used for these activities, see Cline and colleagues (2010) and Orellana (2009).

Here and elsewhere, I have elected to use the term "child brokering," for two reasons. First, I refer to brokers as "children" to emphasize that they navigate social spaces generally reserved for adults in Western society. As such, they risk being viewed as violating cultural expectations of appropriate childhood, which can have consequences for how they and their families are perceived by providers (Cohen et al. 1999; García-Sánchez 2014). Depending on their age and developmental stage, they may also struggle with complex information that at least two adults are depending on them to communicate accurately. Brokering responsibilities generally increase through the preteen and adolescent years as children's language capabilities, cultural sophistication, and understanding of metalanguage develop more fully (Buriel and De Ment 1998; Dorner, Orellana, and Li-Grining 2007). Referring to these young people as "children," as opposed to preteens or adolescents, emphasizes that being their parents' child is their most salient identity when they broker, regardless of their chronological age.[2]

Second, I refer to "brokering" (rather than specifying a focus on "language" or "culture") because brokering activities can fluidly invoke children's skill sets separately or simultaneously, depending on the task (Katz 2010, 2014). Brokering most often involves negotiating languages and (in)formal forms of talk, which children do to facilitate communication between their parents and English-speaking providers. Many of these interactions also require child brokers to engage at least two sets of cultural norms with regard to appropriate behavior and talk. Health-care interactions also invoke the distinctive culture of the U.S. medical system, and sometimes, of a specific institution as well (Taylor 2003). I also focus on media brokering activities like phone calls to doctors' offices or searching for insurance eligibility requirements online (Katz 2010).

Children generally develop linguistic, cultural, and media-related capabilities more quickly than their immigrant parents. From a developmental standpoint, children are more adept at learning language than adults and are more likely to speak unaccented English, since native tongue phonology is more likely in early language learners (Lippi-Green 1997:46). Schools are also powerful sites of cultural socialization. Whereas immigrant parents often interact primarily with coethnics at work, children's interactions with schoolmates, teachers, and the formal curriculum foster forms of U.S. cultural knowledge (Gonzales 2011). Media can also be cultural teachers by familiarizing immigrant families with local news, opportunities, and norms (Durham 2004; Elias and Lemish 2008, 2011). Children often broker their parents' connections to English-language and "new" media, including the Internet[3] (Katz 2010). Even in communities with relatively low broadband penetration, children are more likely than parents to develop new media proficiencies, either at school or from their friends (Ito et al. 2009; Pew Research Center 2011).

Methodological and Theoretical Dimensions of Child Brokering

Tony Cline and associates (2010) noted methodological concerns that have also slowed development of a cohesive literature on this topic. Children's brokering is hard to witness as a naturally occurring event (García-Sánchez 2010). The challenges of systematic observation have led to an overreliance on anecdotal evidence and retrospective reports (Cline et al. 2010:118). Other scholars have collected survey data in schools, treating child brokers as an individual unit of analysis and relying on self-reported data (e.g., Kam 2011; Weisskirch and Alva 2002).

2. Many parents also see the transition from elementary to middle school (in grade 5 or 6) as a point from which children can assume increased brokering responsibilities (Katz 2014). The most intensive period of children's brokering therefore begins around age 11 and ends when they leave home and/or begin full-time work or college, toward the end of their teens.

3. Media brokering is not unique to children of immigrants. Children in middle-class, native-born families may broker media by teaching their parents how to send a text message or how to navigate a particular website (Clark 2011). However, children of immigrants broker parents' connections to media more often and for a wider range of tasks, since their linguistic and cultural facilities are usually also required to make meaning of media content for their parents (Katz 2010, 2014).

While this is a more systematic research design than relying on anecdotes, brokering activities cannot be understood only from the child's vantage point. Children's brokering is by nature intertwined with the behaviors and communication styles of the adults involved in these interactions. The present study contributes to the literature by capturing the perspectives of children, parents, and health-care providers on these practices through interviews as well as systematic observations. These multiple viewpoints provide a more comprehensive picture of these activities and help parse out how conflicting perspectives can explain variation across brokering experiences.

Variance in terminology and methodology have hindered the development of grounded theory capable of explaining how and why children's brokering activities are enacted and received differently across contexts. Moving beyond the descriptive is essential not only to the rigor of research on this topic in its own right, but in order to meaningfully engage with related areas of inquiry. Children's brokering in health-care settings has implications for research on patient-provider communication, immigrant family dynamics, health-care delivery, and institutional and community change, among others. The current study explores providers' perceptions of and interactions with child brokers and their families, taken in context of the institutions in which they work and of the intrafamily dynamics that influence children's brokering in these interactions. This multilevel approach to data collection and analysis has theoretical implications, which I discuss in the conclusion.

Bringing in the Institutional Site

Most previous site-specific research has focused on brokering in schools (e.g., Buriel and De Ment 1998; Chao 2006; Eksner and Orellana 2012; García Sánchez and Orellana 2006). Location-specific studies offer important insights into immigrant families' experiences with particular institutions, as receptivity to children's brokering is influenced by providers' own characteristics and by those of the institution where the interaction takes place. Mario Small (2006, 2010) argues that institutions in underserved areas can be accommodating at the institutional level via formal mandates and mission statements. He also notes that accommodations can result from providers taking personal initiative to go beyond their official duties and assist families. While Small did not focus on children's brokering, his work highlights the importance of considering how families' experiences may be location specific. This project contributes to the growing literature on immigrant families' experiences in institutional sites by comparing children's brokering in a clinic and private medical practice located in the same community.

Children's brokering in health-care contexts has not been a focus of prior research in the United States partly because some states (including California, where these data were collected), have passed or considered laws forbidding these practices.[4] California's proposed policy changes did not include provisions for hiring professional interpreters. Children therefore continued to broker, but in environments that had officially rendered their efforts undesirable. Brokering in health-care settings is more visible elsewhere; researchers in Germany, Spain, Switzerland, and the United Kingdom report that children broker frequently when institutions lack adequate accommodations for diverse populations (Bischoff and Loutan 2004; Cohen et al. 1999; García-Sánchez 2014; Green et al. 2005; Meyer, Pawlack, and Kliche 2010). In these varied locations, children occupy the gaps between language access policies and primary health-care provision—a critical, but often invisible, feature of immigrant families' interactions in host country health-care institutions.

4. In 2003 and 2004, the California legislature considered AB292, which would have forbidden child brokering in health-care settings and censured institutions in violation of this law with loss of state funding. While AB292 did not ultimately pass, many health-care institutions saw the proposal as an indication that change was coming and moved to officially ban child brokering in their facilities—without providing professionals to replace them. Therefore, in spite of these mandates, every child I interviewed still brokered for their families in health-care settings. Practitioners confirmed that children frequently performed these roles.

Since children's brokering is often officially discouraged or forbidden in U.S. health-care settings, no data set specifically documents the frequency of these practices. What is known, however, is that over 20 percent of U.S. children have immigrant parents. Of these children, 61 percent have at least one parent who has difficulty speaking English. This proportion rises to 68 percent for children with a Central American parent and to 82 percent for those with a Mexican-born parent (Child Trends 2010; Urban Institute 2009). While there is no way to gauge what proportion of these children broker for their families, in which locations, and with what frequency, these data suggest that children of immigrants in the United States are growing up in families where parents who need assistance navigating their English-speaking environment are the norm rather than the exception.

Bringing in the Family

Children's brokering activities are inherently interdependent. Even when children take cues from past experiences and act on their own volition, they act in service of their families. More often, these activities occur at the explicit or implicit request of parents who can provide varying levels of support for children's brokering. Parental involvement can take many forms, from emotional support and reassurance to collective sense-making. In the latter case, children contribute their English proficiency, U.S. cultural familiarity, and media literacy; their parents contribute adult understandings and assessments of family needs. In optimal circumstances, these pooled skills and resources help "scaffold" shared understanding and a course of action to address family needs (Dorner et al. 2007; Vygotsky 1978). Scaffolding activities demonstrate how immigrant families can act as strategic systems, in which individual members help address collective needs that facilitate learning and skill building for parents and children alike.

Parents' active contributions to children's brokering are seldom acknowledged by researchers who only consider brokering from children's perspectives, or by providers who perceive children's active roles as indicative of passive parents. There are some similarities between child brokers and other children whose family circumstances require them to assume additional responsibilities, often referred to as "carers." In the context of health care, child carers help parents manage conditions like diabetes, HIV/AIDS, mental illness, or drug or alcohol addictions (e.g., Aldridge 2006; Bauman et al. 2006; Laroche et al. 2009; Vernig 2011).

Child brokering is a form of child caring and therefore shares some characteristics with children with parents who are unwell. To varying degrees, these children all become privy to information commonly reserved for adults. They must negotiate their intimate, private responsibilities to their parents in public places with people who may not recognize or appreciate the challenges they face in doing so. Children who broker may also feel protective of their parents being judged for not speaking English or understanding the system (García-Sánchez 2014), much as a child carer may feel about their parents' conditions being judged by providers.

However, there are several important distinctions between child brokers and child carers, the first of which is that children's brokering responsibilities are not limited to health-care settings or to parents' health concerns—they broker appointments when they, their siblings, or other relatives are the patient. They also broker frequently in other settings. Furthermore, in communities with a high proportion of immigrant-headed households, children's brokering is often normalized as a natural component of their family responsibilities (García-Sánchez 2010, Orellana 2009, Trickett et al. 2010). By contrast, children whose parents have serious illnesses or addictions are often acutely aware that their family responsibilities are not "normal" and are therefore more likely to see them as shameful or as a source of resentment (O'Dell et al. 2010).

A particularly important distinction between immigrant parents and parents compromised by illness is that the former generally retain their parental authority, even as they depend on their children's brokering assistance (Valdés 2003). "Parentification" is common among children whose parents have addictions or serious illnesses; these role reversals carry wide-ranging risks for young people (e.g., Byng-Hall 2008; Kam 2011). Parentification can occur in immigrant families,

but these children are more often desirous of their parents' retained authority, which can also augment their brokering efforts (Katz 2014; Orellana 2009). Therefore, despite perceptions that active children have passive parents, there is limited empirical evidence that children's brokering activities disrupt immigrant family dynamics. More often, children's assistance is an important component of families' strategies to address collective challenges.

To explore how children's brokering influences their families' health-care experiences and what might explain variance among immigrant families in these regards, this investigation was guided by two research questions:

RQ1: How do children's brokering activities influence the interactions they and their families have with health-care providers?

RQ2: What factors can explain variance in these encounters?

Methods

Site Selection

This study was conducted in "Greater Crenshaw," a community located in South Los Angeles. This historically African American community has undergone rapid change over the past two decades. In 1990, 80 percent of the community identified as African American; by 2000, this proportion had decreased to 47 percent, with 40 percent of local residents identifying as Latino. In a 2005 random digit dial telephone survey (described in more detail below), 46 percent of Latino residents identified as foreign born. Ninety-five percent of foreign-born residents reported household incomes below $35,000,[5] and 52 percent had less than an eighth-grade education.

Unlike many Los Angeles communities where Latinos have been settled for a generation or more, Latinos are a relatively new presence in Greater Crenshaw. This community was therefore ideal for exploring how immigrant families manage when local institutions have not fully adapted to their presence. Like residents in many low-income areas, these families had limited health-care options. The area's only full-service hospital was shuttered in 2007, so residents could choose between a few local clinics and private providers if they did not want to venture further afield. Two of these local health-care facilities are described in more detail below.

Research Design

Data are drawn from in-depth, audio-recorded interviews with immigrant parents, the child they identified as their primary broker, and health-care providers in institutions these families frequented. I also draw from 18 months of field observations in two of these institutions. The Appendix contains the pseudonyms for all informants specifically referenced in the findings.

Parent and Child Interviews. Respondent selection began with a random digit dial telephone survey of 304 Latino households in Greater Crenshaw.[6] Spanish-speaking residents who indicated that one or more of their children brokered English-language telephone calls, mail, media, and/or interactions with doctors, service providers, or teachers "often" or "very often," were eligible for interviews. Since many eligible respondents' phones had been disconnected, the interview

5. When this survey was conducted in 2005, the federal poverty line was $19,350 for a family of four (the median household size for Latino residents in Greater Crenshaw). Most public services in Los Angeles use 150 percent or 200 percent of the federal poverty level to determine eligibility, in recognition of the high cost of living. At the time, a family of four living on $35,000 or less was considered a reasonable estimate of living in poverty in Los Angeles County.

6. This telephone survey was conducted under the auspices of the Metamorphosis Project at the University of Southern California.

Table 1 • *Descriptive Statistics of Parents Eligible for Interviews*

	Telephone Survey Interview Pool	*WIC Screening Survey Interview Pool*	*Parents Interviewed*
N	34	34	20
Age (median)	36	35	35
Female (percent)	56	93	75
Household size (median)	5	4	5
Married/living with partner (percent)	71	85	75
Residential tenure (mean)			
Years in United States	21	18	16
Years in Los Angeles	14	12	13
Years in Greater Crenshaw	8	7	8
Immigrant generation (percent)			
First generation	74	85	100
Second generation	21	15	
Household income (percent)			
≤ $35,000	94	87	90
≥ $60,000		4	
Education (percent)			
Eighth grade or less	42	70	60
Some high school/graduate	52	26	35
Some college/graduate	6	4	5
Country of origin (percent)			
Mexico	62	59	70
El Salvador	20	26	20
Guatemala	12	7	10

pool was augmented with screening interviews at a local WIC (Women, Infants, and Children[7]) office frequented by survey respondents. Using the same inclusion criteria, two research assistants identified eligible parents at WIC between October 2006 and March 2007. Screening surveys also collected demographic data to ensure similarities between interviewees recruited via these two methods.

Eligible telephone survey respondents were contacted between November 2006 and March 2007. Once that pool was exhausted, eligible WIC respondents were contacted until 20 parents and their primary child broker had agreed to be interviewed.[8] Each home was visited at least twice, for a total of 65 interviews ranging between 45 and 120 minutes in length. Interviews were semistructured and covered topics related to family communication dynamics, children's brokering activities, family migration history, and experiences with local institutions. Table 1 presents descriptive data for the two interview pools and parents who participated in interviews.

Twelve of the interviewed child brokers were in middle school (grades 6 through 8) and seven were in high school (grades 9 through 12). Maria[9] and Vida (ages 18 and 19) had dropped out of high school during their pregnancies and Maya (age 19) was in her first year of university. The majority were female (n = 17), and most (n = 18) had been born in the United States.

Provider Interviews. Parents and children were asked for names of local health care and related social services that they frequented. I conducted 16 formal interviews in private medical practices,

7. Woman, Infants, and Children (WIC) is a free federal program providing pre- and postnatal care and nutritional assistance to low-income mothers and young children.

8. In two cases, parents indicated that two of their children brokered equally so both children were interviewed, resulting in 22 child broker interviews among the 20 families.

9. All names and other identifying information have been changed to protect informants' privacy.

community clinics, a large hospital, family counseling services, and the WIC office, between May and September of 2007. I interviewed providers in a variety of specialties in these locations who were not Spanish speakers and who had experiences communicating via children's brokering. Interviews were conducted in respondents' offices and lasted approximately one hour.

Field Observations. These analyses also draw from field observations conducted over 18 months in two of the facilities where I had interviewed multiple providers. Observations provided deeper insight into the daily functioning of these institutions and opportunities to observe naturally occurring brokering events. The primary observation site was Union Clinic,[10] which was prominent in the area and had served local residents for over 30 years. Union provided general and specialized adult and pediatric care, as well as treatment and management of chronic conditions including diabetes, hypertension, and HIV/AIDS, accepting a wide range of insurances and sliding scale payment options. Their client base was largely African American and Latino but also included Asian- and Belizean-origin immigrants. Clinic materials announced translation capabilities in Spanish, Tagalog, Japanese, Vietnamese, Thai, and West and Central African languages.

I also conducted observations in a busy local pediatric practice called Kids Kare, comprised of four physicians and a nurse practitioner that served large numbers of local families. Their doctors were all affiliated with a large pediatric hospital in Los Angeles that served as an additional avenue for resources and support for cases requiring more specialized care. Kids Kare also accepted a wide range of insurance options and flexible payment plans. None of the providers were bilingual, though a number of administrative staff members were.

Analysis

Interview transcripts and field notes were analyzed according to Steven Taylor and Robert Bogdan's (1998) "constant comparative" method, which requires simultaneous coding and analysis of data as it is collected. Specific words, phrases, and recurring activities, meanings, and/or feelings were coded as patterns began to emerge. Special attention was paid to occasions where parents', children's, and service providers' perspectives on brokering activities converged or contradicted each other (Barry 2002). This analytical process was consistent with Taylor and Bogdan's (1998) approach, which necessitates developing and refining concepts that explain emerging data patterns and specify relationships between those concepts (p. 137).

Findings

Data collected through field observations and interviews revealed that providers viewed families with child brokers as posing unique challenges to their professional routines. These differences resulted from limitations in institutional support that affected providers' feelings of professional competence and the discomfort many felt when brokering challenged their cultural assumptions of "appropriate" childhood roles. Within these contexts, children and parents tried to successfully manage these interactions as individuals and as a collective family unit.

Providers as Institutional Gatekeepers

While there were many differences between Union Clinic and Kids Kare in terms of size and the scope of available services—the former unquestioningly had more of both—there were many similarities the two locations. Since the doctors at Kids Kare were actively involved with a Los Angeles pediatric hospital, they had more access to and knowledge of resources than smaller practices in the area. Many of Union Clinic's resources were grant dependent, so tight budgets and

10. Names and identifying information have also been changed for Union Clinic and Kids Kare.

chronic understaffing was the norm. In both locations, families reported extensive wait times and hurried interactions with providers with heavy caseloads when seeking care.

Interviews with providers in both locations revealed they found interacting with child brokers and their families challenging, partly because these families exposed acute limitations in institutional resources. While Union Clinic had an interpreting unit, its staff was insufficient for the number of Spanish speakers requiring their services on many days. While Kids Kare did not have dedicated interpreters, standard practice was the same in both locations—to have bilingual members of the administrative staff assist on an ad hoc basis. Since their professional duties did not include interpreting, these employees were often unavailable and providers routinely relied on children. Many found being on the "front lines," as one provider at Union described these encounters, a discomfiting experience that made it difficult to do their jobs.

Meaningful interactions with parents could alert providers to a family's specific needs. Resources to address those needs were sometimes in providers' direct purview, such as a referral to the diabetes management program that Union Clinic ran internally. Providers with longer community tenure were often familiar with other local resources that could ameliorate family difficulties, like food assistance programs. As such, the quality of providers' interactions with families affected their roles as gatekeepers to a wide variety of resources. The challenges they experienced in interacting with Spanish-speaking parents meant that they often knew less about these families' needs and circumstances, as compared with those of other residents.

Children's brokering assistance was often critical to providers' abilities to have these conversations with immigrant parents. However, providers' complex feelings about brokering could constrain the effectiveness of children's efforts. Brokering appeared to implicitly threaten some providers' self-concept as competent professionals, as well as their cultural assumptions about appropriate roles for children. Both issues influenced how providers conducted themselves in interactions brokered by children.

Challenges to Professional Identity. Celeste Watkins-Hayes (2009) found that welfare staff developed their professional identities through assessments of how they were situated within the organization, the community, and in relation to the recipients for whom they are responsible. She argued that, "This complex identity construction is not simply a symbolic exercise; it has consequences for clients in terms of what they receive from service organizations and when and how services are rendered" (p. 189).

While the professional identities that providers espoused varied according to their titles and responsibilities, patterns emerged with regard to how child brokers and their families appeared to disrupt professional routines. Because children's brokering either went unrecognized or was officially unwelcome, even providers who had undergone some cultural competence training had not received instruction on how to best communicate through children. Most providers gamely did their best at "muddling through" these interactions, as Dr. Garber, an internist at Union Clinic, said. She continued, "I feel very powerless in these situations. Am I saying the right thing, am I doing the right thing?"

Providers felt their ability to provide quality care was compromised when children brokered consultations. Dr. Meeren appeared resigned to these interactions being more difficult than her other pediatric consultations at Union:

> I am sort of guilty of being—having like a prejudged notion when I walk into a room. It's a pain that they don't speak English, so I walk in and go, "How are you today? What are you here for?" And they look at me and say nothing. I'll go, "Oh well, *habla Inglés*?" because I make that assumption that they've been here long enough to speak English. So it sort of centers on the kid. Some of the kids are born and raised here and been in school and they speak excellent English, and their Spanish is good . . . [the] problem when it comes to medical translation is that they don't know [the words]. So that's when I sometimes have to pull someone from here to translate; and because they're not professional either, there are things that I'll say that, you know, they don't understand either. So I have actually a little Spanish-English dictionary that I'll use to help.

In her narrative of a "typical" encounter with an immigrant Latino parent, Dr. Meeren describes the stages of work she encounters in these interactions. She began from a normative stance by "[making] that assumption that they've [parents] been here long enough to speak English." She admits to enlisting the help of children, but notes their limitations. Her reference to having to "pull someone from here to translate" refers to enlisting support staff to interpret, who are "not professional either," since they had no formal training and these duties were not part of their job descriptions. Dr. Meeren's narrative was a defense of her professional identity as a competent physician; she carefully documented the thoroughness of her efforts to resolve the challenges presented to her by noting the limitations of parents, children, and support staff, in turn.

For other providers, their primary concern was the fidelity of particular concepts and ideas that even professional interpreters might find difficult. Dr. Thomas, a pediatrician at Kids Kare, said, "It's not just language, but education. If I say, 'How frequently are you wheezing?' . . . what I'm trying to do is understand the nature of the severity of the asthma . . . they don't understand that frequency means some sort of ratio." Conveying an idea as complex as a ratio required medical knowledge beyond the reach of most (if not all) children. For parents with limited formal education, such concepts could be similarly daunting. Dr. Thomas continued:

> Older children I might use [to broker]. But I don't want a free-flowing discussion. I ask specific questions, and I'm looking for specific answers . . . It's not like we're sitting down and talking about how you feel. There is a structure in my mind I want to complete so that I can figure out what is wrong with the child.

Dr. Thomas was primarily interested in the medical details needed to fulfill his professional obligations of diagnosis and treatment. Desires for dispassionate relays of information can conflict with the emotional and physical needs of patients and families (Gálvez 2011). These motivational mismatches are often features of patient-doctor interaction, since many patients, immigrant or not, expect doctors to be interested in how they feel (Erzinger 1999; Watson and Gallois 2004). In the interactions these providers had with child brokers and their families, mismatched motivations had additional layers of complexity due to linguistic divides and limited understandings of the U.S. health-care system.

Providers perceived limitations in children's linguistic and cultural sophistication, as compared with adults, and found them problematic (also see García-Sánchez 2014). Children's subjective attachments to their parents to whom difficult information sometimes had to be relayed exacerbated the difficulties these interactions posed to providers' professional identities. Dr. Garber recalled having an adolescent son broker a cancer diagnosis to his mother:

> You don't really want a kid to know all those serious things. I had a lady . . . [who] was in deep, deep, deep denial about her breast cancer . . . [and] I had to use her son to say the word "cancer" to her, and she was horrified and in tears . . . He was close to grown up, but I'm sure he felt very uncomfortable . . . I think he really didn't want to be in that position, because it was like him telling the bad news, not me telling the bad news.

Dr. Garber's story reflects complexities related to disclosing bad news to patients and of children being the intermediary between their parents and physicians. Noting that the son was "close to grown up" reflects how such challenges were augmented by providers' feelings about children's "place" and their duty to protect innocents from the dealings of adults (Zelizer 1985).

Children Being Seen and Heard. Alyshia Gálvez (2011) noted, "Even though health care providers frequently hold progressive political and social views . . . they serve as gatekeepers administering access to public benefits and schooling [immigrant] patients in acceptable and appropriate behaviors" (p. 26). For providers in Greater Crenshaw, acceptable behaviors invoked their conceptions of permissible responsibilities for children and by extension, for their parents. Providers expressed gratitude for children's assistance while holding value-laden perspectives on these

efforts, as Suzanne Cohen and colleagues (1999) found in the United Kingdom. Children being seen and heard in adult spaces, privy to information providers often felt inappropriate, affected their perceptions of these families and influenced brokering outcomes in ways largely beyond children's control.

Providers' perceptions that these children transgressed boundaries of culturally defined, age-appropriate behaviors were further complicated by their conflicting perceptions of children's capabilities. Dr. Victor, a pediatrician at Kids Kare, said:

> I try not to [have kids broker] . . . asking an eight year-old to explain the pathology isn't the best choice, from what I can tell. I can understand enough [Spanish] to know, like, if I said something and then the child tries and [translates wrong]. Though sometimes the kid and the mom might—because they are so familiar with each other—be able to help each other grasp the meaning a little more.

Dr. Victor first minimized children's brokering capabilities, noting age as a constraint and her ability to check the fidelity of their efforts through her limited command of Spanish. And yet, her next comment revealed a contradictory position by recognizing that parent-child scaffolding may facilitate enhanced understandings of health-care interactions.

Dr. Meeren also recognized the collaborative strategies she had seen between parents and child brokers and elected to imagine children's motivations in these interactions:

> Sometimes [the children] want to take on that role . . . they don't want to maybe seem that there is a difference between them and the other English-speaking families. I think they are sometimes protecting their parents; they're immigrants, and they're not able to communicate in English . . . and I will see them sort of jump on that role.

Here, Dr. Meeren described children's active roles quite positively, viewing them through a lens of family loyalty and as advocates for their parents. In doing so, however, she framed children as "protecting their parents," implying a perceived role reversal from parents being the protectors of children. That providers viewed active children as indicative of passive parenting meant that instead of the family being recognized as a cooperative unit, children's front stage work necessarily demoted parents to backstage roles (Goffman 1959).

Parents and Children in Health-Care Contexts

Children brokered for their families against these complex institutional and interpersonal backdrops. From children's perspectives, brokering in health-care institutions was significantly more difficult than doing so in other local settings, like schools, stores, or at home (Katz 2014). Their families' limited health-care access meant that brokering often occurred in emergency situations and required children to broker difficult and sometimes upsetting information very quickly. Even in nonemergency situations, health-care facilities were often unfamiliar to children. They were uncertain about norms and procedures and struggled with the complex language many providers used. As a result, child brokers were most likely to recall brokering in health-care settings as times when they had experienced feelings of anxiety, helplessness, or fear of failure. Victoria (age 12) said, "Yeah, like when I sit [in the waiting room] I can't stop moving my feet . . . and [my mother] like—she like pinches me or something to get me to stop."

Children whose family circumstances required regular brokering between their parents and specific providers generally felt less fearful than children who had less frequent health-care interactions. Weekly visits to broker at her father's internist made Milagro (age 13) feel comfortable asking questions to ensure that she fully understood the doctor's directives on how to manage her father's diabetes. While Luis (age 11) frequently brokered in health-care settings, he and his family saw a revolving door of pediatricians and specialists and were often in the emergency room for acute needs related to his brother's epilepsy. His brokering experiences, while regular, were therefore not routine. He described these interactions by saying, "I mean, all of them, they use all these terms . . . it's just so hard for me. [They] like, load this stuff on me so I can translate it."

These families entered health-care settings where they faced constraints experienced by other Greater Crenshaw residents, in that they had limited options that were generally under-resourced. They also faced specific challenges, in terms of how providers reacted to children's brokering. Strategies that families had developed at home—both individually and collectively—were tested in these public spaces, which in turn influenced how these strategies might be deployed at home and in future interactions.

Bringing the Family into Health Care. Parents generally preferred to have their children broker for them when the alternative was ad hoc assistance from bilingual support staff. Many parents were uncomfortable with this practice and perceived these employees as rushed or not really wanting to help them. Milagro (age 13) reflected on the situation in a doctor's office she visited regularly with her father:

> Yes, they have some Spanish speakers there, but sometimes [the receptionists] are not having a good day, and it's understandable, but . . . they're not that polite. And I've noticed that a lot . . . They'll try to rush through things, and just try to get through as fast as they can . . . and that's the thing about my dad, he feels bad when he has to go through that, you know. He prefers for me to go over there.

Milagro's description demonstrated empathy for her father and for the receptionists who made him uncomfortable. Children's abilities to read their parents' emotional states provided comfort during what were often stressful interactions for parents. Wait times to see providers were often long and appointments generally rushed. Unless families had a particular caseworker or doctor, they often saw different providers on each visit (Fiscella and Epstein 2008; Heritage and Maynard 2006). Aurora (age 16) said, "When [my parents] have to say something [to a doctor], they want me to say it for them . . . maybe they feel more sure with me." Hilda explained her preference for having Sonia (age 14) broker by saying, "Those people there may speak my language, but my daughter speaks my heart." When the only accommodation she was offered was a rushed stranger, Hilda trusted her daughter to faithfully represent her interests instead.

Visits to health-care facilities were characterized by interdependence among family members, including the brokering activities that facilitated these interactions. Children did not act alone; parents' input and authority were critical supports for their brokering. Parental authority augmented children's confidence in their own capabilities. When asked who she consulted to ensure she understood brokered information correctly, Juana (age 13) said, "My parents . . . they're the people I'm most confident in, to teach me how to do something right." Children with parents who modeled proactive communication behaviors (e.g., asking questions to clarify their understandings) mirrored these strategies in their own information-seeking efforts.

Parents faced many challenges to retaining their authority when they entered health-care institutions. Providers differed markedly from them in terms of education, language capabilities, socioeconomic status, and residency status. These differences were augmented by the standard power differentials between patients and providers, where the latter is framed as the expert from whom the former seeks advice and assistance (Erzinger 1999; Street 2003). Parents' limited experience with the U.S. health-care system made them unfamiliar with its cultural norms, vocabulary, and procedures. Some providers noted that parents were not only reluctant to ask questions, but seemed unsure of what questions to ask at all. Ms. Jaramillo, a community outreach worker, said, "You know, I don't even know if [parents] are empowered to ask questions. A lot of it is that they don't know the system. It's really complicated, you know." Parents' limited understandings contributed to providers' perceptions of their passivity.

Children's Independent Strategies

Children were well aware that parents' limited language skills and education made their brokering assistance essential. Parents' limited demonstrations of authority in health-care settings further challenged brokers, who felt expected to demonstrate courage and proactivity even when their parents did not. Children generally applied the brokering strategies they had developed at

home and in previous health-care interactions, which fell into three broad categories: extracting meaning from contextual cues, negotiating cultural norms, and engaging media as resources.

Context and Meaning: Being Able to Ask. Children's primary opportunities to extract meaning from context occurred during conversations between their parents and providers. Children listened carefully and used the statements surrounding an unfamiliar word or idea to deduce what it might signify. This was a relatively successful strategy with social service providers because the vocabulary and ideas in these conversations was often fairly simple. In medical contexts, however, I witnessed providers inadvertently make it more difficult for children to understand them. By using complex medical terms when simpler ones would have sufficed, not fully explaining complicated ideas, and not checking the fidelity of children's comprehension by asking directly if they understood, doctors' instructions were often well beyond children's capabilities. The strategies child brokers used to extract meaning in other contexts therefore often had limited utility in health-care settings.

What mattered most was what children did next in these situations. They were generally comfortable double-checking that they had understood their parents correctly, though they often did not know when to prod for more detail as a professional interpreter would have (Willen 2011). There were also times when children refrained from prying into parents' answers out of respect, or because they were embarrassed to hear more private information (Green et al. 2005).

Children were more likely to request clarification from providers if their parents modeled proactive communication behaviors for them. Even so, children were generally reluctant to directly question authority figures and were anxious that questions could make them appear less competent. For many, acknowledging that they needed help was more than embarrassing; it was an admission of defeat. Aurora (age 16) said:

> Sometimes . . . I'm just like, "I don't understand what you're saying . . . Can you explain better or say it in other words, describe it to me so I can better translate it to my parents." They try to, but sometimes I just don't get it . . . I feel sad 'cuz I can't help my parents. I try to understand the doctors, but I can't [sometimes].

Acutely aware that their parents were depending on them, younger brokers were particularly likely to feel that asking for help meant that they were not living up to their responsibilities.

As Orellana, Lisa Dorner, and Lucilla Pulido (2003) observed, brokers were also aware of their social positioning as children of immigrants operating in adult situations, which affected "how entitled they felt to ask questions, make demands, or speak on behalf of their families" (p. 522). Older children were more likely to speak up than younger ones, suggesting that brokering strategies change as children age. Younger brokers sometimes asked questions too; when I asked Graciela (age 13) how she ensured she understood the doctor's instructions, she giggled and said, "Because I just won't let them leave until I know I got it right." Few children felt entitled to engage providers this way, but those who did were more likely to successfully broker difficult information.

Negotiating Cultural Norms. Implicit in whether children felt permitted to ask questions were the cultural dimensions of their brokering experiences. Children worked hard to finesse interactions where conflicting cultural expectations could adversely affect their families. When these efforts required pleasing oppositional parties, children admitted to strategically altering messages; García-Sánchez (2014) noted the same practices among children of Moroccan immigrants in a Spanish clinic. Aurora (age 16) said, "Sometimes I think, 'That's not how you say it,' but I don't really tell them nothing, I just let them talk and then I say it in my own words." Her family had recently had a problem where their health insurance coverage was not recognized by the doctor's office. Her parents were very upset and directed their frustrations directly at office staff and doctors. Aurora altered their messages in accordance with her understanding that the problem lay with the insurance company, not the doctor's office. Her approach resulted in the office manager taking responsibility for clearing the problem herself. In this case, Aurora negotiated multiple forms of cultural knowledge to craft a message that ultimately facilitated the outcome her parents desired.

Other forms of cultural knowledge were equally difficult; brokers had to present themselves as appropriate children in interactions that often brought conflicting expectations of them to the fore. As discussed previously, brokers challenged many providers' cultural expectations related to children operating in adult spheres, having access to adult information, or having to "work" (Bourdillon et al. 2010; Orellana 2009). For parents, it was also critical that their children broker in ways that still accorded them appropriate levels of respect and deference.

Some providers inadvertently made it more difficult for children to maintain this delicate balance between adults' expectations. I witnessed interactions where doctors directed their first question to the parent, but only addressed the child once he or she started brokering. Parents felt they were not being respected when they were effectively removed from an interaction and their children felt caught between helping as needed and maintaining their parents' sense of dignity. On the other hand, providers who only addressed parents and effectively ignored the broker, also challenged children's sense of their "place." Feeling removed from the conversation made children even less likely to reassert themselves if they had questions or required clarification.

Maintaining cultural appropriateness also required children being able to recognize the emotional states of adults while brokering. It was difficult for many parents to have their children broker sensitive, embarrassing, or adult matters for them. In these situations, children had to manage their parents' reticence with necessary deference and manage their own feelings about these kinds of information. After all, Mom's gynecological exam or Dad's prostate cancer screening may be "routine" medical visits, but both make children privy to information that parents and children would prefer not to share. Some children were better at managing these feelings than others. Juana (age 13) went to the gynecologist with her mother and with a neighbor whose children were too young to broker for her. Juana framed these experiences as "educational," saying, "It's okay if I know [about gynecological visits] 'cuz one day I'm going to have to know it anyway, right? . . . and they're not [embarrassed] 'cuz they want me to learn."

Juana treating these interactions as "learning experiences" helped her appear appropriate from her mother and the provider's perspectives. Like Juana, many children managed differences between parents' and providers' expectations by foregrounding their desires to be helpful, dutiful children. Providers who recognized these avowals were generally more accommodating because children's acquiescence to parental demands is a relatively consistent expectation across cultures (even if what children were acquiescing to was considered inappropriate by providers).

Brokering Media: Resources and Challenges. Children brokered a variety of media forms and content during visits to health-care institutions and at home, as both a precursor to and consequence of these visits. For example, Aurora (age 16) recounted how a negative experience with a local pediatrician had recently prompted her family to find a new provider. Aurora and her parents first talked with friends and neighbors. When this approach did not yield the answers they sought, Aurora searched online for local pediatricians and called the insurance company to ensure that that doctor would accept their coverage. She then accompanied her mother to that doctor when her younger sister was unwell, where she helped complete required paperwork and brokered the appointment. Aurora's experience emphasizes the recursive relationship between brokering at home and in health-care facilities. Having brokered a connection her family decided not to maintain, Aurora's brokering was central to her family's renewed efforts to make a quality connection to a local provider.

Aurora's story also underscores that children's media brokering involved a wide range of formats, including online content, telephone calls, and paperwork as forms of print media. The landline telephone is a media device that has become largely invisible to researchers (Baym 2010) but was a crucial component of the health-care connections that children brokered. Parents usually screened phone calls on the answering machine to identify Spanish-speaking callers and to ensure that children would have a full record of who to call back if messages were left in English. Most families visited health-care facilities where at least some of the office staff members were not bilingual, so children generally returned messages and initiated phone contact. Parents were directly involved with these calls; Victoria (age 12) said, "When, like, a person that doesn't know Spanish calls, my mom puts [the phone] on speaker. When the person tells it [in English] she tells me to

translate." Parents and children either handled calls jointly, as Victoria described, or used a back-and-forth format so that children could confer with their parents.

Children connected with a variety of media to help them broker health-related materials and interactions. They often used dictionaries to negotiate written materials and to prepare for phone calls when they anticipated having to make specific requests for information. For those with access, the Internet was particularly useful to double-check comprehension, locate information about a health condition or treatment options, and map directions to health-care facilities. Consistent with prior studies, children who reported (even if intermittent) Internet access at home went online to address a wider range of questions and were more successful locating relevant content than those without home access.[11]

While media could enable children's brokering, brokering health insurance forms and other print media was usually very challenging. Some children called these materials "grown-up stuff," revealing that they saw limitations in their capabilities as being linked to their ages. Four children spontaneously described these as times when they "got stuck;" another three called it "getting mixed up." Their struggles reflect Foner and Dreby's (2011) observation that modern bureaucracies are a heavier burden for families today as compared with prior immigration eras.

Even complicated conversations with providers might be managed by asking questions; print documents did not allow for such interactivity. Children reported difficulties completing official forms at home and in health-care facilities, where they often found it daunting to ask busy administrative staff for assistance. They were often left to consult their dictionaries or try to decode forms with their parents, who admitted that they also dreaded these documents, even when they were available in Spanish. Some parents struggled through these tasks alongside their children, attempting to scaffold shared understandings of what was required of them. Others were more avoidant and handed these responsibilities to children to handle independently.

Parents were most likely to hand off brokering related to prescription medications, which they perceived as finite and relatively simple tasks. Child brokers viewed these responsibilities quite differently. For example, Evelyn (age 15) lived with her grandmother and described these responsibilities as follows:

> To me when [my grandmother] needs me to order pills, that's the worst 'cuz I think, what if I say the wrong name and they give her something else? . . . Yeah, even though I've done it for a while I still feel like, you know, it's the first time.

Alicia (age 12) recalled feeling fearful when her father had sent her to the pharmacy on her own: "I was so worried I would mess up the words." Accepting the wrong prescription or a drug not covered by insurance could be extremely costly mistakes, and those possibilities weighed heavily on children charged with these responsibilities.

Children who did not receive parental assistance were often reluctant to ask for it and struggled mightily with these tasks. For children who received parental support, the anxieties of brokering print media often motivated them to work especially hard, seeking assistance online and from dictionaries, parents, siblings, and sympathetic administrative staff to ensure there were no mistakes. The pride children felt when these efforts paid off was that much greater. This pride was evident in the description Milagro (age 13) gave of her father's recent hospitalization and surgery, when she had been "in charge":

> My mom was there, but she didn't know nothing; she really needed someone to figure out [everything] . . . I had all the information on my dad, and like everything . . . little notes, appointments, his history, and um, how he'd been hospitalized before. So I organized everything, and I'm the only one there who knows

11. This is consistent with findings from representative surveys; Livingstone and Helsper (2007) reported that having Internet at home is associated with children being online for longer, using the Internet more frequently, and exhibiting more Internet-related skills. Seventy-four percent of school-age Latino children have home-based Internet, compared with 88 percent of their white and 78 percent of their African American counterparts (Rideout, Foehr, and Roberts 2010).

> everything . . . my mom really was [appreciative]. She even said, "If you hadn't been there I don't know what I woulda done."

Her assistance took many forms the day of the surgery, as she also brokered interactions between her parents, specialists, and nurses. Her proactive preparation of all relevant paperwork showed that she had internalized the expectations of self-care and management embedded in the U.S. health-care system, by regularly brokering her father's appointments. For Milagro, this opportunity to showcase her accumulated skills and knowledge reinforced her important place in the social arrangements her family had developed around her father's illness.

Conclusions

Children's brokering is an important dimension of immigrant family dynamics and of how their families interact with institutions critical to their well-being and social incorporation. Low-income immigrants have less access to health care than other social groups and frequently encounter limited or no accommodations for non-English speakers when they do seek care (Sargent and Larchanché 2011; Willen 2011). By brokering, children of immigrants provide a service for their parents. They also reveal the limitations of health-care institutions to adequately address the needs of families like theirs. As a result, while children's filling this gap in services also helps providers and institutions, providers clearly have misgivings about their efforts.

In their review of intergenerational dynamics in immigrant families, Foner and Dreby (2011) noted: "One of the many challenges for the future is to further explore the repercussions of intergenerational relations within the immigrant family for family members' involvements in social, economic, political, and cultural institutions outside it" (p. 559). This study addresses Foner and Dreby's challenge because children's brokering activities clearly influence and are influenced by communication patterns within immigrant families. The extent to which families are able to successfully deploy collaborative strategies to manage interactions with health-care providers reflects the linkages between families' private and public interactions. These linkages also help explain the consequences of institutional encounters for families' future engagement with local providers (Katz 2014).

This inquiry focused on how children's brokering activities influence their families' health-care interactions and on identifying factors that explain variance in those experiences. As a qualitative study of a single community, generalizing these findings requires caution. Nonetheless, interviews with children, parents, and providers extend current research by accounting for all of these perspectives in brokered interactions. Furthermore, 18 months of observations in two local health-care settings permitted consideration of how institutional environments influenced providers' interactions with child brokers and families in these settings.

Research on children's brokering has burgeoned in recent years, but limited agreement on common terms and methods have hampered development of a cohesive research agenda. Prior research on children's brokering has also often been descriptive, rather than explicitly theory driven. Orellana's research program, guided by sociocultural theory, is a notable exception. Her longitudinal studies of children's brokering have contributed a great deal to understanding how socially situated learning can facilitate skill building for parents and children alike (e.g., Dorner et al. 2007; Eksner and Orellana 2012; Orellana 2009).

In a similar vein, Trickett and associates (2010) issued a challenge of sorts by reviewing the extant brokering literature from an ecological perspective. They considered how prior findings could be considered within this multilevel framework, even though most of the included studies had not been conducted with this theoretical orientation in mind. Trickett and associates (2010:91) noted that researchers have been most likely to account for interdependence between children's brokering and family dynamics. Other levels of influence, including institutional (e.g., schools or health-care facilities) and community characteristics, have been studied less frequently. To their assessment,

I add that brokering activities should be considered not only in terms of relationships *across* levels of influence, but also *within* levels, meaning how brokering in one location may be related to brokering in others.

Considering children's brokering from an ecological perspective clarifies how these activities enable individuals and families to act on their environments and develop strategies to circumvent identified constraints. Moreover, an ecological lens makes it possible to consider agency without minimizing the impact or consequences of the constraints that these families face. The findings from this study clearly demonstrate that agency and structural power are related to children's brokering at a number of interdependent levels. In the interest of contributing to developing theory robust enough to understand children's brokering in broader context, I briefly discuss the primary findings from this study below, paying particular attention to specific mechanisms that serve as linkages across levels of influence.

Individuals and Families

To varying degrees, children developed individual strategies to manage brokering challenges by using context to elicit meaning, negotiating cultural norms, and engaging media as resources. The success of these individual efforts was directly influenced by interdependence with their parents. Children's brokering was enabled by retained parental authority, which provided reassurance and support. When parents modeled proactive communication behaviors (e.g., actively seeking clarification), their children tended to mirror these behaviors and seek out English speakers to confirm their understandings. Parent-child scaffolding also enabled children's brokering efforts, because pooling their respective skill sets facilitated shared understandings and encouraged mutual learning. Brokering without these family-level supports was more stressful for children, as evident in their feelings about handling tasks related to prescriptions on their own.

These findings emphasize children's brokering efforts and successes are reciprocally linked to the communication dynamics of their families. While these data focused on parents and their primary child broker, older siblings and cousins can also support children's brokering (Katz 2014; Pyke 2005). Future research could engage family systems theory to examine how all family members influence brokering activities and outcomes.

Families and Institutions

The reception children and families were given in local health-care facilities affected how successfully they could enact individual and collective strategies to manage their interactions there. This study builds on prior research by considering how interactions are influenced by the physical sites they take place. The two health-care facilities in Greater Crenshaw handled children's brokering in similar ways, which is partially explained by the private practice being larger and better connected than most and the clinic having limited resources being spread across many specialties.

Providers in both locations were also similar; many referenced personal motivations to provide quality care to underserved families in their interviews. Children's brokering presented two challenges to these desires, from providers' perspectives. Many felt their professional identities were compromised by having to communicate through children. Their discomfort with being on the "front lines" with inadequate institutional support affected children's brokering and often resulted in providers knowing less about these families' needs than those of other residents. Constrained communication could therefore lead to differential access to needed resources for child brokers and their families.

Providers also held (largely unexamined) beliefs about appropriate roles for children that influenced how they communicated with brokers and their families. Children walked a cultural tightrope in order to help their families, remain respectful of parents, and manage expectations of providers who were discomfited by their active participation in these encounters. Providers sometimes inadvertently made this balancing act more difficult by talking only to child brokers or

to parents, rather than addressing both. Either case reflects embedded cultural assumptions about communication in health-care contexts being private discussions between providers and patients, not between providers and families. Providers who emphasized individuality in these ways, even unwittingly, strained families' abilities to manage interactions as a team.

Community-Level Features

Trickett and colleagues (2010:96) also noted that despite their relevance, almost no community-level information is provided in most studies of children's brokering. For example, the ethnic makeup of a community affects whether other adult residents can support children's brokering efforts or relieve them of certain responsibilities. This study was conducted in Los Angeles, which became the first U.S. city with as many Spanish- as English-speaking households in 2000, according to the Census that year. The fact that Spanish-speaking parents in Greater Crenshaw so frequently relied on their children to interact with health-care providers demonstrates that while regional demographics matter, immigrants' context of reception is indeed specific to a local community. The rapid demographic shift in Greater Crenshaw exposed how slowly resource-strapped institutions were able to respond to these changes. In the absence of needed accommodations, children acted as crucial linkages between their families, local institutions, and other community settings. One imagines that for immigrants from less demographically dominant groups, language access issues and dependence on their children may be even more acute.

Brokering Across Settings

While site-specific studies provide important context for children's brokering, families do not experience their communities as a set of discrete locations. Children may, for example, test a strategy that worked in a school meeting when they broker a health-care interaction. Data presented in this article were part of a larger study that explored children's brokering at home, in schools, social services, and health-care settings in Greater Crenshaw (Katz 2014). This multisited approach made it possible to identify how children and parents developed strategies at home and deployed them—with varying levels of success—in different institutional settings (e.g., schools and health-care facilities) and across institutions of a particular type (e.g., elementary and middle schools).

These within-level comparisons also helped assess how brokering responsibilities influenced children's developmental trajectories. By examining brokering activities across multiple settings, I found that children's family responsibilities could displace time for homework, after-school programs, and developing relationships with teachers (Katz 2014). The difficulties children had with "grown up stuff" and how they often "got stuck" brokering print media insinuate the consequences of these constraints. These struggles also reveal that child brokers were not always the fluent bilinguals they are sometimes presumed to be.

Prior research focused specifically on brokering and school achievement (e.g., Tse 1996) did not identify these time and energy displacements—they only become visible when examining multiple social settings simultaneously. Clearly, children's responsibilities to their immigrant parents have consequences for their families' social incorporation, but also for their own. Vivian Louie (2012) noted that a college education was not necessary for children of "old" immigrants to achieve intergenerational social mobility—it was often only the third or even fourth generation who pursued higher education (p. 14). For children of "new" immigrants in today's knowledge economy, higher education is increasingly a prerequisite for economic stability and social mobility (Portes and Fernández-Kelly 2008).

And yet, as Foner and Dreby (2011) noted, increased bureaucracy may lead to immigrant families depending on their children's assistance more now than in previous generations. How children's brokering in health-care and other community settings to address families' short-term survival needs might affect their chances of academic achievement in the long-term requires further study. This is a critical question for scholars concerned with immigrants'

incorporation, access to institutional and social resources, and equitable opportunities for the second generation.

Longitudinal studies are needed parse the effects and outcomes of children's brokering. So far, such studies have been limited (cf. Orellana 2009; Valdés 2003). Documenting settlement experiences of immigrant families over time can shed light on how children's brokering relates to the health disparities and other social inequalities that they and their low-income immigrant families are disproportionately likely to experience. The preceding discussion identifies ways that children's brokering efforts can help mitigate these inequalities and facilitate their families' access to resources and opportunities. However, it is possible that brokering may serve families' collective needs at the expense of children's individual desires, thereby addressing certain disparities while exacerbating others. These tradeoffs may vary within and across groups. Regardless, since immigrant integration is so often a family endeavor, children's active roles in these processes is a crucial element of understanding their and their families' social outcomes.

Appendix • *Study Participants Referenced*

Name	*Age*	*Research Method*
Alicia	12	Interview
Aurora	16	Interview
Evelyn	15	Interview
Graciela	13	Case study
Juana	15	Interview
Luis	11	Case study
Milagro	13	Interview
Sonia	14	Interview
Victoria	13	Interview
Hilda	44	Parent interview
Dr. Garber		Service provider interview (internal medicine in community clinic)
Ms. Jaramillo		Service provider interview (outreach worker for subsidized health insurance program)
Dr. Meeren		Service provider interview (pediatrician in community clinic)
Dr. Thomas		Service provider interview (pediatrician in private practice)
Dr. Victor		Service provider interview (pediatrician in private practice)

References

Aldridge, Jo. 2006. "The Experiences of Children Living With and Caring for Parents with Mental Illness." *Child Abuse Review* 15:79–88.

Barry, Christine A. 2002. "Multiple Realities in a Study of Medical Consultations." *Qualitative Health Research* 12:1093–111.

Bauman, Laurie J., Geoff Foster, Ellen J. Silver, Rebecca Berman, Ivy Gamble, and Lorraine Muchaneta. 2006. "Children Caring for their Ill Parents with HIV/AIDS." *Vulnerable Children and Youth Studies* 1:56–70.

Baym, Nancy. 2010. *Personal Connections in the Digital Age*. Cambridge, UK: Polity Press.

Bischoff, Alexander and Louis Loutan. 2004. "Interpreting in Swiss Hospitals." *Interpreting* 6:181–204.

Bourdillon, Michael, Deborah Levison, William Myers, and Ben White. 2010. *Rights and Wrongs of Children's Work*. New Brunswick, NJ: Rutgers University Press.

Buriel, Raymond and Terri De Ment. 1998. "Immigration and Sociocultural Change in Mexican, Chinese, and Vietnamese American Families." Pp. 165–200 in *Immigration and the Family*, edited by A. Booth, A. Crouter, and N. Landale. Mahwah, NJ: Lawrence Erlbaum Associates.

Butow, Phyllis N., David Goldstein, Melaine L. Bell, Ming Sze, Lynley J. Aldridge, Sarah Abdo, Michelle Tanious, Skye Dong, Rick ledema, Janette Vardy, Ray Ashgari, Rina Hui, and Maurice Eisenbruch. 2011. "Interpretation in Consultations with Immigrant Patients with Cancer: How Accurate is it? *Journal of Clinical Oncology* 29:2801–07.

Byng-Hall, John. 2008. "The Significance of Children Fulfilling Parental Roles: Implications for Family Therapy." *Journal of Family Therapy* 30:147–62.

Chao, Ruth K. 2006. "The Prevalence and Consequences of Adolescents' Language Brokering for their Immigrant Parents." Pp. 271–96 in *Acculturation and Parent-Child Relationships: Measurement and Development*, edited by M. Bornstein and L. R. Cote. Mahwah, NJ: Lawrence Erlbaum Associates.

Child Trends. 2010. "*Immigrant Children."* Retrieved February 12, 2012 (www.childtrendsdatabank.org/?q=node/333).

Clark, Lynn S. 2011. "Parental Mediation Theory for the Digital Age." *Communication Theory* 21:323–43.

Cline, Tony, Guida de Abreu, Lindsay O'Dell, and Sarah Crafter. 2010. "Recent Research on Child Language Brokering in the United Kingdom." Retrieved December 29, 2012 (http://mediazioni.sitlec.unibo.it).

Cohen, Suzanne, Jo Moran-Ellis, and Chris Smaje. 1999. "Children as Informal Interpreters in GP Consultations: Pragmatics and Ideology." *Sociology of Health & Illness* 21:163–86.

Documét, Patricia I. and Ravi K. Sharma. 2004. "Latinos' Health Care Access: Financial and Cultural Barriers." *Journal of Immigrant Health* 6(1):5–13.

Dorner, Lisa M., Marjorie Orellana, and Christine Li-Grining. 2007. "'I Helped my Mom' and it Helped Me: Translating the Skills of Language Brokers into Improved Standardized Test Scores." *American Journal of Education* 113:451–78.

Doty, Michelle M. and Alyssa L. Holmgren. 2006. *Health Care Disconnect: Gaps in Coverage and Care for Minority Adults*. Retrieved June 27, 2007 (www.commonwealthfund.org/publications/publications_show.htm?doc_id=38622).

Durham, Meenakshi. 2004. "Constructing the 'New Ethnicities': Media, Sexuality and Diaspora Identity in the Lives of South Asian Immigrant Girls." *Critical Studies in Media Communication* 21:140–61.

Eksner, H. Julia and Marjorie Orellana. 2012. "Shifting in the Zone: Latina/o Child Language Brokers and the Co-Construction of Knowledge." *Ethos* 40:196–220.

Elias, Nelly and Dafna Lemish. 2008. "Media Uses in Immigrant Families: Torn Between 'Inward' and 'Outward' Paths of Integration." *The International Communication Gazette* 70:21–40.

———. 2011. "Between Three Worlds: Host, Homeland, and Global Media in the Lives of Russian Immigrant Families in Israel and Germany." *Journal of Family Issues* 32:1245–74.

Erzinger, Sharry. 1999. "Communication between Spanish-Speaking Patient and their Doctors in Medical Encounters." Pp. 122–40 in *Rethinking Ethnicity and Health Care: A Sociocultural Perspective*, edited by G. Ma and G. Henderson. Springfield, IL: Charles C. Thomas.

Félix, Adrián, Carmen González, and Ricardo Ramírez. 2008. "Political Protest, Ethnic Media, and Latino Naturalization." *American Behavioral Scientist* 52:618–34.

Fiscella, Kevin and Ronald M. Epstein. 2008. "So Much to Do, So Little Time: Care for the Socially Disadvantaged and the 15-Minute Visit." *Archives of Internal Medicine* 168(17):1843–52.

Foner, Nancy and Joanna Dreby. 2011. "Relations between the Generations in Immigrant Families." *Annual Review of Sociology* 37:545–64.

Gálvez, Alyshia. 2011. *Patient Citizens, Immigrant Mothers: Mexican Women, Public Prenatal Care, and the Birth-Weight Paradox*. New Brunswick, NJ: Rutgers University Press.

García-Sánchez, Inmaculada and Marjorie Faulstich Orellana. 2006. "The Construction of Moral and Social Identities in Immigrant Children's Narratives-in-Translation." *Linguistics and Education* 17:209–39.

García-Sánchez, Inmaculada M. 2010. "(Re)shaping Practices in Translation: How Moroccan Immigrant Children and Families Navigate Continuity and Change." Retrieved December 29, 2012 (http://mediazioni.sitlec.unibo.it).

———. 2014. *Language and Muslim Immigrant Childhoods: The Politics of Belonging*. Hoboken, NJ: Wiley-Blackwell.

Goffman, Erving. 1959. *The Presentation of Self in Everyday Life*. New York: Anchor Books.

Gonzales, Roberto. 2011. "Learning to be Illegal: Undocumented Youth and Shifting Legal Contexts in the Transition to Adulthood." *American Sociological Review* 76(4):603–4.

Green, Judith, Caroline Free, Vanita Bhavnani, and Tony Newman. 2005. "Translators and Mediators: Bilingual Young People's Accounts of their Interpreting Work in Health Care." *Social Science and Medicine* 60(9): 2097–110.

Heritage, John and Douglas W. Maynard. 2006. "Problems and Prospects in the Study of Physician-Patient Interaction: 30 Years of Research." *Annual Review of Sociology* 32:351–74.

Hsieh, Elaine. 2007. "Interpreters as Co-Diagnosticians: Overlapping Roles and Services between Providers and Interpreters." *Social Science and Medicine* 64:924–37.

Ito, Mizuko, Sonja Baumer, Matteo Bittanti, danah boyd, Rachel Cody, Becky Herr-Stephenson, Heather A. Horst, Patricia G. Lange, Dilan Mahendran, Katynka Z. Martínez, C. J. Pascoe, Dan Perkel, Laura Robinson, Christo Sims, and Lisa Tripp. 2009. *Hanging Out, Messing Around, and Geeking Out: Kids Living and Learning with New Media*. Cambridge, MA: MIT University Press.

Jones, Curtis and Edison Trickett. 2005. "Immigrant Adolescents Behaving as Culture Brokers: A Study of Families from the Former Soviet Union." *The Journal of Social Psychology* 145(4):405–27.

Kam, Jennifer A. 2011. "The Effects of Language Brokering Frequency and Feelings on Mexican-Heritage Youth's Mental Health and Risky Behaviors." *Journal of Communication* 61:455–75.

Katz, Vikki S. 2010. "How Children Use Media to Connect their Families to the Community: The Case of Latinos in Los Angeles." *Journal of Children and Media* 4:298–315.

———. 2014. *Kids in the Middle: How Children of Immigrants Negotiate Community Interactions for their Families*. New Brunswick, NJ: Rutgers University Press.

Laroche, Helena H., Matthew M. Davis, Jane Forman, Gloria Palmisano, Heather Schacht Reisinger, Cheryl Tannas, Michael Spencer, and Michele Heisler. 2009. "Children's Roles in Parents' Diabetes Self-Management." *American Journal of Preventative Medicine* 37(6):S251–S261.

Leduc, Nicole and Michelle Proulx. 2004. "Patterns of Health Services Utilization by Recent Immigrants." *Journal of Immigrant Health* 6(1):15–27.

Lippi-Green, Rosina. 1997. *English with an Accent: Language, Ideology, and Discrimination in the United States*. London, UK: Routledge.

Livingstone, Sonia and Ellen J. Helsper. 2007. "Gradations in Digital Inclusion: Children, Young People and the Digital Divide." *New Media and Society* 9(4):671–96.

Louie, Vivian. 2012. *Keeping the Immigrant Bargain: The Costs and Rewards of Success in America*. New York: Russell Sage Foundation.

Meyer, Bernd, Birte Pawlack, and Ortrun Kliche. 2010. "Family Interpreters in Hospitals: Good Reasons for Bad Practice?" Retrieved December 29, 2012 (http://mediazioni.sitlec.unibo.it).

Mohanty, Sarita A., Steffie Woolhandler, David U. Himmelstein, Susmita Pati, Olveen Carrasquillo, and David H. Bor. 2005. "Health Care Expenditures of Immigrants in the United States: A Nationally Representative Analysis." *American Journal of Public Health* 95(8):1–8.

O'Dell, Lindsay, Sarah Crafter, Guida de Abreu, and Tony Cline. 2010. "Constructing 'Normal Childhoods': Young People Talk about Young Carers." *Disability and Society* 25(6):643–55.

Orellana, Marjorie, Lisa M. Dorner, and Lucila Pulido. 2003. "Accessing Assets: Immigrant Youth's Work as Family Translators or 'Para-Phrasers'." *Social Problems* 50(4):505–24.

Orellana, Marjorie F. 2009. *Translating Childhoods: Immigrant Youth, Language and Culture*. New Brunswick, NJ: Rutgers University Press.

Park, L. 2002. "Asian Immigrant Entrepreneurial Children." Pp. 161–77 in *Contemporary Asian American Communities: Intersections and Divergences*, edited by L. T. Võ and R. Bonus. Philadelphia, PA: Temple University Press.

Perloff, Richard M., Bette Bonder, George B. Ray, Eileen B. Ray, and Laura A. Siminoff. 2006. "Doctor-Patient Communication, Cultural Competence, and Minority Health: Theoretical and Empirical Perspectives." *American Behavioral Scientist* 49(6):835–52.

Pew Research Center. 2011. *Demographics of Internet Users*. Retrieved January 22, 2012 (www.pewinternet.org/Static-Pages/Trend-Data/Whos-Online.aspx).

Portes, Alejandro. 2010. "Migration and Social Change: Some Conceptual Reflections." *Journal of Ethnic and Migration Studies* 36:1537–63.

Portes, Alejandro and Patricia Fernández-Kelly. 2008. "No Margin for Error: Educational and Occupational Achievement among Disadvantaged Children of Immigrants." *Annals of the American Academy of Political and Social Science* 620:12–36.

Post, Douglas M., Donald J. Cegala, and William F. Miser. 2002. "The Other Half of the Whole: Teaching Patients to Communicate With Physicians." *Family Medicine* 34(5):344–52.

Pyke, Karen. 2005. "'Generational Deserters' and 'Black Sheep': Acculturative Differences among Siblings in Asian Immigrant Families." *Journal of Family Issues* 26(4):491–517.

Rideout, Victoria, Ulla Foehr, and Donald Roberts. 2010. *Generation M2: Media in the Lives of 8- to 18-year-olds*. Menlo Park, CA: Kaiser Family Foundation.

Riyadeneyra, Rocio, Virginia Elderkin-Thompson, Roxane C. Silver, and Howard Waitzkin. 2000. "Patient Centeredness in Medical Encounters Requiring an Interpreter." *American Journal of Medicine* 108(6):470–74.

Sargent, Carolyn and Stéphanie Larchanché. 2011. "Transnational Migration and Global Health: The Production and Management of Risk, Illness, and Access to Care." *Annual Review of Anthropology* 40:345–61.

Siegal, Rebecca, Vilma Cokkinides, Ahmedin Jemal, and Elizabeth Ward. 2006. *Cancer Facts and Figures for Hispanics/Latinos, 2006–2008*. Atlanta, GA: American Cancer Society.

Small, Mario L. 2006. "Neighborhood Institutions as Resource Brokers: Childcare Centers, Interorganizational Ties, and Resource Access among the Poor." *Social Problems* 53(2):274–92.

——— .2010. *Unanticipated Gains: Origins of Network Inequality in Everyday Life* Oxford, UK: Oxford University Press.

Song, Miri. 1999. *Helping Out: Children's Labor in Ethnic Businesses*. Philadelphia, PA: Temple University Press.

Street, Richard L. 2003. "Communication in Medical Encounters: An Ecological Perspective." Pp. 63–94 in *Handbook of Health Communication*, edited by T. Thompson. Mahwah, NJ: Lawrence Erlbaum Associates.

Taylor, Janelle. 2003. "Confronting 'Culture' in Medicine's 'Culture of No Culture'." *Academic Medicine* 78:555–59.

Taylor, Steven J. and Robert Bogdan. 1998. *Introduction to Qualitative Research Methods*. 3d ed. New York: John Wiley.

Trickett, Edison, Sandra Sorani, and Dina Birman. 2010. "Towards an Ecology of the Culture Broker Role: Past Work and Future Directions." Retrieved December 29, 2012 (http://mediazioni.sitlec.unibo.it).

Tse, Lucy. 1995. "Language Brokering among Latino Adolescents: Prevalence, Attitudes, and School Performance." *Hispanic Journal of Behavioral Sciences* 17:180–93.

———. 1996. "Who Decides?: The Effect of Language Brokering on Home-School Communication." *The Journal of Educational Issues of Language Minority Students* 16:225–33.

Urban Institute. 2009. *Children of Immigrants*. Retrieved January 22, 2012 (http://datatool.urban.org/charts/datatool/pages.cfm).

Valdés, Guadalupe. 2003. *Expanding Definitions of Giftedness: The Case of Young Interpreters From Immigrant Communities*. New York: Routledge.

Valenzuela, Abel.1999. "Gender Roles and Settlement Activities among Children and their Immigrant Families." *American Behavioral Scientist* 42(4):720–42.

Vernig, Peter M. 2011. "Family Roles in Homes with Alcohol-Dependent Parents: An Evidence-Based Review." *Substance Use & Misuse* 46(4):535–42.

Vygotsky, Lev. 1978. *Mind in Society: The Development of Higher Psychological Processes*. Cambridge, MA: Harvard University Press.

Watkins-Hayes, Celeste. 2009. *The New Welfare Bureaucrats: Entanglements of Race, Class and Policy Reform*. Chicago: University of Chicago Press.

Watson, Bernadette and Cindy Gallois. 2004. "Emotional Expression as a Sociolinguistic Strategy: Its Importance in Medical Interactions." Pp. 63–84 in *Language Matters: Communication, Culture and Identity*, edited by Sik Hung Ng, Christopher Candlin, and Chi Yue Chiu. Hong Kong: City University of Hong Kong Press.

Weisskirch, Robert and Sylvia Alva. 2002. "Language Brokering and the Acculturation of Latino Children." *Hispanic Journal of Behavioral Sciences* 24:369–78.

Willen, Sarah. S. 2011. "Pas de Trois: Medical Interpreters, Clinical Dilemmas, and the Patient-Provider-Interpreter Triad." Pp. 70–94 in *Shattering Culture: American Medicine Responds to Cultural Diversity*, edited by Mary-Jo DelVecchio Good, Sarah S. Willen, Seth Hannah, Ken Vickery, and Larry Park. New York: Russell Sage Foundation.

Wong, Janelle and Vivian Tseng. 2008. "Political Socialization in Immigrant Families: Challenging the Top-down Parental Socialization Models." *Journal of Ethnic and Migration Studies* 34(1):151–68.

Zelizer, Viviana. 1985. *Pricing the Priceless Child: The Changing Social Value of Children*. Princeton, NJ: Princeton University Press.