First Impressions:

Improving the Connection between Deaf Consumers and ASL/English Interpreters

by

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ABSTRACT

This dissertation examines the first impressions that occur between Deaf consumers and American Sign Language (ASL)/English interpreters prior to a healthcare appointment. Negative first impressions can lead to a disconnect or loss of trust between Deaf consumers and interpreters and increase the risk for Deaf consumers to receive inadequate healthcare. The recognition of this risk led to an action research study to look at barriers to successful interactions between ASL/English interpreters and Deaf consumers. The mixed methods research design and associated research questions discovered factors and perceptions that contributed to the disconnect and subsequently informed a 10-week intervention with a small group of ASL/English interpreters and Deaf consumers. The factors that influence connection are system related and a lack of a standardized approach to using name badges, missing or incorrect appointment details, and an inconsistent protocol for interpreter behavior when a healthcare provider leaves the room. The intervention allowed the interpreter participants to generate solutions to mitigate these barriers to connection and apply them during the 10 weeks. Deaf consumer feedback was gathered during the intervention period and was used to modify the generated solutions. The generated solutions included re-design of an interpreter referral agency's name badge, using small talk as a way to learn information about the nature of the healthcare appointment and proactively discuss procedures when a healthcare provider leaves the exam room. These solutions resulted in a positive influence for both interpreters and Deaf consumers and an increase of trust and connection. The findings of this study show new approaches that create a connection between interpreters and Deaf consumers and may lead to more satisfactory healthcare interactions for Deaf consumers.

DEDICATION

“It is good to have an end to journey toward, but it is the journey that matters in the end.”

– Ursula K. Le Guin

This journey began and ended with the support of the most important people in my life – my husband, Eric, and our three children. None of this would be possible without their unfailing support and belief in my dream. Eric, words are inadequate to show how much your love and support have been a lifeline for me these past several years. Thank you for being the laundry master, head chef, back-up chauffeur, bringer of late-night snacks, cheerleading captain, shoulder to cry on, and guardian of the study zone. You are my forever knight in shining armor and I love you. Olivia, D’Artagnan, and Sophia, you are the reasons behind my dream of advancing my education. The best thing I’ve ever done in my life is being your mom and having your hugs, smiles, laughter and love to be my guiding stars. I love you more than my heart can hold. Thank you to my mom and dad for instilling in me a fierce work ethic and a love for people. Pops, this one’s for you and I know you are smiling from above.

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CHAPTER 1

LEADERSHIP CONTEXT AND PURPOSE OF THE STUDY

Imagine that you are a Deaf person who uses American Sign Language (ASL) and you need to make a healthcare appointment. You contact the doctor's office using a Video Relay Service (VRS) to make an appointment and inform the receptionist that you will need a sign language interpreter for your visit. The receptionist tells you that she will do her best to arrange one and that your appointment is in three days. You hang up from the VRS call, uncertain that the person in the healthcare office knows how to arrange an interpreter or, even if they do, who that interpreter will be. When the day of the appointment arrives, you hope for the best and arrive at your appointment 15 minutes ahead of the scheduled time. You sit in the waiting room, anxiously watching each person coming into the room, looking for some sign that an interpreter has been provided. Numerous people come in and out until finally you notice the receptionist speak to a woman and then point directly at you. There is nothing identifying this person other than a solid-colored top and when she sees you, she nods and walks over to sign, "My name is Sue, I'm your interpreter." Sue does not spend time in 'small talk' and simply lets you know that it's time for your appointment. As you walk to the exam room, you notice that your anxiety level has risen from worrying about your healthcare issues to also worrying if the interpreter will understand you, if you will understand her, and if she will be able to interpret effectively between you and the doctor.

In contrast, on your follow-up visit, you are in the waiting room again when a woman comes in and you notice a name badge clipped to her sweater and recognize the logo of your favorite interpreter referral agency. After checking in with the receptionist, *she walks directly over to you and introduces herself as Nancy, the interpreter. You can now read the identification tag on her lapel that includes her name and the agency she works for. Nancy also shares the appointment details she received prior to the appointment and asks you to verify that the reason for your appointment matches what she was given. While you wait to be called back to the exam room, the two of you chat and Nancy shares how she learned sign language. During the conversation you also learn that you have a mutual Deaf friend, and Nancy asks you if you are aware of an agency policy related to what she will do if the healthcare provider leaves the room. You have gotten a chance to see Nancy's signing fluency and she has made you feel comfortable. You experience a feeling of relief and are confident that you can trust Nancy to provide interpreting for your appointment.*

In this hypothetical story, some of the barriers to connection started before the interpreter ever interacted with the Deaf consumer. Specifically, when the Deaf consumer initiated a request for accommodation for a healthcare appointment, there was uncertainty about whether an interpreter would even be provided. Once an interpreter is scheduled, the Deaf consumer is still left wondering which interpreter will be assigned to the healthcare appointment and how to recognize the interpreter if they are unfamiliar. These levels of uncertainty are created in systemic processes and can also contribute to the disconnect with interpreters. However, as noted in the above example, Nancy, mitigated these barriers by wearing clear identification and engaging in small talk to discuss topics that increased trust.

As an ASL interpreter and educator, I have experienced creating first impressions with Deaf consumers and seen how connections, formed in in the first few minutes of interaction, can have lasting effects, both positive and negative. The experiences that I’ve had interpreting for healthcare appointments, while using soft skills to create a positive first impression, were less stressful to interpret and I left feeling that I had created a connection with the Deaf consumer. I used my soft skills to build connection with the Deaf consumer, healthcare provider, and anyone else involved. However, there were times that I didn’t have all the appointment details, was rushing from another appointment, or some other barrier left me with no time to chat with a Deaf consumer before an appointment and it was not a positive experience – likely for anyone involved. In fact, my lack of connection with a Deaf consumer might have led to a less than optimal healthcare experience for them, putting them at an increased risk.

During my years of practice, I have seen how using soft skills, like interpersonal skills, can mitigate barriers that are outside my control. I have also noticed that the burden for connection does not rest solely with the interpreter. Connection or disconnection also comes from systemic issues that impact the interaction between Deaf consumers and interpreters. These systemic barriers are not always known or identified and blame has historically been placed on the individuals involved, not the system. My research study arose from my desire to learn more about systemic barriers and whether my experiences were common to other interpreters and Deaf consumers. I also wanted to collect data that would show how healthcare interpreting for Deaf consumers could be improved through the intentional use of soft skills to create connection and trust. It is my assertion that connection between interpreters and Deaf consumers is rooted in both the soft skills of interpreters and the use of those skills to lessen any negative impact from larger professional and healthcare system barriers.

ASL/English Interpreter Soft Skills to Create First Impressions

The hard thing about soft skills is that they are difficult to define and measure. However, most people can identify another person who does or doesn’t have them. Soft skills are various skills such as communication and interpersonal skills, emotional intelligence, leadership qualities, team skills, negotiation skills, time and stress management and business etiquettes” (Deepa & Seth, 2013, p. 7). At a social level, conversational skills and appropriate use of social etiquette can help to create good first impressions, which last for a long time (Sharma, 2018, p. 27). Soft skills are also vital to success in interpreted interactions, as shown by the hypothetical story in the beginning. Within the Deaf and sign language interpreter communities, the definition of soft skills has been explained as possessing a ‘Deaf heart’ (Colonomos, 2013), disposition (Bontempo, Napier, Hayes, & Brashear, 2014), or attitude (Napier, 2011). According to an article in Street Leverage by Betty Colonomos (2013), ‘Deaf Heart’ can be defined as interpreters who:

> Reflect on how their choices and decisions affect the Deaf Community; they question their practices that seem to be oppressive or damaging to the lives of Deaf people; they own their mistakes and share them with others. Most importantly, they seek input and advice from Deaf people and are not afraid to be uncomfortable with Deaf people’s responses and viewpoint.

Improvement of soft skills has been a desired component of interpreter education since its early years. One of the early examples given by Dennis Cokely (1986) stated that there must be a focus on “participant/consumer interaction paradigms (one-to-one, small group, large group) in a range of realistic discourse settings (e.g. social services, educational, medical, legal) in order to understand how participant interaction affects or should affect the interpretation process" (p. 12). Often an interpreter's soft skills are what creates first impressions and allows him/her to manage this spectrum of contexts and diverse consumers. Specifically, an interpreter that successfully uses soft skills can create a connection with the Deaf consumer that can be used to navigate and compensate for linguistic gaps and errors. In like manner, a Deaf consumer that trusts the interpreter will be more confident in asking for clarification, repetition, and feel empowered to express themselves openly.

A publication from the Disabilities, Opportunities, Internetworking, and Technology Center (Do-It Center) (2005) included findings from conversations with Deaf people that showed a consensus that entry-level practitioners would benefit from more attention to soft skills (Witter-Merithew, Johnson & Registry of Interpreters for the Deaf, 2005). However, there is not a standardized approach to the instruction of these soft skills. Many interpreter education programs focus on linguistic aspects of the interpreting process (Turner & Harrington, 2001; Pöchhacker & Shlesinger, 2002; Janzen & Korpiniski, 2005; Locker, McKee, & Davis, 2010) and quality of the sign language interpretation (Cokely & Winston, 2008, 2009; Napier, 2003; Napier & Barker, 2004; Napier & Rohan, 2007). However, research related to the non-linguistic aspects of interpreting is limited.

Much like the hypothetical story in the beginning, ASL/English interpreters must utilize their soft skills to create first impressions that can build trust, connect with consumers, and negotiate an interpreted event. Research has encouraged interpreter education programs to "pay attention to their students' personalities as well as to their academic backgrounds and cognitive abilities" (Stewart, Schein, & Cartwright, 1998, p. 75). This research encourages educators to look at the soft skills of their students, in addition to the linguistic skills, and determine how the two are inter-related. Soft skills research for interpreters has been focused on aptitude (Pöchhacker & Shlesinger, 2002) and personality factors and as a predictor of interpreter success (Shaw & Hughes, 2006). While the individual interpreter brings his or her personality and aptitude into an education program, the responsibility for transforming their innate skills to the interpreting process lies with the education process. A lack of direct instruction, application, or experience with how the appropriate use of soft skills impacts the connection with Deaf consumers may result in negative interpersonal interactions, or first impressions between Deaf consumers and sign language interpreters.

As explained earlier, the Deaf community is already at risk with healthcare outcomes before an interpreter is involved. According to Kritzinger, Schneider, Swartz, and Braathen (2014) even if the best possible interpreting services were available in healthcare services, "Deaf people who have grown up in exclusionary and discriminatory contexts (in all probability, most deaf people in the world) have additional barriers to navigate" (p. 383). Once an ASL/English interpreter is added to a healthcare interaction, that does not guarantee a successful outcome. On the contrary, according to an article by Hommes, Borash, Hartwig, & DeGracia (2018), when ASL interpreters were surveyed about their perceptions of an interpreted healthcare event, they identified that "In nearly half of appointments there appeared to be medication misunderstandings for the Deaf and HOH patient" (p. 960) and Nicodemus, Swabey, & Moreland (2014) emphasized a need for interpreters to consistently translate medication instructions for Deaf and Hard of

Hearing patients to avoid potentially dangerous mistakes. Any established challenges for a Deaf consumer would be compounded when working with an ASL/English interpreter that lacked a connection or feeling of trust. However, any challenges or breakdowns in communications could be mitigated when interpreters use initial interactions to establish trust with a Deaf consumer that allows them to feel comfortable in asking for clarification or additional information. For the Deaf consumer, and in cases of high-risk situations, like healthcare or legal situations, a lack of trust and connection with the interpreter can have catastrophic consequences.

The Interpreting Profession

ASL/English interpreters, whether full-time, part-time, self-employed or retired, typically engage in work through agency referral. According to published data in 2013, in the United States, there are approximately 180 individually owned and operated referral agencies (www.nad.org) that exclusively provide sign language interpreter referrals. However in the last few years, that number has grown to include spoken language referral agencies that recruit and utilize sign language interpreters as a way to increase revenue. These spoken language interpreter referral agencies do not have connections to the Deaf community, an understanding of Deaf culture, or extensive knowledge on the role of signed language interpreters. In addition, there are numerous state agencies for the Deaf and Hard of Hearing and offices of Vocational Rehabilitation that often provide referral services for signed language interpreting as mandated by Section 504 of the Rehabilitation Act of 1973 (www.ada.gov). Despite not having an exact number of referral agencies, it is estimated by the Bureau of Labor Statistics that between 2018 and 2028, the employment of interpreters and translators is projected to grow 19 percent which would also translate to a growth in the number of referral agencies; agencies that may or may not understand and incorporate the Deaf consumer into their policies and procedures.

Each interpreter referral agency will provide services from both staff and contract interpreters who are employed in a variety of contexts, including healthcare. Interpreters within these agencies provide services in their local community, neighboring communities and potentially nation-wide. Healthcare providers contract with qualified interpreters for Deaf patient appointments and have been encouraged to avoid using health care staff, minor children, accompanying adults, or unqualified individuals (Jacobs, Ryan, Henrichs, & Weiss, 2018) to provide interpretation. Additionally, most large health-care systems contract annually with local agencies for interpreting to "make reasonable modifications or otherwise provide auxiliary aids and services at no additional costs to the patient in order to comply with the statutes" (Ali, 2012, p. 31). The procedure that a Deaf consumer undertakes when requesting an interpreter is not clear-cut and is fraught with potential barriers that can occur at the healthcare provider level, the language service coordination level, and the interpreter referral agency level before the appointment even begins. With so many opportunities for information to be relayed incorrectly, lost, or forgotten, these barriers often result in the Deaf consumer and interpreter beginning a healthcare appointment at a disadvantage.

An additional barrier that may be indirectly affecting connections between ASL/English interpreters and Deaf consumers has been a growing divide and unrest between the Deaf community and interpreting community. The National Interpreter Certification (NIC), the national test for ASL/English interpreters, was originally developed as a joint effort between National Association of the Deaf (NAD) and the Registry of Interpreters for the Deaf (RID). This work between NAD and RID and provided a collaborative environment for the Deaf and interpreting organizations to work together. On August 4, 2015, RID announced an independent decision to place the NIC exams on a moratorium (www.rid.org). As a result of the moratorium and unresolved requests, in 2016 the NAD board voting unanimously to cease partnership with RID on the NIC testing. As a result, a growing divide was deepened between the two communities and it is in this climate that Deaf consumers encounter interpreters they don’t know, or with whom they are less familiar, further emphasizing the importance for connection in the initial interaction between Deaf consumer and ASL/English interpreter.

Context and Researcher Positionality

I have worked as a nationally certified ASL/English interpreter for over 25 years and been employed in a variety of settings. Additionally, for the past 15 years I have been an educator, and workshop presenter for local, state, national, and international conferences. My own journey as a sign language interpreter began with learning American Sign Language while serving a religious mission. I did not have formal instruction in interpreting outside the missionary training. However, as an outsider, I was embraced by the Deaf communities and they taught me their language and culture through daily interactions. I learned to interpret by simply doing it and relied on continual feedback from Deaf community members to correct me, teach me vocabulary, and guide me in the cultural nuances of the language. My next step was to interpret in the community in a variety of settings and continue my training, ‘on the job’ with the Deaf community. I had Deaf friends, Deaf employers, Deaf co-workers and experienced interpreters that provided ongoing mentoring. I interpreted for many years with a state certification and in 1999 I became a nationally certified interpreter and transliterator. After becoming nationally certified, I continued to work in the community, in educational settings, in Video Relay Service, and religious settings. After several years I felt that I could be considered an insider and use my knowledge and experience to educate others, beginning with workshops for continuing education and eventually as an adjunct instruction in interpreter education programs. Eventually I did return to school and received my bachelor's degree in Deaf Studies with an emphasis in interpreting and completed my graduate work in ASL/English Interpreting with an emphasis in pedagogy. Even as I have taken on these various roles, I keep my certification current and accept interpreting work in the community to keep my skills current and my connections strong with the Deaf and interpreting communities. I work with an interpreter referral agency and am intimately connected to the context for this research.

As an interpreter, workshop presenter, mentor, assessment team member, and educator, I have gained a unique base of experience incorporating practitioner, student, and educator perspectives. The situations that have had the greatest impact on my own learning and development have been within a healthcare setting. My work as an interpreter and interpreter educator has heightened my awareness of the imbalance of power between interpreters and Deaf consumers and the understanding that Deaf consumers enter most interpreted interactions at a distinct disadvantage. As a specific example with healthcare interpreting, my knowledge spotlights the disadvantage for Deaf consumers in potentially high stakes circumstances and how a lack of connection with interpreters can result in life-threating consequences.

In addition to my own practice experience, as an educator, I have had opportunity to observe newer interpreters and Deaf consumers interacting in a myriad of combinations. During my observations as a mentor and faculty member, I have worked with less experienced interpreters and note they can struggle with interpersonal skills, specifically maintaining a positive attitude and feeling confident during interactions with Deaf consumers. Common feedback from both Deaf consumers and interpreters has been that there is a lack of understanding of Deaf culture, a 'bad attitude,' an overly critical approach to feedback from Deaf consumers, and feelings of frustration that often lead to newer interpreters being unable to build trust, connect with Deaf consumers, or even obtain meaningful employment. It is my belief, based on 30 years of experience, that Deaf consumer's perceptions are formed in the initial interactions prior to an interpreted event and can be categorized as first impressions.

The balance of linguistic skills and soft skills for interpreters is important for achieving effective interpretation. The soft skills of personality, disposition, attitude, friendliness, and flexibility—often mentioned in casual discussions between the Deaf and the interpreting communities—are not only challenging to define but also to teach to those wanting to become successful interpreters. Each of the soft skills mentioned in the previous sentence work to creating a first impression between interpreter and Deaf consumer. These first impressions influence connection and trust, an important foundation that can support the linguistic skills used for effective interpreting. In order to create instructional material for students and improve practice for interpreters and agency referral business, it is important that data be collected in real-world environments and that innovative ideas be implemented with practitioners and Deaf patients.

One approach to educating interpreters on how to improve connections with Deaf consumers has been to invite a guest speaker to talk about “Deaf Heart” or how to incorporate more empathy towards Deaf consumers and seeing them as people—not just a commodity or job (Colonomos, 2013; Decker, 2015). Additionally, I have facilitated ‘mock interpreting’ experiences with Deaf consumers in settings outside of the traditional classroom. These learning experiences have occurred in high schools, healthcare facilities, concert venues, and other settings. Participants reported in program evaluations and informal discussions that they enjoyed these experiences and felt they were beneficial. However, specific data related to perceptions of first impressions and the use of interpersonal skills, prior to the actual interpreted event, was not collected. With that in mind, collecting data in real-world interpreted events would highlight the barriers and potential solutions for overcoming those barriers that would not inherently be part of mock interpreting situations.

My dissertation study extended my work as an interpreter educator by addressing what factors influence an interpreters’ initial interactions with Deaf patients and how the first impressions created in that interaction can influence connection with Deaf consumers. The ultimate result of the study would provide data on how to improve the interactions between interpreters and Deaf consumers, prior to a healthcare interpreting event, and result in a better connection for all participants.

Purpose of Study, Intervention, and Research Questions

This action research study looked at how interpreter soft skills and other factors contribute to first impressions that occur during the initial interaction between ASL/English interpreters and Deaf consumers. Specifically, the research examined what external factors, as well as the interpreter's use of greeting and introduction, were important to establishing connection between interpreter and Deaf consumer prior to the interpreted event and how interpreted events could be influenced to increase satisfaction for both parties. Often first impressions are formed during those pre-interpreting event encounters, and "the relational decisions generated therein have a strong and lasting influence on relationships" (Sunnafrank & Ramirez, 2004, p. 1). In order to study and influence behaviors that contributed to successful interactions between ASL/English interpreters and Deaf patients, my action research project included an intervention that incorporated working with interpreters to create practical solutions to enhance interactions between Deaf patients and interpreters.

As mentioned in the first section, when a Deaf patient wants to see a doctor, make an appointment at a clinic, visit the ER, or arrange a hospital procedure, they most often request an interpreter through the healthcare provider, who then works with an interpreter referral agency. For many larger healthcare systems, requests for interpreters are handled by a language services coordinator who fill the request using a list of approved, contracted agencies. Therefore, the referral agencies are on the front lines of coordinating services for Deaf patients with their pool of contract interpreters. While some hospitals and other healthcare providers are also utilizing Video Remote Interpreting (VRI) to satisfy demand for interpreters (Napier, Skinner & Turner, 2017), VRI was outside the scope of my research project and will not be addressed here.

In order to strengthen the identification of a problem of practice, I utilized my knowledge of trends on a national level to conduct preliminary cycles of research as part of my doctoral coursework. The first preliminary cycle included interviews with five colleagues that were working interpreters as well as interpreter educators. The participants were two Deaf participants and three hearing participants. I asked questions to elicit information about ASL/English interpreter’s interpersonal skills, Deaf consumer experiences, and potential ideas for remediation for newer interpreters. All respondents mentioned the need for a positive attitude for interpreters. Attitude was not defined but their responses led me to conclude that a positive attitude included friendliness, openness, willingness to work with the Deaf consumer, and use of cultural norms. The participants also mentioned a need for interpreters to have more exposure to interpersonal skill remediation where the Deaf community would be involved in real-world, interactive practice.

The next preliminary cycle included interviews with five Deaf consumers and a focus group with six Deaf consumers. For the interviews, I asked the Deaf consumers what they felt contributed to successful relationships with ASL/English interpreters and to provide ideas for what interpreters could do differently when interacting with Deaf consumers before an interpreted assignment. All respondents mentioned the need for being included in the interactions that occur at interpreted appointments. The responses ranged from wanting the interpreter to use simultaneous communication when speaking to office personnel, to the interpreter keeping the Deaf consumer better informed about the details surrounding an appointment. When attitude was mentioned, friendliness, openness, willingness to work with the consumer, and use of cultural norms were included. The responses from the interviews were then used to create three video scenarios that were used in the focus group. The video scenarios are explained in further detail in Chapter Three as they were also used in the intervention. The focus group participants provided reactions to the video scenarios and the qualitative analysis of the focus group responses showed themes centered on inclusion and a desire for the Deaf consumer to have more information. While the theme of interpreter attitude did not show up in the findings, I concluded that a bad/good attitude perception of an interpreter may actually be rooted in a Deaf consumer's desire to be informed and included in the pre-appointment process.

The final preliminary cycle included dyad interviews with two pairs of ASL/English interpreters and Deaf consumers. The interviews were held immediately after a healthcare appointment. In addition, I also interviewed a sign language interpreter referral agency representative. For the dyad interviews I asked the participants: 1) Who was first to arrive at the healthcare appointment? 2) What information each participant had, prior to the medical appointment? and 3) What information was provided by the interpreter referral agency? The themes that emerged showed that there was not consensus about who typically arrives first, and that the interpreter participants had more information about the Deaf consumers than the Deaf consumers had about the interpreters. After the dyad interviews, I also interviewed a sign language interpreter referral agency representative. During the interview, I specifically asked about the disparity in information and details about the process of obtaining information for scheduling interpreters. The response highlighted barriers that prevent an agency from getting full details and information to share with the interpreter or Deaf consumer. Those barriers included the use of language coordination departments, a service many healthcare providers use, and HIPAA concerns within the healthcare system.

The data gathered in these cycles influenced the development of my research questions, methodology, and the intervention. During the focus groups with Deaf consumers, they proposed ideas that were related to interpreter identification and small talk. The Deaf consumers also discussed wanting a connection with interpreters both during and outside interpreted events and provided greeting ideas that became the video scenarios I used in the first research meeting of the intervention. My interactions with Deaf consumers, interpreters, a representative of an interpreter referral agency, and colleagues during those preliminary cycles of research formed the foundation of experience and perspectives I used going into this research project.

As a result of my experience, I determined that the context for this research would be on a local level, involving the Deaf and interpreting communities that I was most familiar with. I knew that I needed to partner with an interpreter referral agency in order to gain access to healthcare interpreting work in Utah and neighboring states. The state of Utah has several small interpreter referral agencies; however, for this project I selected a larger interpreter referral agency that held contracts with several large healthcare organizations in both Utah and Nevada. The agency provides services in both states and their contracted interpreters that live in Utah will often travel to Nevada to provide services, and vice versa. This unique interpreter referral agency allowed for a broader base of experience in both interpreters, Deaf consumers, and healthcare systems.

The target sample population included certified, working interpreters of varying years of experience and credentials, as well as Deaf consumers that used ASL as their primary language and worked with those specific interpreters. The interpreter referral agency provided a list of their interpreters that fit the requirements of the study, based on the individual interpreter's frequency of assignment to healthcare settings and, when possible, provided contact information for the associated Deaf consumers.

In the intervention, I engaged with a group of professional interpreters from the referral agency for an intervention that lasted 10 weeks. Together, we met online three times to discuss the disconnect with Deaf consumers and generated solutions on how to mediate the connection during the period where first impressions are formed. The initial meeting included sharing some of my findings from preliminary cycles of research with Deaf consumer focus groups and interviews, and also included Deaf consumer comments related to wearing clear identification and greeting prior to checking in with the front desk. I led the group in discussion about feasible strategies and methods of implementation. The interpreters then applied the generated solutions during professional practice for two weeks before the next research meeting and reported their experiences to me and the other interpreters in the group. During the second and third research meetings, I shared Deaf consumer feedback, collected from satisfaction surveys during the preceding two weeks, and we discussed and agreed on ways to incorporate that feedback on the next iteration of solutions. The participants again applied solutions and met with me one final time before applying the last round of solutions. In this manner, the interpreters and I worked together to co-create ideas for improving the first impressions with Deaf consumers in an authentic setting of professional practice. The goal of my research was to support the idea that connections between Deaf consumers and ASL/English interpreters are substantially influenced by first impressions and soft skills.

My research, used an action research approach and a mixed methods design, to address the following research questions:

RQ1: What factors influence the connection between Deaf consumers and interpreters?

RQ2: How do interpreters and Deaf consumers describe and perceive the interaction prior to an interpreted healthcare appointment?

RQ3: How did the co-constructed solutions influence the connection between Deaf consumers and interpreters?

CHAPTER 2

THEORETICAL PERSPECTIVES AND RESEARCH GUIDING THE PROJECT

Chapter One provided an overview of the context and rationale for my proposed study. In that chapter, I highlighted the local and national perspectives that have influenced the current state of interpreting as well as my problem of practice. In addition, I briefly outlined the innovation that entailed working with professional interpreters to generate solutions to mediate the disconnect with Deaf consumers prior to healthcare appointments. Chapter Two will review pertinent literature about the conventions related to the Deaf community's identification, ASL pragmatics, experiences with interpreters, and the Deaf consumer's increased risk for compromised healthcare. The professionalization of interpreting, including legislation that impacted the growth of the interpreting profession, the evolution of interpreter education, curricular components, current research in healthcare interpreting, and the Deaf community's perspective will also be explored.

Next, I will discuss my theoretical framework, which includes Sociocultural and Experiential Learning Theories as they apply to how interpreters' practices and my intervention. The ability to facilitate communication between Deaf consumers and people who don't know American Sign Language is the core responsibility of an interpreter – a responsibility situated within a human relationship. President Franklin D. Roosevelt said, "Today we are faced with the preeminent fact that, if civilization is to survive, we must cultivate the science of human relationships... the ability of all peoples, of all kinds, to live together, in the same world, at peace." While a myriad of successful relationships are built between nations, states, organizations, and businesses, core relationships are built between two individuals. In the case of ASL/English interpreters and the Deaf consumers they work with, Mason and Ren (2012) state that interpreters embody an interactional power that is employed through “various verbal and non-verbal strategies to negotiate, coordinate, check, and balance power relations” (p. 238). This interactional power is central to a successful relationship between a Deaf person and a hearing person. If the power is imbalanced, misused, or weakened by misinterpretation, the impact will be felt by the Deaf consumer, the hearing service provider, and the interpreter. Thus, studying this dynamic and impact through the lens of Sociocultural Theory and Experiential Learning Theory will shed light on not only how the initial relationship is formed, but also how to improve the disconnect that occurs when the interactional power is not ideal.

Literature Review

The Deaf Community

Statistics related to hearing loss and Deafness in the United States are best found in the Annual Disability Statistics Compendium. In 2016, there were 40,852,226 individuals living in the community with disabilities, 11,430,339 of which were individuals with a hearing disability—28.0 percent (disabilitycompendium.org). In the United States this population is defined by individuals with a little trouble hearing to being deaf (Pleis & Lethbridge-Cejku, 2006), an increase from 2000 when 31.5 million U.S. adults reported trouble hearing (Pleis, Benson & Schiller, 2000). For this research, the focus of Deaf consumers lies with those who are members of a Deaf-World (Bahan, 2004; Padden & Humphries, 1988), a group of Deaf people, within the larger category of all people with hearing loss, that use a natural, visual language, American Sign Language

(ASL) in the United States. The Deaf people in this group are not part of the group who view themselves as hearing impaired and use English in an oral or written form as their primary language of communication (Lane, Pillard, & Hedburg, 2011). The Deaf-World includes those who not only use ASL but also hold a set of beliefs, cultural norms, and connections to one another based on this commonality.

To acknowledge this cultural identification, scholarly literature uses the convention of a capital "D" in the word 'Deaf' versus the use of a small "d" in 'deaf'. People who are born deaf may or may not become part of Deaf community; the capitalization of the "D" indicates the unique cultural and linguistic identity of this community, while a lowercase 'd' indicates an audiological status related to a loss or lack of hearing (Padden & Humphries, 1988; Lucas, 1995). There is a blurred area between the two groups where some hard-of-hearing people interact in the Deaf-World and others who do not. Typically, late-deafened adults and deaf adults that use an oral communication do not self-identify as members of the Deaf-World (Bahan, 2004; Padden & Humphries, 1988). In this light, the Deaf consumers referred to in this research are those who identify with the culture of the Deaf community, use American Sign Language, and regularly interact with ASL/English interpreters.

Disconnect between the Deaf community and interpreters. As part of the Deaf community culture, the use of signed language interpreters to interact with hearing people outside of the Deaf community is essential. The role, or model, of interpreting has changed over time in an attempt to define the role of an interpreter as a 'neutral' or objective participant in a social exchange. For sign language interpreters, this view of objectivity in the process has been referred to as the "machine" or "conduit" model from the 1970s and 1980s in North America. For example, Neumann-Solow (1981) describes the signed language interpreter acting “as a communication link between people, serving only in that capacity. An analogy is in the use of the telephone – the telephone is a link between people that does not exert a personal influence” (p. ix). The principle of objectivity during this time period was a desire to facilitate autonomy for Deaf people who, having experienced being viewed by hearing people as ‘disabled’ and needing assistance, could, with an interpreter, be perceived as in charge of their own interactions and interpreters were encouraged to work hard to not influence either party’s decision making (Jantzen & Schaffer, 2013). This shift from the interpreter as friend, ally, or family member to simply a communication link, has contributed to the growing divide between the interpreting community and Deaf consumers.

An additional factor that has contributed to the disconnect, the professionalization of interpreting, has added challenges by removing the gatekeeping role from the Deaf community and placing it within the educational realm. In the past, Deaf consumers would ask a trusted friend or family member to act as interpreter for many events, including healthcare appointments. However, with the advent of professional training and certification, the interpreter ‘insiders’, who were once familiar to Deaf people, their family or friends, have now shifted to interpreter ‘outsiders’ who enter interpreting through an academic program and may not be aware of or consistently follow the conventions of Deaf culture. In a textbook often used in interpreter education, Mindess (2014) provides a quote from a Deaf person about their perception of interpreters:

> Interpreters…maintain a cool impersonal ‘professional’ relationship. They ‘DRAW-A-LINE-BETWEEN-US.” They are overly concerned with ‘role’ in the

> abstract, the rules and codes of conduct prescribed by their profession rather than "HAVING-HEART", an understanding of the 'role' within the current context (which includes people's feelings), in other words, the Deaf definition of the role (p. 80).

This quote provides a clear example of a line that has been figuratively and literally established between the Deaf community and interpreters. According to this Deaf consumer, the interpreter's role outlined by the profession and the role desired by the Deaf community are not in alignment. Perhaps it is this shift in professional presence that has led to a feeling that the interpreter is now someone simply performing a role instead of someone that is considered an insider or ally.

To further complicate inter-personal relationships between Deaf consumers and newer interpreters, interpreters often have not had the time and experience to build a strong understanding of the cultural, social, and experiential aspects of the relationship dynamics. Thus, a Deaf consumer's perception of an interpreter's skill may be related to: issues of the interpreter's status in the Deaf community, trust between the interpreter and client, familiarity, comfort for the Deaf client and the interpreter, professionalism, the linguistic skill of the interpreter, flexibility of the interpreter, or the interpreter having a "good attitude" (Napier, 2011). While not the intent, the Deaf consumer only experiences a brief interaction with the interpreter, typically 5-15 minutes, before beginning a meeting or event with a third person that does not use sign language. The Deaf consumer must then place trust in a newly met interpreter that he/she will provide a full, interpreted, interaction between the Deaf consumer and service provider; not an easy task. For the average patient, healthcare appointments and hospitalization are times of high anxiety and stress. Research by Sirch, Salvador, and Palese (2017) emphasize that when Deaf patients are admitted into a hospital, they are moving outside the comfort zone of the Deaf community and “into an uncomfortable zone, mainly due to difficulties in communication” (p. 368), where they experience an increase in vulnerability and insecurity. In addition, “if healthcare workers are unable to grasp the specific needs of the patient, the relationship may not be effective and the care not consistent with needs” (p. 371). This can be further compounded with anxiety when a Deaf patient may or may not know the assigned interpreter.

In a recent compilation of narratives from the Deaf community (Holcomb, 2018), this was captured by a Deaf patient and author:

> For my recent doctor’s appointment, I found myself full of anxiety as always. Not because I hated seeing the doctor. Not because I worried about the possible diagnosis. Not because of the scheduled shots I was due to receive. But because I didn’t know who the assigned interpreter would be (Holcomb, 2018, p. 32).

Despite laws that have been passed to improve a Deaf patient’s access to healthcare - a positive intent - a disconnect occurs when the Deaf patient is asked to give trust to someone they may or may not have met before, who might not have connections to the Deaf community and understand their values and culture or have ‘personal ties to a Deaf person whatsoever” (Holcomb, 2018, p. 36). It is common for a Deaf person to leave a healthcare appointment feeling disempowered in the management of his/her health problems (Sirch et. al, 2017). According to an account by Crezee (2013), an interpreter rendered the spoken words ‘major surgery’ as ‘a small operation’ and “the family had signed the consent form, believing the procedure to be a minor one. When the child ended up in the intensive care unit after surgery, they expressed shock and a feeling of distrust towards the doctor who had given them this ‘false’ information” (p. 13). As illustrated by this example, the interpreter was responsible for a linguistic error between ‘minor’ and ‘major’ surgery, however the doctor was held responsible. If this interpreter had used soft skills to build a better connection with the Deaf consumer, there is a possibility that the error could have been mitigated by the interpreter or Deaf consumer asking for clarification. In order to establish a good foundation to minimize error, my research will look at what soft skills can impact the interpersonal connection between Deaf consumer and interpreter prior to a healthcare appointment which can then translate into a successful interpreted event.

Pragmatics and Culture of ASL. Two aspects of interactions that will be studied in this research are pragmatics and the cultural context of ASL. Pragmatics is a branch of linguistics that focuses on the study of how words are understood in context. In a simple definition, pragmatics is how to do things with words (Austin,1962), while upon a deeper examination, pragmatics is the study of how language produces meaning effects in communication. When people communicate, they share a set of underlying assumptions or unspoken rules about how meaning is created. With that in mind, pragmatics refers to “that aspect of communication that involves the interpretation of meaning by hearers (perlocution) and the intention of meaning by speakers (illocution) and the match or mismatch between the two” (Langman, 2008, p. 2). Pragmatics also includes the part of discourse related to the impact of context on how meaning is conveyed (e.g.: time, place, social relationship between speaker and hearer, and assumptions about beliefs); often conveyed by a word or sentence (Valli, Lucas, Mulrooney, & Villanueva, 2013). In most social interactions, there is an initial period of impression forming that participants use to set the stage for the remainder of interaction between them. In most cultures, this initial interaction will begin with a feature of turn-taking in interaction, called a greeting, and can range from a wave of the hand to a formal handshake (Goffman, 1971). This behavior is found in most human languages and cultures, is a universal phenomenon of society (Leech, 2014), and allows an interlocutor "to speak or behave in such a way as to (appear to) give benefit or value not to yourself but to the other person(s), especially the person(s) you are conversing with" (p.3). The content and delivery of a greeting will influence a first impression and can also create a lasting one.

American Sign Language (ASL) is classified as a language, much like English and other spoken and signed languages. ASL is 'an autonomous linguistic system and it is independent of English' (Valli et al, 2013, p. 14). It is not a visual representation of English and uses handshape, movement, and other grammatical features combined to form signs and sentences (Valli et al., 2013). In addition to the linguistic features of ASL, it also has sub-linguistic features like pragmatics. The pragmatics of ASL include attention getting as the initial stage of interaction. Ways to get a Deaf person's attention include waving at or tapping them or tasking a third person to help with this procedure. In large groups, a person may flick the room lights off once or twice to get everyone's attention (Wilbur, 2006). Conversations in sign language, whether interpreted or not, require the participants to pay attention to each other. In addition, eye contact is the foundation of interaction that must be conducted face-to-face. Eye contact also plays a role in turn-taking during conversation and conversation cannot begin without participants making eye contact with one another. Turn-taking regulators are most often non-manual in ASL and may include the following features: hand movements, touching/waving, head shifts, head nodding and facial expressions, etc. (Valli et al., 2013). In contrast to ASL, American English pragmatics utilize verbal turn-taking regulators and subtle attention getting like a smile, a simple ‘Hello’, or a compliment like “I like your shirt” to begin a conversation (Chen, 1993). ASL/English interpreters must become adept at using the linguistic and sub-linguistic features, like pragmatics, of both ASL and English when interpreting.

An additional feature of Deaf culture is its classification as a high context culture as opposed to the low context of American culture (Hall, 1976). Context relates to how much information is explicitly or implicitly shared because of shared experience (Mindess, 2014). Unlike the more formal American culture where information is kept vague and brief, Deaf culture gets to the point quickly and intimate details are often shared with a complete stranger as a way to share valuable information or resources. In addition, Deaf cultural introductions focus on questions about social background and group membership (Mindess, 2014) and include questions related to “what schools they attended, to whom they are related, and which friends they have in common in order to place each other in a known social context” (p. 47). Interpreters navigating the Deaf world, especially in introductions, need to be familiar with and employ these pragmatic features of Deaf culture. A failure to utilize culturally appropriate norms in greeting could cause a disconnect that will impact the success of any interaction with the Deaf community, including an interpreted event.

Interpreters work in an intercultural context heavily laden with both English and Deaf culture norms. As cross-cultural mediators, the obvious place to find error would be in the use or misuse of inter-cultural norms. However, errors in the interactions between ASL/English interpreters and Deaf consumers may be labeled as misunderstandings that are “An unintended and undesirable results, a lack of success at achieving the aim understanding” (Bernstein, 2016, p. 472). Despite a desire for understanding, failure to incorporate linguistic features of ASL, critical to effective communication, may result in a misunderstanding that creates a disconnect between interpreter and Deaf consumer. Some of the elements that are part of ASL linguistic competence are: phonology, morphology, syntax, semantics, and pragmatics (Dawson & Phelan, 2016). If one or more participants do not feel that the initial exchange between Deaf consumers and ASL/English interpreter was successful, there may be an issue with linguistic features often rooted in pragmatics. Hale (2004) provided an overview of the importance of the pragmatic aspects of communication as an interpreter works to understand the intentions of the original language speaker and convey that, as faithfully as possible, in a second language. While Hale’s work is framed in courtroom interpreting, the high-risk nature of healthcare interpreting would naturally follow the same expectations.

The good news is that interpreting students can learn these key pragmatic nuances and practice them prior to the completion of their education. Like learning any additional language, sign language interpreters must immerse themselves in Deaf culture while also acquiring linguistic fluency. There is sufficient evidence in spoken language research to show that “a range of features of second language pragmatics are teachable. These include a variety of discoursal, pragmatic, and sociolinguistic targets of instruction…” (Rose, 2005, p. 396-397). When it comes to greetings, a practical way to prepare interpreting students for what happens outside the classroom environment is through explicit pragmatic instruction. Such instruction should become a regular part of interpreting curriculum regardless of the source and target languages (Zeff, 2016). Anyone wanting to acknowledge, and respect Deaf cultural norms would need to be aware of these differences and how those differences might impact the Deaf experience.

Marginalization and increased risks. The unique differences found in the Deaf community have also historically resulted in marginalization within the greater society and increased risks when seeking healthcare. The roots of marginalization often appear because most Deaf children are born to hearing parents who are advised to not sign and only 10% of parents learn sign language (Lane, Hoffmeister, & Bahan, 1996). The lack of full communication or cultural interactions at home often lead to isolation within their families (Lane, 1992) and means that they must acquire cultural information through schools or community role models (Mitchell & Karchmer, 2004). When this does not happen, Deaf children experience marginalization because of their inability to fully access and integrate with society. This results in restricted social environment and even if they are exposed to Deaf culture, Deaf culture is not widely understood or accepted in the hearing community (Terry, Lê, & Nguyen, 2016).

An added contribution to the marginalization of Deaf people is the limited opportunities afforded in employment. For most people, gainful employment is a central part of their lives with a majority of interactions at the workplace requiring engaging in communication (Koester, 2004). Often Deaf applicants are overlooked for job opportunities because of the disconnect in communication between those who use ASL and those who don’t. This form of oppression has been termed Audism, a term first coined in a dissertation by Tom Humphries in 1975 and later highlighted as a form of discrimination based on one’s ability to hear (Lane, 1992). Because employment is often a gateway to receiving healthcare insurance for many people, this marginalization in employment further complicates access to healthcare.

Another form of discrimination occurs when the Deaf community is considered part of the greater disability population. While the Deaf community does not consider themselves disabled, the pathological view of deafness categories them as such. To add to the oppression and discrimination of marginalized groups, the World Health Organization (WHO) reports that people with disabilities have less access to health care services and therefore experience unmet health care needs (“Key Facts”, 2018, para. 4-5). In addition, health promotion and prevention activities seldom target people with disabilities and specifically many video and audio instruction materials do not include closed captions for the Deaf population, thus further limiting access to healthcare information for Deaf individuals (“Key Facts, 2018, para.14). Doctors’ offices and other healthcare facilities are considered public accommodations and are required to provide auxiliary aids and services, such as an interpreter for the appointments (ADA, 1990). The ADA (1990) also requires that any healthcare service provide an interpreter to the companion of a Deaf patient that the doctor would normally communicate with during the appointment (spouse, family member, caregiver, etc.). Yet access to interpreters is not always guaranteed and often there are challenges in accessing interpreting services as shared in the personal examples collected in a qualitative research study by Terry, Lê, and Ngyuen (2016):

> If I am sick, I call [interpreter service] and they say sorry all interpreters are booked I will have to wait a few days for one. No way! I told them to forget about it (p. 285).

Although there was frustration with interpreting services, it was later revealed that the frustration and annoyance was with the unequal access to services that the hearing community had. A participant stated:

> The Deaf always have to wait…people who are hearing they can go straight away and have access to services. It isn't fair, why are we left last? (p. 285)

In the United States, it is reported that deaf patients experience fear, mistrust, and frustration in health care encounters (Pereira & Fortes, 2010). Many Deaf people "experience their everyday lives as more challenging compared with hearing individuals but have significantly fewer opportunities to access suitable information about health prevention, treatment, or care" (Kuenberg, Fellinger, and Fellinger, 2016, p. 5). Despite the positive intent of the ADA, when a Deaf patient does seek healthcare, oppression and discrimination can also show up in a disconnect between Deaf consumers and interpreters due to perceived linguistic, social, or cultural differences. The disconnect results in problems with communication that can lead to feelings of mistrust and frustration with the health services, miscommunication with health care providers and harbored feelings of mistrust towards both interpreters and healthcare providers (Steinberg, Barnett, Meador, Wiggins, & Zazove, 2006). To mediate the disconnect, interpreters and Deaf people must have mutual trust and respect between them (Ostrove & Olivia, 2010), leading to an increased access and understanding of healthcare for the Deaf patient. Direct instruction for interpreters "aimed at facilitating the acquisition of conventional expressions in L2 pragmatics is both warranted and worthwhile" (Bardovi-Harlig & Vellenga, 2012, p. 87). If interpreters are no longer introduced to the work through the Deaf community, instruction that includes the use of pragmatics and soft skills to form positive first impressions will necessarily need to be included in interpreter education.

The Professionalization of Interpreters

The work of interpreting has been around as long as people have desired to interact with someone that uses a different language. Historically, signed language interpreting was performed by family members, children of Deaf adults, friends, and neighbors (Cokely, 1992). As such, the intimate nature of personal relationships would blur the 'work' of interpreting, and the Deaf community retained the responsibility of gatekeeping who did or didn't enter a situation in the role of interpreter (Cokely, 2012). This gatekeeping process guaranteed protection for the Deaf community and ensured that interpreters possessed a connection to the community (Cokely, 2012). Deaf individuals would also use personal time and energy to foster the mastery of ASL, provide an immersion into the Deaf-World, and introduce hearing individuals to the work of interpreting (Witter-Merithew, 2013). These added benefits to interpreters were diminished with the increase of interpreting requests, legislature, and the professionalization of interpreting.

The professionalization of interpreting began with a meeting at Ball State Teacher's College in 1964 (Ball, 2013) when a group of interpreters met to discuss the professionalization and certification of ASL/English interpreters. This initial meeting became a discussion on credentialing/certification and that same weekend the first official organization for interpreters was established, the Registry of Interpreters for the

Deaf (RID). While RID was founded in 1964, it was not incorporated until 1972. Since that time, RID has grown to a national membership organization with over 16,000 members (www.rid.org) in 58 affiliate chapters. RID has a Code of Professional Conduct, an ethical review board, and administers a National Interpreter Certification (NIC) test. The professionalism of sign language interpreting has evolved from a voluntary, intimate working relationship with the Deaf community to a legitimate way to earn a living with or without ties to the Deaf community. Additionally, The ASL/English interpreting profession now includes Deaf interpreters (Certified Deaf Interpreters) who often work with hearing interpreter teams to provide effective communication for Deaf and Hard of Hearing (HoH) community members (Registry of Interpreters for the Deaf, n.d.). To further compound the complexities of interpreter credentialing, individual states are faced with the issue of regulating the interpreting profession and practice within their state. Some states have gone so far as to create their own tests, write laws to require certification, and pass legislation requiring licensure to practice interpreting. “This is an issue of great importance considering the impact their decisions can have on the state of the profession as well as the quality of service consumers receive” (www.rid.org).

Legislative impacts. A significant factor in the professionalization of interpreters came with the passage of PL 94-142, The Education of All Handicapped Children Act (now known as the Individuals with Disabilities Education Act/IDEA) in 1975, just three years after the incorporation of RID. This law requires children to be educated in a least restrictive environment, meaning a shift from children being educated in schools for the Deaf to Deaf children in public school classrooms. After the passing of the IDEA Act, Deaf children would access educational information through interpreters (Padden &

Humphries, 1988), thus increasing the market for the services of interpreters. This rapid rise in demand resulted in interpreters being hired into education that were uniformed about the professional standards and was the beginning of an era where the profession has struggled to balance supply and demand (Witter-Merithew & Johnson, 2004). The growth in demand for interpreters necessitated training programs across the United States and in many other countries.

The advent of professional certification and interpreter education for ASL/English interpreters also advanced the opportunities for Deaf members of society to more readily interact with non-signing friends, family, co-workers, and other community services. Another impact came with the passing of the Americans with Disabilities Act in 1990, ensuring Deaf people could receive ASL/English interpretation as a covered accommodation (ADA National Network, n.d.) and resulting in greater awareness, usage, and demand for ASL/English interpreters. However, with this advancement and a greater market demand, one negative consequence is that the Deaf community is no longer utilized as the 'gatekeeper' to individuals entering the interpreting profession and interpreters may or may not have met a Deaf person prior to seeing them 'on the job'. According to Witter-Merrithew and Johnson (2004), "The composition of practitioners is still represented by a notable number of volunteer workers (marginalized workers), or those who are on the fringe of the profession due to lack of credentials, lack of affiliation with the professional association, and lack of enforceable compliance with ethical standards of practice" (p. 18). As the interpreting profession has worked to be seen as professionals, an identity distinct and independent from the Deaf community, it is easier for society and the Deaf community to view them as 'service providers for the community instead of service agents of the community (Cokely, 2009). As the Deaf community has slowly been edged out as gatekeepers, "it has become apparent that there is a growing divide between the deaf and hard of hearing community and the interpreting profession. Such a divide has contributed to a large increase in distrust and suspicions between consumers and interpreters" ("Updating the Code of Professional Conduct", NAD, 2017).

According to ADA Regulations (1990), a qualified interpreter is required to achieve 'effective communication' by interpreting accurately, both expressively and receptively, using any specialized vocabulary needed for the communication. While professional certification is not required under the law, an important measure of an interpreter's proven ability is professional credentials by an accrediting organization such as Registry of Interpreters for the Deaf, Inc. (RID). Even those interpreters who hold a generalist certification from RID do not always have specialized training in healthcare terminology and practices. To further compound the lack of training, there is currently not an endorsement or specialized certification for healthcare interpreting (Roberson & Shaw, 2018). Historically, RID has offered certification specializations for educational, legal, and oral transliteration but placed a moratorium on those certifications in 2016 (www.rid.org). The moratorium was enacted to do a risk assessment of the current testing procedures and determine the feasibility of establishing a separate LLC to administer the testing. As of 2019, the moratorium has been lifted on some of the interpreter certifications, however, the moratorium led to a division between NAD and RID.

In 2005, the current certification exam, the National Interpreter Certification (NIC), was developed as a joint effort between NAD and RID. Not only that, the two organizations also co-authored the Code of Professional Conduct (CPC), the ethical code of conduct for interpreters. As mentioned earlier, during the RID certification moratorium, the NAD raised concerns about the establishment of a new LLC to oversee the certification process and asked RID to address these concerns and to provide a definite time to lift the moratorium (www.nad.org). However, despite RID's invitation for NAD to partner in developing the LLC, the NAD board unanimously voted to "cease partnership with RID on the on the NAD-RID National Interpreter Certification (NIC) effective as of January 17, 2016" (www.nad.org). The NAD decision was communicated to RID via an open letter from NAD President, Chris Wagner, in January 2016, that also included the sentiment that "The decisions made by the RID and its LLC representatives will have a significant impact on the quality of interpreter services throughout the nation" (https://www.nad.org/about-us/board/president-report-about-nad-rid-transcript/). This letter was shared publicly and the influence of the separation of NAD and RID has been felt on many levels.

The RID moratorium came to an end and in June 2016, RID established the Center for the Assessment of Sign Language Interpretation, LLC (CASLI) to "take over the administration and ongoing development and maintenance of exams. Eligibility requirements and the credentialing of any and all individuals will remain the responsibility of RID" (www.rid.org). However, the division between NAD and RID has yet to be repaired. In an interview with The Daily Moth (February 2016), Chris Wagner, the President of NAD, was asked to share the primary reason why the NAD board voted to break ties with RID. Wagner responded that RID had not responded to requests recognize the BEI test, another certification test, during the moratorium. In addition, Wagner commented that “NAD has serious concerns about how the RID is governed including how its bylaws requires the RID Board to subject many issues to a membership vote and the constant change in representation on the RID Board from year to year” (The Daily Moth, February 2016). The partnership between RID and NAD was dissolved over differences in how interpreter certification should be handled – a departure from their collaboration to establish testing.

While RID has re-instated their generalist interpreter certification, there is not, currently, a national standard or special certification for healthcare interpreting. Interpreters in the health care setting must be familiar with “special terms, specialized signs, and healthcare procedures and processes, and be able to effectively communicate the procedures and processes to the Deaf patient” (Roberson & Shaw, 2018, p. 9) yet there is not a standardized way of measuring these skills. Without a formalized healthcare certification process, or specialization, Deaf consumers may experience a disconnect as both a member of the national Deaf community with negative views of the interpreting profession in general and on an individual level. A lack of specialized certification leaves Deaf consumers unable to assess an interpreter’s ability to successfully interpret a healthcare appointment or trust that a certifying body has deemed them qualified.

Professional training for interpreters. Training for interpreters has been researched extensively in spoken language interpreting as a way to support the full realization of their potential and to develop translation skills more rapidly (Gile, 2009). Likewise, signed language interpreting students begin their training by entering a 2 or 4-year Interpreter Education Programs (IEP). Despite the attainment of an associates or bachelor’s degree, graduates are still required to be able to pass a proficiency exam (NIC, EIPA, or State certification) in order to practice in most of the United States. This additional requirement necessitates that formal IEP education include instruction on skill domains that address professional knowledge, language competencies, interpreting knowledge and skills, and the ability to function effectively in diverse settings (Winston, 2005) and prepare them for both certification and professional practice.

In spoken language interpreter training, programs will often require students to attend 400 hours of interpreting class for one year as well as 600 hours of group work and self-directed practice (Wang, 2015). Interpreting research estimates that 3,000–5,000 hours of deliberate practice (including class activities, group work and individual work) would be the minimum to achieving professional standard requirements (Moser-Mercer, 2000).

Considering these requirements for professional interpreting practice, interpreter training should strive to be skills-based, profession oriented, and include simulated real-world features (Wang & Ye, 2009). However, despite the best efforts of class instructors, Wang (2015) identified issues still encountered in spoken language interpreter education: 1) Insufficient practice hours; the number of class hours offered in the curricula of most interpreting programs are far from sufficient. 2) Lack of authenticity in course materials and classroom activities; difficulty for classroom instructors to create mock activities which retain the same level of authenticity as real-world interactions, and 3) Lack of guidance for students' out-of-class practice; students are often required to undertake out-of-class practice but may not have access to suitable material or know how to evaluate their own performance.

Related to sign language interpreter education, the Commission on Collegiate Interpreter Education Standards (CCIE) provides guidelines for IEPs that are seeking accreditation. As of October 2019, 15 bachelor's degree programs and four associate degree programs, out of approximately 75 associate programs and 44 bachelor programs in the United States (www.rid.org), are CCIE accredited – approximately 16% of the total IEPs. As part of their prerequisites, the CCIE also outlines that programs must have "an authentic interpreting fieldwork experience where students are supervised by interpreter mentors who are nationally certified, holding psychometrically reliable and valid credentials (e.g., RID) (CCIE Standards, 2014). In Standard 8.0 the CCIE states that "Field experience(s) must provide at least 300 hours of observation, shadowing, teaming, professional responsibilities, duties, and/or activities" (www.ccie-accreditation.org). In other CCIE competencies, in addition to linguistic competencies, IEPs are required to have curriculum that addresses human relations, professionalism, multicultural awareness and diverse populations. However, with only 16 accredited programs, the likelihood of a program not following these recommendations in their interpreter education curriculum is high. Without specific requirements, a program may choose to focus on the linguistic competencies over soft skill competencies.

Interpreter education does not end with graduation from an IEP. In order to maintain certification, interpreters must provide evidence of continuing professional development and credits are allocated for different activities related to interpreting, such as formal study of subjects related to interpreting, attendance at workshops, and participation at conferences. "This is an effective way of ensuring that all practicing interpreters remain up to date with the field and continue to reflect on their own interpreting skills. The licensing system ensures that those who are committed to the profession can continue to practice while maintaining a high standard of service provision" (Napier, 2004, p. 356). The RID requires that certified members continue to further their professional education through the Certification Maintenance Program (CMP). The CMP requirement for members is that they earn 8.0 (80 contact hours) total CEUs in a 3-year cycle (2.0 CEUs in General Studies and 6.0 CEUs in Professional Studies). RID defines General Studies as anything that adds to base of general or world knowledge and Professional Studies as content that directly applies or effects the field of interpreting. Examples provided on the website include advanced studies of language, culture, and human behavior (includes pragmatics), theoretical and experiential studies, and specialization studies (including healthcare). However, because RID does not specify a specific number of CEU's within the PS category, members can elect to complete all 6.0 CEUs in one area without a broader base in all areas. This does not encourage or require members to engage in discussion or instruction that would enhance their understanding of the relationship with Deaf consumers, how pragmatics can be used to increase trust, or even a required track of professional development to enhance healthcare interpreting skills. It is merely a suggestion and up to the individual to determine the workshops or trainings taken in three years (www.rid.org).

It would be simple to point the finger at lack of training or linguistic differences as the framework for disconnect between ASL/English interpreter and Deaf consumers, however, a deeper look into Sociocultural Theory and Experiential Learning Theory will provide a more broad picture of potential threats to the relationship as well as shed light on information that may support an intervention aimed at improving those ‘first impressions’ that happen between ASL/English interpreters and Deaf consumers.

Theoretical Framework

The construction of meaning between Deaf people and ASL/English interpreters, as well as the learning and education that is part of interpreter training, is rooted in Sociocultural and Experiential Learning Theory. In addition, habits formed in practice can best be explained by Experiential Learning Theory as well as any interventions employed to change those habits. This section will discuss how each relate to my problem of practice as well as the overlap between theories.

Sociocultural Theory and Related Theories

Sociocultural Theory, grounded in the work of Lev Vygotsky (1978), asserts that individual development is dependent on social interaction and meaning is constructed between two or more individuals (John-Steiner & Mahn, 1996). As children, we are able to accomplish more with others than we would be able to do on our own and “social learning thus paves the way for development: New skills appear first on a social plane, mediated by more-expert others, and later, on an individual plane” (Bernstein, 2017, p. 491). The term “sociocultural” is used to refer to contexts, both social and cultural, where people live and interact with one another. In addition, it focuses on the impact of “culturally organized and socially enacted meaning on the formation and functioning of mental activity” (Lantolf & Thorne, 2006, p. 2). This mental activity is a core concept of Sociocultural Theory and this inner mental world has also been termed ‘internalization’ within Vygotsky’s work. For my research project’s theoretical framework, I will specifically utilize four sociocultural concepts: internalization, mediation, situated learning, and co-construction of meaning.

Internalization. Vygotsky (1978) defines internalization as knowledge of a social activity where people use language and physical signs to change social relations into psychological functions. In conjunction with internalization, Vygotsky also supported the idea that learning must be situated in the Zone of Proximal Development (ZPD); both forward looking and predictive of what a person can learn or apply in the future. The ZPD is rooted in Vygotsky's law of cultural development and the assertion that "internalization transforms the process itself and changes its structure and functions. Social relations or relations among people, genetically underlie all higher functions and their relationships" (Vygotsky, 1978, p. 57). Vygotsky believed that people, working together to solve a problem, will move from actual development level to their immediate potential for development with a domain (Jaramillo, 1996). Essential to this movement is the interaction of a less competent peer with a more competent peer to support "cooperation, communication, exploration, and conceptual development" (Jaramillo, 1996, p. 139).

The concept of internalization is relevant to the work of interpreters. ASL/English interpreters must possess cultural competence, defined as the ability to work effectively across cultures while acknowledging and respecting the culture of the person that is being served (Hanley, 1999). For people outside the Deaf world, this competence is typically acquired through academic coursework and at times supplemented with experience gained in social interactions with the Deaf community. In this light, ASL/English interpreters must learn to internalize their experience of interacting with Deaf consumers and other more experienced interpreters, eventually leading to independent thought and application. This idea of internalization begins as a representational activity, occurring in both a social practice and in the human brain that leads to development of symbol systems and develops learning (John-Steiner & Mahn, 1996). It is through repeated exposure that ASL/English interpreters learn to navigate the cultural norms associated with the Deaf community and become culturally competent. This cultural acclimation occurs as an individual interacts with mediational artifacts (Lantolf, 2001) and then processes internally what happened externally.

Mediation. Mediation is the way an individual interacts with the world, not through direct relationships, but through the use of tools that allow the world to be changed and relationships to be mediated and regulated (Lantolf, 2000, 2001). Vygotsky identified three kinds of mediators: material tools, psychological tools, and other human beings (Kozulin, 1998). Lantolf (2006) went further to explain how tools fit in a greater system of human psychological processes and are organized by three foundational cultural factors: 1) activities, 2) use of physical tools, and 3) symbolic tools that including language and concepts (the understandings that communities construct of the personal, the physical, the social and mental worlds) (p. 69). The use of both physical tools and symbolic tools will form the basis for interaction between interpreter practitioners as well as between Deaf consumers and interpreters.

Additionally, what separates Sociocultural Theory from other theories is the emphasis on cultural variation and the emphasis on the interrelationship of culture and development. According to Lantolf (2006), individual participation in culturally organized practices and the use of tools and artifacts (including language) impact cognitive development and functioning. These artifacts evolve over time as they are passed down through generations and each generation reworks the artifact to meet the needs of both individuals and communities (Lantolf, 2001). Within the Sociocultural Theory, culture is understood as an objective force that 'mediates the relationships between people, between people and the physical world, and between people and their inner mental worlds." (Lantolf, 2006, p. 69). As interpreters have evolved within the interpreting profession, their inner mental worlds have been influenced by training, practice and experience with the Deaf community. As the Deaf community has also evolved culturally, their inner worlds reflect different ways of meeting needs for individuals and communities. When the development and functioning of each group are not formed together, it can create a disconnect in approaches to mediating a shared experience that occurs during interpreting.

Situated Learning Theory. Situated Learning Theory is related to Sociocultural Theory as both draw on natural learning. According to situated learning theory, optimal learning that is both transformative and long-term happens when situated in or near communities or practice. According to Wenger (1998), there are essential dimension of "practice" that must be present in order to constitute a community of practice (COP). Those dimensions are mutual engagement, a joint negotiated enterprise, and a shared repertoire. Additionally, the concept of "legitimate peripheral participation" (Lave & Wenger, 1991) is learning that occurs unintentionally and is embedded in activity, context and culture. Knowledge needs to be presented in authentic situations and settings that encourage the acquisition of beliefs and behaviors associated with a community of practice (Lave, 1991). In addition, situated learning theory application can shape the identity of newcomers (Lave, 1991; Lave & Wenger, 1991; Wenger, 1998), which is vital to the longevity and richness of a community of practice. As new interpreters are exposed early on to experience with Deaf consumers, they bring not only their experiences in a situated environment but also their enhanced decision-making into professional practice. Situated learning is related to Vygotsky's idea of learning through social development and reinforced through co-constructed meaning within a group or community of practice.

Co-construction of meaning. The concept of co-construction of meaning is something that incorporates internalization, mediation and any social learning situation. Any linguistic interaction can be also considered a social interaction. The role of a sign language interpreter is to represent the interaction of the primary participants through words and phrases, signs and phrases all while paying specific attention to the intent of those participants. The interpreter plays a part in co-constructing meaning and builds intersubjective relationships with both the source text speaker and the target text recipient. An important distinction of this exchange of meaning, outside that typical experience, is the interpreter's need to recognize that while they are mediating their own intersubjective relationships, the relationship between Deaf and hearing participants is also developing and they must attempt to let that happen without impediment (Meurant, Sinte, Herreweghe, and Vermeerbergen, 2013). To state it simply, interpreters work between at least two cultural and linguistic contexts – making meaning in both at the same time. This working between two world involves learning 'how to negotiate and act upon our own purposes, values, feelings and meanings rather than those we have uncritically assimilated from others" (Mezirow & Associates, 2000, p. 8). This type of learning is transformative and is the process of 'constructing and appropriating new and revised interpretations of the meaning of an experience in the world" (Taylor, 2008, p. 5). Interpreters and Deaf consumers bring their unique internalized world experiences to an interpreted event where together they construct meaning. The interpreted event is the situated learning event that allow all parties to apply learning in a social, cultural, and linguistic environment.

Experiential Learning Theory

Kolb's Experiential Learning Theory has origins in frameworks by Dewey (1938) and Lewin (1939) and focuses on internal cognitive processes for learning. Dewey utilized the term "experience" as a philosophical category for addressing educational, political, economic and cultural problems (Seaman, Brown, & Quay, 2017). Lewin led a team in 1944 to address interracial and religious conflicts and was instrumental in establishing a collaboration between researcher and practitioners called "action research"– an experimental training program that encouraged group discussion and decision making among peers (Seaman, Brown, & Quay, 2017). Later, Kolb built on the approaches of Lewin and Dewey to develop the Learning Style Inventory (1976), an instrument for a person to self-describe how he or she learns compared with self-descriptions of a normative sample (Kolb, 1981). Kolb asserts that there are non-physical aspects of the learning environment, such as psychological, social, cultural, and institutional/systemic factors, that influence learning. Learning is also influenced by the learner's prior experiences. New concepts are learned through experience and happen in a four-stage cycle of learning. The four stages are: 1) Concrete Experience (Do), 2) Reflective Observation (Observe), 3) Abstract Conceptualization (Think), and 4) Active Experimentation (Plan) (Kolb, 1984). The idea of variation of learning styles, utilized in different situations, is essential to Experiential Learning Theory since "change and adaptation to environmental circumstances are central to any concept of learning" (Kolb, 1981, p. 290).

A common usage of 'experiential learning' is applied to learning that happens from life experience as opposed to classroom or lecture learning. Keeton and Tate (1978) defined it as:

> Learning in which the learner is directly in touch with the realities being studied. It is contrasted with the learner who only reads about, talks about, or writes about these realities but never comes into contact with them as part of the learning process (Keeton and Tate as cited in Kolb, 1984).

For colleges, universities and other training programs, experiential education often takes the form of internships, field projects, classroom learning exercises, service learning, problem-based learning, action learning, or team learning (Kolb, 1984). While many interpreter education programs require internship hours, those experiences typically happen at the end of the coursework and prior to graduation. According to Hall & Hord (2011), sequencing and placing situated learning earlier, rather than later in a coursework may assist in providing interpreting students with experiential learning that will impact later practice. Additionally, because of certification requirements, internship hours often are accrued through observation only and do not provide situated, experiential learning through actual interpreting practice. This lack of real-world, situated learning that supports co-constructed meaning between Deaf consumers and interpreters can contribute to feelings of disconnect. My research innovation will help mediate this by providing experiential learning experience in not only generating ideas for improving the initial interactions with Deaf consumers but also supporting interpreters in immediately applying strategies in professional experience. This fills a need for interpreters that builds on limited exposure to authentic practice in the classroom.

Conclusion

In summary, this chapter highlighted the factors that contributed to the disconnect between interpreters and Deaf consumers and involves several considerations: The Deaf consumer as part of a unique culture, language, and shared experience as an oppressed group; the impact of professionalization in interpreting and the resulting educational path; and the experiences of Deaf individuals in healthcare settings. The chapter also explored key frameworks found in social-cultural and Experiential learning theories. All of these concepts provide the background needed to understand the problem of practice as well as how the proposed intervention may generate real-world and practical solutions for mediating the disconnect as well as inform future practice for both interpreters and those that employ interpreters.

CHAPTER 3

METHODOLOGICAL APPROACH

In this action research study, I explored the current experiences of ASL/English interpreters and Deaf consumers as they interacted prior to a healthcare appointment. Specifically, I supported interpreter participants in generating strategies to improve these first impressions to positively impact the actual interpreted event. To study this intervention, I used observations, group research meetings, interviews, and surveys to explore the strategies that were generated and how those strategies were perceived by Deaf consumers. My study, which was informed by the theoretical frameworks of Experiential Learning Theory and Sociocultural Theory, seeks to answer the following questions:

1. What factors influence the connection between Deaf consumers and interpreters?
2. How do interpreters and Deaf consumers describe and perceive the interaction prior to an interpreted healthcare appointment?
3. How did the co-constructed solutions influence the connection between Deaf consumers and interpreters?

Research Design

The design of my study was informed by constructionism and my theoretical frameworks. My research focused on perspectives from both interpreters and Deaf consumers related to first impressions and the reasons that were behind the perceived truth of their actions and potential causes. The interpreter participants and researcher worked together to construct new understanding and learning that could eventually lead to improved agency practice and interpreter education. This new body of knowledge fell within the epistemology of constructionism, where there is “no meaning without the mind” (Crotty, 1998, p. 7). In this research, the participants created meaning together in different ways based on personal and professional experience. However, by situating the participants in a group meeting and limiting interaction to the healthcare interpreting setting, the differences were minimized. According to situated learning theory, a branch of Sociocultural Theory, optimal learning that is both transformative and long-term happens when situated in or near communities or practice (Wenger, 1998). In addition, according to Experiential Learning Theory (Kolb, 1984), once something is learned in a group setting, it can be applied to later experiences of a similar nature as well as other aspects of life. This co-operative learning combined essential elements of positive inter-dependence, face-to-face interaction, individual accountability and personal responsibility, interpersonal and small-group skills, and group reflection (Johnson & Johnson, 1991). This approach supported knowledge that was ongoing and evolved beyond mere instruction to a dynamic process of creating meaning.

The action research was situated with the researcher and a group of working interpreters as they developed strategies that were applied in actual interpreting interactions. As stated in Chapter Two, future interpreters would benefit from real-world or near-world experience where they can engage in experiential learning focused on “cognitive processing, interpersonal, linguistics, professional, setting-specific and sociocultural skills” (Angelelli, 2006, p. 25). Ideally this learning would occur prior to employment where they would be assigned to work with Deaf consumers during healthcare interpreted events. In addition, in situated learning theory, and in this research, application shaped the identity of newcomers, which is vital to the longevity and richness of a community of practice. (Lave, 1991; Kiraly, 2012). I brought over 30 years of interpreting experience into this action research project and our work together allowed each of us to experience transformative social and cultural learning that could be applied to professional practice. The research project exposed the interpreter participants to authentic experiences with Deaf consumers in "situationally embedded real-life or realistic projects, rather than on the memorization of discrete pieces of knowledge" (Kiraly, 2012, p. 23).

Action Research Design

The research design that best suited the improvement of interpreting practice was action research (AR), which I used in this study. According to Creswell (2015), key characteristics of AR include: a practical focus with immediate benefits, a researcher experimenting with their own practice and then interpreting the action, collaboration with the goal of understanding through interaction, a spiral of activities in a dynamic process, and finally a plan of action that included sharing data with stakeholders and discussion of future implications.

In order to meet these criteria, my research included working with a group of interpreting practitioners to generate and implement ideas to improve first impressions with Deaf consumers prior to healthcare appointments. I followed the AR criteria (Creswell, 2015) by collecting data using both qualitative and quantitative methods and focused on project collaboration to empower individuals. The data collected came from the qualitative data collected from research meeting records, interviews, and focus groups with both the Deaf consumers and the interpreters as well as the quantitative data collected from Deaf consumers, through satisfaction surveys about their experience working with those same interpreters. This met the criteria for a mixed-methods approach to collecting data before, during, and after the intervention. This iterative process of thinking, acting, and looking followed the Action Research Helix (Stringer, 2008) seen below:

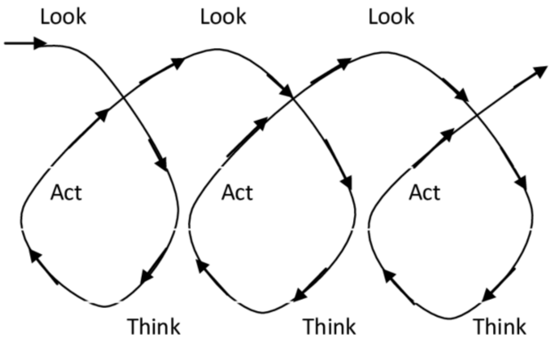

Figure 1. Stringer's Action Research Helix (2008)

The researcher and interpreters met together to discuss (think) the disconnection problem and brainstormed strategies that were implemented in a period following each research meeting (act). Finally, I collected data from the Deaf consumers during that same period through a satisfaction survey provided at the end of each healthcare appointment. The data then became part of the next research meeting when I shared results with the participants (look). The cycle began again when the interpreters re-strategized and implemented in the next period while additional data was collected from Deaf consumers. A final research meeting took place, thus completing a third cycle of think-act-look, culminating with final data collection. The strength of this type of intervention allowed the participants and researcher to "co-create knowledge, policy, and practice through an iterative process of action and learning" (Ivankova, 2015, p. 56).

Because I was involved in the intervention as well as the data collection, this research also met the criteria for participatory action research.

Participatory Action Research

Participatory action research (PAR) is a subset of action research, which ideally aims to impart social change, with a specific action as the ultimate goal (Greenwood & Levin, 1998). A participatory action researcher has a goal to study sensitive issues, promote democratic aims, involve participants in an open, collaborative decision-making process, and view participants as equals in the research (McIntyre, 2008; Creswell, 2015). PAR is heavily influenced by six central features: (a) a social process where the researcher deliberately explores the relationship between an individual and other people, (b) a participatory inquiry form, (c) collaborative and practical research, (d) an aim to assist people in changing unjust structures that limit self-development and self-determination, (e) an aim to help people overcome constraints embedded in larger social, political, and cultural conditions, and (f) a reflexive process for both researcher and participant that leads to action (Atweh, Kemmis, Weeks, & Ebrary, 1998). What makes PAR project unique is the learning about real practices of particular people and places while building a relationship between theory and practice (Kemmis & McTaggert, 2015). While my research project was informed by PAR and included several of these central features, the research project was not co-created with participants and the research questions were developed by the researcher, without participant feedback. However, the opportunity to implement changes that improved relationships with Deaf patients and impacted their healthcare experience was grounded in social justice and provided the interpreters a way to have practical impact on that change.

Setting and Participants

The research was conducted with interpreters and Deaf consumers that provided or received services from an interpreter referral agency that covered multiple areas within neighboring states. The interpreter referral agency coordinated services for a variety of settings that ranged from legal to educational. However, for this study, only healthcare settings were used, and the referral agency assisted in tracking the assignments and the Deaf consumers and interpreters that were involved. When a Deaf patient made a healthcare appointment and requested a sign language interpreter, the request was handled in a variety of ways. Most often, the doctor's office or clinic contacted the referral agency directly. For larger practices, clinic, and hospitals, the requests were routed through a language services department, typically led by a spoken language interpreter. Once a request was received in a hospital setting, the language service coordinator contacted a contracted referral agency to request an interpreter. The referral agency then gathered logistical information about the appointment and any known particulars about the Deaf patient before working, in-house, to find an interpreter with the availability and skills necessary to fill the request.

The referral agency I worked with for this project, SignOn Interpreter Referral Agency[1], had contracts with several healthcare organizations as well as individual providers. The interpreters that worked with SignOn Interpreter Referral Agency contracted to provide services but were not regular, full-time employees. However, within the agency, there were interpreters that received consistent weekly hours and are

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[1] Pseudonyms for the interpreter referral agency and all participants have been used throughout the paper.

given top priority for work. The agency retained sole decision-making about which interpreters were hired and utilized and consistently worked to provide the Deaf consumers with the highest caliber of interpreters and service.

SignOn Interpreter Referral Agency is responsible for filling requests for service, maintaining updated information, and matching consumer needs when possible. Because of this unique relationship with both interpreters and Deaf consumers, the referral agency was ideally suited to provide support for the intervention and assisted in connecting me with both interpreters and the Deaf consumers I worked with during the intervention period. SignOn Interpreter Referral Agency was also involved in contacting Deaf consumers and interpreters prior to the intervention and helped ensure all participants were willing to consent to be part of the intervention. Once participants had agreed to be part of the intervention, the agency also assisted in collecting contact information for Deaf consumers that received the pre- and post-intervention surveys. An agency representative met with me prior to the intervention to review the timeline, participant requirements, and discuss the name badge design and use of the company's logo for both the name badge and satisfaction survey card.

Interpreters

Ten interpreter participants were selected using typical sampling, a type of sampling that illustrated the normal, typical interpreter participant in this project (Plano, Clark, & Creswell, 2015). Due to the nature of the referral agency relationship with contracted interpreters, it was difficult to do random sampling without knowing ahead of time which interpreters would be engaged in healthcare appointments during the intervention period. The interpreters were selected from those that contracted with the referral agency and represented a geographical mix from two different states. The participants were sent a recruitment email and asked to commit to the entire intervention period and signed consent forms before the first meeting. Particular attention was given to those interpreters who engaged in frequent healthcare appointments prior to the intervention period and were more likely to have a similar engagement during the intervention. The interpreters were not required to have any specific certification or set years of interpreting experience but were required to be certified as a requirement for employment with the agency. The broad range of practitioner experience and certification provided a range of perspectives for the research meetings and focus group. The ASL/English interpreters were all at least 18 years of age and had technology available that allowed them to connect to the online meetings from their home location. The technology required included a webcam, high speed internet, and an internal, or external microphone.

The ten interpreter participants included four male and six female interpreters. Only one of the male interpreters also self-identified as having Deaf a parent. The geographic breakdown included two interpreters in Southern Utah, three interpreters in the Las Vegas area, one interpreter in northern Utah, and the remaining four interpreters in the greater Sale Lake City area. This breakdown provided a broader experience and perspective base that covered a variety of geographical, community, and linguistic backgrounds. During the intervention period, SignOn Interpreter Referral Agency reported that the 10 interpreter participants went on an estimated 250 appointments with Deaf consumers. Out of the 250 Deaf consumers there were about 34 Deaf consumers with repeated interactions with one or more of the interpreters during unique healthcare visits.

Deaf Consumers

The Deaf consumers were those served by the referral agency and the interpreter participants during the intervention. Participation was voluntary and a request for participation and a consent form was provided prior to participation in the survey. The Deaf consumer participants used ASL as their primary language, regularly utilized professional interpreters, and were at least 18 years of age. The agency kept records of all appointments; however, while all included interpreter contact information, not all included Deaf consumer contact information. The original intent was for SignOn Interpreter Referral Agency to act as the 'go-between' with contacting the Deaf consumers. However, the agency only had a limited amount of contact information that could be used for email contact. The surveys used in the study will be described in further detail below and my initial recruitment emails resulted in a low response. I received two email replies from Deaf consumers asking how I received their email address, despite that being clearly stated in the body of the email. I did send out follow-up reminder emails and one Deaf consumer shared that the first one had been deleted because he wasn't sure if it was a scam, or not.

Therefore, to increase recruitment and participation, after a healthcare appointment the interpreter participants provided Deaf consumers with a card (See Appendix that included the SignOn Interpreter Referral Agency logo, and a link to a satisfaction survey and consent form. However, while the full text of the explanation of consent, risks, benefits, etc. was in English, I also provided an ASL explanation via a video link that was embedded in the written form and could be accessed by Deaf consumers prior to signature. As explained in Chapter Two, ASL and written English have distinct grammatical differences and written English would not deliver the information in the same way that an ASL video would. The videos were to mediate the challenges that Deaf consumers might encounter when accessing the information in their L2 and not in their native language of ASL.

The number of participating Deaf consumers included those contacted from the larger population of Deaf consumers that SignOn Interpreter Referral Agency and those served by the 10 interpreters. At the beginning of the intervention, the recruitment form and pre-intervention survey was emailed to 18 Deaf consumers. While the total number of Deaf consumers served by SignOn Interpreter Referral Agency is higher than 18, there was limited contact information for each consumer and the limited contact information will be explained in a later section. In addition to the initial recruitment of Deaf consumers, consumers that worked with the 10 interpreters during the intervention took one or more satisfaction surveys following any healthcare appointments. While the interpreter participants gave out roughly 200 satisfaction survey requests at the end of healthcare appointments, due to repeated interactions, or Deaf consumer reluctance to participate in the survey, only 18 Deaf consumers consented to participate and returned surveys. After the close of the intervention, I contacted 18 individuals amongst the subset of Deaf consumers who had worked with participating interpreters and returned satisfaction surveys, recruiting three of them for individual interviews. I conducted the interviews with one male Deaf consumer from Nevada and two female Deaf consumers from Utah.

Intervention

To address the disconnect between Deaf consumers and ASL/English interpreters, I developed an intervention that supported the generation of strategies and application of those strategies in the healthcare interpreting context. The intervention included three research meetings that lasted an hour and were held online via Zoom videoconferencing software. Participants connected remotely and Zoom allowed everyone an opportunity to see and hear each other and the meeting was audio recorded. Each online meeting was followed by a 2-week implementation period. The 10-week intervention aimed to provide a platform for a group of working interpreters to identify perspectives on the first impressions with Deaf consumers and to create solutions that were immediately implemented and reviewed, as a group. In addition to the 3 meetings, the group decided on a platform for checking in and staying connected during the intervention. The platform that was selected was Google Hangouts and all 10 interpreter participants and I were involved in messaging during the intervention.

During the first research meeting, I followed a designed protocol (See Appendix B) that included sharing information from preliminary research cycles, as explained in Chapter One, and asked participants to share their current experiences with meeting and greeting Deaf consumers prior to a healthcare appointment. The next step was for me to show the participants three videos that were created during a preliminary research cycle focus group with Deaf consumers. The brief videos showed the following scenarios:

- Scenario A: An interpreter walked into a healthcare appointment office, bypassed a waiting room full of people (including a Deaf patient) and walked to the front desk and let the receptionist know she was there to interpret. The interpreter asked if the receptionist knew who the Deaf patient was and the receptionist answered that she did not.

- Scenario B: An interpreter walked into a healthcare appointment office, bypassed a waiting room full of people (including a Deaf patient) and walked to the front desk and let the receptionist know she was there to interpret. She used Sim-Com (simultaneously signing and speaking) to let the receptionist know she was there and asked where the Deaf patient was. The receptionist pointed to the Deaf patient and identified her as the one in the pink shirt. The interpreter then walked over to the Deaf person, identified herself and began a conversation.
- Scenario C: An interpreter walked into a healthcare appointment office, stopped briefly in the waiting room full of people (including the Deaf patient) and, in sign language, identified herself as the interpreter and asked in sign if there was a Deaf person there needing her services. The Deaf patient raised her hand and the interpreter walked directly over to her. The two engaged in a brief conversation that included exchange of name and greeting. The interpreter and the Deaf patient then walked up to the front desk together and checked in while the interpreter interpreted for the conversation between the Deaf patient and the receptionist.

Once the participants had viewed the videos, I led a discussion to get their perspective about the reality of the scenarios. Once the discussion was complete, I shared information from my preliminary research with the Deaf consumer focus group that highlighted these themes: (a) their desire to be greeted first and included in the entire healthcare appointment process, (b) the group's opinion that while Scenario C is most desirable, Scenario A or B is what they typically experienced, and (c) feedback that if an interpreter wore a visible name badge it would make it easier for everyone to identify each other.

As part of the intervention, I asked the participants to accept name badge wearing as the first strategy to be implemented during the 10-week period. This suggestion was a direct results of ideas generated from a Deaf consumer focus group in a preliminary cycle. Prior to the first research meeting, I sent the interpreter participants a new name badge that SignOn Interpreter Referral Agency had authorized me to re-design for them to wear during the intervention period. The participants discussed and agreed how the badges were to be worn during appointments. The group then generated additional strategies that were used for the next two-week period. For the next two weeks, all participants wore the name badge and implemented the strategies agreed upon in the first research meeting. The final piece was for the interpreter group to check-in with each other and me through Google Hangout, an agreed upon method.

In the second and third research meetings, the interpreter participants were involved in a discussion about their experience in the prior two weeks. In addition, I shared feedback from the Deaf Consumer Satisfaction Surveys that were gathered after an appointment. (See Appendix A). We worked together to utilize their own experiences and Deaf consumer feedback, in an iterative manner, to generate solutions for the next two-week period. Throughout the intervention the interpreters gave the Deaf consumers they worked with on healthcare appointments, a satisfaction survey link at the end of each healthcare appointment. The survey asked the Deaf consumer questions about the name badges and strategies employed during the first impression phase of the appointment. Summary information about the data collected from the Deaf consumers was shared with the interpreters during the online research meetings. The participants had an opportunity to discuss how to incorporate any feedback in the iterative process.

The satisfaction surveys were originally designed to inform the intervention only and be used to show the effectiveness of the solutions we had agreed to implement. Data collected from these surveys was shared with interpreters. However, due to the low response rate for the pre- and post-surveys sent to Deaf consumers, the satisfaction surveys were later analyzed for relevance to the research questions. Table 1 shows the timeline for the intervention, highlighting the activities of the interpreters and Deaf consumers:

Table 1: Intervention Timeline

Week	Interpreters	Deaf Consumers
1	Initial training and solution generation with interpreter participants	No activity
2 & 3	No online meeting. Application of solutions generated by Meeting #1. Check-ins through Google Hangout	Complete satisfaction survey at the completion of each interpreted appointment
4	Meeting #2 to revisit iterations of solutions; share generalized data collected from Deaf consumers, and develop iterative changes Any appointment with Deaf consumers will continue to utilize solutions generated by Meeting #1	Complete satisfaction survey at the completion of each interpreted appointment
5 & 6	No online meeting. Application of solutions generated by Meeting #2. Check-ins through Google Hangout	Complete satisfaction survey at the completion of each interpreted appointment

Table 1 (continued)

7	Meeting #3 to revisit iterations of solutions; share generalized data collected from Deaf consumers, determine if changes are necessary for the final application period Any appointment with Deaf consumers will continue to utilize solutions generated by Meeting #2	Complete satisfaction survey at the completion of each interpreted appointment
8 - 10	No online meeting. Application of solutions generated by Meeting #3. Check-ins through Google Hangout	Complete satisfaction survey at the completion of each interpreted appointment

Data Collection

For this study, a mixed methods approach to data collection was used, due to the small sample size in both the interpreter and Deaf consumer groups. The qualitative data collected was taken from the three research meetings, Google Hangout interactions, Deaf consumer satisfaction surveys, a focus group, and individual interviews. The quantitative data was collected from the Deaf Consumer Satisfaction Survey (see Appendix A), which was given at the end of interpreted interactions with the interpreters participating in the intervention. By combining the two types of data, I had a better understanding of the data and the research problem (Creswell, 2015). I used a mixed methods approach (Plano, Clark, & Creswell, 2011) to compare thematic results with quantitative survey data. This body of data provided a more robust understanding of both the state of interactions before the intervention and the influence the intervention had on interactions during the intervention.

Quantitative Data

The quantitative data was drawn from a satisfaction survey for Deaf consumers (Appendix A). Deaf consumers received the satisfaction survey during the intervention period and the interpreter participants shared the link with them at the end of a medical appointment. The intent of the satisfaction survey was to capture the Deaf participants' experience immediately after an appointment where an interpreter participant should have employed one or more of the strategies developed in the meetings with the researcher. The satisfaction survey consisted of 15 questions grouped into three sections: 1) Arrival and check in, 2) Language and communication assessment, and 3) Factors that impact interactions prior to an interpreted event. In addition to the 15, Likert-scale questions, there were two open-ended questions that asked, "What did you notice about this interpreter's interactions with you before the appointment?" and "Do you have any additional comments you would like to share?". I printed 200 recruitment cards with information about the satisfaction survey and dispersed those among the interpreter participants. The interpreter participants distributed all 200 of the satisfaction survey cards to the Deaf consumers with whom they worked during the intervention period. I received 18 responses to the satisfaction survey.

In addition to the satisfaction survey, a pre-intervention survey was sent to 17 Deaf consumers that SignOn Interpreter Referral Agency had an email address for, and only one survey was returned. For this reason, no data collected from that survey was examined as part of this dissertation.

Qualitative Data

This research project included multiple types of qualitative data to provide a more rounded understanding of what was currently happening with the connection between Deaf consumers and interpreters, as well as the effectiveness of the intervention.

Researcher observations. In order to establish a baseline assessment of current interactions, I designed an opportunity to collect qualitative data from video-recorded observations of interactions between Deaf consumers and interpreters before a healthcare appointment. However, due to HIPAA regulations and SignOn Interpreter Referral Agency's contract with the healthcare providers, this was not possible. As a substitute for video observations, I asked the interpreter participants if they would allow me to do in-person observations at the beginning of the intervention. I selected three interpreter participants to observe, two in Utah and one in Nevada. I was limited in the number of observations because of geography and outside work commitments. I also had a fourth observation in Nevada arranged but there was a last-minute cancellation, typical to interpreter experience. I arrived at the healthcare appointment and brought a consent form with me. The interpreter participants took on the responsibility to ask for consent before introducing me. I did not ask them to do this, but they felt that it would be more natural and less stress for the Deaf consumer if consent was given or denied before meeting me. All three Deaf consumers agreed to have me observe. I made field notes to capture the environment, who arrived first, who introduced themselves first, and any initial conversation between participants. The observations were brief and after each interaction, I reflected on my experience and made handwritten notes. In two of the cases, the interpreter participants called me afterward to share additional feedback on what had transpired before or after my arrival that they felt was pertinent to the observation context. I added additional details and reflections to the hand-written field notes and transferred my notes into a Word document to use in the coding process.

Recordings of online meetings with interpreters. Online meetings with the 10 interpreters were held using Zoom web conferencing software. The meetings occurred on Weeks 1, 4, and 7 of the intervention. Zoom meetings were recorded and transcribed into a Word document for coding. The meeting questions for the initial meeting are found in Appendix C.

Semi-structured interviews with Deaf consumers. After the intervention, in Week 13, I conducted interviews with three of the Deaf consumers involved in the intervention. For linguistic access, the interviews were conducted in ASL and video recorded. I then interpreted the video recordings into written English and transcribed into a Word document for coding. These interviews included ten open-ended questions and were intended to assess the Deaf consumer's feedback about the first impressions of the interpreters they worked with during the intervention and determine the effectiveness of the strategies employed by the interpreters. My primary goal of the interviews was to capture how Deaf consumers described the interactions and the impact they had on the healthcare appointment. Please see Appendix C for the interview protocol.

Focus Group. During Week 12 (post-intervention), I conducted a focus group with all 10 of the interpreter participants. The focus group was held online using Zoom and was recorded and later transcribed into a Word document for coding. The focus group questions promoted discussion about the participant views of the strategies generated and their effectiveness during the intervention. For focus group protocol, please see Appendix D.

Table 2 shows how quantitative and qualitative data were designed to align with a research question and analysis then served to answer the research questions. There are some data sets that are aligned with more than one research question and less direct methods, like the observations, showed any changes related to the intervention.

Table 2: Data Collection Alignment with Research Questions

Data Collection Method	**Research Question**
• Observations • Interpreter research meeting recordings • Interpreter focus group • Deaf consumer Satisfaction surveys • Deaf consumer interviews	RQ1: What systemic factors influence the connection between Deaf consumers and interpreters?
• Interpreter research meeting recordings • Interpreter focus group • Deaf consumer Satisfaction surveys • Deaf consumer interviews	RQ2: How do interpreters and Deaf consumers describe and perceive the interaction prior to an interpreted medical appointment?
• Interpreter research meeting recordings • Interpreter focus group • Google Hangout interactions • Deaf consumer interviews	RQ3: How did the co-constructed solutions influence the connection between Deaf consumers and interpreters?

Data Analysis

Quantitative

To conduct data analysis, all satisfaction survey responses (n=25) were converted to numbers and I used SPSS software to conduct the analysis. While the total number of responses was 25, there were multiple responses from three Deaf consumers and an additional two responses did not include Deaf consumer name and email. However, because each satisfaction survey was completed after a unique healthcare appointment, responding to interactions with one or more interpreter participants, I determined that I would include all 25 responses. While the interpreters went out on 252 appointments during the 10-week intervention period, only 9.92% of satisfaction surveys were returned (n=25).

Descriptive statistics were calculated on the satisfaction survey and I ran percentage statistics for each survey question. After completing descriptive statistics, I did try to run Cronbach's Alpha, chi-squared and t-test analyses on the results. However, the issue was that the dependent variable (Q15) had only 1 'no' and 25 'yes' responses. I was unable to compare a group of 25 people to 1 person. Therefore, I could not do the t-test or the other measure. I did consider using different independent variables: Q1 had all yes responses and Q13 only had 2 no responses which left me still unable to do an analysis without any valid groups to compare. This was a "ceiling effect," which occurs "when scores on a variable are approaching the maximum they can be. Thus, there may be bunching of values close to the upper point. The introduction of a new variable cannot do a great deal to elevate the scores any further since they are virtually as high as they can go" (Cramer & Howitt, 2004, p. 21). Thus the ceiling effect made analyses outside of descriptive statistics inadvisable.

Qualitative

My approach to the qualitative data collected as part of this study was informed by thematic analysis. Thematic analysis is a technique where the data is segmented, categorized, summarized, and reconstructed to capture important concepts within the data (Given, 2008). In addition, thematic analysis identifies key patterns in the data that are "important features of the phenomenon in question, according to the purposes of the research question" (Nishishiba, Jones, & Kraner, 2014, p. 8). This type of analysis requires multiple passes through the data to establish patterns and themes. I used a coding combination that utilized both *a priori* codes, and values coding, created inductively. Codes are short phrases or words that assign a "summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data" (Saldaña, 2016, p. 4).

To begin the coding process, all collected qualitative data was transferred to Microsoft Word documents. This required an extra step for the Deaf consumer interviews as I first had to interpret the dialogue between myself and the Deaf consumer from ASL to English and then transcribe into written English. Once that was complete, the observation field notes, meeting recordings, and focus group were also transcribed into Word documents. Finally, I uploaded all of the Word documents into the MAXQDA software and the first round of coding began after all documents were imported into MAXQDA.

To begin the data analysis, I chose to look at all data sources holistically and code segments without directly relating them to the research questions. I created a list of *a priori* codes found in my preliminary cycles of research and in the literature review. I anticipated these codes would appear in the data because I designed questions to specifically collect that data. Those codes are shown in Table 3:

Table 3: A Priori Codes

Satisfaction	Information
Attitude	Introduction
First Impressions	Greeting
Learning	Positive Impact
Trust	Negative Impact
Solution	Deaf Culture

The first round of coding was to use these a priori codes with the full set of collected data. At this point the a priori codes were used as coding categories, “receptacle for promising ideas” (Given, 2008), and were found through analytic induction within individual cases and across case comparisons. In order to organize the coded segments into patterns or themes that explained, supported, or contradicted the research questions, I used a code cloud in MAXQDA. The code cloud analysis began by looking at all the documents I had loaded into MAXQDA and also utilized the 1,004 coding segments from my first pass. The code cloud setting was set to a minimum coding frequency of 20 and returned 17 codes that met that criteria. The following Figure, shows the visual organization of those codes:

Figure 2: *MAXQDA Code Cloud*

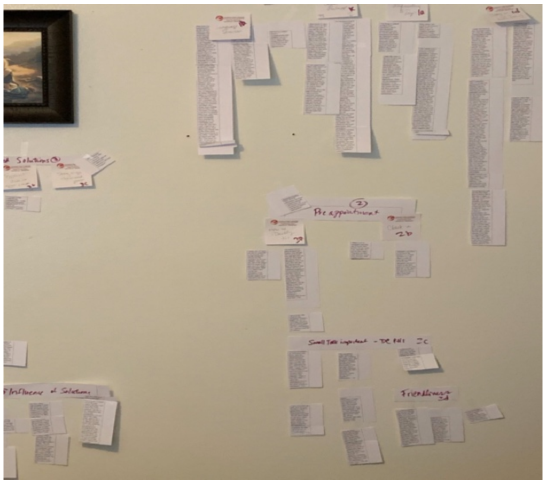
The code cloud allowed me to see the central patterns and ideas that were emerging in the data, specifically the prominence of data coded with: name badge, information, satisfaction, and interpreter friendliness among the others. The next step I took was to take the codes that did not occur in the code cloud and group them in themes that related to the most frequent codes. Some of the thematic categories I used were: satisfaction with interpreter, dissatisfaction with interpreter, communication channels, healthcare personnel, greeting, logistics, and name badge. Within these categories were specific coded segments that related to these larger thematic categories. This provided an initial framework for me to organize my data for the subsequent coding passes. As I went through the first round of coding data, I also began to notice how often a participant would attach value to perspectives on the interactions or application of solutions. The patterns I noted in the values led to the next round of coding that focused on inductive coding, also called literal, verbatim, or natural coding (Saldaña, 2016), and is defined as a code that “refers to a word or short phrase from the actual language found in the qualitative record" (p. 105). Recognizing these emerging values led me to the next round of coding.

The second round of coding focused on finding coded segments that reflected "a participant's values, attitudes, and beliefs, representing his or her perspective and worldview" (Saldaña, 2016, p. 131). This type of coding analysis fit with the theoretical framework concept that learning is internalized by an individual – the interpreter or the Deaf consumer. Some of the values represented in the coded segments were more comfortable, very frustrated/frustrating, initial moments, wanting, sharing information, not enough time, not enough information, and feel more in control. These coded segments were present in data collected from both Deaf consumers and interpreter participants and reflected individual internalization and value from both perspectives.

Finally, with over 1,000 coded segments, and despite the smaller thematic categories, it was still a challenge for me to see the overarching themes that occurred in the data. For the third round of coding I decided to use a more visual and tactile method of organization. Because I had not originally coded the data based on my research questions, it became necessary for me to correlate my coded segments with the research questions. I printed the qualitative data that pointed to key words or themes that coincided with the research questions and cut them up into participant quotes. I then took the printed quotes and visually organized them according to research question relevance and sub-categories that supported each research question. For the first research question (RQ1), I chose codes and quotes that showed factors that were outside the interpreter participants or Deaf consumers control, yet still contributed to the disconnect. Examples of the code categories that were related to RQ1 were: communication channels, healthcare personnel, agency expectations, layers of scheduling, and logistics. For the second research question (RQ2), those code categories focused on phrases that the Deaf consumer or interpreter used to describe the pre-appointment interaction. The categories for RQ2 included: dissatisfaction with the interpreter, greeting, introduction, and interpreter friendliness. Finally, for the third research question (RQ3), the categories focused on specific solutions and the influence of those solutions. Examples of categories used for RQ3 were reason for the appointment, name badge, small talk, positive impact, and satisfaction with the interpreter.

This final step allowed me to organize the data in a way that visually and logically made sense to me when writing and for alignment with the research questions. Specific quotes that did not directly answer the research questions, while still contributing to the overall context, were not included in this paper. The visual organization system I used can be seen in the following figure:

Figure 3: *Data Organization Using Quotes*



The visual organization resulted in the general themes and sub-themes that will be explained in Chapter 4. The final step was reorganizing the codes and accompanying quotes into a word document that following the order of the research questions.

Mixed Methods

The mixed methods design process allowed me to collect different types of data in order to better understand my problem of practice that could not fully be understood with only one method (Creswell, 2015). In this way, a convergent parallel mixed methods research approach was used where both types of data were collected, analyzed separately then compared to “see if results confirm or disconfirm each other” (Creswell, 2015, p. 269). My research exemplified several of the requirements of Convergent Parallel Mixed Methods Research Design. First, my research used quantitative methods by administering the satisfaction survey. This quantitative assessment included Deaf consumers’ view of the interactions with ASL/English interpreters during the intervention. To complement that method, the qualitative methods included the ASL/English interpreter and Deaf consumer views of the intervention as it was being conducted and immediately after.

Role of the Researcher

I am both an educator and practitioner in Utah, which brought an automatic affiliation with both the Deaf consumers and ASL/English interpreters. I was considered an insider as a member of the local chapter of the National Association of the Deaf (NAD) and the local chapter of the Registry of Interpreters for the Deaf (RID). In addition, I am also listed, along with my national credentials, on a state-wide interpreter recognition website. There was a possibility that I interacted with the Deaf consumer or ASL/English interpreter participants in a role other than researcher, as an educator or practitioner. This presented a challenge in perceived power difference with both Deaf consumers who might have been former consumers as well as interpreters that may have been former students or hold a certification that is lower than mine. Finally, I held a dual role as both the researcher and participant in the intervention meetings and it was important that I was seen as a co-constructor of meaning. All factors had a potential to influence participant engagement and response; however, I mitigated this by sharing my concerns with participants at the beginning of our work together.

To maintain the cultural and linguistic integrity of the interviews with Deaf consumers, questions were delivered in ASL. In order to make the ASL data accessible for coding and review, the researcher provided ASL to English interpretation via an audio recording before transcription. For interviews with Deaf consumers, I also worked with a Deaf certified interpreter to review the English interpretation provided on the transcripts before coding. The focus groups with ASL/English interpreters were conducted by the researcher and the researcher used spoken English. The focus groups were also audio recorded for data analysis.

Validity and Validation Strategies

The overall validation for my research came from collecting data from multiple and varied sources. As stated by Fraenkel & Wallen (2005), "There is no single piece of evidence that carries the day for construct-related validity. Rather, researchers attempt to collect a variety of different types of evidence-the more and the more varied the better…" (p. 159). The use of observations, meetings, interviews, survey, and a focus group provided multiple sources to cross-validate the data.

Qualitative

The primary way I validated the qualitative data was through member checking. According to Frey (2018), member checking should occur at multiple points throughout the research both informally and formally. The informal member checking occurred in the meetings with interpreters to check for understanding and I reported back on previous discussions for accuracy. Formally, the member checking also included sharing the transcription of the meetings and focus group recording, with interpreter participants, to check for accuracy and intent of each person. For the Deaf consumers, I also provided an English transcript of my interpretation of the interview for their review.

Quantitative

I used one method of quantitative data collection with surveys administered to Deaf consumers. I made sure the survey went through a feedback process to avoid "changes from time to time, person to person, or group to group, then these changes in the instrument can be confused with changes in the subjects" (Smith & Glass, 1987, p. 128). As stated earlier, there was also potential for bias due to my familiarity with the Deaf community. Researcher bias can impact analyses based on information from the group. In order to maximize validity in the survey, I developed and tested the survey instrument prior to giving to actual participants. Additionally, all participant information was converted to numbers and I worked only with raw data, void of identifying factors.

CHAPTER 4

DATA ANALYSIS AND RESULTS

The data collected in this study looked at how factors and interpreter soft skills contributed to first impressions that occurred during the initial interaction between ASL/English interpreters and Deaf consumers. Data collection focused on the intervention involving my work with interpreters to create practical solutions to enhance interactions between Deaf patients and interpreters. In mixed methods studies, "Investigators intentionally integrate or combine qualitative and quantitative data, to maximize the strengths and minimize the weaknesses of each" (Klassen, Creswell, Plano Clark, Smith & Meissner, 2012, p. 378). While this section relies heavily on qualitative data, quantitative data are also used to support findings related to my research questions: 1) What factors influence the connection between Deaf consumers and interpreters? 2) How do interpreters and Deaf consumers describe and perceive the interaction prior to an interpreted healthcare appointment? And 3) How did the co-constructed solutions influence the intervention?

Qualitative Results

The results of the qualitative data analysis indicated that a variety of factors have contributed to the disconnect between Deaf consumers and interpreters. First, the data collected from Deaf consumers and interpreters showed additional factors that have impacted the pre-appointment connection. While I began this research study assuming that the interpreter participants were responsible for the disconnect due to a lack of interpersonal or other soft skills, what I found was that there were considerable systemic factors. These systemic factors included 1) the Deaf consumer's lack of information about the interpreter stemming from layers of communication between the healthcare provider and interpreter referral agency, 2) the mandated check-in protocol that has been established by healthcare systems and agencies, and 3) the lack of consistent agency policies that would govern an interpreter's ability to stay or leave an exam room when a provider leaves the room. This section will share data that showed evidence of the above assertions and provide rich examples from both Deaf consumers and interpreter participants.

Second, I found that the Deaf consumers and interpreters both perceived that the barriers that arose from the above systemic factors created less opportunity for connection. These pre-appointment barriers resulted in the Deaf consumer lacking information on how to identify the interpreter providing service, issues with identifying an interpreter once they were at the appointment, and an overall desire for missing information to be mediated through the use of small talk period to assess language and build connection.

Third, during the intervention period, the interpreter participants generated solutions to mediate these challenges. The generated solutions were aimed at utilizing pragmatic features in the pre-appointment period and incorporated wearing a name badge with clear information on the upper part of the body, using the small talk period to ask the Deaf consumer about the reason for the appointment, and using that same period of conversation to discuss the potential protocol should a healthcare provider leave the exam room. The findings also showed that increased attention to wearing a name badge, directly asking Deaf consumers the nature of their appointment, and pro-actively discussing a protocol for staying or leaving the room resulted in a positive impact for the

Deaf consumers, the interpreters themselves, and healthcare personnel. The quantitative data of overall satisfaction from the Deaf consumers complemented these findings.

RQ1: Factors Affecting Interpreter-Deaf Consumer Connection

Several systemic factors were identified as potential contributors to the disconnect between Deaf consumers and interpreters. These factors included challenges in communication between the agency and healthcare provider, the required check-in procedure, and interpreter referral agency policies. These systemic issues appeared to have a negative influence on the connection between Deaf consumers and interpreters. The disconnect often began within communication from the healthcare provider's office when an interpreter was arranged as an accommodation for a Deaf patient. I discuss these areas further below, addressing my first research question, about systemic factors. In addition, I discuss participants' perceptions, which touches on the second research question.

Omission of appointment details affected connection. The use of interpreting services begins with a Deaf consumer making a request for an interpreter when scheduling a healthcare appointment. If the healthcare provider is familiar with the Deaf consumer, they may already have a standing request but in most cases the Deaf consumer initiates the accommodation with the healthcare provider. The healthcare provider, if willing to provide the accommodation, will then contact an interpreter referral agency to request an interpreter. However, because the Deaf consumer is not the one making the request directly to the interpreter referral agency or interpreter, the power of selection and completion of the request has shifted to the healthcare staff member assigned to take care of these requests. It is important to understand the communication chain relaying information about the healthcare appointment, which formed the context of my research. First, the healthcare staff member contacts an interpreter referral agency to request an interpreter. Then, the interpreter referral agency collects as much information about the appointment with the intent to share any collected information with the interpreter. Lastly, the interpreter receives appointment details that include the Deaf consumer's name, location, time, and at times, the nature of the appointment. However, in larger hospital systems, an additional barrier is added when the healthcare provider submits the request through a language services coordinator and does not contact the interpreter referral agency directly.

This communication chain removed the Deaf consumer participants in my study from a position where they would have had the opportunity to make decisions about the interpreter assigned for their healthcare appointment. In this manner, when a Deaf consumer is removed from the decision-making position, they had to rely on the healthcare provider to relay crucial appointment details. When that didn't happen, the Deaf consumer and interpreter were already at a disadvantage before the appointment began. Unfortunately, because not all healthcare providers were familiar with the role of the interpreter or the importance of communicating detailed information about the healthcare appointment, this resulted in omission of information. The missing information, as described later in this chapter, often created challenges for both the Deaf consumer and interpreter.

Deaf consumer lacked information. An initial finding, related to omitted information, was that there was an inequality between the amount of information interpreters had about the Deaf consumers versus how much information Deaf consumers had about interpreters. The general practice, as mentioned above, was that the agency would provide the interpreters details about the appointment, including date, time, location, doctor name, and Deaf consumers' names. However, the Deaf consumers were left without any information about the interpreters. When asked during the interviews, there was consensus among Deaf consumers that the interpreter is unknown to them prior to a health care appointment. Ann, a Deaf consumer, when asked if she receives information about interpreters, said, "Oh no! No, never! Never!" Another Deaf consumer, Sara, when asked the same question, also emphasized, "Oh, no, no, no, no, no. I never know until I get there and I see somebody walk in the door." The emphatic responses from both Ann and Sara indicate that they viewed the idea of knowing the identity of an interpreter in advance as unthinkable. Likewise, Peter, another Deaf consumer, indicated that, despite being familiar with many of the interpreters in his area, he still didn't know which interpreter, or which interpreter referral agency, would provide services for an appointment: "I do know most of the interpreters in the area. I know which agency they work for, especially those that work for SignOn Interpreter Referral Agency. I'm pretty familiar with who works for which agency. So I know them when they walk in."

Thus, the Deaf consumers that were interviewed were in agreement that prior to seeing an interpreter at a health care appointment they are unaware of which interpreter, if any, would be arriving at the appointment. However, despite consensus with the Deaf consumers that this was a common practice, Sara said, "It doesn't bother me that much. You know, as soon as they get there, then I know who they are, I don't really think about it." This quote illustrates two points: 1) That Sara has accepted not knowing who the interpreter is before an appointment as routine, and 2) The moment an interpreter arrives at an appointment is when she will have the information about who is providing the interpreting service. When asked the same question, Ann said:

> It's fine. That's the way it is. I don't really care that much about who's coming. You know, I'm always hoping that a specific interpreter comes, because I know the communication will be easy and that the interpreter is friendly.

These quotes illustrated that Ann and Sara have accepted the practice of not knowing which interpreter, in advance, would provide interpreting services for their health care appointments. But, Ann, in addition to affirming that she didn’t know which interpreter was coming, also had a desire for self-determination in working with a certain interpreter that she felt a connection to. Without having the information prior to the appointment, the Deaf consumers assumed a ‘wait and see’ attitude that, should a familiar or ‘hoped for’ interpreter not show up, could create a disconnect.

In a like manner, interpreters also shared their perceptions about the appointment information, and indicated an acceptance of details they received prior to a health care appointment. During the interpreter participant focus group, Melissa reflected that “the agency makes these standard practices easier by communicating with us in a manner that gives us all the information we need, whether it be location, time, client name, type of appointment, male or female, so that we can do our job better.” As Melissa indicated, the standard practice came from an interpreter referral agency, and as an independent contractor with that agency, the information she received was accepted as a ‘matter of fact’ part of the work. While both the Deaf consumers and interpreters didn’t consider the amount of information included in the healthcare appointment details a problem, there was an identified inequality between who would know the other, before an appointment, and be able to use that information in the pre-appointment interaction. As will be discussed later, when the Deaf consumer didn't know the interpreter's name in advance, and the interpreter had the Deaf consumer's name, there was still an additional barrier for connection.

Missing information about the nature of the appointment. An additional barrier to the pre-appointment interaction occurred as information about the nature of the appointment was not accurately relayed to the interpreter. In an open-ended interview question, Ann, a Deaf consumer, expressed her frustration with providers that did not give the full details of an appointment to the agency that scheduled the interpreter:

> I think that most of the time doctors just call and make an appointment and just say we need an interpreter and are done with it. I don't know that all doctors really explain more about what's going on. I think they could say, "It could be a sensitive appointment, make sure the interpreter is prepared." If the interpreter wanted to, they could call and ask them questions. They could give them some more information.

This quote provides an example of how the nature of a sensitive appointment impacted how both the Deaf consumer and interpreter approached the appointment. In addition to lack of information regarding the nature of an appointment, there were additional challenges when the interpreter couldn't directly communicate to the healthcare provider due to incomplete appointment details. Jane, one of the interpreter participants, shared her experience being delayed and the impact on the appointment:

> Yesterday I had an appointment, a doctor's appointment, and on the way, I was going to be 10 minutes early and then six cars got in an accident on the 15 right

> by Charleston. So I called and said I was going to be 10 minutes late. I came in the door and this woman says, "You're here!" and takes off running down the hall… I start running after her ‘cause I'm like, she must need me to come right now. So I'm running down the hall…I go in exam room one and I see the Deaf person sitting there and I'm like, “Hey,” and the doctor is right next to her. And I'm like, "You didn't want to wait for me?" He's like, “No, don't worry. I wrote it down.” And then we were done, and we left. I was like, I can't believe you guys didn't wait for me. I was 10 minutes late for a legit reason…they proceeded without me and the doctor kind of just wrote the notes that he thought about.

Jane was incredulous that despite her best attempts at keeping the healthcare provider’s office informed of her delay, they proceeded without her. The Deaf consumer was left to rely on handwritten notes from the doctor and Jane was unable to provide the service she was hired for. This illustrated how various communications channels, required when requesting an interpreter, removed the Deaf consumer even further from a position of power. Deaf consumers did not have the opportunity to receive information about the interpreter in order to accept or reject the interpreter that could be assigned to a healthcare appointment. The interpreters didn’t always have the correct information about the appointment, including the nature of the appointment or how to contact the healthcare provider. Given this disempowerment for the Deaf consumer and interpreter, there was already potential for disconnect before the appointment began.

The check-in protocol affected connection. As mentioned above, an additional challenge arose when larger systems employed a language service coordinator to take care of interpreting services. In order to account for interpreter services, the language services mandated that an interpreter check-in and check-out for each appointment at their facility. The check-in process was an electronic or hard-copy form that had to be signed in order for the agency, and ultimately the interpreter, to receive payment for services. Interpreters navigated this process before and after a health care appointment and this took away from time that could have been spent with the Deaf consumer. Dean, an interpreter participant, shared his frustration with the check-in procedure when trying to follow protocol during an evening/off-hours appointment:

> With some medical appointments I can do check in and check out, as needed, but it seems like when I go to the hospital or something like that, they always have to call language services and it just seems like they can never get ahold of language services to release me, you know? And so I think that might be a difficult problem with the agency and language services at the hospital…I usually go at nighttime and interpret, and I can be there the whole time waiting for somebody just to sign. It's happened to me before where I've waited for somebody to sign… And there I was just sitting there for another hour waiting for somebody to call…You know, we just got to figure this out. How we can make it better?

In this quote, Dean showed consistent effort in trying to complete the check-in protocol and yet was unable to do so because of the time of day. He also acknowledged that the check-in protocol is another level of ‘red-tape’ that stands between the interpreter referral agency and the healthcare system; resulting in the interpreter being further removed from autonomous decision making about how time is spent before and after a healthcare appointment.

In addition to the interpreters' awareness and frustration with the check-in process, Deaf consumers also indicated knowledge of the check-in process and their acceptance of the protocol. However, despite their awareness of the protocol, the Deaf consumers' signature or consent was not a requirement. This was an example, again, of a Deaf consumer being on the sidelines of their healthcare appointment and added an additional factor of disconnect when the check-in protocol was followed. Ann, a Deaf consumer, said, "The interpreter would be there, and I know they use their phone to check-in at the appointment. So I know the routine." Another Deaf participant, Sara, shared a similar understanding about what is taking place at the beginning of an appointment, "They already see me most of the time and then they go up at the front desk and I know they're checking in…That's pretty much the routine of every appointment." The Deaf consumers have been exposed to this check-in procedure enough that it has become routine for them and an accepted part of the pre-appointment process.

The interpreters also noted that the Deaf consumers encouraged them to complete the check-in process before an appointment. Felicia, an interpreter participant said, "They know because they go to the doctor all the time, so they know that it's required…and in my experience they will tell me, 'Go ahead and check in' or 'I waited for you.'" However, despite knowing this process must occur, the Deaf consumers were excluded—their signature, acknowledgement and agreement were not a required part of the protocol. Their 'bystander' status in their own healthcare appointment highlights an additional factor of disconnect that is created within the check-in protocol.

Once an interpreter had been scheduled and the interpreter had successfully checked-in, there were additional systemic factors that affected how Deaf consumers and interpreters perceived the pre-appointment interactions. An example of how agency policy, established without Deaf consumer consent or agreement, affected the connection with the interpreters is shared in the next section.

Agency policies affected connection. There was a lack of policy standardization within the professional interpreter organizations or between agencies about best practices in handling a healthcare provider leaving the exam room. Some agencies had policies instructing the interpreter to leave the room with the provider/healthcare professional. Other agencies did not have a policy and placed the responsibility for that decision on their contracted interpreters. Without guidance from the interpreter referral agency, not all interpreters were comfortable self-determining and expressed a desire for the Deaf consumer or agency to make that decision. While not a pre-appointment event, the pattern of confusion and bureaucracy was noted in most of the data, including the Deaf consumer and interpreter perspectives. Melissa, an interpreter participant, shared her frustration with the lack of consistent guidance and how that affected her trepidation before an appointment:

> I experience a lack of consistency on the interpreter profession, to provide guidelines as to how we will interact with other professionals in the room, whether we will stay in the room alone with the patient. So you've got the last interpreter, "She sat up here on the table with me" and then "This interpreter is going to wait outside until there's another professional in the room with you." And so that irritation that the client experiences as well. "The last interpreter was so much nicer!"

Melissa expressed her own frustration with the lack of standardization and also acknowledged how that impacted a Deaf consumer. She specifically mentioned the irritation and comparison from a Deaf consumer who experienced different interpreters, resulting in an impression that interpreters that stayed in the room and engaged in casual conversation during that time were seen as “nicer.” Melissa’s understated conclusion is that if she was one of the interpreters who decided to leave the room, even when following agency policy, she would be perceived as “not nice.”

As the above quote illustrated, agency policy directly impacted the interpreter’s ability to interact with the Deaf consumer. In like manner, Deaf consumers were also affected negatively when the policy was unclear, or the interpreter chose to stay/leave the room. Several of the Deaf consumers commented that, as a cultural and linguistic minority, the opportunity to communicate with someone else who signs is infrequent and any encounter with an interpreter provided a chance for them to sign with another person, even briefly. Sara, a Deaf consumer, said that she enjoyed the time spent chatting with interpreters when they stayed in the room:

> I really like them to stay. It doesn't bother me. I like the chatter. I know some of them have rules that say they have to go outside the door, but that's so terrible because then I'm sitting there by myself. Isolated. I prefer to have somebody chatting, even if they're standing halfway in the door, outside the hall. But some of them tell me that they can't stay in the room with me and so, um, they have to go out in the hall. I don't quite understand what that's about. I mean, what's the harm in chatting? But that's the way it is.

This provides an example where Sara, despite understanding the policy, didn’t agree with it and preferred that the interpreters stay in the room, or within eyesight, so she would have had an opportunity to connect through chatting. Another Deaf consumer, Peter, shared his negative experience with an interpreter’s decision to leave the room with the healthcare provider:

> I remember when I went into the appointment, I was chatting with the interpreter and we went into the exam room and I sat down and the doctor left and then [the interpreter] immediately went out and closed the door. I was left by myself in the room and I had no idea what was happening. I was all alone. I just kept waiting and waiting and waiting. And I thought, “Where is the interpreter?” No one was coming in. I thought, well, maybe she went to the bathroom and she'll be right back. But some time went by and she never did come, and I kept waiting. I decided to go outside the room, and kind of opened the door a little bit and there she was standing just outside the door! Just standing in the hallway looking around and texting on her phone or doing something else on her phone. I asked her, “Is there something wrong?” and she replied, “No, why?” I said, “Well, I am wondering why you left the room and why I am by myself in the room?” She said, “Oh, it's for Deaf mental health” …And it was very insulting. I was offended. I didn't really have a response. I just closed the door and sat down again and began waiting.

Peter disagreed with the interpreter’s decision to leave the room but was unclear what rationale the interpreter used for the decision. As a result, Peter was left in the room without information or access to anyone that signed and felt upset and offended. While this situation did not occur during the pre-appointment interaction, prior negative experiences affected both the Deaf consumer and interpreter and may have decreased connection and trust for any subsequent appointments, regardless of who the Deaf consumer or interpreter was.

The data presented in this section highlights the need for intervention that is framed within Sociocultural and Experiential Learning Theoretical approaches and incorporates engaged learning. These theoretical approaches are embedded in experiences that are both forward looking and predictive of what a person can learn or apply in the future and include “social relations or relations among people, [that] genetically underlie all higher functions and their relationships” (Vygotsky, 1978, p. 57). As seen in the above examples, interpreters have internalized their past experiences interacting with Deaf consumers and created an approach to interpreting. In the same way, the Deaf consumers have acted as co-creators of meaning within their own experiences and bring that to their interactions with interpreters. Through the intervention, which included authentic situations and settings, additional meaning was co-created and new experiences in the intervention resulted in an acquisition of new beliefs and behaviors.

RQ2: Perceptions of Interactions Prior to Health Care Appointments

As outlined in the above section, there were several systemic challenges that provided the context for the interaction between the interpreter and Deaf consumer. These systemic challenges, commented on by both Deaf consumers and interpreters, highlighted that the pre-appointment waiting period presented challenges and opportunities for making a connection. One of the specific challenges mentioned was difficulty in identifying one another based solely on prior experience with one another or by using only a name. All participants commented, related to insufficiencies in identification, that in the absence of robust appointment information, they would use non-traditional methods to identify each other upon arrival and glean additional information through small talk. In addition, small talk was used as a means to enhance the interpreter-Deaf consumer connection through friendly behavior. In the following, I discuss these areas, which specifically addressed my second research question, about participants' perceptions of the interactions preceding appointments.

Alternative methods used for identification. In order to work around the lack of information relating to which interpreter would be at a health care appointment, the Deaf consumers reported that, in the absence of a name badge, they used visual cues to identify the interpreters. As an important feature of ASL pragmatics, Deaf consumers rely on attention getting as the gateway to conversation. If the interpreter was someone they had worked with in the past, then they looked for a specific face and signs of recognition between them. Without a badge, the Deaf consumers often watched the front desk to see if the healthcare staff motioned someone towards them. For instance, when asked how she identified the interpreter, Sara, a Deaf consumer, responded:

> I'll kind of look at them [the reception/front desk] and I'll see somebody pointing at me and then I'll wave and that's kind of how they identify me. I think that's how they know…. I'm not usually a new face [to the interpreter] and I'll look for anybody coming in the door to see if it's a new interpreter.

This quote illustrated how Sara used pointing, waving, and vigilant watching to spot a new-to-her interpreter. Again, without having prior information about which interpreter was assigned to an appointment, the Deaf consumer assumed the responsibility to watch the door, the front desk, and anywhere in the waiting area for clues to the identity of the interpreter.

Interpreters also commented on the clues Deaf consumers used to identified interpreters. For instance, one of the interpreter participants, John, relayed his experience when a Deaf consumer did not recognize him as the interpreter: “One of the things that I've heard in the past was, “Oh, I didn't see your name badge, or I didn't know you are the interpreter. I just thought you were another patient or, or what have you.” As John indicated, the lack of identification led to a case of mistaken identity and added an extra layer of work for both Deaf consumer and interpreter.

Yet, there were times that the interpreters arrived first and reported that, despite having the information about the Deaf consumer, they also engaged in clue-finding behaviors. The interpreters also positioned themselves where they could be easily seen. For example, in one of my observations I noted that interpreter sat near the entrance of the waiting room and the Deaf consumer walked up to her after looking at her name badge, and signed “Are you the interpreter?” The interpreter explained that yes, she was the interpreter, and informed the Deaf consumer that she had already checked in at the front desk, prior to the Deaf consumer’s arrival, and informed them that she was there and where she would be waiting and watching. The interpreters in the research meetings also commented that they often waited in a visible area to ‘scout out’ the Deaf consumer prior to the appointment. These examples supported the perspective that interpreters also shared the responsibility for identification and watching for visual cues as a behavior that Deaf consumers also engaged in.

Information learned through small talk. Both Deaf consumers and interpreters considered small talk to be an important sociocultural tool to use in the pre-appointment period to gather vital information from one another and establish a connection. For both Deaf consumers and interpreters, small talk prior to an appointment was used to gauge each other's language. On a related note, the participants also felt that small talk could be associated with friendliness.

Deaf consumers and interpreters used small talk to assess language. For both the Deaf consumers and interpreters, small talk served to provide information about language use. For Deaf consumers, small talk helped illustrate the interpreter's fluency with the language. For instance, Peter, a Deaf consumer, commented:

> I've had interpreters ask me before, you know, what my appointment is for and I'll tell them briefly and explain what to expect and make sure also that they understand my signs. That way I know whether I have to kind of dumb it down for them or can use more fluent American sign language. I want to have that ability to match the interpreter's level of understanding and that gives us both an opportunity.

This quote illustrates that small talk served a linguistic purpose as Peter adjusted his sign system dependent on the interpreter's fluency as evidenced through signed responses. The other Deaf consumers shared similar perspectives that small talk was used to find out how or where an interpreter learned sign language. This information assisted Sara, a Deaf consumer, with assessing fluency by learning where interpreters "picked up their signs" (learned sign language), which also gave information about the interpreter's connection to the Deaf community. Learning sign language through a Deaf family member or friend can mean the language is more natural compared to that of an interpreter that attended a training program where they are formally taught the language. In her interview, Sara showed a preference for interpreters that have Deaf parents because “they sign better at times,” indicating her view that interpreters with Deaf parents possess a natural style and mastery of American Sign Language or other sign language systems.

In a similar manner to how a Deaf consumer used small talk, Melissa, an interpreter participant, shared how she used even a brief period of small talk to assess language:

> Unless you're…unless you're not from here and you don't know these clients and they're not familiar with who you are, you are using those initial moments to gauge language, to gauge trust, all of that in a very, very short window.

Thus, the small talk was essential for both Deaf consumers and interpreters as they utilized information from the discussed topics to assess language through seeing each other sign during casual conversation.

Friendly behavior associated with small talk. In addition, small talk emerged as a method of engaging in friendly behavior that assisted the Deaf consumers and interpreters to establish connection with each other. The topic of an interpreter’s friendliness came up in all three interviews with Deaf consumers and eight satisfaction surveys. In addition, I observed friendly behavior in all three of my observations of interactions prior to appointments. During one observation, I noted that, within a few minutes of arrival, both Deaf and interpreter participants were laughing, and while I was not within eyesight of the participants, I could tell that they were joking with one another and considered it to be a friendly exchange. After they both came into my view, I asked the interpreter what they were laughing about and she reported that when asking the Deaf consumer's consent to be observed, he responded that he would be glad to, "for a fee" and both chuckled as this was shared with me. There were fewer than five minutes from the time of check in until the Deaf consumer and interpreter were called back to the appointment, yet the tone of friendliness was set for both the interpreter and Deaf consumer through the vehicle of small talk.

In addition to my observations, one of the satisfaction survey responses from a Deaf consumer remarked that after the initial check-in process, the interpreter "got up when he saw me and was friendly and cheerful" and their small talk continued, "After checking with the receptionist, he explained about the survey and handed me the card [satisfaction survey link]." This was an example of how small talk was not always limited to the waiting room and could occur throughout the appointment. It also showed that the interpreter took the lead in explaining the satisfaction survey, used for this research project, and took the time to explain it to the Deaf consumer. An additional seven survey responses commented on the interpreter's friendliness for the open-ended survey question that asked, "What did you notice about this interpreter's interactions with you before the appointment?" These qualitative examples provide evidence that the type of topics discussed in small talk and the friendly mannerisms of the interpreter are interconnected.

For a Deaf consumer, first impressions can be based on whether an interpreter chooses to be friendly and engage in small talk. For one of the Deaf consumers in this study, Peter, he expressed a desire for the interpreter to be someone he could engage with and 'be there' for him. He said that he prefers:

> “Interpreters that are very friendly right off the bat and smile. Sometimes they look so grumpy, they don't even engage with me. They sit there on their phone; they have an unfriendly face and I always assume that it's their problem and not mine. Maybe they're having a fight or an argument with somebody else that I don't know. But I think it's important that when they're on the job that they are friendly. Once they're out of the job or before the job, they can have whatever personal life they want. But for me, especially if I'm hurting or I'm sick, I want the interpreter to be there for me”.

This brief narrative illustrates the importance of first impressions, especially positive ones, and how a Deaf consumer can connect or disconnect with an interpreter based on those first brief moments.

While the specific quotes shared above focused on friendliness, there is an underlying feeling that an interpreter’s friendliness can lead to increased trust. In fact, in addition to the Deaf consumer perception of friendliness, an interpreter participant, Felicia also stated how a brief small talk window is a key component of the pre-appointment interaction to build trust and create comfort:

> And I would add to that, what I call building the trust, building the foundation of trust with the client before I go in. I mentor interpreters and that is a big part, I think, if the Deaf person trusts you and they're comfortable with you, even if it's just for three minutes of time.

These quotes suggested that when there was a new relationship established with a Deaf consumer, the interpreter used the small talk to build trust, a critical component of connection.

The data presented in this section provided perspectives from both Deaf consumers and interpreters about the pre-appointment time period and how it served to establish connection through the identification process and through small talk. As mentioned in the previous section, some barriers to connection were found in the inequality of information possessed by the Deaf consumer compared to the interpreter and the interpreters' lack of detailed information about an appointment. The data suggested that when there was clear identification of the interpreter, small talk was used, and friendly interactions occurred, the potential negative influence of these challenges could be minimized.

Sociocultural Theory emphasizes the primacy of social interaction in human cognitive development in which human mental abilities emerge twice: "first, on the social level, and later, on the individual level; first, between people (*interpsychological*) and then inside the learner (*intrapsychological*)" (Vygotsky, 1980, p. 165). From this perspective, learning and development of identification, occurred for both Deaf consumers and interpreters on two planes: first during the social plane in situated learning interactions with each other prior to the health care appointment that led to mediation and co-construction of meaning. And on the second plane, learning occurred with internalization of each individual. Each participant, whether Deaf or hearing, when faced with the challenge of identification and in the absence of a standardized approach, developed alternate methods for identification in the psychological plane. As a result, both the Deaf consumers and interpreters used visual cues, location, and social cues for connecting pieces of information in the social plane. The social and individual interactions led to the process of identifying each other, whether through cues or prior information, and was developed in both Deaf consumers and interpreters.

The intervention I facilitated incorporated generation and application of solutions to navigate these challenges and leverage the benefits of small talk. This intervention, supported by Experiential Learning Theory (Kolb, 1984), created increased opportunities for positive interaction between Deaf consumers and interpreters through cycles of transformative learning. The following section illustrates how interpreters and Deaf consumers utilized concrete, immediate experiences to reflect, act upon, and extend those learning experiences (Kolb, 1984). Specifically, the next section addresses how the interpreter participants extended their experiences to include not only their individual learning but also incorporated data collected from Deaf consumers during the intervention to generate solutions.

RQ3: Co-Constructed Solutions and Influence on the Connection Between Deaf Consumers and Interpreters

During the 10-week intervention period, the interpreter participants met with me three times to discuss their ideas for how to overcome the challenges represented above and improve the connection with Deaf consumers. The interpreter participants generated solutions to the challenges listed above: 1) an imbalance of information, which created difficulty with identification, 2) a lack of linguistic knowledge about the Deaf consumer and vice versa, and 3) missing appointment details that could help facilitate the interpretation. There were some additional challenges that came up during the first two research meetings and the interpreters also worked to mediate those challenges by incorporating the solution within small talk. Those additional challenges were discussed earlier and related to ascertaining the reason for the appointment and negotiating the protocol for interpreter presence when a healthcare provider leaves the room. Discussion about solutions within the three meetings created an opportunity for interpreter participants to co-construct meaning with each other, with me as the researcher, and the Deaf consumers. The following section shows how these solutions were positively accepted and noted in all forms of data collection.

During the first research meeting I provided context and background information for the interpreter participants by shared preliminary research findings from a Deaf focus group from a previous cycle of research; the above challenges, along with others, were included in the discussion. I brought one solution to the research meeting, based on the Deaf focus group feedback, and presented it to the interpreter participants. To mitigate the challenge of identifying the interpreter, a finding from my preliminary research, I introduced a new version of the SignOn Interpreter Referral Agency's name badge. The new name badges were sent to the interpreters prior to the first week of the intervention and we discussed the name badge wearing during that first meeting. This solution was a way to not only begin the conversation as we worked together, but to also provide them with an example of a simple solution that we would implement during the intervention.

The remaining solutions generated were part of the organic discussion that took place in our meetings together. Those solutions included: 1) a redesigned name badge, 2) using the small talk period to pose a direct question to the Deaf Consumer about the nature of an appointment, and 3) using the small talk period to discuss, with the Deaf Consumer, agency policy or preferences when a healthcare provider leaves the exam room. At the conclusion of each meeting we discussed what solutions would be implemented in the follow two-week period and each participant agreed to implement them during that time.

The interpreter participants and I worked together as a Community of Practice (Wegner, 1998) during the intervention. According Situated Learning Theory, the research project work between myself, interpreters, and Deaf consumers could be considered an example of a community of practice (COP) that included mutual engagement, a joint negotiated enterprise, and a shared repertoire (Wenger, 1998). Additionally, this learning occurred unintentionally and was embedded in activity, context and culture (Lave & Wenger, 1990). As a community of practice, it was important to stay connected during the intervention and I asked the interpreters what means they would like to use for sharing information outside the research meetings. The interpreters discussed email, Facebook, and text, and ultimately agreed to use Google Hangout. The Google Hangout became an additional 'meeting place' for feedback, questions and allowed all participants to connect with each other and me between meetings.

During the research meetings we also discussed the satisfaction surveys that were disseminated to Deaf consumers immediately after a health care appointment. My goal in sharing the anonymous survey responses with the interpreter participants was to help them see immediate data related to the impact of the solutions they adopted. At the first meeting there were no satisfaction surveys shared but there were responses shared in the subsequent meetings. In the following section I discuss the three solutions generated by the interpreters and the impact of those solutions, thus addressing my third research question.

Name badges. As mentioned earlier, I introduced the name badge solution during research meeting one and over the course of our meetings together the interpreter participants offered their own suggestions on how to use and enhance the badge. As background information, each interpreter that works for SignOn Interpreter Referral Agency was issued an identification badge to use for any interpreting appointment. The established SignOn Interpreter Referral Agency name badge included a red background to match the company logo, the interpreter's picture, the company logo, the interpreter's name and "Independent Contractor" in a white font. Additionally, the name badge was laminated and had an attached clip. I obtained permission from SignOn Interpreter Referral Agency to re-work their badge. I created a new name badge to reflect those that I have seen worn by healthcare personnel and staff. The new badge was slightly larger, had a white background, included the interpreter's picture, their name and "ASL/English Sign Language Interpreter" in black type, and the SignOn Interpreter Referral Agency logo. My reworked badge used a different photograph than my original SignOn Interpreter Referral Agency badge; however, the participant badges used the same photos that were kept on file with SignOn Interpreter Referral Agency. The paper badge was housed in a plastic badge holder with a detachable clip. Figure 4 shows a side-by-side comparison of the two badges, using my own badges.

Figure 4: *Name Badge Comparison*

Interpreters' enthusiastic adoption of and engagement with the name badge. The interpreter participants received a new name badge as the first solution of the intervention. I mailed out the new badges to the interpreter participants during the first week of the intervention and before the implementation period, and the interpreters showed an enthusiasm for the name badge solution. When the first research meeting started, John, an interpreter, joined the online meeting and was already wearing his badge. He excitedly shared the following:

> I like the way I'm wearing mine…. The point is that they can see that, hey, you're an official person. I can go and talk to you…and by the way, I think these are fantastic!

John's enthusiasm for the name badge was apparent at the first meeting. In like manner, the other interpreters favored the new name badge design and enthusiastically embraced it as a solution they would readily adopt for the duration of the intervention. Their enthusiasm indicated that the interpreter participants had already noted challenges with the former name badge and those challenges were discussed during each research meeting.

In addition to the adoption of the new name badge design, the interpreters collectively negotiated how to wear the name badge. Paul and Melissa, two of the participants, proposed using a lanyard for their badge by saying, “We wear them on lanyards. We like lanyards.” Other interpreters disagreed and suggested that the badges be clipped to the lapel or shirt collar, and in an attempt to include all perspectives, Noah, an interpreter participant suggested that each interpreter should have choice about how to wear the badge (lanyard or lapel) as long as it was in a visible location:

> Let’s just say if we feel it's more effective above the waist, then let's just say it needs to be however you feel appropriate, but it should be prominently displayed above the waist and you know, pinch it to your nose, whatever works.”

Noah’s comments and the ensuing discussion with other interpreters showed that the interpreters were concerned that the focus of wearing the name badge should be on visibility, not on specifics about where the badge should be worn. At the conclusion of the discussion about where to place the name badge, the interpreters agreed each would determine whether to clip it to the lapel or wear it on a lanyard. The consensus reflected the interpreter’s desire to ensure that the name badge was visible to the Deaf consumer and anyone else involved with the healthcare appointment.

Deaf consumer feedback informed the name badge use. A complementary solution was generated during the first week of wearing the new name badge after the Deaf consumers did not readily notice the changes to the name badge. The input gathered from the Deaf consumers was vital to the interpreters' collective use of the name badge. The need for additional Deaf consumer feedback was shared in the Google Hangout. Rachel commented that the Deaf consumers she was working with were not voluntarily commenting on the new name badge. She wrote, "I've received no unsolicited comments about the name tag. I'm willing to solicit feedback." This was an example of Rachel's concern for both the name badge solution and her desire to ensure feedback was collected from Deaf consumers. After a brief round of messages with three other interpreters, they agreed that they would directly solicit feedback from the Deaf consumers by asking them what they noticed about the name badge. The decision was relayed to the remaining interpreters so that, in the event that the Deaf consumer overlooked the new badge, the interpreters would show the old and new badge before asking for feedback.

During the second research meeting, the interpreter participants shared the responses they collected about the name badges. In addition to what they gathered, I also shared feedback from the survey respondents. In one of the satisfaction survey responses, a Deaf consumer directly addressed how the interpreter solicited feedback about the name badge: "This interpreter did take the time…showing me which [SignOn Interpreter Referral Agency] (red or white) badge is appealing to me and I chose the white background." During research meeting #2, Melissa, an interpreter, shared that she believed the Deaf consumers didn't like the white badge because they associated the color red with the SignOn Interpreter Referral Agency logo:

> One client said, "Oh, but red, know SignOn Interpreter Referral Agency." So they were comfortable with the red because without even thinking they see red. They

> know it's us and we're the largest agency in the valley, so they know we're coming.

Melissa’s quote not only incorporated how she solicited feedback but also the Deaf consumer’s response and an indication that she was concerned that all perspectives of Deaf consumers be included. There were echoes of the same perspective shared by other interpreter participants as they proposed changing the ‘new’ name badge to appeal to those Deaf consumers that expressed an association between the color of the badge and brand recognition for SignOn Interpreter Referral Agency. Felicia, an interpreter, commented, “I think what they're recognizing is the red color. And so what if you did like a red square behind the picture.” Felicia’s idea for a compromise was quickly accepted as another interpreter designed a quick mock of the badge with the red border. The interpreter participants generated several modifications to the name badge color and design but after seeing the changes on a shared screen, the group consensus was that the name badge would be left as-is. The interpreter participants agreed that the design of the badge was secondary to the wearing of clear identification. The interpreter participants’ discussion of changing the badge design reflected not only their enthusiasm in continuing to use the name badge but also showed a collective agreement to incorporate the feedback from the Deaf consumers.

As found in Experiential Learning Theory, this is one example that reflected the interpreter’s cycles of learning. First, the concrete experience occurred when the interpreters applied a generated solution, like wearing a new name badge. Second, the interpreters observed how the solution was perceived by the Deaf consumers. Third, they internalized and considered how the Deaf consumers’ feedback either supported or detracted from the original solution and reflected on modifications or alternative approaches. Lastly, the interpreters discussed their ideas with one another and experimented with different approaches, including a consideration of further implications of those changes. The interpreters' sharing of feedback in different situations was critical since "change and adaptation to environmental circumstances are central to any concept of learning" (Kolb, 1981, p. 290).

Influence of the badges. The comments about the name badge were positive from both Deaf consumers and the interpreter participants. The impact of wearing the name badge was noted in the satisfaction survey responses when the Deaf consumers wrote, "I love the badge. It was easier. It's easy to see overall" and "I think the ID tag hanging from his shirt collar was neat and impressive." During a post-intervention interview, I asked what was noticed about the badges, and Peter, a Deaf consumer, shared the following:

> It looked very professional and I knew who the interpreter was immediately, and I feel like, well that's their job. They should be identified. I wish all interpreters had that…I think the white is more professional, more classy. It's not sad like the other one, the red one. So, the white one is just easy to recognize, and I know the interpreters had asked me what I thought about them and I told every single one of them I prefer the white one and I don't want to see the red one again!

Peter's comment highlighted the reason why the name badge was a positive change; the new name badge was professional, the white background made it easy to read, and the interpreter was quickly identified. The positive identification, through the name badge, created an immediate and timely connection with the interpreter before the healthcare appointment began.

In addition to positive feedback from Deaf consumers, the interpreter participants noted that the new badge also affected how they were perceived by healthcare personnel during the appointment. Jane, an interpreter participant, indicated that she felt other personnel treated her with increased professionalism and that the badge added credibility to her presence at the appointment:

> I did have several providers look at the white badge and talk to me more as a nurse or an equal, than as a family member. Before with the red badge, they basically just ignored it and, and they were like, “Well, you already know this person, so you need to give me the background”.

This quote indicated that the healthcare personnel viewed the white name badge as proof of the interpreter’s professional role; that they were not there as a family member or friend of a patient. In situations where a family member or friend attempts to provide interpretation it can be viewed as unprofessional and in some cases unethical. Kristy also said, “It just seemed like the staff at the hospital was more drawn to it and I kind of liked that because you don't have to introduce yourself all the time.” This type of positive reaction allowed the interpreter participants to see an unexpected impact of wearing their name badge. The name badge, as designed and adopted, was met with positive reactions and increased the ability for all participants of a healthcare appointment to identify the interpreter.

The decision to adopt the new badge was an effective solution and garnered positive feedback from Deaf consumers in both the satisfaction surveys and interpreter feedback shared during the remaining research meetings. The name badge, as a tool, changed the nature of the relationship with Deaf consumers, enhancing the learning for the interpreter participants. Once the interpreters saw the positive reaction with Deaf consumers and healthcare personnel, they agreed in the third research meeting to extend wearing the name badge and solicit feedback until the end of the intervention. The name badge was so successful that Paul, an interpreter participant, asked, "I'm just wondering if we get a green light to, keep the white card [name badge] going forward?" and all of the interpreter participants agreed that they wanted to permanently use the new name badge.

Direct question about the nature of the healthcare appointment. During the second research meeting with the interpreter participants, while discussing the response to name badges, Melissa added that while she was soliciting information about the badges, she was also incorporating other questions with the Deaf consumers. She said:

> I made it a point to start chatting with the client to see if they would tell me what the appointment was going to be about. So I would know going in. So I said, oh, so what are you here for today? And they gave me a little bit of background or whatever. But I do feel very strongly, if had I not asked, they would not have volunteered that information. But I made it a point to ask every appointment I was on, what are you here for? You're going to talk to the doctor about what? And then they were like, oh, let me tell you.

Melissa's comment stressed the importance of a direct question and opened up a discussion about what additional topics could be discussed with a Deaf consumer. Noah mentioned how asking the nature of the appointment was also related to protocol for when the doctor leaves the room:

> I think if that does end up being a best practice, then what we were talking about earlier with having the chance to sit down with the client before, makes it even more important because oftentimes when you're sitting there in after the nurse has left, right? That's often the opportunity that you can take to be like, all right, tell me what's up with your foot or whatever. And so they can give you that information. But without that, if you're forced to go outside of the room, then it should also be best practice then to make sure you ask the client about that information previous to going in. If you have that opportunity, because people show up late and you can't do anything about that but generally it seems like those two are very closely linked.

Noah’s comment added an additional barrier that required a solution that will be addressed in the next section. However, the interpreter participants wanted a solution that would be able to address multiple barriers.

In response, the interpreter participants generated another solution that would serve to fill in information missing from the pre-appointment details. The interpreters proposed a solution to ask the Deaf consumer, directly, about the reason for the health care appointment. This direct question gave them a topic for the small talk, as well as prepared them for the appointment through confirmation or disconfirmation of any appointment details received from the agency or healthcare provider. This solution arose during the second research meeting, when I asked the question, “I wonder though, could we ask something like, ‘Is this your first time seeing this physician? Is this a follow up appointment? Is this you know, recurring?’” Paul, an interpreter participant, had an interesting response to the question and shared his rationale for why he would not ask the reason of the appointment:

> Just a thought too, Teddi, there are multiple appointments that I'm not going to bother asking them what they're there for because it's pretty obvious either in my job…or the nature of the facility, pain center, or whatever it is…So some of those things I don't even think to ask, even though we did discuss this in the previous meeting, because to me it was just so glaringly obvious why they were there.

Paul's comment did not show opposition to the solution but rather provided a sound reason for why there would be times he wouldn't ask the nature of the appointment if the reason was clear in the pre-appointment details or through observation at the facility. Felicia, another interpreter, offered a different application of the solution:

> I never really asked "Hey, why are you here today?" I just kind of approached it as "Oh, my paper says it's a follow-up on a toenail or something. And they're like, Oh no, I'm coming for this reason, or that reason, or whatever.

In this manner, Felicia changed the mode of soliciting the reason for the appointment and allowed the Deaf consumer to take the lead in confirming, or changing, the reason for the appointment. Thus, the interpreters agreed to ask the Deaf consumer, when feasible, to discuss the reason for the health care appointment, when and where it would be appropriate, and to include this question in the 'small talk' prior to an appointment.

Positive benefit for the interpreters. The use of a direct question, related to the reason for a health care appointment, had a positive influence on both Deaf consumers and the interpreter participants by giving all a chance to verify information and introduce a topic for small talk. The interpreter participants had first-hand experience with the relationship between this direct question, during ‘small talk’, and the impact on trust and connection. For Felicia, an interpreter participant, when she asked this question, she noted an increase in trust:

> I realize the value in doing it before we get into the room… It's more smooth. It’s like more trust being built between me and the Deaf person if I'm asking them ahead of time… when it's appropriate, obviously.

This positive experience was shared by all interpreters that asked the direct question which then translated into the interpreter participants wanting to continue using this approach. Melissa, an interpreter, felt that focusing on asking that question heightened her awareness of its importance to both the Deaf consumer as well as her own preparation for the appointment:

> Every time I asked, the client told me the reason they were there was completely different than what was on my [job detail form] which means when the doctor's office made the request, they told the agency so-and-so is here for a broken foot. But when so-and-so showed up, they were there to remove their stitches. So, I just thought that was interesting because I've never really...I never paid attention to the difference because I didn't need to. I just thought, ‘Oh well maybe that was what the last appointment was for’ but because I was actively asking every one of them why they were there, and I had just read why they were supposed to be there, I thought that was interesting.

This quote showed that when the interpreter confirmed the information, she was able to correct it; an added benefit to asking the nature of the appointment. Melissa also noted an increase in her own awareness of the influence direct questioning can have on small talk and connection with the Deaf consumer.

Positive benefit for the Deaf consumers. The Deaf consumers also responded positively to being asked about the nature of the appointment and utilized the discussion as an additional method to connect and chat with the interpreter. Ann, a Deaf consumer, shared that she liked to take the lead in explaining why she had a health care appointment: "I do like to talk about the purpose of the appointment and explain a little bit about what's going on." This was an example of how a Deaf consumer, taking the lead in discussing the reason for the appointment, was given a chance to have small talk that could lead to increased trust. A similar positive influence was perceived when the interpreter led the direct questioning. I asked Sara, a Deaf consumer, how she felt when the interpreter asked her the reason for the appointment, and she shared how she considered her response as a way to extend trust because of her knowledge of the interpreter's code of conduct:

> Oh yeah. It doesn't bother me. Not really. I think the interpreters, you know, are confidential. They're professionals. So if they have that information and I explained that to them, I think that they're going to keep it confidential. So I'm not worried about it.

The Registry of Interpreters for the Deaf (RID), along with the National Association of the Deaf (NAD), co-authored the ethical code of conduct for interpreters. The code of conduct includes seven tenets, which are followed by guiding principles and illustrations. Tenet 1 of the code of conduct says, "Interpreters adhere to standards of confidential communication." (www.rid.org). It was apparent from Sara's comments that she expected interpreters to adhere to this basic tenet when divulged information about her healthcare.

The solution to engage in direct questioning about the health care appointment had a positive influence on both the Deaf consumers and interpreters when each had an opportunity to not only engage in small talk but to also verify information and increase small talk prior to the appointment. The increased small talk could lead to increased connection between both parties.

Discussion of protocol for leaving the exam room. As noted earlier, during the second research meeting, the interpreter participants brought up an additional challenge related to inconsistencies between individuals and agencies about how to solve an issue that often arises during healthcare appointments: leaving or staying in an exam room when the healthcare provider briefly leaves. I proposed that they could incorporate that in the same pre-appointment period, during small talk:

> Let's just add in that conversation beginning, "This is the policy for the company I work for or, or what do you want to do if this occurs? That could be something to increase trust, preemptively, and be proactive about that particular stance.

As noted in my comment, I proposed when to have the conversation with a Deaf consumer, and because all of the interpreters had experienced an unsurety about what to do when a healthcare provider leaves the room, this led to the interpreters sharing their diverse perspectives, which led to a rich discussion on how to mediate this challenge. The subsequent conversation developed into generation of another solution where the interpreters would discuss this issue directly with the Deaf consumer during the small talk period prior to an appointment.

Interpreters' discussion and application of the new solution. The interpreters collectively discussed how to mediate the diversity of perspectives among interpreters and between interpreter referral agencies. To begin with, the interpreters discussed individual experiences with the 'right' versus 'wrong' way to approach the exam room conversation when a provider leaves the room. Jane, an interpreter, shared her experience interpreting in two different states and how each area approached this challenge differently:

> And before the 12 weeks I was in another state. We always…I don't know who set it up, but most of the agencies require the interpreter to leave the room. But, when I started going down to Vegas, people had no idea why we do that. So there was a lot of explaining.

This quote showed that Jane was conflicted about what to do and wasn't clear on where the policies associated with staying or leaving the room were established. Jane, an interpreter, also noted that even if she knew the policy, she was not sure how to explain it to a Deaf consumer. Jane was not the only one with this experience. During the ensuing discussion, there was inconsistency in both individual experiences, perspectives on approach, and how to solve the issue; however, there was agreement that something needed to be done to help Deaf consumers and interpreters navigate this challenge more smoothly. Kristy, one of the interpreter participants, took a pro-active approach to solving this issue by polling agencies that she was familiar with and brought that information to the second research meeting:

> I emailed the three agencies that I've worked for and asked them if they had set policies on if they wanted us to leave the room or stay in. Agency "A" and

> SignOn Interpreter Referral Agency both said they would leave it up to the discretion of the interpreter and the Deaf client, kind of what Melissa was saying like, you know, ‘you two could figure it out’. Agency “B” said it's now their set policy to do [leave the room] because they see it as a national trend that is coming and also for legal reasons so that nothing would be… could be said against the interpreter or something…Agency “B” has said they want you to do that [discuss with the Deaf consumer beforehand].

Kristy’s comments showed the inconsistency among interpreter referral agencies and how frustrating it was when working with multiple agencies – there was not one, clear-cut way of approaching the challenge.

Together with Kristy’s comments, the other interpreter participants also expressed concerns during the second research meeting, and it became obvious that there was not a standardized approach to an interpreter’s behavior when a healthcare provider leaves the room. Kristy was additionally concerned about how a policy or solution to standardize the approach to leaving the room could negatively impact the Deaf consumers in her area:

> They want you to say that you're leaving the room, which is very difficult in our small community because we've known them [Deaf consumers] for years and they're very offended that we don't want to sit in and chat and catch up with them. So one of our interpreters down here has decided that she would stand by the door with the door open and continue to chat with them. So making them still feel comfortable but also you know, following the policy of that agency.

A couple of the interpreter participants also voiced concerns that perhaps staying in the room would lead to a liability or legality. Rachel, one of the interpreters, shared her experience in a different state:

> I was raised up in a different interpreting community where the philosophy was quite different. You never stayed in the room with the patient and the one of the reasons was the legal liability. So the same thing about asking prior or getting information, it was kind of the way we were taught was ‘you don't want that information because now you're liable if something should be omitted or included or whatever’.

Both of these comments showed concern for the Deaf community’s need for connection and comfort, their own comfort and potential liability, and the interpreter’s unsurety in how to make the decision to stay in the room or leave. Given that there was no consistent approach between agencies or interpreters, the participants agreed to attempt broaching the subject in the pre-appointment time period, whether that be asking the Deaf consumer’s preference or sharing the policy of the interpreter referral agency.

As an outcome of the discussion shared above, the interpreter participants began addressing the topic of staying or leaving the exam room with the Deaf consumers prior to the appointment, when possible. Each interpreter had discretion about when and where to have the discussion and choice of whether to stay in the room or leave. There were times that a few of the interpreter participants did not ask at the beginning of the appointment but found another viable option for discussing the Deaf consumer’s preference when a healthcare provider was going to leave the room. Felicia, an interpreter participant, chose to modify the solution in this way:

> One thing that I'll do is that, unless I'm super uncomfortable staying in the room or with a person, then I will always ask, “Would you like me to stay while you're waiting for the doctor or would you like me to step out?” Cause I found a lot of clients do not appreciate or enjoy the interpreters that step out in the hallway without explaining…So how I normally ask that, is when the nurse comes in, because you always get checked in by the nurse, right? As the nurse is leaving, I say to them, “Would you like me to follow the nurse out and come back with the doctor to give you privacy? And they're like ‘No, no stay please [because] that other interpreter left without explaining. I don't like it. I want you to stay’ So that's the moment that I always ask.”

Felicia illustrated how she modified the timing of the direct question to coincide with the nurse leaving the room. She also demonstrated sensitivity to the Deaf consumer’s response for her to stay as well as the Deaf consumer’s dissatisfaction with a prior interpreter that left the room without explaining or asking their preference. All of the interpreter participants readily adopted the practice of explicitly discussing the ‘what if’ when a healthcare provider left the room, with a Deaf consumer. The interpreters also indicated they would continue asking this direct question after the intervention, which demonstrated their belief in the positive impact this discussion had on the interaction with Deaf consumers.

Deaf consumers benefit from direct questioning. The Deaf consumers responded positively to the interpreter directly asking them what should be done when the healthcare provider left the room. The following quote also showed that the Deaf consumer felt empathy for the interpreter’s dilemma. Ann, a Deaf consumer, shared her experience after I asked her if the interpreters proactively discussed what would happen if the healthcare provider left the room:

> Yes. They always ask me. They'll say, “Do you mind if I go out?” I'm like, “Oh, it doesn't bother me at all. Or you can stay in the room. That's fine with me too.” We can chat and the interpreters honor whatever I request. And I know that that's not the same for all interpreters. It's important for them to feel comfortable. I like that they ask me the question, that's important… I think it's good that they offer options to patients, especially in those situations.

Ann affirmed that not only did she appreciate being asked about what to do in this situation, but also recognized how the decision to stay or go is difficult for the interpreter. In spite of Ann’s recognition of the challenge, this quote also indicated that given a choice, Ann preferred that the interpreter stay in the room so she could chat. Another Deaf participant, Sara, also showed her sensitivity to the interpreter’s dilemma when asked the same question: “Sometimes they'll ask me, you know, if they should stay or go, but some of them do say that's the way the policy is, and they don't have a choice.” In addition, one of the survey respondents shared a positive experience when the interpreter left the room briefly when a sensitive situation arose in the exam room: “I like how the interpreter remained professional when I asked him to leave for a moment while changing clothes and being very discreet when the doctor examined my upper part of the body.”

These responses indicated that both Deaf consumers and interpreter participants felt the open discussion about policies and preferences, related to the exam room, was an important part of connecting and building trust with one another. In an earlier section, the name badge was discussed as a sociocultural ‘tool’ for mediation. In these examples, the Deaf consumers and interpreters also utilized communication, as a sociocultural tool, when discussing the potential conflict if a healthcare provider left the room. This cooperative approach to sharing information and cooperating with each other mediated the challenge and created new learning.

An explanation for the effectiveness of the name badge and direct communication can be found within an essential concept of Sociocultural Theory, that the human mind is mediated. According the Kolb (2001), “Vygotsky argued that just as humans do not act directly on the physical world but rely, instead, on tools and labor activity, which allows us to change the world, and with it, the circumstances under which we live in the world, we also use symbolic tools, or signs, to mediate and regulate our relationships with others and with ourselves and thus change the nature of these relationships” (p. 1). For the interpreter participants, the name badge was the sociocultural tool used to mediate the relationship with Deaf consumers.

As the interpreter participants discussed each generated solution, incorporating Deaf consumer feedback that I shared, individual and collecting learning occurred and participants co-constructed and applied meaning to the generated solutions and the influence of those solutions. This temporary Community of Practice (CoP) acted on mutual engagement a shared repertoire (Wenger, 1998) to identify best practices in wearing the name badge and collaborated with Deaf consumers to gather feedback on how the sociocultural tool, the name badge, was received as a way to create meaning and increase learning. As shared above, one of the interpreter participants, Kristy, came prepared with information that she had gathered about agency practices and that information was included in a discussion aimed at a possible solution. Kristy's behavior is an example of a key concept in Sociocultural Theory, internalization, when faced with a "difficult task, where the difficulty was ultimately determined by the individual, the person then attempts to regain control by performing the task" (Lantolf, 2000, p. 15). Kristy took control by doing her 'homework' and reaching out to various interpreter referral agencies, showing her care for the process and the potential impact for Deaf consumers.

Quantitative Results

The satisfaction survey, given to Deaf consumers during the intervention, included closed-ended and open-ended questions that contributed to the qualitative analysis. In addition to qualitative findings in the satisfaction survey responses, I also analyzed the survey for quantitative findings that answered the third research question. Twenty-seven satisfaction survey responses were collected during the intervention period and each represents a separate and individual encounter with one of the interpreter participants. While some Deaf consumers returned more than one satisfaction, each survey was given at the conclusion of a unique appointment that may or may not have involved a repeat interpreter, doctor, location, or time. In this way, multiple responses from one Deaf consumer are not duplicates but unique evaluations for individual events. Deaf consumers were given the option to provide an email address at the end of the survey. In total, there were 20 unique emails used in the survey responses with three survey responses where an email was not provided. One survey respondent completed 5 satisfaction surveys, and another 2 respondents completed 2 surveys each.

The first step in analyzing the quantitative data was to convert the satisfaction survey question results to numerical values (0=no, 1=yes) and upload the responses to IBM SPSS. Prior to the data analysis, I developed hypotheses to predict the results using Q15 as the Dependent Variable (DV). They are:

> H1: The mean Check-In Satisfaction of satisfied people (Q2 = yes) > the mean Check-In Satisfaction of not satisfied people (Q15 = no).
> H2: The mean Communication Satisfaction of satisfied people (Q6 = yes) > the mean Check-In Satisfaction of not satisfied people (Q15 = no).
> H3: The percent of satisfied (Q15) people is > among those who knew the interpreter prior to the appointment (Q14)

Next descriptive statistics were run on all survey questions with the following results:

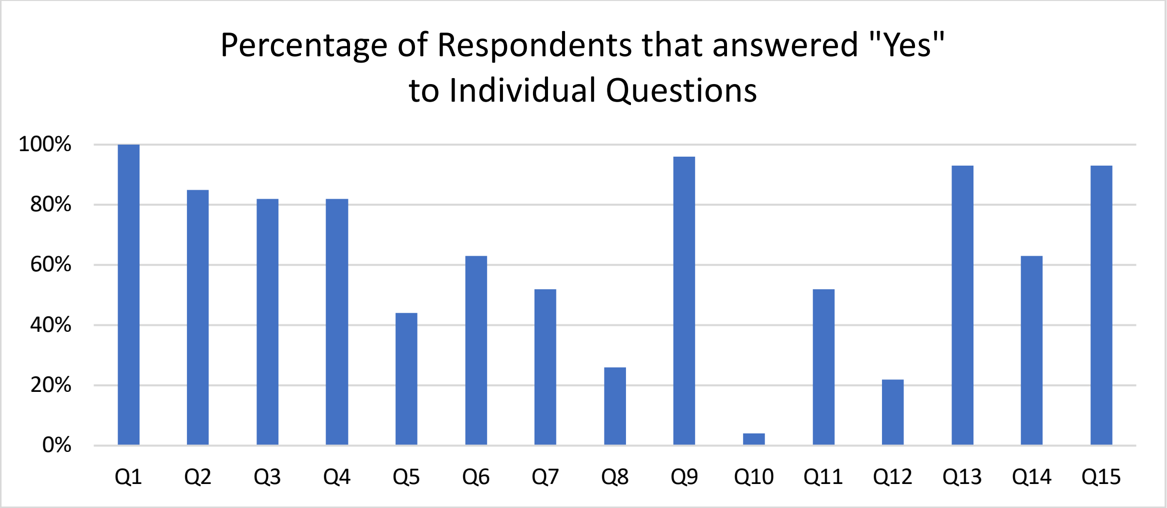
Table 4: Descriptives for Satisfaction Questions Percent Yes/No (n=27)

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15
Yes	100	85	82	82	44	63	52	26	96	4	52	22	93	63	93
No	0	15	18	18	56	37	48	74	4	96	48	78	7	37	7

Question 1: I was satisfied with who the interpreter checked in with before the appointment.
Question 2: The interpreter checked in with me before they checked in with the receptionist.
Question 3: The interpreter was wearing identification that could easily be seen.
Question 4: The interpreter introduced themselves with their name, agency name, and asked for my name.
Question 5: The interpreter asked me about the reason for my appointment.
Question 6: The interpreter asked me how they could support my language and communication access needs.
Question 7: The interpreter shared information with me about how they learned ASL.
Question 8: The interpreter shared information with me about Deaf people they know in the community.
Question 9: The interpreter was friendly and let me take charge of the appointment.
Question 10: The interpreter took charge of the appointment.
Question 11: I knew who the interpreter would be prior to the appointment.
Question 12: The doctor's office told me who the interpreter would be prior to the appointment.
Question 13: I would recommend SignOn Interpreter Referral Agency again for future medical appointments.
Question 14: The interpreter was my interpreter for another appointment in the past.
Question 15: I would request this interpreter again for future medical appointments.

The descriptive statistics were also converted to a graph in order to see a visual representation of which survey questions not only received the highest percentage of ‘yes’ answers but also how responses to questions that directly related to the solutions, generated in the intervention, were evaluated.

Table 5: Descriptives Graph for Satisfaction Questions Percent Yes/No (n=27)



The graph provides a visual method for recognizing that of the 27 survey responses, 100% were satisfied with the check-in process (Q1), 96% of the survey responses were satisfied with the interpreter’s friendliness and choice to let the Deaf consumer take charge of the appointment (Q9) and 93% of the survey responses would recommend both the agency, SignOn Interpreter Referral Agency (Q15) and the interpreter provider (Q13) for future appointments. While respondents showed a 4% ‘no’ response for Q10, this correlates with the opposite responses given in Q9, validating that the interpreters were not perceived as taking charge of the appointment. This data contributes to the overall research findings as these responses were collected during the 10-week intervention period and provide data to support that the interpreter’s efforts to incorporate solutions to increase connection were identified.

I attempted to run tests on Q15 as the Dependent Variable that had only 1 ‘no’ and 25 ‘yes’ responses, but because the questions were written as yes/no, I was unable to compare a group of 25 people to 1 person. Due to the nature of the ceiling effect with the collected data, Cronbach's Alpha, chi-square, and t-test analyses were not possible.

Conclusion

In summary, qualitative and quantitative data that were collected provided evidence to address my research questions. In answer to the first research question, several systemic factors were identified as potential contributors to the disconnect between Deaf consumers and interpreters. These factors included 1) challenges in communication between the agency and healthcare provider, 2) the required check-in procedure, and 3) interpreter referral agency policies.

In response to the second research question, the perceptions associated with the pre-appointment period that possibly caused disconnect, were 1) an inconsistent means of identification resulting in the Deaf consumers and interpreters use of visual cues, and 2) an absence of small talk that would yield vital information related to the nature of the appointment and protocol for when a healthcare provider left the room was not considered. In combination with systemic issues, these perceptions appeared to have a negative influence on the connection between Deaf consumers and interpreters.

To address the third research question, the interpreters generated solutions to mediate the systemic challenges and leverage the benefits of small talk. Both the Deaf consumer and interpreter participants expressed a desire for small talk as a way to assess language, gauge friendliness and ultimately build trust.

The solutions that I supported the interpreter participants to generate and adopt were: 1) wearing a newly designed name badge to make identification of the interpreter clear, 2) using the period of 'small talk' to directly engage the Deaf consumer in conversation about the nature of the appointment, and 3)involving the Deaf consumer in a discussion about protocol should the healthcare provider leave the exam room. These solutions answered the third research question and led to the influences found in the final research question.

The generated solutions had a positive impact on the Deaf consumers as evidenced by both the quantitative and qualitative data. The quantitative satisfaction survey results that showed an overall satisfaction with the entire experience with the interpreter participants. The qualitative data also provided rich examples of both the interpreters engagement with, and the Deaf consumer's reactions to, the generated solutions. The interpreter participants embraced the application of the solutions and were encouraged to sustain those solutions throughout the intervention as well as demonstrated an increased desire to apply them to the post-intervention period.

CHAPTER 5

CONCLUSIONS, DISCUSSION & FUTURE CONSIDERATIONS

We all form first impressions in a variety of interactions throughout our day. For a Deaf consumer, first impressions can be based on something as simple as whether an interpreter chooses to be friendly or engage in small talk. As noted in Chapter Four, one of the Deaf consumers in this study, Peter, expressed a desire for the interpreter to be someone he could engage with and 'be there' for him. He shared this about interpreters in general: "Once they're out of the job or before the job, they can have whatever personal life they want. But for me, especially if I'm hurting or I'm sick, I want the interpreter to be there for me". This brief quote illustrates the importance of first impressions, especially positive ones, and how a Deaf consumer can connect or disconnect with an interpreter based on those first brief moments.

This action research study focused on how interpreter soft skills contributed to first impressions that occurred during the initial interaction between ASL/English interpreters and Deaf consumers. Specifically, the research utilized principles of Sociocultural and Experiential Learning Theories to examine the factors that contributed to establishing connection prior to an interpreted event and how collaboratively generated solutions could influence future interpreted events to increase satisfaction for both Deaf consumers and interpreters. In order to collect evidence of behaviors that contributed to successful interactions between ASL/English interpreters and Deaf patients, my action research project included a 10-week intervention where I guided a group of interpreters as we created practical solutions to enhance interactions between Deaf consumers and interpreters. The experience of generating and applying solutions during the intervention provided an opportunity for learning to occur in real-world settings through the immediate incorporation of feedback. In addition to the interpreter participants' experience, another piece of the research project collected feedback from Deaf consumers during and after the intervention about the generated solutions as well as perceptions of the effectiveness of each solution. With the data collected through these avenues, the study focused on the following research questions:

1) What systemic factors influence the connection between Deaf consumers and interpreters?

2) How do interpreters and Deaf consumers describe and perceive the interaction prior to an interpreted healthcare appointment?

3) How did the co-constructed solutions influence the connection between Deaf consumers and interpreters?

Summary of Findings

The mixed methods research study led to the discovery of several themes that highlighted the challenges and experiences of both Deaf consumers and interpreters prior to a healthcare appointment. The following sections provide a summary of those findings as well as how some of those findings mirror what has been shown in relevant literature. In order to understand the way that current interactions between Deaf consumers and interpreters are perceived, it was important to begin with an examination of systemic factors that contributed to the disconnect and an acknowledgement that these challenges are established prior to any interaction between Deaf consumer and interpreter and extend outside the control of both Deaf consumer and interpreter.

Factors Affecting Interpreter-Deaf Consumer Connection

The systems in place for requesting an interpreter for a healthcare appointment added barriers to the connection between Deaf consumer and interpreter. These findings echoed other literature on system challenges. For example, Sirch et al., (2017), stated that "studies focused on healthcare communication with deaf patients have mainly documented barriers and health accessibility and…deaf people are often excluded from healthcare research and surveillance" (Sirch et al., 2017, p. 369). The literature also showed that scheduling interpreter services was "a considerable source of frustration and delay in appointment scheduling" (Steinberg et al., 2002, p. 737). My study found the same challenges in communication between the agency and healthcare provider, the required check-in procedure, and interpreter referral agency policies.

Perceptions of Interactions Prior to Health care Appointments

One of the crucial components of Sociocultural Theory is the co-creation of meaning that happens between two or more parties. In order to have an interaction there must be a basis for relationship that begins with the identification of each person. However, as shown above, often the Deaf consumer does not know who the interpreter is before an appointment and must rely on visual cues to find the interpreter. One of the specific challenges was difficulty in identifying one another based solely on prior experience with one another or by using only a name.

When considering ASL pragmatics, a process that typically includes waving at or tapping them or tasking a third person to help with this procedure, additional methods like a name badge and small talk were used. In a healthcare setting, it was not comfortable or appropriate for an interpreter to engage in overt attention-getting methods like flicking the room lights off once or twice to get everyone's attention. However, the use of a clear name badge was a tool that was used by both interpreter and Deaf consumer to identify one another as a gateway into greeting.

All participants commented that, in the absence of clear identification or pre-appointment details, they would use non-traditional methods to identify each other upon arrival and glean additional information through small talk. For both Deaf consumers and interpreters, small talk prior to an appointment was used to gauge each other's language. In addition, small talk emerged as a method of engaging in friendly behavior that assisted the Deaf consumers and interpreters to establish connection with each other.

The use of small talk in this research added to the literature about the importance of small talk because the Deaf community is a high context culture (Hall, 1976) and information must be shared (Mindess, 2014). Deaf culture typically shares intimate details, and introductions focus on questions about social background and group membership (Mindess, 2014) in order to place each other in a known social context.

Co-Constructed Solutions and Influence

The interpreter participants generated solutions to the challenges listed above: 1) an imbalance of information, which created difficulty with identification, 2) a lack of linguistic knowledge about the Deaf consumer and vice versa, and 3) missing appointment details that could help facilitate the interpretation. As a result, the interpreter participants and I provided the following solutions: 1) a redesigned name badge, 2) using the small talk period to pose a direct question to the Deaf Consumer about the nature of an appointment, and 3) using the small talk period to discuss, with the Deaf Consumer, agency policy or preferences when a healthcare provider leaves the exam room.

The influence of these solutions resulted in positive responses from the Deaf consumers, the interpreter participants, and associated healthcare personnel. The findings showed that the name badge, the use of a direct question related to the reason for a health care appointment, and the intentional discussion about protocol when a healthcare provider left the room were received favorably. The Deaf consumers and interpreters were able to utilize these solutions to connect with one another, verify information and introduce topics for small talk.

Theoretical Connections

The learning and development of the connection between Deaf consumers and interpreters took place through social and cultural interactions. According to Sociocultural Theory (Vygotsky, 1978), historical conditions form a basis for theoretical study, and because those conditions are in a constant change of flux, the resulting opportunities for learning are also changing. For that reason, there must be a look at both internal and external aspects of learning and development in order to understand "new combinations and complexes [that] arise in the process of development" (John-Steiner & Mahn, 1996, p. 194). The external aspects of learning and development were found in the established procedures embedded in the healthcare system and interpreter referral agency policy. The internal aspects of learning and development were based in how Deaf consumers and interpreters chose to internalize and navigate the challenges presented within the established procedures.

Implications for Research

Agency Procedure and Policy

The interpreter referral agencies are the mediator between interpreters and healthcare providers. Therefore, the opportunity for further research on how agency policies and procedures can impact Deaf consumer and interpreter interactions deserves further examination. Interpreter identification is an important procedural consideration for interpreter referral agencies. As there is no current literature related to how Deaf consumers use interpreter identification, this research created a new understanding of the importance of using a visible name badge, adding to the understanding of how identification and connection are interrelated.

In addition to the standardization of a name badge, there is a need for research that measures how agencies are currently establishing practices surrounding an interpreter's presence in an exam room when the healthcare worker leaves. As noted in my research data, the interpreter participants from Utah and Nevada shared a lack of standardization between agencies which also indicates a need for identification of policies in other interpreter referral agencies across other communities and states. There is debate about the 'correct' protocol from various stakeholder communicates and once data is collected about current practices, studies can be done on the impact of standardizing those practices and how that can benefit both Deaf consumer and interpreter. An added recommendation would be that research studies include Deaf consumer perception and feedback about the experiences when interpreters stay in the room versus those that choose to leave the room with the provider.

Interpreter Education

Related to sign language interpreter education, the Commission on Collegiate Interpreter Education (CCIE) outlines that “field experience(s) must provide at least 300 hours of observation, shadowing, teaming, professional responsibilities, duties, and/or activities” (www.ccie-accreditation.org). Interpreter education programs are required to have curriculum that addresses human relations, professionalism, multicultural awareness and diverse populations. Further research needs to be conducted that looks specifically at what the field experience opportunities include, specifically how small talk and the pre-appointment period is currently being conducted with all interpreted appointments, not just healthcare.

In addition, the Registry of Interpreter for the Deaf (RID) requires that certified members continue to further their professional education through the Certification Maintenance Program (CMP). The General Studies category is defined as anything that adds to base of general or world knowledge. Current offerings could be investigated to see how practices, related to small talk, are being taught to the certified members. The research would gather evidence of members engagement in discussion or instruction that enhanced their understanding of the relationship with Deaf consumers, and how small talk is used to increase trust.

Deaf Consumers and Interpreters as Communities of Practice

This study suggests that there is an opportunity for further investigation on how the Deaf community and interpreter community can fit the definition of a Community of Practice (Wenger, 1998). According to situated learning theory, the research project work between interpreters and Deaf consumers could be considered an example of a community of practice (COP) that includes mutual engagement, a joint negotiated enterprise, and a shared repertoire (Wenger, 1998). The Deaf consumers and interpreters, as members of a shared COP during the intervention, were both aware of the challenge when a healthcare provider leaves and the solution to discuss this openly supported both in negotiating a solution.

Another example of application to situated learning and COP occurred as the interpreter participants worked together during the intervention. Specifically, one of the interpreter participants, a new member to the Utah interpreting community, was a part of creating a 'standard of practice' related to this challenge and the discussion potentially shaped her identity as a newcomer (Lave, 1991; Wenger, 1998; Lave & Wenger, 1990), an essential factor for the longevity and richness of the interpreting COP.

An additional consideration for a COP would be the work between interpreters and Deaf community members. Typically, the interpreting community and Deaf community are seen as separate communities of practice. Interpreters are considered invited members to the Deaf community and the disconnect that often exists between the communities may result in a further divide. However, the intervention showed the benefit of collaboration between interpreters and Deaf consumers when generating solutions and the application of those solutions. In the case of the interpreter participant that was new to the Utah interpreting community, her work in the intervention also increased the opportunity for her connection with the Utah Deaf Community COP. Future collaborative approaches to learning in COPs could become a gateway for increased connection with current and new members of both the Deaf and interpreting communities.

Implications for Practice

The habits formed in practice can best be explained by Sociocultural and Experiential Learning Theories as well as any interventions employed to change those habits. In order to change ineffective standard practices, this intervention highlighted how simple and slight changes to approaching a healthcare appointment can result in learning transformation and a positive impact for all participants.

Enhanced Identification

An inexpensive and simple change to the design of a name badge garnered a great deal of positive feedback from Deaf consumers, interpreter participants and non-participating healthcare workers. Within this study, I designed the name badge to reflect what is typically seen in a healthcare setting. It had a white background with the interpreter's picture, name and agency prominently displayed. I produced the name badges on my home computer and printer, utilizing software that came with the purchase of the paper and badge holders. This illustrates the simple and inexpensive nature of the solution that could easily be adopted by interpreter referral agencies. An additional factor was that the interpreter participants agreed to wear them consistently and displayed in a prominent place on the upper torso. Interpreter referral agencies should develop procedures that clearly define how an interpreter should wear their company name badge during the pre-appointment event and give them self-determination on the use of a clip or lanyard as well as how to wear the badge during the appointment. The goal would be to consider how the name badge impacts the Deaf consumer as well as other participants in a healthcare appointment.

In regard to other participants in a healthcare appointment, an unexpected response to the name badges came from the healthcare workers that the interpreters came in contact with. The badges gave them recognition as members of the team and an unexpected benefit being recognized as a general healthcare personnel. In Chapter Four, an interpreter participant, Jane, commented, “I did have several providers look at the white badge and talk to me more as a nurse or an equal, than as a family member.” And Kristy, another interpreter participant said, “It just seemed like the staff at the hospital was more drawn to it and I kind of liked that because you don't have to introduce yourself all the time.” These comments illustrate the added benefit for the redesigned name badge to be seen as a symbol of professionalism and credibility. A professional name badge, as designed and adopted in this intervention, can be met with positive reactions and increases the opportunity for all participants of a healthcare appointment to identify the interpreter.

Healthcare Interpreting Service Contracts

The interpreter referral agencies often bid for work with healthcare systems through the RFP process. Once a referral agency wins the contract, they are then authorized to provide interpreters for healthcare appointments under that specific healthcare system. With that in mind and given the data on how the check-in protocol both excludes and influences the Deaf consumer before an appointment, consideration could be given to negotiate a way for the Deaf consumer to have input during the check-in protocol. This could include something as simple as a signature from the Deaf consumer indicating that they acknowledged the interpreter’s service. It could also include a step where the Deaf consumer or healthcare personnel would be provided with an opportunity to provide feedback about the interpreter, or interpreter referral agency. Because neither the interpreter referral agency nor the language service coordinator is present in the interaction, it would give those that are present, specifically the Deaf consumer, a chance to have input and strengthen the position of the Deaf consumer in his/her healthcare appointments.

Pedagogy for Interpreter Education

The findings in this research highlight an opportunity for enhanced focus on small talk within interpreter education programs. The pre-appointment use of small talk incorporated several of the themes in the data: 1) assessing language for both Deaf consumer and interpreter, 2) confirming the reason for the healthcare appointment, and 3) discussing Deaf consumer preference for the interpreter leaving the room or sharing agency policy regarding the same. The information learned during small talk can allow the Deaf consumer and interpreter to connect and build trust. These topics are not typically considered part of ASL pragmatics used in greeting and introduction. However, the data suggested that the use of these topics for discussion increases the opportunities for connection between Deaf consumer and interpreter. Therefore, it is crucial that interpreter education programs emphasize the benefits of using small talk as a sociocultural tool for connection.

Interpreter education should consider offering opportunities for interpreting students to investigate how their soft skills contribute or detract from a connection with Deaf consumers. For interpreters that do not feel confident in soft skills, spiraled curriculum can incorporate direct instruction on ways to enhance or build soft skills and aptitude that students bring with them into the education program. In addition, programs should provide opportunities for new and established practitioners to engage in deliberate practice in small talk. An example of deliberate practice with small talk would be a 'mock interpreting' scenario in the classroom or workshop audience. Ideally, Deaf consumers would be invited to participate in 'role play' during classroom instruction and ultimately provide guidance during field experience and post-graduation workshops and training. Both interpreters and Deaf consumers would continue to co-construct meaning and improve the quality of connections for future practitioners.

Next Steps

To advance my practice and research beyond this project, the next cycles of action research, I would like to focus on the healthcare personnel and interpreter referral agency perspectives. In this study I focused on the experience of ten interpreter participants and a limited number of Deaf consumers. In order to strengthen the data found, in the next phase, I will also consider including the interpreter referral agency where the interpreter participants were employed and a small group of healthcare providers, thus expanding the implications of the name badge to include additional perspectives and influences of the re-designed name badge. An important consideration is the identity of the interpreter referral agency and how they would want to approach a standardized protocol for name badge identification for the interpreters in their employ.

The perspective of healthcare providers and support staff would be a crucial next step in determining how interpreters and Deaf consumers, interacting at healthcare appointments, are viewed by others. Specific attention would be given to analyzing how healthcare personnel would describe the role of an interpreter and learn more about the request process when a Deaf patient asks for an interpreter as an accommodation. The healthcare system is large and with numerous levels of administration it could be difficult to assess and influence the systemic challenges. However, there are smaller healthcare provider organizations that could yield valuable insight that may be applied to larger scale organizations and providers.

Second, the next cycle will add an additional method for collecting Deaf consumer feedback and perspectives. With only three Deaf consumer interviews, there is a need for additional data from a wider variety of Deaf perspectives. An additional focus group with Deaf consumers in Nevada and Utah will highlight their experiences with the general interpreter community and provide insight into whether the solutions generated in the intervention would be appropriate for wider use. Additionally, a focus group conducted in ASL, would allow Deaf consumers to have a larger ‘voice’ related in their challenges with the healthcare system and connecting with interpreters. The collection of further Deaf consumer data should be conducted in person, with a Certified Deaf Interpreter (CDI) present for linguistic accuracy and utilizing video technology that can capture multiple signed comments from Deaf participants.

Last, because this research focused on healthcare settings, it would be beneficial to look at other settings for interpretation that would also include a brief period of interaction between the interpreter and Deaf consumer. Those settings could include education, professional workplace, community events, and conferences. It would not include settings like legal interpreting where the interactions are dictated by the nature of the court or legal systems. The intervention described here could be applied to these additional settings and research data could be collected to see if the solutions and influence would yield similar results.

Limitations to the Study

Limitations of this study are related to language used in conducting research, sample selection, survey distribution, reluctance of Deaf consumer participants, and the subjectivity and position of the researcher. An overarching limitation is that American Sign Language is not my primary language. I have been learning and using ASL for 30 years, however as a hearing person, it is possible that my ASL fluency and cultural medication may have impacted Deaf participant responses. An additional consideration was the quality of interpretation from ASL to English for the interviews, depending on my familiarity with the Deaf consumer and signs being used.

Technical Limitations

The technical limitations began with using written English for all emailed communication with Deaf consumers. The consent form, research information form, and surveys were in written English. I did attempt to mediate that by inserting ASL versions of the survey instructions and questions, however the initial recruitment email was in English. Based on the ASL linguistic information I have acquired in my own experience and as outlined in Chapter Two, I a Deaf consumer could face a language barrier with the preliminary stages of understanding who I was and what my research was. This confusion in the early stages led some potential Deaf consumer participants to mistrust my email and some thought it was a scam while others deleted it because they were unclear about what the email was asking. For future surveys, I would research a survey platform that could support a fully visual survey where both the survey questions, response scales, and open-ended responses could be recorded in ASL, eliminating the need for written English or at a minimum giving a fully accessible option to Deaf consumers that prefer receiving the information in their native language.

Additionally, I am acutely aware of the limitations of transcription when collecting data in American Sign Language. For this research project, I provided the Spoken English interpretation of the ASL used in the interviews. However, despite my years of experience and fluency, the written English conventionalities do not lend themselves to fully document the linguistic nuances of ASL. In this manner, what is transcribed is an interpretation, to the best of my ability, of what was signed by the participants. I did have a Deaf colleague review the accuracy of my transcription; however, it will remain an interpretation of participant utterances. I intend to look into ways to annotate videos and coding processes that may have been used by Deaf researchers at Gallaudet University and other research institutions. However, I believe that because the standard of research publication requires written English, that will continue to be a challenge. At best, I can include the limitation in my research writings and work towards finding resources that better support direct access to the Deaf participant's true intent.

The technical limitations are reflective of the larger issue of language barriers that exist between interpreters and Deaf consumers, Deaf consumers and interpreter referral agencies, healthcare providers and Deaf consumers, and researchers that use English as a first language and work with Deaf consumers that use ASL as their first language. Within each of these subgroups there are language barriers that create limited access to linguistic nuances, cultural variation, and meaning. In this way, research projects conducted with

Deaf consumers, should consider how the language used to recruit, collect data, and analyze data can support or detract from the findings.

Sample Selection Limitations

The interpreter participants were selected by SignOn Interpreter Referral Agency. I provided criteria that the interpreter participants be working regularly for the agency and be willing to commit to the full intervention period. However, the demographic mix of the interpreters was based on their consent to be part of the research project and not on random selection. The referral agency did select interpreters from both the Nevada and Utah interpreting communities and the interpreters represented the upper tier of those employed by Sign On. The upper tier of interpreters are defined as those who typically work 30 or more hours a week and as a result experienced more healthcare appointments. However, because the interpreter participants were selected from this group, it did not include interpreters that may be less experienced or working less than 30 hours a week. In this manner, interpreters with limited availability or experience were excluded from possible inclusion in the research project.

Deaf consumer participants were selected from those that returned the satisfaction survey. Due to all survey results being so low, this reduced the sample population to select from for the final interviews. This reduction in selection opportunity may have eliminated Deaf consumers that were infrequent users of email or savvy with technology. Also, I discussed above, written English may have posed as an additional barrier for those Deaf consumers that did not possess a mastery of English.

Survey Distribution Limitations

I encountered difficulty sharing the pre- and post-intervention surveys. I assumed that the interpreter referral agency would have the Deaf consumer's contact information and could disseminate the survey for me. However, the agency did not always receive the Deaf consumer's contact information…in much the same way that the Deaf consumer did not receive the interpreter's information. The interpreter referral agency also receives limited information from the healthcare provider that is requesting an interpreter. While they have a Deaf consumer's name, they do not have a phone number or email number to contact them. The pre- and post-surveys were sent to Deaf consumers when they happened to have contact information, likely based on a prior interaction or community interactions. However, the response rate for the pre-survey was only one and the post-intervention survey was four. This was problematic for my survey distribution and also highlighted the challenge for an interpreter referral agency to relay any information directly to a Deaf consumer.

Researcher's Subjectivity and Positioning

My prior background and experience as an ASL/English interpreter was not entirely neutral when conducting the interviews, research meetings and focus group. As a practicing interpreter in Utah for the past 13 years, I knew seven of the interpreter participants, through working relationships prior to the interviews. In addition, my professional experience with interpreting medical appointments stretched throughout my 30-year career likely influenced the interactions. Thus, reflexivity was crucial in examining how my presence may have had an "effect on what is being investigated" (Rossman & Rallis, 2016, p. 37). However, I used Deaf colleagues to review survey questions, interview questions, and videos for linguistic accuracy and cultural nuances that might be missed. The referral agency chose the interpreter participants, thus alleviating researcher bias in selection.

In contrast, my experience and background allowed me to quickly connect with the interpreter participants through our shared language and profession. The ‘warm up’ period at the beginning of the recruitment and intervention was greatly reduced because many of us knew each other, had worked together, or knew of each other. Being a nationally certified and established interpreter in the Utah interpreting community helped build my credibility with the interpreter participants. In addition, my fluency with ASL along with my shared connections in the Deaf community acted as a gateway to trust with the Deaf consumers that I interviewed. In my first interview with Peter, a Deaf consumer, he seemed surprised that I could sign and remarked, “I didn't realize that you'd be signing, I thought you'd be hearing and so I'm a little thrown off.” This is also reflective of the perception that when using written English to communicate, a researcher is assumed to be hearing and know little about ASL or Deaf culture. In each of the interviews, I utilized small talk in the first few minutes to establish how I learned ASL, to talk about my friends in the Deaf community, to explain that the rationale behind my research project was based on my own experience with Deaf consumers, and to ask the Deaf consumer about their connections and background. My ability to engage in this type of small talk reflected the findings of my research, as well as followed established methods of ASL pragmatics. My status as an ‘outsider’ changed once they were able to build rapport and trust through small talk.

A final consideration would be that as a hearing person, I am considered an ‘outsider’ to the Deaf community. Despite my years of experience and linguistic fluency, I am not a native user of American Sign Language. While my connection with the interpreter participants was strong and we shared a common first language and experience, that was not the case for my interactions with the Deaf consumers in my second language. If this research had been conducted by a Deaf researcher, using ASL as the mode of communication, the results would include additional linguistic and cultural insights and nuances that may be lacking in my findings.

Lessons Learned

I was pleasantly surprised at the bonding that occurred between the interpreter participants and myself during the intervention process. Meeting frequently and discussing issues that we are all passionate about was invigorating. Typically interpreters work in isolation and occasionally with a team; however, it is rare for us to have experiences where we can come together on a regular basis to discuss the interpreting work. One of the interpreter participants, Noah, echoed my feelings in the final focus group when he said, “We are always around people but we work alone and we eat lunch alone. We do everything alone, so it’s nice to spend time with some colleagues, so I appreciate this time.” That is something to consider moving forward: How can interpreters and Deaf consumers work together to generate solutions and build a stronger community? How can interpreter referral agencies support interpreters in meeting together often to discuss standard practices and have opportunities to discussion challenges and propose solutions? The interpreter participants in this study all expressed a desire for a continued platform for meeting together.

As noted earlier, considering the interpreting and Deaf communities as Communities of Practice, there might be additional opportunities for learning through collaboration. For the intervention, the data was collected separately from the interpreter and Deaf participants. However, it would be interesting to discover additional findings should any future interventions or research projects look at collecting data from a fully collaborative work within the COP. Ideally a Deaf/hearing research partnership with a fully integrated Deaf consumer/hearing interpreter group of participants could yield rich data related to solutions and applications of those solutions.

Final Thoughts

I started this research with the thought that the disconnect between interpreters and Deaf consumers was largely the fault of the interpreter's lack of soft skills. This focus on soft skills implied that the issue was the interpreter lacking these skills, but the research showed the problem to be bigger and that the generated solutions were more related the proactive use of soft skills through small talk and not solely the linguistic skills of interpretation. The intervention provided a clear picture of the multiple systemic factors that influenced healthcare appointments and the ability for Deaf consumers and interpreters to make those connections. The responsibility for connection lies with all participants: Deaf consumers, interpreters, referral agencies, language service coordinators and healthcare providers. However, despite this shared responsibility, it was clear that the interpreter participants and Deaf consumers were both limited in their ability to act based on larger systemic factors. As discussed in Chapter Four, these systemic barriers related to: scheduling, the information that is or isn't shared with Deaf consumers or interpreters, and the check-in protocol; all outside the control of both the interpreter and the Deaf consumer.

What I did find was that the interpreter participants were doing the best they could within the system limitations. The interpreter participants were eager to discuss the challenges they faced in healthcare interpreting, and they were transparent about owning the fact that they could do better. Not only were they eager to discuss the challenges, they were equally enthusiastic about generating solutions that would alleviate the negative impact of some of the systemic factors. The interpreters in my study showed empathy for Deaf consumers by considering how the name badge was designed, through incorporation of the Deaf consumer feedback, and through their commitment to all aspects of the intervention.

The interpreter participants also assisted me in collecting the data and voluntarily asked the Deaf consumers about the research study which in turn was a conversation starter, opening up a way for further connection. Interpreters that are not actively involved in a study like this could also ask simple questions about the Deaf consumers perception of their greeting, name badge, or demeanor. Like the interpreter participants it would be easy to include the Deaf consumer in those initial interactions and create a better connection and experience for everyone.

For the Deaf consumers, they were also active participants in attempting to connect with interpreters. When faced with the necessity of using an interpreter for healthcare appointments, Deaf consumers desired information that would assist them in connecting with an interpreter so that the appointment would be effective. Their comments showed a respect for and understanding of the challenges that interpreters face before a healthcare appointment. This understanding and empathy did not, however, overshadow the Deaf consumer's desire for autonomy in taking charge of their own healthcare. For the Deaf consumer, autonomy begins when they are able to identify the interpreter either prior to the appointment or with a name badge. Once they are at the healthcare appointment, autonomy continues as the Deaf consumer has the opportunity to assess the interpreter's language and participate in small talk. The small talk discussion empowers Deaf consumers to pro-actively discuss the nature of the appointment and any agency policies or interpreter preferences that could impact their understanding of the interpreter's actions when a healthcare provider leaves the room. In cases where there is not an established agency policy for what an interpreter should do when a healthcare provider leaves the room, the discussion empowers the Deaf consumer to readily share his/her preferences for an interpreter to stay or go.

Lastly, the findings in this research project aligned with the literature that shows that systems have worked to supplant interpreters as "service providers for the community instead of service agents of the community" (Cokely, 2005, p. 16). This was evidenced in the data showing that the interpreters were conflicted in how to handle protocol when a healthcare provider left the room. While some felt they had autonomy in deciding what to do, others were concerned about following agency policy. As noted in Chapter Four, Kristy, one of the interpreter participants shared a concern that an interpreter agency policy stating they must leave the room when a healthcare provider leaves the room was "Very difficult in our small community because we've known them [Deaf consumers] for years and they're very offended that we don't want to sit in and chat and catch up with them." The interpreter participants were aware of how agency policy could affect their connection with Deaf consumers, both in the moment of the interaction and also in their general connections with the Deaf community as a whole. The growing divide between Deaf consumers and interpreters is compounded by healthcare systems and interpreter referral agencies when the two parties have less and less interaction prior to an interpreted event.

The solutions generated in the intervention were not complicated. They were readily embraced and implemented by a small, enthusiastic group of 10 interpreters and were positively received by the Deaf consumers. In fact, the solutions did not require a systemic overhaul or large investments of money. The name badge re-design can be carried out by any interpreter referral agency as they work to make sure the interpreter's identification has a positive influence on all participants in a healthcare appointment. The small talk period was a pivotal environment for using simple and direct questions about the nature of the appointment and a discussion of interpreter referral agency policy, or Deaf consumer preference when a healthcare provider leaves the room. The financial impact is little or none when a referral agency takes the time to train and require their contracted interpreters to enhance the use of small talk in healthcare appointments, and potentially benefits all interpreted events.

Therefore, as a researcher, I feel strongly that solutions need to begin with those that are engaged in challenges – the Deaf consumers, the healthcare personnel, the interpreter referral agency, and the interpreters. Working together, all participants can devise solutions that allow Deaf consumers to take charge of their healthcare appointments and empower them to make further changes in other challenges associated with interacting with hearing people through an interpreter. In addition, interpreters and

Deaf consumers that build connections with one another in the pre-appointment interaction experience an increase in satisfaction with the interpreted experience as a whole, something I found that both interpreters and Deaf consumers would like to see happen.

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APPENDIX A

DEAF CONSUMER SATISFACTION SURVEY

(Please reflect on the most recent interaction with an interpreter before your medical appointment)

Section One: Arrival and Check In

1. I was satisfied with who the interpreter checked in with before the appointment.

☐ Yes
☐ No

2. The interpreter checked in with me before they checked in with the receptionist.

☐ Yes
☐ No

3. The interpreter was wearing identification that could easily be seen.

☐ Yes
☐ No

4. The interpreter introduced themselves with their name, agency name, and asked for my name.

☐ Yes
☐ No

5. The interpreter asked me about the reason for my appointment

☐ Yes
☐ No

Section Two: Language and Communication Assessment

6. The interpreter asked me how they could support my language and communication access needs.

☐ Yes
☐ No

7. The interpreter shared information with me about how they learned ASL.

☐ Yes
☐ No

8. The interpreter shared information with me about Deaf people they know in the community.

☐ Yes
☐ No

9. The interpreter was friendly and let me take charge of the appointment.
- ☐ Yes
- ☐ No

10. The interpreter took charge of the appointment.
- ☐ Yes
- ☐ No

Section Three: Factors that impact interactions prior to an interpreted event

11. I knew who the interpreter would be prior to the appointment.
- ☐ Yes
- ☐ No

12. The doctor's office told me who the interpreter would be prior to the appointment
- ☐ Yes
- ☐ No

13. I would recommend SignOn Interpreter Referral Agency again for future medical appointments
- ☐ Yes
- ☐ No

14. The interpreter was my interpreter for another appointment in the past.
- ☐ Yes
- ☐ No

15. I would request this interpreter again for future medical appointments.
- ☐ Yes
- ☐ No

Other Questions:

What did you notice about this interpreter's interactions with you before the appointment?

Do you have any additional comments you would like to share?

APPENDIX B

INTERPRETER MEETING QUESTIONS (INITIAL)

1. What do you perceive as a problem or an issue seen in pre-appointment interactions with Deaf consumers that need to be addressed?
2. Why do these issues/problems exist?
3. What systemic issues might prevent immediate solutions?
4. What do we already know about these problems (Preliminary research data)?
5. Which strategies from the preliminary research data do we think are easy to implement?
6. What resources do we need to proceed with implementing solutions?
7. How will these solutions benefit interpreters and the Deaf community?
8. How will we make the decisions on which solution/strategy to use?
9. How will we address issues of confidentiality while engaging in this project?
10. What are the criteria we will use to assess the impact and success of the project?

APPENDIX C

SEMI-STRUCTURED INTERVIEW PROTOCOL FOR DEAF CONSUMERS

1. What does a good first impression mean to you?
2. What is your impression of the interpreters you typically work with?
3. What things did you notice went well with the interpreters you worked with these past 12 weeks?
4. What are some challenges you experience when first meeting an interpreter before an appointment?
5. What did you notice about the interpreter prior to the medical appointment? If you didn’t notice anything different, what would you have wanted them to do differently?
6. Did you notice any difference with the way that interpreter identified themselves or greeted you?
7. Did you notice about the name badges the interpreters wore? If so, what about them stood out?
8. How did the name badge impact your perceptions of that interpreter?
9. How did the interpreter behaviors change your perception of the interaction?
10. If you noticed anything about the interpreter, how did that impact the medical appointment?
11. What did the interpreter do that helped you feel comfortable before the medical appointment started?

APPENDIX D

FOCUS GROUP PROTOCOL FOR INTERPRETERS

1. How would you describe your interactions with Deaf consumers, prior to the intervention?
2. What ideas did you already have about improving first impressions with Deaf consumers prior to the intervention?
3. Overall how satisfied are you with the strategies generated in our meetings together?
4. How would you describe your application of those strategies?
5. How do you feel about the badge/identification?
6. What strategies do you feel were easiest to implement? More difficult to implement?
7. How would you describe the Deaf consumer's reaction to the implementation of these strategies?
8. Did you notice any impact of the strategies on the interpreted appointment?
9. Which strategies will you continue to use now that the intervention is over? Are there specific strategies you will use with other interpreting appointments in the future?
10. How likely would you be to recommend these strategies to other interpreters? interpreters in other agencies? Other states?

APPENDIX E

IRB APPROVAL

ASU Knowledge Enterprise Development

APPROVAL: MODIFICATION

Melanie Bertrand

Division of Educational Leadership and Innovation - West Campus -

Melanie.Bertrand@asu.edu

Dear Melanie Bertrand:

On 4/18/2019 the ASU IRB reviewed the following protocol:

Type of Review: Modification	
Title:	First Impressions: Improving the Connection between Deaf Consumers and ASL/English Interpreters
Investigator: Melanie Bertrand	
IRB ID: STUDY00009478	
Funding: None	
Grant Title: None	
Grant ID: None	
Documents Reviewed:	• Appendix I - Deaf Participant Interview Protocol, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • HRP-503a- vonPingel_PROTOCOL_SocialBehavioralV02-_04- 18-19.docx, Category: IRB Protocol; • Appendix C_Deaf Participant Recruitment Letter_Spring 2019.pdf, Category: Recruitment Materials;

	• Appendix K - Interpreter Meeting Questions, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • Appendix L-Deaf Participant Interview_Consent Form_Spring 2019.pdf, Category: Consent Form; • Appendix H - Deaf Consumer Pre- Post Survey, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • Appendix D-Deaf Participant Consent
	Form(Surveys&Observations)_Spring 2019.pdf, Category: Consent Form; • Appendix N-Deaf Participant Consent Form_in person_Spring 2019.pdf, Category: Consent Form; • Appendix G - Satisfaction Survey, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • Appendix J - Focus Group Protocol, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • Appendix E - Letter of Support, Category: Other (to reflect anything not captured above); • Appendix B_Interpreter Consent Form_Spring 2019.pdf, Category: Consent Form; • Appendix F - Observation Protocol, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • Appendix O - Deaf Participant Recruitment Card.pdf, Category: Recruitment Materials;

	• Appendix A_Interpreter Recruitment Letter_Spring 2019.pdf, Category: Recruitment Materials;

The IRB approved the modification.

When consent is appropriate, you must use final, watermarked versions available under the “Documents” tab in ERA-IRB.

In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Sincerely,

IRB Administrator

cc: Teddi Covey von Pingel