

Blog: Language Deprivation and Deaf Mental Health: Introduction to a Webinar

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In many respects, the processes of providing mental health care to native users of sign and providing mental health care to users of spoken languages are comparable. This is especially the case when working with deaf people who are native users of either spoken or sign languages. In those cases, a cultural perspective on Deaf people is often much more useful than a disability perspective in planning services.

Mental health care of culturally Deaf people has many parallels with mental health care of other linguistic, social, or cultural minorities (Glickman, 2013; Glickman & Gulati, 2003; Glickman & Harvey, 1996; Leigh, 2010). Cultural self-awareness, a respectful, affirmative attitude, a body of specialized knowledge about the target community, specialized language, and communication and intervention skills are all essential, as they are when working with other minority populations (Glickman, 1996; Sue, Arredondo, & McDavis, 1992).

Many Deaf people object to the notion of deafness as a disability. They experience themselves as members of a community who have a language and culture or several cultures. The capital D in Deaf reflects this use of Deaf to represent a culture, not a kind of sensory deprivation. This positive view of sign language and all-other-things-Deaf is reflected in the title of an important recent book, *Deaf Gain: Raising the Stakes for Human Diversity*, by H-Dirksen, L. Bauman & Joseph J. Murray.

However, many deaf people (notice the lower-case d), especially those unaffiliated with the Deaf community who lose their hearing later in life, do experience their hearing loss as disabling, and for them deafness may well be associated with psychological conditions like depression and anxiety. Becoming deaf can certainly be experienced as traumatic. An example of this is Beethoven, for whom deafness was the worst calamity of his life. Like many people deafened late in life, he struggled to hide his hearing loss, at great psychological cost to him. Deafness also meant for him, as it does for many others, *not* membership in a special community, but isolation and loneliness.

While deafness may or may not be experienced as disabling for particular D/deaf people, there is an unquestionably disabling condition to which deaf people are vulnerable—language deprivation. Deaf people are the only people in the world who, with normal intellectual potential, may grow up without native language skills. This is not just because they are unable, even with new medical interventions like cochlear implants, to hear sufficiently to acquire spoken language as hearing children do, but also because they may not be exposed sufficiently to natural sign languages (American, British or French Sign Languages, for example) to acquire native signing skills.

Whereas acquiring native sign language skills can be natural and effortless if the right environment is present, for children with severe or profound deafness, acquiring spoken language skills requires great effort and is often not possible. Without native abilities in either spoken or sign languages, deaf people develop dysfluent or impaired language abilities, and dysfluent language skills can be associated with cognitive impairments and social-emotional and behavioral problems. The

dysfluencies range from mild and barely noticeable to profound and complex, but they are often clinically significant in mental health contexts.

At the extreme end of the language deprivation continuum are a-lingual deaf people—people with no or minimal formal language skills. Hearing people have usually never met such people and may find it hard to believe that human beings with normal intelligence can be, essentially, language-less. Inside the Deaf Community, however, the problem of language deprivation is well-known. Programs and specialists that serve D/deaf people usually know some a-lingual or semi-lingual deaf people.

In the United States, we are most likely to find a-lingual deaf people among immigrants from third world countries where they received minimal education, but you can also find them in rural, isolated American communities or other places where they have been hidden from the larger world. When a-lingual deaf people are discovered, they are often referred to mental health agencies, which are always unprepared for them.

There are a number of famous cases of a-lingual deaf people, such as that of Donald Lang, who in 1979 became the subject of a movie with Lavar Burton, of *Star Trek, The Next Generation* fame. Susan Schaller wrote *A Man Without Words* about a community of a-lingual deaf people (Schaller, 1991). Most states have some of these difficult-to-serve people identified in either their state department of mental health or their correctional system.

In the last few years in the Deaf Community and the Deaf mental health provider community, increasing attention is being paid to the problem of language deprivation. This is due in part to the vast majority of deaf children now being mainstreamed who lack the opportunities of previous generations to learn natural sign languages (Spencer & Marschark, 2010).

It is also because the practice of cochlear implantation, which does help some deaf children develop spoken language skills, commonly comes with a strong recommendation to the parents that they prevent their deaf child from having sign language exposure (Szarkowski, 2019). The results of cochlear implantation are highly variable, and dependent on factors other than the medical procedure itself. Discouraging early childhood sign language exposure is a high risk strategy, and when implantation fails, the child may have neither a sign nor spoken language foundation (Gulati, 2019; Szarkowski, 2019). Thus, opportunities for deaf children to develop native sign language abilities are dwindling, resulting in more deaf people without native language skills in any language.

If you ponder the issue of language deprivation, you'll realize how easily it can become the cause of learning and other cognitive deficits. People with significant language deprivation are unlikely to be literate, even at an elementary level, and they are also likely to have impaired abstract reasoning abilities and difficulty learning.

Consider this thought experiment: Is it possible to think about a squirrel in a tree without language, without names for squirrels or trees? It is. One can think about the image of the animal we call a squirrel moving about in an image of something we call a tree. You can do this without language.

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The author of this article, who worked for 17 years in a specialty Deaf psychiatric unit, had numerous opportunities to work with near a-lingual deaf persons who were able, sometimes, to give detailed accounts of events or things they experienced using very little formal language. It was a bit like watching a masterful mime, although mimes usually have the advantage of knowing spoken language and therefore having capacities for story-telling already established linguistically. People with severe language deprivation, by contrast, often struggle to tell a clear story which has a beginning, middle, and end, a defined set of characters or actors, logical segues, different points of view, and an appreciation of what details are essential to include. Even when they are expert gesturers, their language and thinking is often imprecise and difficult to follow.

By contrast, Is it possible to consider without language a question like, "Why do squirrels climb trees?" That question, and everything else you might want to know about squirrels and trees, requires formal language. Of course, it does not require spoken language. Such a question can be pondered equally well in sign languages which offer linguistic strategies for describing aspects of the visual environment that are often vastly superior to spoken languages.

Language deprivation has impact beyond cognitive impairment; it impacts psychosocial development. For instance, the mental health skills we refer to as emotional self-regulation, or coping, which is the focus of so much contemporary cognitive behavioral therapy, can be done without language (think of sensory strategies like rocking or jumping for self-regulation). However, understanding the concept of self-regulation and advancing beyond sensory movement interventions, requires formal language. Certainly, language deprivation can dramatically limit one's set of strategies for self-regulation.

Similarly, interpersonal skills such as communication, problem-solving, and conflict resolution, which are also common foci of evidenced-based CBT, require formal language, though not necessarily full native language (Glickman, 2009, 2017). Indeed, appreciation of theory of mind (the idea that other people think differently than you do) also seems to require formal language (Ketelaar, Rieffe, Wiefferink, & Frijns, 2012). Failure to develop adequate language skills may be associated with failures to develop empathic attunement (empathy) with other people (Gulati, 2019).

When deaf people are significantly language deprived, they are also vulnerable to developing behavioral problems. If you can't express yourself in language, and you have few of the tools that language enables, you are likely to "act out," to express yourself behaviorally. This is why we tell children to "use your words." But what could we tell a child, or, for that matter, an adult, who lacks many words or signs or who has vocabulary but limited grammar for organizing vocabulary? Would we send them to therapy? Does not therapy, the "talking cure," also require language? Does it not also require the linguistic ability to tell one's story?

Of course, one can do therapy in sign language, and we need more providers who have this skill. But the highly variant language abilities of language-deprived deaf people means that, in addition to interpreters, we are going to need communication specialists who can guide treatment providers in understanding what communication resources are needed.

These resources will likely include Deaf interpreters who have a variety of creative interpreting strategies, all of which take more time, to "unpack" formal American Sign Language and English and approximate linguistic equivalencies (Wattman, 2019). They also are likely to include clinicians who have specialized knowledge and skills to work competently in mental health settings with deaf people whose language foundation, and therefore whose conceptual world, is very deprived.

These questions are coming increasingly to preoccupy specialists in Deaf mental health. They are discussed in depth in a new book edited by myself and Wyatte Hall, *Language Deprivation and Deaf Mental Health* (Glickman & Hall, 2019). They are also the subject of an upcoming NASMHPD webinar by Steve Hamerdinger, the Director of the Office of Deaf Services in the Alabama Department of Mental Health. Some of the crucial questions emerging from work with language deprived deaf people are:

- How might language deprivation complicate assessment of deaf people served in mental health programs? (Glickman, 2007; Pollard, 1998b)
- Is there such a disorder as what Deaf psychiatrist Sanjay Gulati calls "language deprivation syndrome," and might it exist as a common form of clinical co-morbidity in some deaf persons treated in mental health settings? (Gulati, 2019; Hall, Levin, & Anderson, 2017).
- What are the challenges for interpreters when they are working with persons who are not fluent language users? Are interpreters effective as reasonable accommodations when clients lack significant language skills? When do we add Deaf interpreters to the interpreting team? What do clinicians need to know about the interpreting challenges with dysfluent language users? (Glickman & Crump, 2017; Pollard, 1998a; Wattman, 2019).
- What would a comprehensive and valid communication assessment look like for deaf persons who appear to have dysfluent sign and/or spoken language skills? Should specialized communication assessments be required for deaf persons served in mental health or developmental disability agencies, as is currently the case in four states? (Williams & Crump, 2019) What questions could such assessments answer? (Henner, Reis, & Hoffmeister, 2019; Williams & Crump, 2019).
- Are there emerging pedagogical practices that can enhance the language and communication skills of people who are past the critical period for childhood language acquisition? (Spitz & Kegl, 2019).
- How does one adapt mental health interventions so that they are more likely to be effective with deaf persons with language deprivation? (Glickman, 2017) Can this be done without hiring staff with highly specialized skills?
- How do state mental health agencies insure they are providing services attuned to the cultural, linguistic, and disability issues of diverse D/deaf people? (Gournaris, Hamerdinger, & Williams, 2013).

Steve Hamerdinger, Director of the Deaf Services Division of the Alabama Department of Mental Health, will be presenting on this issue during the October 18 NASMHPD Commissioner Meet-Me Call. Details to follow.

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