Language Deprivation and Deaf Consumers

An Under Recognized Barrier to Effective Mental Health Services

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Agenda

• What are Language Deprivation and Language Deprivation Syndrome?
• Issues resulting from LDS.
• System issues in working with consumers with LDS.
• Suggestions for more effective services.
Iris. Cole.
Points to Ponder

“The first psychological trauma someone with hearing loss encounters is not their disability of deafness but rather the deprivation of full access to language.”
- Larry Siegal, 2002

Psychiatry is unique among the medical fields in that most of the symptoms are conveyed by or through communication, and communication is also the primary method and nature of treatment. - Robert Pollard, Ph.D.
What is a “Typical” Deaf Person? There’s No Such Thing!

• Up until the late 20th century, deafness was largely either:
  • Acquired deafness (Post natal) often post lingual – Likely have well-developed L1.
  • Hereditary (i.e. genetic) often had no other neurological involvement. (See Parker, et.al) – may or may not have well-developed L1.
    • 70 – 80% will be non-syndromic.
    • Deaf children with deaf parents are more likely to have an intact L1, assuming the parents have a functional L1.
What is a “Typical” Deaf Person? There’s No Such Thing!

• Late 20th century forward
  • Decrease in acquired deafness (but increase in acquired trauma-induced hearing loss).
  • Increased pre and perinatal syndromes involving deafness.
    • Increased possibility language dysfluency and disrupted language acquisition.
    • Medical intervention focused on ameliorating deafness rather than language acquisition.
  • Approximately 7% of deaf children have deaf parents – likely to develop L1.
  • Another small percentage, perhaps 10%, will have hearing parent(s) who have appreciable fluency in American Sign Language.
The Case of Pablo

- Oldest son in non-English speaking family
- Moved from Puerto Rico 10 years ago
- Neighborhood “nuisance”
- Can be scary when confronted
Terms

• Language Dysfluency is an umbrella term encompassing medical, developmental, and psychiatric causes for impaired language use.
• Language Deprivation is one type of dysfluency.
• Communication issues may be attributable to more than one cause.
Language Deprivation As a Spectrum

- Many “born deaf” individuals will experience some level of language deprivation, ranging from insignificant to alingual

Dysfluency Compared
Robert Pollard, Ph.D.
Critical Period Hypothesis, Eric Lenneberg (1997)

• A biologically determined period of life when language can be acquired naturally and effortlessly, after which language is increasingly difficult to acquire.

• This principle has another application: hearing people learning ASL as adults, as we will discuss later.
Search for a “Cure” vs Language Acquisition

• Search for a “cure” overrides acquisition of functional language,
  • “Medical professionals are not able to assure that hearing aids and cochlear implants will result in positive language outcomes.” (Hall et al., 2017)
• High degree of variability of results; Success of auditory verbal approaches is highly dependent on commitment of parents to the habilitation process.
  • Most (perhaps as high as 2/3) do not achieve L1 fluency. Years spent trying “cure deafness and focus solely on learning to “hear” and speak English are thus lost to language development.
What is Language Deprivation

• Inadequate exposure to functional language at critical language acquisition stages (0 – 3 years of age.)

• It is a phenomenon virtually unknown among hearing children without impaired brain functioning.

  With extremely rare exceptions, only deaf people can have neurologically intact brains and not develop language. Glickman, 2018
People With Language Deprivation Struggle With:

- Concepts of time
- Story sequencing/developing a coherent narrative
- A sense of self
- Cause-and-effect/the concept of why?
- Experiences of powerlessness/confusion
- Rigid modes of behavior
- Ability to learn from mistakes (use of generalizations)
- Lacks awareness of others’ need for context
- Lacks theory of mind (understanding others perspectives)

- Lack of understanding of limits to others’ ability to figure out the message
- Abstract concepts
- Difficulty learning
- Emotional regulation
- Acting out of emotions/feelings
- Struggles in relationships
- Can lead to victimization or victimizing
- Competency to stand trial
- Reduced fund of information

Gulati, 2019
Glickman Has a Similar List

- Glickman details specific issues among people who are language deprived:
  - Extensive trauma/abuse history.
  - Highly compromised verbal IQ skills leading to issues with performance IQ as well.
  - Poor ability to recognize, name and manage internal experiences like feelings.
  - Poor psychosocial skills leading to problems in several areas: Addictions, mood, anxiety, impulse control.
  - Difficulty with social competencies like making friends, or crucial social skills like communication and conflict resolution.
  - Lifetime of negative experiences with hearing authorities (teachers, doctors, courts, mental health).

Glickman, 2009
Language Deprivation Syndrome

• Gulati, Hall, and others advocate for recognizing the syndromic nature of the sequela, coined the term Language Deprivation Syndrome (LDS).
  • Not yet have a consensus regarding who is included in this category.
  • This constellation of symptoms is well known to people in the field and has been for 50 years.
Societal Issues

• Lack of language often leads to “acting out” as a method of communicating. Often labeled intermittent explosive personality or impulse control disorder, etc.

• Does not understand, thus cannot follow social rules. Often labeled antisocial personality disorder.
  • Lack criminal intent.

• Cannot be tried in courts, (not competent to stand trial) and cannot be held in custody without a conviction.
  • Donald Lang is one famous (and extreme) case, but most states can point to similarly intractable cases with less notoriety.
    • Unrestorable – civil rights issues
System Challenges

- Multi agency, multi jurisdiction complicates effective services.
- Few state systems have specialized deaf programs.
- General lack of awareness of how deaf consumers are different from hearing consumers.
  - Assumptions founded on misinformation and myth.
- System inflexibility:
  - Contract/billing rules.
  - Rate structures.
  - Hiring.
Recommendations

Seek first to understand – Stephen Covey

• Essential resource:
Recommendations

A person with LDS may superficially appear to use sign language fluently, but on closer examination show characteristic linguistic deficits. – Sanjay Gulati, M.D.
Assess Communication

“
It is a good thing to follow the First Law of Holes: if you are in one, stop digging.”
- Denis Healey

• A comprehensive communication assessment is imperative.
  • Are the language problems observed due to medical and psychiatric conditions or are they more likely to be due to language deprivation?

• Few states actually formally assess deaf peoples’ communication skills. Most of those that do, record deficits of English rather than concepts of communication in general.
  • Current best practice is the South Carolina/Alabama Communication Assessment
Assess Communication

• Communication Skills Assessment (Williams & Crump, 2013) looks at
  • Etiology and social history.
  • Patterns of language dysfluency.
  • Communication strengths.
  • Makes specific recommendations for effective communication with assessed person.

• Assessors need to be highly trained and skilled at working with language dysfluent consumers generally and LDS specifically. Teams provide best results.
Recommendations

• Direct intervention by clinicians highly skilled in visual gestural communication is most effective.
  • Learning ASL as an L2 is a limiting factor for many clinicians (see critical period hypothesis). Few achieve native fluency.

• Recognize that interpreters are not an adequate solution.
  • Interpreters need to be trained in mental health.
    • Alabama one of few states that require specialty certification
Recommendations

- Develop and promote use of communication specialists/Certified Deaf Interpreters.
  - Even competent deaf clinicians benefit when working with people with LDS.
- Adoption of current best practices, which seek to build skills needed to engage in treatment.
  - Immersion in 24/7 fully accessible (communication) environment, staffed with highly trained direct care providers.
    - These will usually be deaf staff.
  - Look to work being done by the Deaf Wellness Center (NY), Advocates (MA), and other places adapting EBP to deaf consumers.
Recommendations

• Establishment of specialized deaf programming.
  • Models for state-operated programs include South Carolina, Alabama, and Minnesota.
  • Models for state contracted programs include North Carolina and Georgia
  • Both have advantages and disadvantages.

• Increase incentives for using ASL-fluent clinicians and communication specialists.
  • Supply of such professions is limited. Workforce development initiatives will be imperative.
Recommendations

• Consider adopting standards that require:
  • Communication Assessments.
  • Presumption of services directly from ASL-fluent clinicians
    • Opt-out rather than opt-in.
  • Mental health interpreter training/certification.
    • Prompt the training and use of Certified Deaf Interpreters.

• Interstate Compacts for smaller jurisdictions working with low-incident populations with highly complex issues.
Take Home Thoughts

• Language deprivation among deaf people is common, but under appreciated in the mental health system.
• Language deprivation syndrome has a predictable sequela of behavior that challenges the system on multiple levels.
• Building successful programs will require specific skills and adaptations.
Questions? Contact Me:

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References


