Language and education options for deaf children

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Hearing loss remains a common birth defect and a major concern for many countries (The National Child Traumatic Stress Network, 2006). According to the National Institute on Deafness and Other Communication Disorders (2005), approximately 17 in 1, 000 children under the age of 18 are diagnosed with hearing loss. Parents of children with hearing loss face the challenge of deciding which language and educational options to choose for their child. It is also important for them to determine what interventions best suit the age and the needs of their child to promote his or her maximum social and communicative development. Educating parents on what options are available to them and presenting to them the advantages and disadvantages of each option will allow them to decide more effectively.

This essay highlights the case of a 3-month-old baby girl recently diagnosed with a moderately severe sensorineural hearing loss. The parents are fluent AUSLAN users and use AUSLAN to communicate at home but are however uncertain about the language and educational options for their child. The primary objective of this essay is to inform the parents of the child of the four available language and educational options: Auditory-Verbal, Auditory-Oral, Total Communication and Bilingual-Bicultural. It presents helpful information on the different perspectives on hearing loss, the importance of early identification and intervention and presents a discussion of the disadvantages and advantages of each communication and education option, respectively.

Different perspectives on hearing loss

Prior to discussing the importance of early intervention as well as language and educational options for the deaf child, it is essential for every parent to understand that there are two conflicting and very different perspectives that influence how society views hearing loss. The two most prevalent views are 1) the medical view; and the 2) cultural view, the former more widely-held than the latter. Understanding these two different perspectives will empower parents to make more educated decisions that will affect the language and learning development of their child when he or she eventually grows up.

Medical perspective. The medical or pathological view on hearing loss regards “ deafness” as a tragedy, a disability or a disease that should be “ fixed” and that the deaf individual should be sympathised (Tucker, 1998). Those who support this perspective would commonly seek the help of a medical professional, and are more inclined to support intervention using hearing aids, cochlear implants, and/or speech therapy, where recommended. Some deaf individuals believe in assimilation with members of the hearing world and believe that in order to do so, they must first welcome the technology that can assist the deaf (The National Child Traumatic Stress Network, 2006). This perspective has been the subject of much debate. An issue that has been raging among the Deaf community has been the use of cochlear implantation, which is viewed by some to be a tool that could open up opportunities for deaf people and put them in a position to achieve their maximum potential like any normal hearing person in terms of education and career paths (Tucker, 1998).

Cultural perspective. The cultural view recognizes the existence of a Deaf community wherein people share a common culture, social affiliation, and heritage (Tucker, 1998). The cultural perspective regards deafness as “ a cultural identity rather than a disability” (Tucker, 1998). They believe that a deaf child will be able to develop great self-esteem and learn a rich set of values, language and culture by interacting with Deaf people, and as a result, will develop a sound identity and become part of his or her own community (Tucker, 1998). Those who support and identify with the Deaf community are inclined to follow Deaf cultural norms, socialize mainly with Deaf individuals, and use sign language such as ASL or AUSLAN, depending on the country they grew up in (every country has their own national sign language) (The National Child Traumatic Stress Network, 2006). The Deaf community acknowledges sign language as superior to English and downplays the medical view that technology can “ fix” their deafness (The National Child Traumatic Stress Network, 2006). Deaf individual who share the cultural view resist the use of auditory devices such as the cochlear implant, which they fear will lead to “ a cultural genocide” of their culture (Tucker, 1998). They do not support the objective of assimilation and do not regard oral training as n efficient mode of communication learning for deaf children, preferring sign language in its stead (Tucker, 1998). The Deaf community primarily uses ASL (American Sign Language) or in the case of Australia, the AUSLAN (Australian Sign Language). The National Child Traumatic Stress Network (2006) describes sign language as “ a gestural, visual, and a spatial method that uses movement, and placement, of hand, face, and body expressions to communicate.” Breivik (2005) states that the language itself helps to create bonds found within the Deaf community, and

that it is within this community that deaf children and deaf adults feel the most comfortable. Breivik (2005) further mentions that the Deaf community are proud of their heritage and culture, and more importantly, proud of their deafness.

Effects of communication and early intervention

Communication is an important aspect for developing a child's language and speech development. Lynas (1994) states that human communication is vital for speech and language development, and that language itself is where a person can become " a fully socialised, integrated human being." For hearing people, the primary system of communication is through speech or the auditory-oral system of language (Lynas, 1994). For individuals born deaf, the development of language and communication skills are hindered or limited (Lynas, 1994). Studies have found that age is a significant factor in developing the necessary speech and language skills required for effective communication. According to Woll (1998), every infant born is capable of learning any human language but the type of language they will eventually learn depends on which language they can access. The first six months in a child's life is a sensitive stage for development of language because it is the time when the child progresses from just babbling to the formation of syllabic combinations (Woll, 1998). Hence, clinicians regard early identification of deafness among children as key to learning language and developing intelligible speech. In a 1993 report by the National Institute of Health, clinicians were recommended to identify hearing loss at three years, then make successive follow-ups and coordinate with the family and child for intervention services (Halpin, Smith, Widen, & Chertoff, 2010). Getting

diagnosed and securing the right intervention within the child's first six months of life assists the child in achieving better outcomes in therapy (The National Child Traumatic Stress Network, 2006).

Parents of deaf children have to make the informed decision about which type of communication their child should acquire – signed or spoken. Petitto and Holowka (2002) recommend that young children be given exposure to bilingual language at the earliest possible time. Bilingual language could be either a combination of two spoken types of language or one spoken and one signed language. This allows deaf children to adjust better in a world that has become multi-cultural and multi-linguistic. Furthermore, research has indicated that the optimal period for language acquisition by a child begins at birth until the child is five years old (Petitto and Holowka, 2002).

Language and educational options: advantages and disadvantages

There are four communication methods that a parent of a newly diagnosed deaf child can consider: Auditory-Oral, Auditory-Verbal, Total Communication, and Bi-lingual and Bi-cultural (Bi-Bi). Each option has its own set of advantages and disadvantages that parents must be aware of.

Auditory-Oral Method. The Auditory-Oral method emphasizes on oral language building by prompting the deaf child to use whatever hearing he or she has, along with speech-reading to speak effectively (Lynas, 1994). The focus of this model is to provide the deaf child the skills to be mainstreamed into regular classrooms with hearing children (Lynas, 1994). However, most Auditory-Oral programs require full-time therapy sessions combined with Auditory-Oral education. Schools offering Auditory-Oral programs use self-

contained classrooms and instruct using the English language (The National Child Traumatic Stress Network, 2006). The Auditory-Oral method is one of the more traditional approaches to teaching the deaf child (Lynas, 1994). The child under an Auditory-Oral therapy needs to be equipped with assistive listening devices or hearing aids that enhance their auditory senses (The National Child Traumatic Stress Network, 2006). An advantage of this therapy is that the child is trained to speech-read. However, to excel in this method, the child must have the ability to grasp language quickly and effectively (National Child Traumatic Stress Network, 2006). Another great disadvantage of this mode of therapy is that it entails great cost.

Auditory-Verbal Therapy. The Auditory-Verbal method teaches a child who is deaf to use a hearing aid or cochlear implant to learn to talk and understand language (Lynas, 1994). With the use of these devices, a child no longer depends on visual cues (Lynas, 1994). Hearing aids are devices worn at the ear that amplify sound ear. The cochlear implant, on the other hand, is a surgically implanted hearing device designed to enhance the hearing of sound. It also has the potential of improving speech understanding in children with profound hearing loss (The National Child Traumatic Stress Network, 2006). The Auditory-Verbal method maximizes a child’s residual hearing and works closely with the child’s parents by educating them how to instruct their children (Lynas, 1994). This method focuses on preparing the hearing impaired child for regular mainstream classrooms. One major disadvantage of the Auditory-Verbal method is that it is not readily available in the community (The National Child Traumatic Stress Network, 2006). Another disadvantage is that this program is only for children diagnosed at a

very young age and for the thrapy to be effective, the child must have some residual hearing (Deaf Linx, 2007). Supporters of oralism believe that verbal language should be used in education and that sign language should not be permitted in the learning process (Lynas, Huntington, & Tucker, 1997).

Total Communication Method. The Total Communication method is an educational philosophy that utilizes several communication modes such as oral, auditory, manual, and written. One of the major advantages of the Total Communication method is that it is adjusted to suit the child (Lynas, 1994). Ideally, parents or teachers can use sign language, writing, speech, pictures, or other methods of communication. The important thing in Total Communication is that the child is comfortable with the method of communication used. One disadvantage of Total Communication is that clinicians are concerned that learning to sign and talk simultaneously could damage the child’s ability to learn both (Lynas, 1994). Supporters of oralism believe that Total Communication reduces the rate of speech used by the instructor, and that English could be simplified in the effort to use sign language (Lynas, 1997). The advantages of Total Communication is that it acts as a “ safety net” for those who are unable to learn using oral methods because it uses English supported by sign language. Unlike other methods, Total Communication enables expressive communication from the child. In the case of the 3-month-old girl with a moderately severe hearing loss whom both parents are fluent in AUSLAN, this method would be more preferred as compared to other methods.

The Bilingual-Bicultural method. The Bilingual-Bicultural or Bi-Bi method combines both sign language, and the spoken word (Lynas, 1994). The use

of the Bi-Bi method is premised on the belief that sign is the “ biologically preferred” communication method for deaf children. With Bi-Bi, the child is taught ASL first and English is taught subsequently as a second language. In the process, the child is allowed to experience the deaf culture as well as the culture of the hearing. Before a child reaches seven years old, sign is the main language used for interaction with others (Lynas, 1994). At this stage, he or she identifies with Deaf Culture. When the child is able to master sign, the child is taught to speak English and allows him or her to experience with the hearing culture. In this manner, the Bi-Bi method allows the child to experience two identities.

The advantage of the Bi-Bi method is that the child is taught language skills which prepare him or her to be mainstreamed into the regular classroom (Pittman & Huefner, 2001). Parents can also participate fully in their child’s education. For hearing parents, a deaf adult can model ASL to them until the parent’s sign skills are sufficient. There are also psychological advantages to the Bi-Bi method. Other advantages of the method are that sign language is available to the child. Feelings of isolation may be diminished if the child goes to a residential where all of the children sign. It also allows the deaf child to identify strongly with Deaf culture and can actively participate in it.

There are also drawbacks to the Bi-Bi approach. First of all, it is not readily available. Beyond residential schools that focus on the deaf, the Bi-Bi method of teaching is rare. Moreover, there are few deaf teachers who can serve as “ role models” to serve the needs of the Deaf community. The Bi-Bi method also poses a great challenge to homes where parents are hearing. Signing may be too difficult to master and may cause alienation in the home.

Clinicians have recognized that results of educational methods used to promote learning and communication among deaf children may vary depending on the kind of home the child is reared in (Wiesel & Yosipor-Kaziar, 2005). In the 1970s, research studies suggested that deaf children with Deaf parents exhibit learning advantage on several areas in social and cognitive skills such as in socio-emotional adjustment, education, and language competence (The National Child Traumatic Stress Network, 2006). Moreover, Berke (2007) found in a study that Deaf children born to Deaf parents are also “ linguistically superior” compared to Deaf children born to hearing parents.

Conclusion

In conclusion, the learning and communication skills of a Deaf child is dependent on how committed the child’s parents in preparing for the child’s education. Studies have suggested that the earlier a child is diagnosed with a hearing loss and the earlier he or she receives intervention services, the better a child would perform in language, communication and social skills. Today, Deaf children are presented with more opportunities to maximise their full potential because a) they have greater access to technology such as assistive listening devices and b) they have greater access to various educational and communication options to facilitate language and intellectual development.

In relation to the case in consideration, the Bi-Bi approach seems like an excellent method to provide the child with the opportunity to participate actively in both Deaf and hearing cultures. However, there is presently no Bi-

Bi program available that is close to the family’s residence. The same drawback applies to the Audio-Verbal therapy. Upon evaluation of the family’s financial capability, commitment, and geographical location, this study finds that the Total Communication method is the best educational option to meet the needs of the 3-month old child diagnosed with moderately-severe hearing loss. The Total Communication promises flexibility and adaptability to meet the unique the needs of the child. Should the child be found to have difficulty speaking, signing can be used to fill the gap. There will be no conflict within the home environment because both parents are fluent with ASL and AUSLAN. There will be little need for teachers or “ role models” to assist the parents of the deaf child. While the Total Communication approach opens several avenues for communication to the deaf child and promotes continuous communication in the home, the approach also has disadvantages. Ultimately, it is the family that must make an informed decision on what educational option is best for their child. Not only that, it will require dedication, commitment, and hard work (Lynas, 1994).