

Working With Deaf and Hard-of-Hearing Children From Linguistically Diverse Backgrounds

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EXECUTIVE SUMMARY

An increasing number of deaf and hard-of-hearing (D/HH) children live in homes where languages other than English or American Sign Language (ASL) are used. This chapter reviews issues of culture and linguistic diversity when working with D/HH multilingual learners (DMLs) from identification and early intervention through school entry. The authors will provide two case studies to explore the issues of service delivery to DMLs and their families: 1) Ji-Hun, who appears to use several spoken languages, including Korean, Japanese, and English, and 2) Ana, who is a recent immigrant to the USA and appears to use ASL, spoken Spanish, and spoken English. The discussion of these two case studies will encompass some cultural differences, including 1) openness to engagement with providers, 2) cultural beliefs about hearing loss, 3) community systems and familiar support, 4) perceptions of systems and authorities. The case studies presented are not based on actual clients but are drawn from the clinical experiences of the authors.

INTRODUCTION

According to National Center for Education Statistics (2019), English language learners (ELLs) account for 9.5% of all the students who are enrolled in public schools. The most recent data available from the Gallaudet Research Institute Annual Survey (Gallaudet Research Institute, 2013) indicated that 18.3%

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of deaf or hard-of-hearing (D/HH) children in public schools were identified as ELLs. Furthermore, 35% of the families in the Gallaudet Research Institute survey reported using a language other than English or American Sign Language (ASL) in the home, suggesting that identification of ELLs for the purposes of the *No Child Left Behind* initiative reporting may underestimate the number of D/HH children in multilingual environments. Even though these statistics indicate a significant proportion of D/HH children are D/HH multilingual learners (DMLs), compared to the hearing multilingual population, very little information is available about how to provide appropriate services that account for their diversity. Furthermore, the literature on service provision to DMLs may be obscured by philosophical issues related to communication modality.

It is well documented that children who are D/HH are at risk for poor language, social-emotional, and academic outcomes (Spencer & Marschark, 2010). The primary risk factor is not the hearing loss itself, but the lack of an accessible language (Knoors & Marschark, 2014; Lederberg, Schick, & Spencer, 2013). Children living in the U.S. who come from households where English is not the primary language face a more challenging task because they may need to negotiate English, ASL, and the spoken and/or signed language(s) which they use in the home. Linguistic and cultural diversity has implications for service delivery from diagnosis through transition to post-secondary settings.

Pediatric hearing loss is estimated to affect 5-15% of the population (Centers for Disease Control & Prevention, 2016). One percent of school-age children with an individualized education program (IEP) receive services based on a code related to hearing loss (American Speech-Language-Hearing Association, 2016; U.S. Department of Education, Office for Special Education, 2019). More than 90% of deaf children are born to hearing parents (Mitchell & Karchmer, 2004), and 35-40% have other conditions/disabilities (Gallaudet Research Institute, 2010; Yoshinaga-Itano, Sedey, Coulter, & Mehl, 1998). Almost 45% of speech-language pathologists (SLPs) who work in a school setting regularly serve children with hearing loss. Early Hearing Detection and Intervention programs have significantly decreased the age at which childhood hearing loss is diagnosed and early intervention services can be initiated (Gaffney, Green, & Gaffney, 2010; Yoshinaga-Itano, 2003). The younger age of diagnosis and subsequent early intervention have shown promising results for developmental outcomes. However, no known studies specifically on outcome measures for DMLs exist.

Upon the diagnosis of hearing loss, families face a decision in determining the communication modality (Table 1) they will use with their children (Decker, Vallotton, & Johnson, 2012). Parents receive and must consider this new information while still processing the emotional response to the diagnosis (Stredler-Brown, 2010). The selection of a communication approach is stressful to families, and they report valuing accurate, impartial, and respectful information (Meadow-Orlans, Sass-Lehrer, & Mertens, 2003). With earlier age of diagnosis, the historical debate of the correct approach is being replaced with the notion of parental informed choice. Informed choice includes the provision of comprehensive, meaningful, relevant, and evidence-based information, so that parents are empowered to make decisions for their children (Moeller, Carr, Seaver, Stredler-Brown, & Holzinger, 2013; Young et al., 2006). For families from developing countries, attitudes and cultural beliefs towards disability play an important role. There may be a delay in acceptance of a disability, and in the case of hearing loss, hearing technology that may draw further attention to the disability (Olusanya, Luxon, & Wirz, 2004). Counseling services for families should consider diverse cultural orientations.

Furthermore, new opportunities to acquire and develop a variety of skills mean that commitment to a single approach is not necessary. Families report a desire for their children to develop skills and flexibility to choose what is best for them in a variety of contexts (Wainscott, Sass-Lehrer, & Croyle,

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