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12-1-2016

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### Recommended Citation

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# Avoiding Linguistic Neglect of Deaf Children

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**ABSTRACT** Deaf children who are not provided with a sign language early in their development are at risk of linguistic deprivation; they may never be fluent in any language, and they may have deficits in cognitive activities that rely on a firm foundation in a first language. These children are socially and emotionally isolated. Deafness makes a child vulnerable to abuse, and linguistic deprivation compounds the abuse because the child is less able to report it. Parents rely on professionals as guides in making responsible choices in raising and educating their deaf children. But lack of expertise on language acquisition and overreliance on access to speech often result in professionals not recommending that the child be taught a sign language or, worse, that the child be denied sign language. We recommend action that those in the social welfare services can implement immediately to help protect the health of deaf children.

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**INTRODUCTION**

Deaf children (a label used inclusively here to cover children with a wide range of hearing loss, including those who are hard of hearing) have historically been and continue to be at increased risk for maltreatment. While many types of maltreatment of deaf children are documented and actively discussed, the majority of people who live and/or work with deaf children have yet to recognize the most prevalent type: linguistic deprivation (also known as language deprivation) due to failure to provide access and effective exposure to a language. New research shows that inadequate access to language is associated with negative health and psychological outcomes. The lack of recognition of this type of maltreatment is significant, since linguistic deprivation results in other types of maltreatment. In this way, then, failure to provide exposure to an accessible language constitutes child neglect. The critical means of avoiding this risk for a deaf child is providing the child with exposure to a sign language.

The issue of how to raise and educate deaf children is not a new one, and it has been fraught with debates that largely concern matters of culture and parental rights—debates grounded in philosophical, political, and sociological concepts. We do not enter into those debates. Instead, we focus on recent studies of biological harm and its psychosocial effects if a child does not fully access language during the period in which the brain's plasticity is primed for language development.

Not all deaf children who are not taught a sign language wind up with linguistic deprivation and become targets of abuse. Just as not all children who are not wearing a seat belt wind up in an accident and are the victim of injury or death, we agree, as a society, that children (and adults) should wear seat belts to guard against potential harm, and we expect the responsible adults to ensure the child's use of a seat belt. We conclude in this article that sign language exposure is just as critical an aspect of caring for the deaf child.

Examining the ways in which linguistic deprivation occurs helps to clarify the responsibilities of individuals and institutions to ensure the safety and humane care of deaf children. We discuss here the social and cultural conditions that restrict deaf children's access to language, including beliefs and practices of individuals and institutions that hinder parents' ability to protect their deaf children from harm. We also discuss

the need for all deaf children to learn a sign language. We end with suggestions for policies and practices that can assure protection from harm due to linguistic deprivation.

### **WELL-RECOGNIZED MALTREATMENT: A REVIEW OF THE LITERATURE**

Considerable recent research documents the prevalence of child maltreatment among deaf people. Lindsay Schenkel and colleagues (2014) used the English version of the Childhood Trauma Questionnaire to assess five types of childhood maltreatment that occurred prior to age 16. The self-reported child maltreatment occurrence for the deaf college sample in the United States ( $n = 104$ ) is as follows: 48 percent for emotional abuse, 44 percent for emotional neglect, 44 percent for physical neglect, 40 percent for physical abuse, and 31 percent for sexual abuse. A study in the United Kingdom finds that children with speech and language disorders were at increased risk of emotional and physical abuse, associated both with psychological disorders and with neglect (Spencer et al. 2005). A Norwegian study finds that deaf females run double the risk of sexual abuse as their hearing peers, while deaf males run triple the risk (Kvam 2004), and a German prevalence survey study indicates that 52 percent of deaf women are at high risk for violence, including sexual abuse (BMFSEJ 2012). In an older American study, 54 percent of deaf boys and 50 percent of deaf girls reported sexual abuse (Sullivan, McCay, and Scanlan 1987).

Deaf people's high susceptibility to maltreatment of many sorts (Knutson and Sullivan 1993) is part of a larger trend. The second National Incidence Study (NIS-2), compiled in 1986 and published in 1988 (NIS-2 1998), shows that children with disabilities ran nearly double the risk of maltreatment as children without disabilities (although in the case of physical maltreatment, it can be unclear whether the correlation reflects on disability as a precursor or a result of maltreatment; Kolko 2002). Other studies confirm that the presence of a disability puts a child at higher risk of maltreatment (Brown et al. 1998), including neglect (Connell-Carrick 2003). While the prevalence of self-reported childhood abuse and neglect varies depending on methodological issues, with the result that prevalence is recorded as much higher in some countries than in others (Stoltenborgh et al. 2011), it is a global problem, one that is consis-

tently exacerbated among children with disabilities (Kendall-Tackett et al. 2005).

It is important to outline what we mean when we talk about neglect, since the definition and determination is neither simple nor straightforward, although certain situations are generally understood to constitute negligence. Susan Sullivan (2000, 8) lists neglect as “failure to provide basic physical health care, supervision, nutrition, personal hygiene, emotional nurturing, education, or safe housing. It also includes child abandonment or expulsion.” The failure to provide emotional nurturing—that is, emotional neglect—is highly pertinent to the deaf child and should be understood as involving broad conceptual parameters, including parental failure to recognize the child’s need for self-esteem (Hegar and Yungman 1989) and for encouragement (Barnett, Miller-Perrin, and Perrin 1997). James Garbarino, Edna Guttman, and Janis Seeley (1986) define five subtypes of psychological maltreatment: spurning, terrorizing, isolating, exploiting/corrupting, and denying emotional responsiveness.

Emotional harm is less obvious to detect and more difficult to document than physical and sexual harms, which leave visible marks; nevertheless, it is at least as damaging (Erickson and Egeland 2011). Neglect is a chronic stressor, and if not addressed early, it can lead to abnormal activation of neurobiological stress system responses that are associated with worse cognitive and psychological outcomes (Gunnar and Quevedo 2007; Bernard, Lind, and Dozier 2014).

While all types of maltreatment risk cognitive harm (Gauthier et al. 1996; Glaser 2000; Schore 2001; Norman et al. 2012; Spratt et al. 2012), in a brain imaging study of children who were admitted for psychiatric evaluation (some with a history of neglect/abuse and some without), neglect is found to have the most variability in the reduction of the corpus callosum compared to abuse (Teicher et al. 2004). Abnormal development of the corpus callosum is associated with dysfunctions in cognitive processing, including language processing (Hinkley et al. 2012). Ross Vanderwert and colleagues (2010) show that the effects of neglect are biological by establishing a sensitive period for brain plasticity regarding neglect; in an electroencephalogram study of children who were exposed to severe psychosocial neglect as infants in institutions and then placed in foster care intervention, results indicate that the desirable increase in brain activity associated with a sensitive period occurred only for neglected children who were placed in foster care prior to 2 years of age.

We note further that neglect and abuse are intensified by isolation (Zebell and Peterson 2003). Isolation can be considered a form of abuse, which brings us to the issue of linguistic neglect.

### LINGUISTIC NEGLECT

In the general literature, early life stressors, including those involving social rejection and neglect, are linked to depression (Slavich and Irwin 2014) and greater emotional sensitivity to stress (Dougherty, Klein, and Davila 2004; McLaughlin et al. 2010). The influence of neglect is likely to be significantly higher for deaf children, who have reduced access to language, are often isolated socially, and are already at risk for worse psychological and cognitive development that can affect academic disparity. Research on deaf youth ages 11–18 documents that self-perception of poor access to language and communication is significantly associated with higher depressive symptomatology (Kushalnagar et al. 2011). Also, there is evidence of greater depression severity in deaf adult patients who retrospectively reported feeling left out from family communication during childhood compared to deaf adult patients who had better communication with their parents (Leigh and Anthony 1999).

Difficulties with communication at home are repeatedly listed as one of the risk factors for depression disorders among deaf children (Fellinger et al. 2009). More recently, a study of 143 deaf college students finds that difficulties in basic communication with parents significantly increase the odds of depression symptomatology during adulthood (Kushalnagar et al. 2016). The higher odds ratio may be partly due to the invisible emotional neglect that deaf children experience, which is not documented or reported until much later, after the individual seeks psychological treatment.

Isolating a child and denying emotional responsiveness to a child go hand-in-hand with not maintaining an environment for the child to build a solid foundation in a language. All children need regular and frequent exposure to an accessible language during the critical (or sensitive) period between birth and 3 or 4 years old (Mayberry, del Giudice, and Lieberman 2011) or they risk linguistic deprivation—a biological state that interferes with the development of neurolinguistic structures in the brain (Skotara et al. 2012; see also Leybaert and D’Hondt 2003; Lyness et al. 2013) and that appears to decrease gray matter in certain parts of the brain (Penicaud et al. 2013). Linguistic deprivation inhibits fluency in any lan-

guage and correlates with a range of poor cognitive and academic outcomes (Wolkomir 1992; Humphries et al. 2012). The more famous examples of linguistic deprivation, such as Jan Itard's "wild child" (Malson and Itard 1972), "Genie" (Fromkin et al. 1974), and others (Nelson, Zeanah, and Fox 2007), have captured the interest of those seeking to document the effects of linguistic deprivation on humans. However, many less sensational cases exist, where early lack of ordinary care is associated with cognitive deficits, particularly language deficits (Schaller 2012; Spratt et al. 2012). Early and prolonged lack of human language interaction has been shown to produce severe disorders that are unlikely to be reversible (Kumar et al. 2013). Deficiencies of appropriate input at critical points in development are more likely to cause harm to a child's cognitive development, and, therefore, relate directly to the determination of neglect (Sullivan 2000).

Many deaf children who are raised using only spoken language do not receive enough access to auditory information to develop language. Some cases fall near the extreme end of the spectrum of disorders or harms in that these children do not become entirely fluent in any language and have cognitive deficits associated with those faculties that require a firm foundation in a first language (Mayberry 2002). As early as 1993, Mather and Mitchell (1993, 120) introduced the term "communication abuse" to describe the failure to provide deaf children with "full access to communication." Severe language deprivation can be considered its own mental health disorder, the language deprivation syndrome (Gulati 2003, 2014; Glickman 2009b; Hall, Levin, and Anderson 2016). We argue that not protecting children against this syndrome is severe neglect.

On top of these biological harms, the notion of social communication has emerged over the last few decades as a way to group together a range of concepts related to language deprivation, with much of the discussion revolving around children with autism (McEvoy, Rogers, and Pennington 1993; Mundy and Crowson 1997; Wetherby et al. 2007; among many), but it is applicable to any child who is deprived full access to language, including deaf children (Peterson and Siegal 2000; Astington and Baird 2005; Peterson, Wellman, and Liu 2005, among many). Without full access to language, the child's privilege of social communication is taken away, which has severe consequences. Lack of social communication inhibits development of a healthy, strong sense of self (Breivik 2005; Hintermair 2008; among many), inhibits developing resiliency in order to deal with adver-



sity, so it impedes executive function (Figueras, Edwards, and Langdon 2008; Hauser, Lukomski, and Hillman 2008; among many), and makes it hard for children to get along with and have empathy for others, which impedes the development of a theory of mind (Woolfe, Want, and Siegal 2002; Hughes and Leekam 2004; Schick et al. 2007; among many). That is, the children will have trouble understanding that others have their own mental states and do not simply have the same beliefs, needs, desires, intentions, and perspectives that they have. The child without social communication does not have the chance to develop these social and cognitive skills, which are prerequisites for education and for assuming a productive and satisfying position in society. Thus, we consider not protecting a child's social communication to be severe neglect. Additionally, anyone left without social communication is left without health communication, another instance of neglect.

In deaf children with no language delays (meaning deaf children who sign from an early age), the architecture of the brain is protected and social communication is strong. These children have been found not to have an issue with sustained attention, which is an important cognitive skill for being able to function in an educational setting (Dye and Hauser 2014), and this is one reason why signing deaf children do better academically than nonsigning ones (as outlined in the following section on sources of linguistic neglect).

What makes a language accessible to a child? If a child is exposed regularly and frequently to a language and picks up that language naturally without explicit training and exercise (as generally happens with hearing children in a speech environment and with deaf children in a signing environment), the language qualifies as accessible to that child. On the other hand, if a child is exposed regularly and frequently to a language but does not pick it up even after explicit training and exercise (as can happen with deaf children in a speech environment), the language is arguably inaccessible to that child. Between those two ends lies a gray area in which decisions by caregivers and professionals have as much bearing on the lack of access as the fact of the hearing loss. Just as hearing loss can affect access to spoken language, which is a biological constraint on language exposure, so decisions to exclude exposure to sign language can affect access to language, which can lead to social constraint.

It is important to note that sign languages are accessible to all deaf children (including deaf-blind children, given that there are tactile variations

of sign languages). That is why a recent panel of experts reporting in *Pediatrics* concludes that providing a sign language as early as possible is the more reliable way to ensure a deaf child's language development and prevent linguistic deprivation (Napoli et al. 2015). Providing deaf children with a sign language also combats the isolation that characterizes much of the neglect reported in the literature. The harm of failing to assure language development is compounded by the fact that this particular neglect increases deaf children's risk for other maltreatments (Mather and Mitchell 1993; Embry 2000; Sullivan and Knutson 2000) and decreases their ability to report these maltreatments (Johnson 2011).

#### SOURCES OF LINGUISTIC NEGLECT

If failing to provide a sign language to a deaf child risks linguistic deprivation and therefore, like not requiring a child to wear a seatbelt, constitutes neglect, one may wonder why families and those giving professional advice to them decide to take this risk, given that parents have a natural desire to protect their children and that professionals who work with deaf children and their families are committed to their welfare. The answer lies in historical views about language acquisition and sign languages that have resisted change despite new research requiring social attitude change about sign language and updated informed practice by professionals. This resistance has led many to delay acceptance that deprivation is occurring. In their work on the sexual abuse of deaf children, Cindy Cassady and colleagues (2005, 4) say, "They [deaf children] may have been surrounded by rich language input, but were unable to access it; often unbeknownst to their caregivers, but sometimes because caregivers are aware but in denial and do not address the need for their children to learn communication skills." Here, we explore the issues of social attitudes and lack of information among professionals, and we show how the combination of the two can lead to denial.

Language development, a critical part of overall cognitive development, is under most circumstances a naturally acquired artifact of human interaction. As outlined earlier, when human language interaction is withheld or absent, the result is severe cognitive deficits. Although social services typically intervene when abuse is detected (Iwaniec 2006; Jenny 2010), it is rare for adult caregivers of these children to be held liable for these harms, which creates handicaps. In fact, the idea that caregivers

can create handicaps in their children through neglect is generally discussed with respect to unborn fetuses (such as in Parness 1982; Scott 2002), not small children. It is assumed that it is sufficient to employ treatments, therapies, and interventions long established by the hearing sciences with deaf children. If the deaf child has deficits, it is assumed that these are due to the condition of deafness rather than to the lack of action on the part of caregivers. Even in the most extreme cases, public policy does not consider the fact that these harms are preventable or avoidable and does not hold anyone responsible for avoiding them.

One historical misconception behind this thinking is that language is taken as equivalent to speech. This assumption is outdated and comes with severe consequences. Language is a cognitive faculty that can be manifested in more than one modality: oral–aural, realized as speech, and manual–visual, realized as sign. The two modalities are equal cognitive citizens, so to speak; language development is modality-independent and people can express themselves fully in either modality. Evidence supporting this comes from research in many areas, including linguistic analysis (Padden 1988, among many), first language acquisition (Chamberlain, Morford, and Mayberry 2000, among many), neurology in matters of language pathologies (Campbell, MacSweeney, and Waters 2008, among many), and language processing (Emmorey 2002, among many), as well as expressive capacity (Bauman et al. 2006, among many). To be cognitively and psychosocially healthy, children need language, regardless of its modality. For deaf children, visual language—that is, a sign language—satisfies that need naturally.

Despite the preponderance of relevant scientific evidence supporting the equivalence of sign language and speech, the status of sign languages as bona fide languages has not been understood by medical professionals (Humphries et al. 2014) and society at large. The reasons for this may be multiple, including the desire to make deaf children as “normal” as possible, thus sidestepping the potentially stigma-carrying use of a sign language (Lane 2005, among many). Another factor may be the desire to avoid work that seems impossible; families would need to learn to sign in order to raise their deaf children with a sign language, and that task appears daunting to many. Whatever its source, this misunderstanding makes it difficult to fully realize the long-lasting effect of language deficits and other ensuing cognitive deficits on deaf children. As a result, underinformed child-welfare and educational-policy perspectives enable behaviors that contribute to

deaf children's language and cognitive deficits, which in turn contribute to subsequent maltreatments.

Research over the past several decades reveals that full and prolonged exposure to a sign language for a deaf (or hearing) child results in language development that follows the same patterns and produces the same developmental results as exposure to a spoken language does for a hearing child (Courtin 2000; Woolfe et al. 2002; Mayberry et al. 2011; among many). The research suggests that sign languages are exactly what the deaf child needs for good cognitive development across the board, including good social communication, as noted earlier. Deaf children need to have their visual attention captured in order to learn best (Dye, Hauser, and Bavelier 2008). To withhold a sign language from deaf children and to instead invest hope in their acquiring a spoken language is to miss a natural pathway to cognitive development, and it constitutes a risk not justified by historical patterns of development in deaf children. Deaf children who acquire a sign language from birth do not risk language delay or deficit, their reading abilities are better than deaf children from other backgrounds (Goldin-Meadow and Mayberry 2001; Moores 2006; Chamberlain and Mayberry 2008; Holmer, Heimann, and Rudner 2016), and the spoken language skills of the children who have cochlear implants in this group are better than the spoken language skills of the children whose parents are hearing (Hassanzadeh 2012), a factor that opens up personal and professional opportunities. There is a strong correlation between better signing skills and better print literacy in study after study (most recently, Hrastinski and Wilbur [2016], and see the earlier work of Lederberg, Schick, and Spencer [2013]). With continued means of direct communication appropriate to the individual (sign, speech, or writing) and with appropriate accommodations such as amplifications, frequency modulation (FM) systems, captioning, or interpreting services throughout schooling, deaf children can grow up to be productive adults in the workforce (Cawthon, Schoffstall, and Garberoglio 2014).

#### RESPONSIBILITY FOR LANGUAGE DEPRIVATION AND NEGLECT

Parents of deaf children do not make their decisions about how to raise their child in a vacuum. Typically, parents are selectively informed, at least initially (in the United States, around 96 percent of deaf children are born

to hearing parents; Mitchell and Karchmer 2004), and are more likely to be vulnerable as they are stressed by an unexpected situation for which they are unprepared (Koester and Meadow-Orlans 1990; Aras et al. 2014). It is natural that parents turn to the higher-status medical and hearing science professions for guidance.

These professions too often provide misinformation. Partly that is because medical schools have been remiss in not covering relevant information in their curricula (Humphries et al. 2014), and continuing medical education (CME) programs have not taken up the slack. In particular, most medical schools and CME programs do not teach about the biological foundation of language acquisition, the cognitive harm of linguistic deprivation, and the fact that sign languages satisfy cognitive needs just as well as spoken languages do. From social stigmatization and uninformed beliefs comes a bias among medical professionals against sign language. Since they are not kept abreast of the relevant scientific research, medical professionals have historically taken the view that deafness is a problem that needs to be “treated,” and some even say “cured” (Branson and Miller 2005); deafness does not conform to the norm, and deaf children are seen in a sense like apples that fall far from the tree (Solomon 2012). This lack of modern understanding about language, cognition, and sign language creates a gap that hearing science professionals and cochlear implant (CI) manufacturers fill with the offer of the treatment or cure needed for deafness via technology, a means that the medical profession is inclined to trust and that parents are willing to accept. The medical profession plus the CI manufacturers together then tend to promote a speech-only approach to the raising and educating of deaf children.

Some manufacturers and implant teams even ask parents to sign an agreement saying they will keep their deaf child away from a sign language (Knoors and Marschark 2014), despite evidence that many deaf children with CI receive no language benefit (Giraud and Lee 2007). In a survey of over 20,000 deaf children implanted since 2000, 47 percent had stopped using their CI (Watson and Gregory 2005), which is a strong indication that the children were not receiving significant benefit (although the children report many additional reasons, including facial twitching, post-surgery scarring, stigma from wearing the device, and pain from both the device and the auditory input). Both the medical profession and CI manufacturers are aware of the variable success rate with CIs and know that it is impossible to predict with accuracy which children will have suc-

cess—witness the large number of articles about training to use CIs in the medical literature.

A set of factors, including higher socioeconomic status of the family, implantation before the age of 12 months, motivation of the family to carry out the training required to use the CI, and several others (Svirsky, Theo, and Neuburger 2004; Santarelli et al. 2008; Szagun and Stumper 2012), has been found to positively correlate with CI success. However, even children who have all the positive correlates—the optimal cases—experience failure (Humphries et al. 2012), and most CI children are not optimal cases. In fact, poverty is implicated in higher levels of sensorineural deafness around the globe (for Canada, see Bowd 2005; for India, see Reddy et al. 2006; for Malawi, see van Hasselt and van Kreten 2002; for Pakistan, see Musani et al. 2011; for the United States, see many, especially Oghalai et al. 2002 and Prince et al. 2003). Further, families have little time for focusing on the training regimen that is required (Most and Zaidman-Zait 2001; Punch and Hyde 2010).

Once such a speech-only approach is promoted, public policy falls in line with what is argued to be standard acceptable medical practice. There is awareness and often documentation in child welfare services that language and other developmental delays of deaf children are culprits in a variety of maltreatments the children suffer, but they have not challenged medical or hearing professionals with regard to the speech-only approach. For example, Richard Embry and Frank Grossman (2007) report on what they deemed a successful community practice effort to deal with child abuse, particularly with respect to deaf children. This practice focused on linguistic access, as deaf people do better with clinicians who are culturally competent (Black and Glickman 2008; Glickman 2009a; Gournaris and Aubrecht 2013) and “who sign themselves and who use counseling techniques that resonate with deaf people” (Glickman 2013, 15). The use of signing in these counseling situations can create a strong bond, as well as ensure full communication (similar to what White [2001] reports for deaf children adopted by deaf parents). While this practice is commendable, the organization that Embry and Grossman described, the Los Angeles Child Abuse Councils, to this day does not list among their Prevention Tips on their website the recommendation that deaf children be taught a sign language so that they will not have a language deficit and, thus, be less vulnerable to abuse—this despite the fact that they acknowledge that language deficit is a culprit. It seems that even well-intentioned

child welfare practices stop short of making appropriate recommendations.

Given the state of the professions and their reluctance to acknowledge the issues, parents may be confused, especially since in some instances mandated reporters (physicians, nurses, social service providers, audiologists, and psychologists) might decide that implantation and avoidance of a sign language is in the best interest of the child, thus implicitly threatening the parents if they do not follow their advice (see discussion in Bender [2004], Zimmerman [2009], and Byrd et al. [2011]).

A large portion of the responsibility, then, lies with the professionals. Parents cannot be expected to be equipped to carry that responsibility fully, but the professionals have committed to that responsibility by virtue of their profession. If professionals are truly to protect and serve deaf children, they are obligated to understand and operationalize the cumulative evidence of the importance of sign language to deaf children's cognitive development.

#### **ACTION**

The responsibility to protect deaf children against linguistic neglect and the vulnerability to abuse that ensues falls on many: the medical profession, hearing science professionals, the CI industry, educators, and child welfare services. The last several years have witnessed considerable advocacy for remedial action among medical and hearing science professionals (including Kushalnagar et al. 2010; Humphries et al. 2012, 2014, 2016); however, no advocacy work we know of has been directed at child welfare services. This is a gap that needs to be remedied for two critical reasons. First, doctors (and other medical professionals) often do not follow the children's development after the initial consultations and thus are not positioned to know the consequences of their own advice, while child welfare services witness the consequences firsthand. Second, the potential for conflict of interest arises with medical professionals (kick-backs from CI companies are an example; see Department of Justice 2010), but no such potential for conflict of interest arises with child welfare agencies. Child welfare agencies are, therefore, strategically positioned to play a key role in addressing the problem of linguistic neglect.

We offer initial suggestions for encouraging positive effects that are based, in part, on comparison with how laws against corporal punish-

ment of children in several countries have come about and their positive effects.

#### COMPARISON TO ANTI-CORPORAL PUNISHMENT LAWS

Whether or not a parent is justified in punishing a child with a spanking or other corporal violence has been a topic of controversy for the past few decades, and the controversy is complicated by the fact that the practice has been part of family traditions at a personal, ethnic, and even national level in many places. The issue of corporal punishment offers a useful comparison to the issue of a speech-only approach to the raising of deaf children precisely because it is controversial and the controversy involves what parents may see as their rights in raising their children within their culture, and because the intent on the part of the parents is not harm (Durrant 2006) yet there are significant potential harms, both physical and psychosocial. Further, the comparison allows for a useful practical model for what child welfare services can do.

As recently as 1992, a survey in the state of Ohio finds that 59 percent of pediatricians and 70 percent of family physicians supported mild spanking in some disciplinary situations (McCormick 1992). Since then, three forces have brought about a significant change in the attitudes of professionals in North America, turning them against corporal punishment: recognition of children's rights, advances in pediatric psychology, and greater understanding of the dynamics of parental violence (Durrant 2008). In particular, research shows that physical punishment is positively correlated with negative developmental outcomes, including aggression and antisocial behavior (see Gershoff 2002; Aucoin, Frick, and Bodin 2006) and depression and suicide (see DuRant et al. 1994; Turner and Finkelhor 1996), regardless of the cultural group a family belongs to and regardless of the fact that the intent in most cases is to punish or teach, not to harm (for an overview, see [Durrant 2008]). Research also shows that parental factors, such as stress (Travillion and Snyder 1993) and socioeconomic status (Straus 1991), correlate with increased corporal punishment. Just 6 years after the Ohio survey, the American Academy of Pediatrics recommended against spanking (American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health 1998).

In some countries, institutions outside the medical profession have taken a lead in opposing corporal punishment. In 2004, for example, the



Canadian Psychological Association issued this policy statement (Canadian Psychological Association 2004, online):

Physical punishment has been consistently demonstrated to be an ineffective and potentially harmful method of managing children's behaviour. It places children at risk of physical injury and may interfere with psychological adjustment. To reduce the prevalence of physical punishment of children and youth, public awareness campaigns must deliver a clear message that physical punishment may place children at risk of physical and psychological harm. Second, public education strategies that increase Canadians' knowledge of child development should be supported. Third, evidence based programs for developing parenting skills should be supported.

Many other Canadian organizations have joined in the campaign (Durrant 2008).<sup>1</sup> Of particular importance here, the Child Welfare League of Canada (CWLC) is working with the Public Health Agency of Canada to examine family violence with the goal of supplementing policy, programming, and future research, as well as working with the Family Violence Initiative of the Department of Justice on prevention efforts and priorities at the national level (CWLC 2013).

Many countries have passed laws banning corporal punishment with children, Sweden being the first (in 1979), with 17 other European nations following over the next 30 years (Bussman, Erthal, and Schroth 2011).<sup>2</sup> Other countries have declared physical punishment of children illegal, though not via the establishment of a specific law (such as Italy, with a highest court ruling; Durrant 2000). The movement is global in scope (Durrant 2008).

1. These include Canadian Academy of Child and Adolescent Psychiatry, Canadian Association of Child Life Leaders, Canadian Association of Occupational Therapists, Canadian Association of Paediatric Health Centres, Canadian Dental Association, Canadian Institute of Child Health, Canadian Nurses Association, Canadian Paediatric Society, Canadian Physiotherapy Association, Canadian Psychological Association, Canadian Public Health Association, Canadian Red Cross, and the College of Family Physicians of Canada.

2. These include Finland (1983), Norway (1987), Austria (1989), Cyprus (1994), Denmark (1997), Latvia (1998), Croatia (1999), Germany (2000), Iceland (2003), Bulgaria (2003), Ukraine (2004), Rumania (2005), Hungary (2005), Greece (2006), the Netherlands (2007), Portugal (2007), and Spain (2007).

Sweden seems to be the country most studied with respect to the banning of corporal punishment, so we report on those studies here. One of the goals of the law in Sweden was to shift parental attitudes (Sverne 1993); although violence against children had been illegal for decades, many children were still being injured as “discipline,” and parents needed to be educated that this amounted to abuse (Durrant and Olsen 1997); hence, the passing of a specific law. Large-scale public awareness campaigns resulted in over 90 percent of the Swedish population being familiar with the law a year after it was introduced (Zieger 1983). Parental attitude has changed; Swedish parents now engage much less frequently in corporal punishment (Edfeldt 1996; Janson 2005), and, though on occasion they might “err and strike their children,” they view these as lapses in good parenting (Durrant 2011, 381). Organizations such as Save the Children Sweden (<http://resourcecentre.savethechildren.se/publishers/save-children-sweden>) support the law by keeping up efforts at informing and educating parents and children; in Germany, by contrast, the law banning corporal punishment was publicized, but not as intensively and continuously as in Sweden, and a much lower percentage of the population is aware of it (Bussmann 2005). In a study comparing five countries with laws banning corporal punishment, many indicators point to Sweden as having the lowest incidence of such family violence (Bussmann et al. 2011). Evidently, a combination of public education with law reform is a more effective strategy than either alone (Durrant and Ensom 2012).

Most important, since the 1979 law, the negative outcomes at least partially attributed to corporal punishment have been reduced in Sweden, including rates of youth suicide and alcohol and drug use (Durrant 2000). Additionally, youth involvement in crimes (theft, narcotics trafficking, rape, homicide, and other assaults) has declined substantially (Durrant 2000), suggesting that the law is doing the job it was intended to do.

In looking at the example of efforts against corporeal punishment of children, we see several strategies for changing social attitudes and professional practices. One such practice, which has already begun, is greatly increasing social awareness of sign languages and the benefits of visual access to language for deaf children. Increasing training and awareness of language acquisition in two modalities, aural and visual, also needs to be a priority in the social services and in medical professions. Policies and codes of practice need to be reviewed, written, and practiced in child services. Existing laws may need to be tweaked, and new laws may need to be

passed. Advocacy by institutions and associations, as well as by consumer and public support groups, is needed to spur and bolster interest and a sense of responsibility from professionals and their organizations. Although the controversy about corporeal punishment may still exist, social and cultural pressure coupled with research indicates that an alternative path is better for children. The situation of language development for deaf children is even stronger: regardless of one's stance on the place of sign language in deaf children's lives, to continue to exclude it is a significant risk, while including it poses no risk at all.

#### CHANGE IN PRACTICE

Child Protective Service (CPS) agencies respond to reports of child neglect, limiting the targets of their interventions to the particular caregivers in a given situation. CPS agencies have no direct responsibility for changing the behavior of other individuals or institutions that may contribute to parents' failure to protect their children. Yet, in the case of deaf children, those other professionals and institutions with zero tolerance for alternative approaches to speech contribute to parents' failure to provide their children with sign language. We, therefore, recommend a fundamental change in the involvement of CPS with the health of deaf children: CPS agencies need to assume an active role in recognizing the problem, defining responsibility, assigning accountability, laying out what needs to be done, and educating the public.

The crucial first step is explicit recognition by child welfare and social service communities of the chronic and widespread problem among deaf children and their families with regard to the linguistic development of the children. Child welfare and social services communities need to document the problem and publicize their findings in publications and websites directed at expectant parents, parents, medical professionals, and educators of small children. Again, as the law banning corporal punishment in Sweden shows us, educating the public plays a major role in changing attitudes and behavior.

The second step toward change is for professionals to inform themselves more deeply about sign languages, the benefits of bilingual and bimodal language acquisition, and the need for both sign and spoken/print language exposure as the deaf child progresses in early childhood, in the educational system, and throughout his or her life. This information should

help to explicitly identify that the locus of delay in language acquisition is due to insufficient exposure to accessible language for the child. The basis for a new standard of care then becomes clear: early and well-informed advice to parents of deaf children by all professionals that exposure to sign language is the most effective way to protect their child's cognitive and psychosocial health.

Child welfare and social service communities are in a position to take this step immediately if they share their own awareness of this problem and its remedies. When they publicize their own documentation of linguistic deprivation, they can conclude with recommendations for all involved in the health, raising, and educating of deaf children.

In this way, child welfare services can support parents in their desire to maximize their children's chances of healthy cognitive and psychosocial development. By giving public information, they can reduce parents' confusion and sense of powerlessness and help them adopt behaviors that will build their parental confidence and that protect their children's health.

Documentation of the sort recommended here will go a long way toward changing public attitude. Even before that documentation is done, it is important to recognize that neglect is happening at the time of writing. Therefore, we believe that a health emergency exists for deaf children who are not receiving adequate exposure to language for timely cognitive development. While education of the public would be very helpful in the long term, immediate action should be taken based on the preponderance of evidence already available from research in psychology and linguistics. States' child welfare statutes, in particular those involving abuse and neglect, need to be reviewed now and should be amended or added to in order to recognize linguistic neglect as a harm to deaf children.

While we argue that not providing a deaf child with exposure to a sign language constitutes maltreatment, professionals' pervasive lack of information about language acquisition and the historical prejudice against sign languages are so extreme that it would be advisable to add language explicitly stating that not providing a deaf child with a sign language can constitute child neglect to existing statutes. This would alert medical and other professionals to reconsider the advice that they presently give to families. A wide range of helping professionals, and not just mandated reporters, might be inclined to report to CPS cases of deaf children who are suffering from language deprivation. Early detection and contact with the parents who most need help in the form of information and sugges-

tions for behavior are critical in early years of the child's development. Every month that is lost further worsens the effects of deprivation.

Although child welfare services should not shoulder the responsibility of protecting deaf children alone, there are certain strategies that would kick-start the social action that is needed to deal with this urgent problem. A starting point would be for child welfare personnel to become informed themselves so that they can better inform others. Institutions that offer undergraduate- and/or graduate-level degrees in social welfare, as well as continuing education credit programs for social workers, should include and highlight information about language acquisition and the need for sign language acquisition among deaf children. Child welfare services can then produce policies, guidelines, procedures, and materials that inform families and other responsible professionals about the potential and the reality of language deprivation in deaf and hard-of-hearing children. Professionals need to strengthen policies and regulations to empower action related to language neglect and need to encourage reporting and intervention as early as possible when harm is done to prevent further harm, since the developmental process is time sensitive.

One of the purposes of this article is to initiate necessary professional development of social service providers and of anyone involved in the Early Hearing Detection and Intervention (EDHI) Program. As a start, the web-based informational brochure on "hearing loss" issued by the Centers for Disease Control and Prevention (CDC 2015) and similar agencies in other countries should be revamped to reflect the urgency and severity of language neglect.

For our part, we offer a place to start. Social service providers can point all families of deaf children who are referred to them to the option grid "Deafness in Infancy and Childhood: Language Options" (<http://patient.info/decision-aids/deafness-in-infancy-and-childhood-language-options>). Additionally, suggestions on how to advise families can be found in the recent *Clinical Pediatrics* article by Tom Humphries and colleagues (2016).

## CONCLUSION

All deaf children should be enabled to acquire a sign language through early, frequent, and regular exposure; failure to do so greatly increases the risk of cognitive harm and thus constitutes neglect. Professionals working with deaf children have the responsibility to keep abreast of

scientific findings and modify their recommendations about the raising and educating of deaf children accordingly, rather than perpetuate practices that do harm to a class of children—deaf children. Because acquiring sign language does no harm and carries no risk, it is much safer for deaf children to have early and sustained exposure to it than the alternative of a speech-only approach, which carries a strong risk of inadequate exposure to language. Professionals who work with families of deaf children are responsible advisors when they strive to ensure that deaf children are continually exposed to a sign language.

An established principle in society, the right to language, is becoming more applicable to deaf children and their right to intact and natural language. Sign language ensures this right because of its accessible nature. Deaf children have a legal right to language (Humphries et al. 2013), and they have a right to grow up bilingually, using a sign language and a spoken language (often in the written form of that language; Grosjean 2001).

We close with this reminder (for elaboration, see Humphries et al. [2013]): following the Salamanca Statement and Framework for Action on Special Needs Education (UNESCO 1994) and following the United Nations Convention on the Rights of Persons with Disabilities Article 24.3(b) and Article 24.4 (CRPD 2006), professionals, including physicians, hearing science specialists, advocates and participants in the cochlear implant industry, and those in child welfare services should ensure that a sign language not be seen as a competitive option but as an inclusive option. Better still, it should not be seen as an option at all but as an urgent remedy to the problem of language neglect.

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