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Language Deprivation and Deaf Mental Health brings together an intergenerational group of deaf and hearing scholars who share their lived experiences and professional journeys as they address the topic. As a Deaf professional whose career has traversed several disciplines in academic and practice settings, I am energized by the interdisciplinary approach to this book's thesis that the clinical specialty of Deaf mental health service is needed to address the insidious, pervasive, life-long consequences of inadequate early access to language. This collaboration across professions undergirds promising practices in intervention and prevention, and holds critical implications for academic programs preparing future mental health professionals.

The foreword by Corinna Hill couches the thesis in an historical context, reviewing the establishment of deaf education in the United States, the oral-manual debate and the forerunner of bilingual education for deaf students, the disparities in educational opportunities related to social class and income and race, and the official recognition of American Sign Language (ASL) through work led by the famed linguist William C. Stokoe. In their introduction, co-editors Neil Glickman and Wyatte Hall provide the reader with two conceptual frameworks for the book's organization: a wheel with language deprivation at the center, and a three-section pie chart. They also summarize each chapter.

The book's thesis is carefully laid out in the introduction and first chapter, and then explicitly addressed in subsequent chapters on mental health forensic evaluations, therapeutic interventions, and prevention. Other chapters address language deprivation as it relates to technology, language evaluation, interpretation, legislation, and education with more implicit implications for Deaf mental health care. The authors are forthcoming and transparent in discussing their different perspectives; for example, whether expressive as well as receptive ASL skills should be evaluated, and whether, when, and how to work with Certified Deaf Interpreters (CDIs).

Deaf mental health is a specialty that embraces Deaf culture and emphasizes the key role of ASL-proficient Deaf professionals. It also recognizes and addresses the disabling effects of the complex sequelae of language deprivation syndrome (LDS), which Dr. Sanjay Gulati explicates in Chapter 1. This two-pronged perspective of Deaf mental health signifies a departure from a long-standing dichotomy with professionals ascribing to the cultural perspective in one camp and those with a disability perspective in the other camp. Those who saw the value of integrating both elements in their work with some students and clients often could not bring the discussion to the proverbial table with colleagues from either perspective.

Establishing language as the essence of being human in Chapter 1, *Language Deprivation Syndrome*, Dr. Gulati describes LDS in the deaf and hard of hearing population as a "devastating, permanent, and preventable disability" (p. 24), tantamount to a "human emergency." Due to

unintended harmful medical, educational, and social practices, inadequate access to a first language is the norm, occurring on a continuum, with LDS as characterized by incomplete neurodevelopment at its worst. He reviews the history of discussions in the professional literature evidencing this persistent phenomenon, once thought to attributable to being deaf, now understood as perpetuated by insufficient input during the critical period for language acquisition.

Dr. Gulati also explores bio-psycho-social variables that influence individual trajectories of language acquisition, risk for language deprivation, and amelioration of its effects. He then describes the clinical presentation of LDS, in milder and more severe iterations, with respect to language, cognition and learning, and behavioral health, explaining how clinicians lacking appropriate training misdiagnose, inappropriately medicate and ineffectively treat persons with LDS, and provides guidance for appropriate assessment and diagnostic protocol. With neurolinguistic research confirming that language deprivation impacts brain development, he emphasizes that even when deaf children seem to benefit from amplification technology, grammatical dysfluency, limited fund of information, and deficient development of theory of mind are indicators of language deprivation. He derides the practice of denying young deaf children language input by prohibiting the use of sign language both prior to and after cochlear implantation, especially while waiting to observe its effectiveness.

Finally, Dr. Gulati explains how visual as well as auditory language input can interchangeably stimulate language brain development. Language deprivation can interfere with attachment and the ability to form relationships and navigate interpersonal interactions, as well as increased vulnerability to abuse and experience of multiple types of trauma. As an appendix to Chapter 1, Neil Glickman discusses why LDS is often tied to asocial and aggressive behavior, which may lead to conduct issues and sometimes a DSM-5 diagnosis of “pervasive pattern of disregard for and violation of the rights of others.” He explores the complex issues of differential diagnosis and appropriate educational, clinical, and forensic interventions with this subset of the LDS population, a topic further examined in Chapter 4.

Chapter 2, *Pre-therapy with Deaf People with Language and Learning Challenges* by Neil Glickman, Wendy Heines, and Melissa Watson describes the process of effective clinical interventions with persons who do not have the fundamental language and cognitive abilities to present a coherent narrative, form a therapeutic alliance, and/or engage in introspection. Pre-therapy essentially teaches and coaches the fundamental communication strategies and skills needed to participate in cognitive-behavioral therapy. They explain that teachers, mental health clinicians, and interpreters have generally not been trained to work with this population. Central to this approach is a “one-down stance,” which conveys understanding, is not authoritarian, and prioritizes positive feedback. Pre-therapy involves breaking things down, paraphrasing, role-playing, asking simple questions, working together with clients to build their stories, and identifying, reinforcing, and building on their strengths. The chapter further discusses how pre-therapy strategies have been implemented at PAHrtners Deaf Services in the greater Philadelphia area.

In Chapter 3, *Developing Therapy Approaches for Deaf Clients Impacted by Language Deprivation*, Melissa L. Anderson and Kelly S. Wolf Craig build upon the principles outlined in

the previous chapter and address the adaptation of evidence-based interventions for use with Deaf clients, especially individuals affected by language deprivation. For clients who have experienced trauma and struggle with addiction, their multidisciplinary Deaf and hearing bilingual team developed *Signs of Safety*, a toolkit for use with a cognitive behavioral therapy (CBT) intervention program, *Seeking Safety*. Implementation of the toolkit is illuminated through case examples. However, the authors caution that the intervention may not be effective with those most severely impacted by language deprivation and encourage readers to consider working in alternative modalities to augment talk-focused therapy.

In Chapter 4, *Forensic Evaluation of Deaf Adults with Language Deprivation*, Robert Q. Pollard, Jr. and Meghan L. Fox address the prevalence of language deprivation among deaf individuals in criminal justice contexts, and the complex challenges in determining competency and fitness, and provide guidelines for selecting and adapting evaluation instruments, noting progress in creating ASL versions of existing instruments and new measures for signed administration. Pollard explains why he does not work with CDIs when doing forensic evaluations, but provides guidance to optimize effective collaboration between evaluators and interpreters. In this chapter and the following two chapters, linguistic variation among the deaf and hard of hearing population are recognized with different perspectives regarding spoken language and expressive language during language evaluations.

In Chapter 5, *Communication Skills Assessment for Individuals who Are Deaf in Mental Health Settings*, Roger C. Williams and Charlene J. Crump provide case examples illustrating how results of communication assessment can guide intervention in mental health contexts and note that assessment protocol must be sensitive to linguistic variation in the population and asymmetry in some clients' receptive and expressive language abilities, consider lived experiences, and assess communication across content and contexts. They propose stringent criteria for evaluator qualifications, emphasizing a team approach, in which at least one member is a native ASL signer; however, they note that even deaf "sign fluent clinicians" may not be able to communicate optimally with all clients.

Jonathan Henner, Jeanne Reis, and Robert Hoffmeister discuss in Chapter 6, *Using Standardized, Receptive ASL Assessments in Deaf Mental Health*, the history of language evaluation of deaf and hard of hearing people, and, maintain that test administration by nonnative signers may interfere with accurate assessment of expressive language. They propose that evaluations instead focus on receptive language: signed language phonological awareness, understanding of morphology, syntax, lexical abilities, and overall language proficiency. They discuss each of these components of ASL, and how available signed language assessments can be used to evaluate clients' capabilities in each area. They note that further work is needed to improve the sensitivity of these instruments to cultural and linguistic diversity within the deaf population.

Indeed, in Chapter 7, *Enhancing Communication Skills in Persons with Severe Language Deprivation: Lessons Learned from the Rise of a Signing Community in Nicaragua*, Romy V. Spitz and Judy Kegl describe the adult deaf population encountered in Nicaragua by their research team over 30 years ago: a markedly language-deprived, uneducated, largely isolated from one another people who were at best able to use idiosyncratic gestural communication

repertoires or home sign systems with their families. Schools were established, bringing deaf people of all ages together, and a community sign language evolved, with subsequent generations building upon existing input to create Nicaraguan Sign Language. The chapter describes *Gramaticas*, video clips developed for assessing and developing communication skills with late language learners and an intervention protocol that draws on their own stories. For late language learners, some aspects of language are more sensitive to critical period constraints than others, and the potential for improvement beyond that period varies. The intervention or habilitation process needs to be deliberate and structured, meeting individuals where they are, using scaffolding strategies, modeling increasing elaboration and detail, and coaching them in how to clarify their communication. Kegl and Spitz discuss how this approach, which aligns with the pre-therapy strategies described earlier in the book, can be applied in Deaf mental health.

Similarly, Joan Wattman addresses in Chapter 8, *Interpreting for Deaf People with Dysfluent Language in Forensic Settings: Application of the Integrated Model of Interpreting*, how language deprivation calls for specialized skills from interpreters. The integrated model of interpreting (IMI) involves consecutive, rather than simultaneous, interpretation, feedback, and monitoring, allowing the interpreting team (which likely includes a CDI) to employ strategies to help achieve understanding among parties. For example, the interpreters may need to parse information into smaller chunks, pause to check understanding or request clarification, use visual aids or engage in role play, and report, in third person, when their co-interpreter is clarifying or explaining something to the deaf client. At times the team may have to inform the legal team that they cannot achieve effective communication.

In Chapter 9, *Language Development in Children with Cochlear Implants Possibilities and Challenges*, Amy Szarkowski addresses optimizing early language access in young deaf children. She carefully discusses the research related to implantation outcomes and neural processing, and the critical period for first language acquisition, concluding that providing young implanted children with language access through both auditory and visual modalities reduces the potential risks of the sequelae associated with delayed full language access that are the subject of this book. A similar argument is made by Tawny Holmes in Chapter 10, *Current Laws Related to the Language Development of Deaf Children and Recommended Advocacy Strategies*. Holmes brings a dual perspective to the discussion as an attorney and education advocate. Through that lens, she revisits some of the key themes that weave through the book and provides a clear and informative analysis of how legislation can be utilized to ensure deaf children's early full bilingual language access. She discusses the role of deaf mentors working with hearing families and the Language Equality and Acquisition for Deaf Kids (LEAD-K) initiative, and outlines educational measures that offer promise in preventing language deprivation.

Overall Impressions

A core strength of *Language Deprivation and Deaf Mental Health* is its nuanced, comprehensive coverage of the topic through the cross-disciplinary contributions of a stellar intergenerational roster of deaf and hearing authors. The book provides an extensive and thorough review and synthesis of research from multiple fields of study and delineates research-to-practice implications, often structuring the discussion around case examples. Appended or linked

assessment instruments, sample reports, graphs, and tables further illuminate the challenges of definitive diagnosis and intervention with severe LDS.

The book argues for an inclusive approach, rather than making a case for signed language in opposition to spoken language or negating the benefits of hearing aids and cochlear implants. Noting that language is at the heart of what makes us human and thus affecting every aspect of development, the book often discusses the potential negative ramifications of barriers to language accessibility throughout the deaf and hard of hearing population, underscoring the benefits of sign language even for individuals for who are hard of hearing or users of spoken language in providing full access to information, learning, and socialization, important for the development and sustenance of the whole person. Importantly, there are discussions about cultural and linguistic diversity, the intersectional identities of deaf people, and the disparities in opportunities for deaf people of color, and considering a global context in discussing the dangers of language deprivation and what is needed to ameliorate it.

The book's greatest strengths, its interdisciplinary composition and wide reaching appeal, could also be potential weaknesses. Will those who most need to learn from this book—physicians, special education directors, or criminal justice administrators, to name just a few—read it? If they do read it, will they see how the chapters from different disciplines can be useful in their work? Will education and social work graduate programs and interpreter training programs select this text for their courses? It will be important to reach out to each of these fields individually. Similarly, benefits of the integration of theory and practice might be lost on some readers. Will researchers see how the case discussions and practice applications inform their work? Will teachers and parents read and understand the sections about neuroscience and linguistics?

Another challenge is the assessment material. Some materials are included in the book, but in other cases, the reader is directed to find assessments online or in previous works and refer to them while the protocol is discussed in the chapter. It likely would be useful to have a companion volume with expanded focus on assessment and intervention.

The conclusion of the final chapter in *Language Deprivation and Deaf Mental Health* is a rallying call for everyone to do their part to ensure fully accessible language access for deaf children from birth. Returning to the book's thesis, this access is critical to lifelong mental health and well-being.

Dr. Judy Mounty is a psychotherapist with over 40 years of interdisciplinary experience in education and human services. In 1996, she became the first deaf woman to hold the endowed Powrie Vaux Doctor Chair of Deaf Studies at Gallaudet University where she subsequently held administrative and research positions, taught courses in several departments, and was an intergroup dialogue facilitator until her retirement in May, 2018.

Before coming to Gallaudet, Dr. Mounty was a faculty member at what is now McDaniel College in Westminster, Maryland, taught at Boston University, and was a research scientist at Educational Testing Service. Earlier in her career, she was one of the first educators to implement a bilingual, multicultural perspective in programs for deaf students.

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