Operationalization and measurement of sign language

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We outline a number of fundamental issues in how sign language exposure and proficiency were operationalized and reported by Geers et al. Most importantly, the authors did not distinguish between those exposed to American Sign Language (ASL) versus English signing systems (e.g., signing exact English, sign-supported English, baby sign) when classifying children. This is a fatal flaw because, in contrast to artificial English signing systems, natural sign languages such as ASL are legitimate languages – as long-affirmed by the Linguistic Society of America – with all the cognitive benefits a natural language provides. The study is recklessly misleading because of this inappropriate conflation, especially given that the authors' conclusions will contribute to long-standing bias, resistance, and misperceptions against natural sign languages in clinical recommendations for deaf children.

Among other issues, there is not enough information provided about participants' sign language proficiency and exposure. At minimum, it is critical to know the number of children exposed to only ASL (as opposed to artificial signing systems), the age of first exposure to ASL, the number of ASL language models, and the ASL proficiency of parents and children. Effects of ‘sign language exposure’ may have been carried by participants who used an artificial signing system, received late exposure relative to the critical period of language acquisition, had only one ASL model, and families with limited-to-no ASL proficiency. The little information provided about sign language exposure was not collected using direct measurement; rather, it appears to have been measured using an unvalidated parental-report questionnaire. The criterion for positive indication of sign language exposure was – in our view – very low (> 10% of the time), and there was no rationale offered for why 10% is minimally-sufficient. It is possible that the sample in this study represents a straw man hypothesis; no one would argue that such language conditions are sufficient for a child to thrive.

ASL is typically used within a bilingual approach encouraging both natural sign language and spoken/written English acquisition, and should be evaluated as such. Because those children are emerging bilinguals, their combined proficiency in both ASL and English must be considered to draw any conclusions about ASL-based intervention efficacy. Further, because bilingual and monolingual language acquisition differs, bilingual signing children’s appropriate comparison group are other bilingual children and should not be compared to monolingual norms.

Although this study was designed to look narrowly at English-based outcomes, the authors over-interpret the results as evidence against the assertion that a natural sign language can be beneficial for deaf children. While English proficiency is certainly one route to success, it is not a necessary condition for it. The results of this study have no bearing on whether exposure to a natural sign language has any effect on the holistic well-being and health-related outcomes of deaf children, but they are dangerously framed and misinterpreted as such.
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References