

MY VOICE

The Power of Accommodations for Hearing Loss During and Beyond COVID-19

I was born hearing but grew up hard of hearing from the age of ten due to illness. I am profoundly hard of hearing, but I do not use sign language. Instead I heavily rely on lipreading and facial cues to communicate with hearing people. In the age of COVID-19, mask-wearing has taken away these tools as well as muffling the sound that my residual hearing might pick up and that I use in conjunction with other cues. In the beginning of the pandemic, face coverings were controversial, and there was reason to fear that mask-wearing increased the risk of racist violence. The Centers for Disease Control and Prevention's official recommendation for face coverings in early April 2020 alleviated this fear.

But the difficulty of communicating with others wearing face masks remained for me. Often, I have felt desperate and helpless, staring at the eyes of a person in a face mask, unable to understand what they are saying. Rising anti-Asian violence makes these moments terrifying. Once very independent and capable, I suddenly became dependent and incapable in many places, including grocery stores.

I got cochlear implant surgery right before the pandemic. I was able to see what accommodations might work for people like me in regular appointments with my Ear, Nose, and Throat (ENT) specialists in the subsequent months. The practice catered to hard of hearing people, and people in the ENT clinic started wearing clear face masks, which enabled me to read their lips and relieved me enormously. The small transparent panel window of the face mask allowed me to be fear-free and communicate independently with the people in the clinic. It was an example of how an accommodation could enable me to be just as independent as I used to be, and I wish that every grocery store had at least one cashier who wore one.

I have relied upon accommodations to be my fullest self since I became hard of hearing. As a former teacher educator, accommodations were critical to my teaching. As a bilateral hearing aids user at that time, I needed as much amplification as possible directly to my hearing aids to interact with over 20 students in a classroom. I taught in a particular classroom where three microphones were installed on the ceiling and a transmitter at the front table. These devices hooked and transferred students' voices directly and clearly to my hearing aids through a wireless streamer that I put on. Even so, I relied heavily on facial information. I asked students throughout the semester to keep their faces visible so that our conversations were less restricted. With these accommodations I have memories of vivid conversations with my students and a strong sense that I was making a difference in the eventual quality of their teaching.

But without reasonable accommodations, I experienced significant difficulties. When I was a graduate student and a research assistant, a member of the team asked me to take minutes in a meeting I attended. I told her about my hearing loss and explained that it was almost impossible for me to understand others and take notes on what was being said simultaneously. I would have limited chances to see a speaker's face while also writing notes. She was dismissive, saying, "You can do it." I felt like she thought I was lazy or insufficiently confident. I ended up seeking some note-taking help from a team member next to me. I wish I had asked if the meeting could be video recorded so that I could assemble notes as requested; today I would have.



Joo Young Hong

I hope that the clear face masks such as I experienced in my ENT clinic will become more prevalent. They are vital in K–12 settings for children with hearing loss and in all educational settings. This simple measure can allow hard of hearing students to fully participate in the classroom. Likewise masking has made amplifiers all the more valuable. Assistive listening devices and wireless microphones have provided significant technological solutions for many people with hearing loss. My research colleague’s reaction to my request during my graduate program should be eliminated. Indeed, educators themselves should become active advocates for their students with hearing loss; teaching advocacy skills to students will help equip them with independence as well as confidence at school and in life, allowing them to fully realize their potential, as I believe I have.

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The take-home message is that students who are deaf or hard of hearing are not a one-language-fits-all sort of population. The language used by students depends heavily on the language of the home, the best-fitting accommodations for school, and the peer group, who may be more linguistically diverse than the family (e.g., students may have deaf friends who use ASL, but no family members who are deaf).

Effects of Childhood Hearing Loss on Language and Literacy

When hearing loss occurs at birth or within the critical period of language development (approximately the first 3 years of life), significant delay in language acquisition can occur for several reasons. Typically developing babies’ brains are particularly sensitive to auditory information, especially speech. Babies listen to the steady speech in their environments and “collect data” like little scientists about all of the interesting differences between sounds in words (Saffran & Kirkham, 2018). These databases of spoken language continue to get larger and more complex as the listening experience of babies increases. By the time babies reach their 1st birthday, they have heard millions of words and are ready to start producing some of these wonderful words themselves.

By contrast, the brain of a deaf or hard of hearing baby has fewer opportunities for listening (e.g., reduced quantity—the baby cannot hear as much or possibly any speech information). Even when these listening opportunities do exist, they are typically of poor quality (e.g., sensorineural hearing loss means that the speech sounds are distorted because of the ear’s anatomy). Accordingly, students who are deaf or hard of hearing often have delayed spoken language compared to hearing students, especially in the areas of vocabulary and syntax (Antia et al., 2020).

You might wonder whether providing a visual-spatial language (like ASL) is the solution when listening opportunities are either not available or of poor quality. For those children who are exposed to fluent ASL from birth, indeed there are no lost opportunities for language learning. Children with hearing loss whose parents use high-quality visual language meet all linguistic milestones on time (Meier, 2016). However, relatively few deaf children are born to families who are fluent in ASL. Even if caregivers begin learning ASL as soon as they learn about their child’s hearing loss, they struggle to acquire fluency in time for their child to be exposed to a fluent model during the most critical language-learning months. For this reason, early interventionists typically recommend that families immerse a child in their most fluent language (often spoken), even while learning an additional language (such as ASL). The bottom line is this: Babies must be exposed to language—either via listening to spoken language or watching native signers use ASL—in order to learn new words, learn word order, and be able to communicate with other people.

In general, the more hearing a child has for a longer period, the less the language delay. For example, students who are born with typical hearing and who contract meningitis as a toddler, resulting in profound deafness, should be expected to have less language