Position Statement: American Sign Language (ASL)

Ad Hoc Committee to Develop a Position Statement on American Sign Language (ASL)

About This Document: This position statement is an official policy of the American Speech-Language-Hearing Association (ASHA). The position was developed by the ASHA Ad Hoc Committee to Develop a Position Statement on American Sign Language (ASL): James Mahshie, chair; Katie Brennan; Tina Childress; Cheryl DeConde Johnson; Brenda Seal; Aaron Shield; and Adena Dacy, ex officio. Marie Ireland, Vice President for Speech-Language Pathology Practice (2018–2020) served as the Board of Directors liaison.

The request to draft this statement was based in part on inconsistencies among federal agencies about whether ASL is a distinct language. The United States Department of Education’s (ED) guidance letter to state administrators of Title III programs prohibits administration of funds for language services for students whose primary language is ASL because ED does not recognize ASL as a native language distinctly different from English (U.S. Department of Education, 2011). However, the National Institute of Health’s National Institute on Deafness and Other Communication Disorders (NIDCD) and National Science Foundation (NSF) identify ASL as a complete, non-English language associated with its own culture (NIDCD, 2019; NSF, 2019).

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Position Statement: American Sign Language (ASL)

It is the position of the American Speech-Language-Hearing Association (ASHA) that American Sign Language (ASL) is a complete language, possessing similar levels of language organization found in spoken languages, including phonology, morphology, semantics, syntactic structure, and discourse and pragmatic rules. ASL is a naturally occurring visual–gestural language with an associated culture. It is distinct from other signed languages around the world and from spoken English. ASL also differs from invented sign systems (e.g., Signing Exact English) and approaches (e.g., simultaneous communication, cued speech) designed to support spoken language.

Rationale

Introduction

ASL has existed in the United States and parts of Canada for more than 200 years. ASL signs are composed of purposeful handshapes, locations, orientations, and movements combined with facial expressions and body postures. ASL users\(^1\) are historically and culturally identified by this shared language that is acquired naturally through interactions with other ASL users. ASL linguistics has evolved as an independent research discipline, with graduate courses and doctoral studies in universities throughout the United States and abroad. Support for research on ASL continues to be provided by the NIDCD and the NSF.

Historical Background


\(^1\)ASL is used for face-to-face communication by individuals who are d/Deaf, hard of hearing, DeafBlind (d/D/HH/DB), and hearing (e.g., Children of Deaf Adults [CODAs], teachers of the deaf and other service providers). For purposes of this document, we refer to this collective community as “ASL users.”
Neurobiological Equivalence of Signed and Spoken Languages

ASL has the essential hallmarks and characteristics of naturally occurring spoken languages (ASHA, 1982; Klima & Bellugi, 1979; Stokoe, 1960; Stokoe, Armstrong, Karchmer, & Van Cleve, 2002; Valli, Lucas, Mulrooney, & Rankin, 2011). For example, deaf babies acquiring ASL will babble with their hands before producing first signs similar to vocal babbling in hearing infants prior to first words (Petitto & Marentette, 1991). Babies acquiring ASL from ASL users reach language milestones on the same trajectory as hearing children acquiring spoken languages (Anderson & Reilly, 2002; Emmorey, 2002; Meier & Newport, 1990; Newport & Meier, 1985). Moreover, the “critical period” of language acquisition also applies to ASL, such that late learners do not attain the same degree of fluency as early-exposed signers (Mayberry & Eichen, 1991; Newport, 1990). The language centers of the brain involved in the comprehension and production of ASL and other signed languages are also implicated in the comprehension and production of spoken languages (Campbell, MacSweeney, & Waters, 2008).

Autonomy of the Linguistic System

ASL is distinct from English and from invented sign systems, such as Signing Exact English (Pfetzing, Zawolkow, & Gustason, 1972). ASL possesses its own rules of phonology (Brentari, 1992; Sandler, 1989; Stokoe, Casterline, & Craneberg, 1976), syntax (Aarons, 1994; Chen Pichler, 2002; Liddell, 1980; Neidle, Kegl, MacLaughlin, Bahan, & Lee, 2000) and morphology (Aronoff, Meir, & Sandler, 2000, 2005; Bahan, 1996; Padden, 1988), which differ in significant ways from English. ASL also has conventions for formal and informal communication, as well as pragmatic rules for turn-taking, initiating, maintaining and changing communication topics (Holcomb, 2013; Mindess, 2014; Wilbur, 2006; Wilbur & Petitto, 1983).

ASL is not a translation of English, nor is it derived from English. ASL users may offer vocal sounds and speech movements that correspond to spoken English, but individuals cannot communicate in both ASL and spoken English at the same time. Signed languages also differ throughout the world. ASL is not mutually intelligible with the signed languages of other English-speaking countries such as the United Kingdom and Australia, which have their own unrelated signed languages (Johnson & Schembri, 2007).
ASL and English

ASL and English exist in a situation of language contact. Because English is widely spoken and written throughout the United States, and individuals who are d/D/HH/DB are typically educated to read and write English, many words from English that do not yet have a corresponding ASL sign have made their way into the ASL lexicon via fingerspelling, a system of handshapes and movements representing the English alphabet (Battison, 1978; Emmorey & Petrich, 2011; Keane & Brentari, 2016). Similarly, some signs show the influence of English through the use of handshapes that also represent the English alphabet (e.g., “initialized” signs; Akamatsu & Stewart, 1989; Brentari & Padden, 2001). However, the core lexicon of ASL is independent from that of English, and fingerspelled words appear relatively infrequently compared with non-fingerspelled signs (Padden, 1991). Individuals who use both ASL and written and/or spoken English are referred to as “bimodal bilingual” (Emmorey, Borinstein, Thompson, & Gollan, 2008).

Because a written language like English is not an orthographic code for a signed language like ASL, many children who are d/D/HH/DB must learn to read and write English like non-native speakers who learn to read and write English as a second language. Learning both English and ASL requires specialized knowledge and skills from professionals trained in ASL. These professionals include but are not limited to bilingual (ASL and English) audiologists and speech-language pathologists as well as teachers of the d/D/HH/DB and interpreters.

Research and Teaching of ASL

A relatively young but growing literature exists on ASL linguistics and ASL users, with periodicals that are both dedicated only to sign language (e.g., Sign Language Studies, Sign Language & Linguistics, Journal of Deaf Education and Deaf Studies) and periodicals that publish to a broader readership (e.g., Science, Journal of Applied Psycholinguistics, Journal of Child Language, Brain and Language, Language and Cognition). Similarly, many federal agencies (e.g., NIDCD, NSF, Office of Special Education Resources) support research on the linguistics of ASL and ASL users. Research by Looney and Lusin (2018) indicated that ASL was the third most studied “foreign” language in the United States (after Spanish and French), with increasing numbers of students enrolling in college ASL courses. Moreover, ASL was the fastest growing foreign language in terms of college enrollment, with a 34% increase over a 10-year period, whereas overall foreign language enrollment declined by 10%.
Conclusion

Because ASL and English are separate languages with distinct histories, because ASL is influenced by but not derived from English, and because most d/D/HH/DB children are born to hearing parents who use spoken language in the home, exposure to both ASL and English requires specialized knowledge and skills from professionals trained in ASL and Deaf culture. These professionals include but are not limited to bilingual teachers of the d/D/HH/DB, audiologists, and speech-language pathologists.

ASHA members serving individuals who are d/D/HH/DB promote early acquisition of linguistic skills and development of communicative competence using modalities, languages, and strategies that are most fitting for those individuals and their families (ASHA, 2004a, 2004b, 2008, 2013). Audiologists and speech-language pathologists who are proficient in ASL provide direct assessment and intervention for ASL users to ensure a strong language foundation for future learning. Those who are not bilingual in ASL and English collaborate with interpreters to serve those who use ASL (ASHA, n.d.). Recognizing ASL as a language supports the work of these professionals.

References


